New York State
Office of the Medicaid Inspector General

2010 Annual Report

Andrew M. Cuomo
Governor

James C. Cox
Acting Medicaid Inspector General

STATE OF NEW YORK

OFFICE OF THE MEDICAID INSPECTOR GENERAL

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Enclosed herewith is the 2010 Annual Report for the Office of the Medicaid Inspector General (OMIG). The report, required pursuant to Public Health Law §35, provides information about the work of OMIG and other Executive agencies in promoting the integrity of the Medicaid program during the preceding calendar year.

With your support, and the cooperation of our agency partners, OMIG will continue to work diligently in identifying and preventing fraud, waste, and abuse in the Medicaid program, and promoting program integrity through provider education, cost avoidance, data mining, and other compliance activities.

Sincerely,

James C. Cox

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Acting Medicaid Inspector General

Executive Summary

In 2010, New York achieved significant results in several areas of Medicaid program integrity. Some of the highlights include:

- **Assisting Providers with Compliance Issues –** In 2010, the OMIG created the Bureau of Compliance. The Bureau's responsibilities focus on monitoring and assessing providers' success in meeting their mandatory compliance obligations; providing outreach to providers on their compliance obligations; providing opinions and preparing guidance through issuance of Compliance Alerts and other publications and forms for providers; and negotiating and enforcing Corporate Integrity Agreements.

- **Conducting Provider Education –** OMIG held five webinars during 2010 with more than 4,000 registrants. OMIG also improved its outreach and coordination with providers regarding changes in federal health care law, self disclosure requirements and procedures, and mandatory compliance program obligations.

- **Posting Audit Protocols –** OMIG was the first program integrity agency in the United States to post its protocols. This was done at the request of the provider community.

- **Referring 110 Fraud Cases to Law Enforcement –** OMIG referred 110 cases to the New York State Attorney General for potential criminal prosecution.

- **Collaborating with other State and Federal Agencies –** OMIG worked with the State Attorney General's Medicaid Fraud Control Unit and other state and federal agencies on the Medicare Fraud Strike Force led by the United States Department of Justice. The work led to 21 arrests, 16 complaints and 20 indictments of individuals alleged to have committed health care fraud against the Medicare and/or Medicaid programs. This work also lead to major improvements in coordination with Executive agency partners.

- **Returning Medicaid Funds to Counties –** In 2010, OMIG issued its first round of recovery checks to participants in its County Demonstration Program.

- **Referring Fraudulent or Abusive Recipients to Local Government for Prosecution or Restriction –** OMIG referred 1,957 cases to local agencies for further action.

- **Avoiding Almost $2 Billion in Costs** – OMIG succeeded in avoiding costs of $1.9 billion through various initiatives, including the restricted recipient program, pre-payment reviews and use of card swipe terminals at points of service. Full cost savings can be found in the Appendix of this report.

- **Recovering Over $450 Million in Inappropriate Payments –** Approximately $454 million in improper Medicaid payments were recovered as a result of OMIG's program integrity activities.

- **Ending Program Participation for 939 Providers who Placed Recipients or the Program at Risk –** OMIG excluded 861 providers from participating in the Medicaid program and terminated 78.

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Table of Contents

Office of the Medicaid Inspector General

The mission of the Office of the Medicaid Inspector General (OMIG) is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care. As part of this mission, OMIG is responsible for educating providers while also coordinating fraud and abuse control activities with the Department of Health, the Office of Mental Health, the Office for Persons With Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, the Commission on Quality of Care and Advocacy for Persons with Disabilities, the State Education Department, the Medicaid fiscal agent, and local and county governments and entities. OMIG also works with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the New York State Comptroller, federal prosecutors, local district attorneys, the Welfare Inspector General, and the special investigative units maintained by each health insurer operating within the state.

In 2010, program integrity as a field moved further away from the "pay and chase" model to look more closely at both cost avoidance and provider compliance. In order to improve its operations, OMIG premiered several signature initiatives in 2010 focused on program integrity from these perspectives.

Executive Initiatives

Provider Education, Outreach and Webinars

On June 8, 2010, the OMIG began a series of webinars, the first of which attracted more than 1,000 registrants. The inaugural webinar focused on "Addressing Excluded Persons in Medicaid Employment and Contracting in New York."

Other presentations during 2010 included:

- July 13: "Mandatory Reporting of Medicaid Overpayments Under the Obama Health Program" (The Patient Protection and Affordable Care Act)
- September 14: "Self-Disclosures by Medicaid Providers"
- October 20: "Third-Party Payer Obligations: Medicaid Third-Party Billing, Payment and Enforcement"
- November 17: "Evaluating Effectiveness of Compliance Programs"

The five webinars held during 2010 averaged more than 800 registrants per session. OMIG webinars help the agency to fulfill statutory obligations under Public Health Law § 32 "[t]o conduct educational program for medical assistance providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program."

Webinar participants are able to e-mail questions to OMIG, which posts answers on its website. All webinars are posted on the Web site for later listening and viewing of the presentation.

OMIG will continue to present webinars in 2011 and beyond, scheduling one per month based on topics that are of interest to providers and other constituent audiences. OMIG seeks provider feedback after each session, as well as suggestions for future topics.

Provider Self Disclosures

OMIG is responsible for the statewide mandatory self-disclosure process for all Medicaid providers, regardless of the type of service made available to beneficiaries. OMIG conducts active outreach with various provider associations, professional societies, other state agencies and the New York State Bar Association to encourage providers to disclose internal issues of fraud, waste, abuse and billing errors which providers have self-identified.

OMIG's disclosure process outlines the steps a provider should follow to identify the reason(s) for the disclosure, the financial impact to the Medicaid program and the corrective measures implemented to prevent the reoccurrence of the error. To ensure the parameters of the disclosure are true and correct, each claim's data was analyzed , its medical and/or billing records were reviewed and financial data assessed. If the provider contracts with an outside consultant to perform an internal review, it is required that the disclosure include an engagement letter, a description of the methodology used to examine the provider's records, the sampling technique used to extrapolate findings and overpayments to include a universe of payments as well as the sample cases, and a description of the documents reviewed.

In 2010 there was a large increase in the number of self-disclosures submitted to the OMIG. OMIG received 227 self-disclosures, of which 179 were finalized with findings of $28,695,843 and recoveries of $13,441,184. OMIG anticipates that self-disclosures will continue to increase due to provisions of the federal Affordable Care Act which requires providers to report, repay and explain billing/claiming errors within 60 days of identification. To encourage self-disclosures, OMIG waives the interest on any self-disclosed identified overpayments repaid within two years.

Provider Compliance Programs

During 2010, OMIG expanded its outreach, training and guidance regarding the mandatory requirement for providers to maintain a compliance program. The compliance program sought to have continued collaboration with the provider community in order to promote greater program integrity on the front end of the Medicaid program.

OMIG has been involved in information sharing and collaboration initiatives with the Center for Medicare and Medicaid Services (CMS). The focus of this collaboration has been on New York's Medicaid and CMS's Medicare compliance initiatives to assist both agencies' compliance oversight obligations. CMS has adopted OMIG's Self Assessment Tool

(published on OMIG's website as Compliance Alert 2010-02) as the basis for CMS's self assessment tool for Medicare providers. Best practices in oversight are continually being discussed.

Innovative Data Mining Capabilities

A cornerstone of OMIG's strategy to detect and prevent fraud, waste, and abuse in the Medicaid program is to avoid costs by detecting behaviors, controlling point of service transactions and determining which claims to select for review. This is accomplished by effective data mining. In 2010, OMIG began using Salient's Medicaid MuniMinder data analysis tool. This tool allows OMIG to improve targeting methods used to further fraud detection and analysis. Some of the results highlighted in this report were the result of using of this new tool.

Compliance Activities

Providers are required to have and maintain reasonably effective compliance programs must annually certify the effectiveness of their compliance programs. OMIG actively oversees providers' performance through the certification obligation and use of computer databases and direct outreach to providers who appear to have failed to meet the annual certification requirement. In 2010, OMIG commenced onsite Effectiveness Reviews of providers' compliance programs with the following goals:

- to determine if specific providers are satisfying the mandatory compliance program requirement;
- to identify best practices in compliance that can be shared with other Medicaid providers;
- to recommend enhancements to providers' compliance programs where appropriate; and
- to provide the results of the Effectiveness Reviews to other appropriate New York State agencies with responsibility for program oversight of the provider.

Effectiveness Reviews

In 2010, four day long effectiveness reviews were completed with determinations being made that three providers had reasonably effective compliance programs and a fourth provider's compliance program was not reasonably effective. A period of time was granted to the fourth provider in order to address the insufficiencies noted and a follow-up effectiveness review was scheduled for 2011.

Credential Verification Reviews

In 2010, OMIG staff participated in a credential verification review (CVR) of high ordering physicians. Providers with non-existent or insufficient compliance programs were given an opportunity to implement reasonably effective compliance programs. As a result, some providers now satisfy the mandatory compliance requirement while the one that do not will be referred for proposed agency action. Similar collaboration opportunities will be pursued into 2011.

Corporate Integrity Agreements

In 2010, OMIG imposed Corporate Integrity Agreements (CIAs) on a dental provider and a physician who failed to meet their compliance obligations but whose removal from the Medicaid program would negatively impact access to necessary services. Under a CIA, a provider consents to implement specific compliance structures, processes and activities aimed at building integrity on the front end of providing and billing for care, services or supplies. Most CIAs include a provision requiring the provider to engage an independent review organization responsible for monitoring provider compliance with the provisions of the CIA. Providers that breach their CIA obligations face sanctions in the form of stipulated penalties and/or exclusion from the Medicaid program.

Compliance Alerts

In 2010, OMIG created a new web site section devoted to Compliance Alerts. Compliance Alerts focus on best practices in Medicaid compliance. This improvement will assist providers in formulating and implementing effective compliance programs.

Outreach and Educational Activities

OMIG debuted several new features to its website in 2010 designed to improve program integrity, provider compliance and information accessibility. These improvements are highlighted below.

Posting of Audit Protocols

In 2010, the OMIG began posting audit protocols to its website. The posts included audit protocols for ambulette, taxi, livery and personal care services. Additional protocols will be posted as they become available.

Webinars and Other Information

As mentioned earlier, OMIG held a series of webinars which covered topics of importance to Medicaid providers. Along with this, OMIG also began sharing slide decks from public presentations and other prepared remarks, including those given to health provider associations, bar associations, health policy experts and universities, for other members of the provider community.

OMIG Works

The OMIG added a new section, "OMIG Works," to its Web site in 2010. This feature allows users to learn about OMIG initiatives and hopefully spotlight provider practices that can be improved.

In addition to improving its website, OMIG also strengthened its provider education, outreach and coordination with other agencies. Listed below are a few of the new opportunities which OMIG pursued.

Face-To-Face Visits

OMIG used field investigators to inspect facilities and improve provider education. In some instances, investigators conducting face-to-face visits noted irregularities that warranted a written notification in the form of a warning letter. The provider receiving the warning letter is notified that he/she has violated a State regulation and OMIG expects that the circumstances of the violation will be remedied. Investigators revisit the provider to confirm that the specified change occurred. Warning letters have had a measurable direct effect on future provider activity, as well as an indirect effect on others in the provider community. During any visit where there were no findings, providers were given information about compliance plans, self-disclosure instructions, and other OMIG initiatives.

Interagency Workgroup

The Interagency Workgroup coordinates the Medicaid fraud, waste, and abuse control activities of the state agencies with direct roles in administering the Medicaid program. In addition to the OMIG, the workgroup is comprised of staff from the:

- Office of Alcoholism and Substance Abuse Services
- Office for People With Developmental Disabilities
- Office of Mental Health
- Office of Children and Family Services
- Office of Temporary and Disability Assistance
- Department of Health Commission on Quality of Care and Advocacy for Persons with Disabilities.

Representatives from those agencies meet to address issues, coordinate plans, and foster the communication necessary to monitor program integrity and administer the Medicaid program. In 2010, OMIG started a series of monthly meetings with participants to foster more effective issue management and resolution. Activities included:

- Affordable Care Act guidance and implementation
- Clarification of OMIG audit protocols
- OMIG's self-disclosure program and protocols
- Compliance and State Corporate Integrity Agreements (CIAs)

In 2010, OMIG had one-on-one meetings with Interagency Work Group members to improve understanding between individual agency objectives, issues and concerns. OMIG expects that this work will improve interagency processes.

Investigative Activities

OMIG uses an investigative review process to detect and deter potential instances of fraud, waste, and abuse in the Medicaid program. These activities deter improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billings and services, and cooperating with other agencies to enhance enforcement opportunities.

Cases involving providers conducting suspected illegal activities are forwarded to the New York State Deputy Attorney General for Medicaid Fraud Control (MFCU), the United States Attorney, or local district attorneys for civil or criminal prosecutions. If convicted, these providers and recipients may face confinement and/or restitution.

Enrollment and Reinstatement Investigations

Enrollment and reinstatement investigations screen providers to enhance quality and regulatory compliance in the Medicaid program. In 2010 these investigations identified unqualified, fraudulent or abusive practitioners, as well as those providers whose lack of quality of care would present a danger to Medicaid recipients. Based on these investigations, OMIG denied enrollment or reinstatement to those parties. OMIG initiated reviews of dental groups and pharmacies seeking enrollment in the Medicaid program, as well as reviewing currently enrolled providers requesting to expand the services they currently offer to begin providing footwear services. On-site inspections were conducted of all entities seeking enrollment within this expanded service area. Reviews of ownership changes of rate-based providers, and checks for individuals listed on applications that may have been sanctioned were also conducted.

Dental Investigations

Dental investigations utilize clinical and forensic investigators to review and evaluate dental services provided to Medicaid recipients. Pre-payment review, a front-end detection system that identifies aberrant billing patterns, was used to suspend payments before they were made. In 2010, dental investigations resulted in the exclusion of six Medicaid providers, the issuance of 15 warning letters to providers, the review of 10,000 claims to ensure services were appropriate and in compliance with the current standards of professional care and the denial of over $1.1 million in payments for claims that violated program rules and/or regulations.

Pharmacy Investigations

Pharmacy investigations identify, prevent, and deter pharmacy and prescription medication fraud and abuse leading to significant savings for the New York State Medicaid program. Pharmacy investigations identify kickback schemes, false claims, and quality of care issues.

Clinical expertise is utilized to investigate quality of care issues such as inappropriate drug therapy. Pharmacy investigations also review early refills, black box medications (those medications that have a black warning box indicating the potential for severe side effects and suggesting caution when using) and off-label use of prescriptions. OMIG investigators identify aberrant pharmacy and prescription practices. These practices include billing for services not rendered, inaccurate data submissions on claims, duplicate billings, rendering unnecessary services, unlicensed or excluded providers rendering services, as well as quality-of-care issues. OMIG pharmacy investigative initiatives in 2010 are outlined below.

Narcotic Diversion Initiative

In 2010, OMIG commenced a narcotic diversion initiative. Prescribers and recipients were analyzed for patterns of prescribing high doses of opiate narcotics, "cocktail" prescribing (opiates, anxiolytics, and muscle relaxants), and recipients traveling significant distance to fill a narcotic prescription and cash payments by recipients for narcotics. OMIG also reviewed the number and type of drug utilization review overrides by pharmacies for narcotic prescriptions.

One prescriber was referred to the High Intensity Drug Trafficking Areas (HIDTA) Task Force in New York City and is currently under joint investigation by several agencies, both federal and State, including OMIG.

There is a drug abuse migration occurring from Oxycontin (extended release oxycodone) to oxycodone IR (immediate release) formulation. This is the result of the new formulation of Oxycontin which is intended to reduce abuse. OMIG identified an aberrant prescriber who was facilitating Oxycodone abuse. OMIG also identified several recipients traveling unnecessarily long distances to have Oxycodone prescriptions filled.

Immediate Exclusion – Imminent Danger

OMIG followed up on an anonymous tip that a pharmacy in Brooklyn was operating without a pharmacist on duty. OMIG initiated an investigation into this allegation. OMIG found no pharmacist was present at the time of the investigation. There were also misbranded adulterated medications in the pharmacy area. The pharmacy was storing prescription drugs for non-clients, which had the labels of other pharmacies, and there were medications without any labels. The store was closed by the investigators from the State Education Department Office of Professional Conduct and all questionable drug products were seized. Despite these actions, the pharmacy continued to operate. OMIG issued an immediate exclusion of this provider because the health and/or welfare of Medicaid recipients was imminently endangered by the pharmacy's continued participation in the Medicaid program.

Recipient Investigations

In cases where Medicaid funded care and services are may be duplicative, excessive, or contraindicated, targeted recipients' information is thoroughly reviewed by a team of

physicians, nurses and pharmacists. Follow-up actions may restrict a recipient to one primary care provider. Local districts implement the restrictions to primary providers.
In 2010, OMIG conducted 5,864 reviews leading to an average of 9,022 recipients restricted. These restrictions resulted in improved quality of care for recipients and a cost savings in excess of $150 million; additionally, 1,099 identified forgeries were evaluated and processed for referral to either law enforcement or the local districts, a significant increase from the 683 in 2009. Recipient eligibility related cases rose to 781 in 2010, up from 405 in 2009.

In addition to restricting recipient activity, OMIG conducted numerous recipient investigations. For example, OMIG conducted a seven month joint investigation with the Orange County Department of Social Services and the New York State Department of Taxation and Finance. The investigation concluded with an Orange County Medicaid recipient pleading guilty to Welfare Fraud in the Fourth Degree and Criminal Tax Fraud in the Fourth Degree, both class E felonies, for failing to report income and receiving over $20,000 in incorrectly paid Medicaid benefits.

OMIG also worked on the Drug Enforcement Agency (DEA) Tactical Diversion Squad (TDS) located at the DEA Albany District Office. OMIG actively participated in several prescription drug diversion cases resulting in 10 felony narcotic related arrests. OMIG investigators conducted undercover surveillance and added valuable data to investigations including up-to-date pharmacy and drug information.

Referrals to AG and Other Agencies

OMIG refers suspected fraud or criminality to the Attorney General's Medicaid Fraud Control Unit (MFCU) for possible criminal prosecution. In 2010, preliminary findings from OMIG investigations led to 110 referrals to MFCU. While the majority of these referrals involved Medicaid providers, OMIG also referred 21 non-enrolled providers. In 2010, OMIG excluded 229 individuals and entities from the Medicaid program as a direct result of MFCU prosecutorial activity.

OMIG also works in close collaboration with the New York City Human Resources Administration Bureau of Client Fraud Investigation and 57 other Local Departments of Social Services (LDSS) to encourage recipient compliance. In 2010, 1,501 cases were referred to HRA and 365 cases were referred to other LDSS for appropriate action.

OMIG shares its findings with agencies such as the State Education Department's Office of Professional Discipline, the Department of Health's Office of Professional Medical Conduct and law enforcement agencies. In 2010, a total of 91 cases were referred to these other agencies.

Federal Health Care Strike Force

During 2010, OMIG's participation with the Department of Justice's (DOJ) Medicare Fraud Strike Force led to 21 arrests, 16 complaints, and 20 indictments of individuals alleged to

have committed health care fraud against the Medicare and/or Medicaid programs. Several of the defendants subsequently pleaded guilty to health care fraud charges for their role in schemes to defraud the programs.

Amongst other investigative activities, OMIG's participation included conducting interviews, analyzing documents, surveillance, translating, and assisting on searches and seizures. Additionally, OMIG conducted various undercover operations to assist the DOJ Medicare Fraud Strike Force in furthering several of its cases. Significant cases included those highlighted below.

- On March 24, 2010, the Brooklyn United States Attorney's Office filed two separate criminal complaints, charging four Medicare/Medicaid providers for their alleged involvement in health care fraud schemes in the Eastern District of New York. Three podiatrists and a pharmacy owner were arrested and charged with allegedly billing for treatment and/or items that were allegedly not provided to Medicare beneficiaries. Based on this conviction, the owner of the downstate pharmacy, who was also a Medicaid provider, was excluded from participation in Medicaid by OMIG on May 12, 2010. Both provider entities billed more than $90,000 in connection with these fraudulent claims.

- Several individuals, including a number of dual-eligible Medicaid-Medicare recipients, were arrested for participation in a kickback and fraudulent billing scheme perpetrated at a downstate therapy center. The scheme involved the fraudulent billing of physical and occupational therapies.

- Three individuals affiliated with a home service agency were arrested for their participation in a $3.5 million scheme to defraud the Medicaid and Medicare programs by submitting fraudulent claims for Durable Medical Equipment (DME).

- Two individuals affiliated with a Medicare and Medicaid medical supply provider were arrested for submitting fraudulent claims for orthopedic shoe inserts.

- Lastly, a podiatric provider was indicted on a health care fraud charges for a scheme involving the submission of fraudulent chemical cauterization service claims.

Federal Health Care Fraud Task Force in New York City

OMIG participates in the FBI Health Care Fraud Task Force. OMIG has provided Medicaid related record searches, made undercover investigators available, and provided Spanish, Russian, Armenian and Chinese speaking staff members to assist translators for on-going investigations.

In 2010, OMIG's participation in the Health Care Fraud Task Force resulted in the arrest of a physician in New York City. The physician, a Medicaid provider, was arrested and charged with distributing approximately 11,000 Oxycodone pills purchased with nearly $1,000,000 in

funds procured fraudulently from the Medicaid program. The scheme was perpetuated by the physician, who provided unnecessary prescriptions for Oxycontin to patients, and then diverted the drugs by buying them back and offering them for sale.

Drug Enforcement Agency Task Force

OMIG continues its working relationship with the Drug Enforcement Agency's (DEA) Office of Diversion Control (ODC). The ODC consists of diversion investigators, special agents, chemists, pharmacologists, and program analysts including OMIG Senior Investigators working with the DEA Task Force's New York Tactical Diversion Squad (NYTDS). The primary mission of NYTDS is to investigate and combat the diversion of controlled pharmaceuticals and chemicals.

In 2010, OMIG actively participated as part of the Albany District Office of the DEA resulting in 10 felony arrests. OMIG assisted by identifying Medicaid fraud suspects and criminal prescription drug diversion, conducting undercover surveillance, and added valuable data to investigations including up to date pharmacy and drug information. In some cases, recipients lead to prescribers.

Joint Investigation Leads to Recovery of $443,505 in Restitution from Pharmacy Fraud

On April 20, 2010, Deputy United States Attorney Boyd Johnson presented OMIG with a check for $443,505 stemming from a restitution agreement in the case against a Brooklyn physician. Deputy United States Attorney Johnson publicly lauded OMIG investigators for their contributions to the investigation. The physician was indicted on charges of paying cash kickbacks to Medicaid recipients in exchange for using his services. He then directed these recipients to fill their prescriptions at pharmacies owned by his family members, where their prescriptions were filled with lower priced, diverted and black market medications. Medicaid was also billed over a million dollars for medications never dispensed. A joint investigation between the Federal Bureau of Investigation, OMIG and NYC HRA led to the arrests and conviction of these three corrupt providers.

Pharmacy Provider Excluded and $1.8 million in Restitution to the Medicaid Program Determined

A joint investigation between OMIG, the New York City Police Department, the New York City Human Resources Administration, and the New York County District Attorney's Office resulted in a Supervising Pharmacist being excluded from Medicaid based on an indictment alleging Grand Larceny in the Third Degree, Falsifying Business Records in the First Degree, Criminal Diversion of Prescriptions in the Third and Fourth Degrees, and Health Care Fraud in the Third Degree. This indictment alleged that cash payments were made to recipients in exchange for unfilled prescriptions for medications that were subsequently billed to Medicaid. In five instances, the Supervising Pharmacist allegedly paid cash to undercover investigators for their prescriptions. OMIG investigators conducted undercover investigations

at the pharmacy, and OMIG investigators and pharmacists were on site for the search warrant and arrest of the supervising pharmacist conducted on March 18, 2010.

OMIG investigators also conducted an inventory audit of pharmacy records which revealed that 65.75% of the paid Medicaid claims submitted by the pharmacy could not be supported by purchase orders from wholesalers.

After several follow-up visits by OMIG investigators and investigators from the New York State Education Department, OMIG issued a final Notice of Agency Action to the pharmacy, its owner, and the Supervising Pharmacist. OMIG determined to exclude the owner, the supervising pharmacist and the pharmacy from the Medicaid program and to seek restitution in the amount of $1,836,847. Additional restitution of $784,588 was sought based on the findings during follow up visits.

Summary of Financial Investigative Activities and Referrals

Investigations are opened and closed by OMIG and a number of these investigations may result in monetary penalties and restitutions. Below is a summary of those investigations which have related monetary findings.

Number of Reports	Penalties	Recoveries
6	$ 3,525,388	$ 3,608,204

OMIG investigations often result in referrals to other entities. OMIG refers preliminary findings to many different agencies. The first table below shows referrals made to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for 2010. The second table shows investigative referrals made to outside agencies other than MFCU.

Provider Type	2010
Capitation Provider	1
Clinical Psychologist	2
Dental Groups	1
Dentist	9
Diagnostic & Treatment Center.	4
Home Health Agency	6
Hospital	1
Long Term Care Facility	4
Medical Appliance Dealer	2
Multi-Type	1
Non-Enrolled Provider	21
Nurse	6
Optician	10
Optometrist	1
Pharmacy	22
Physician	6
Physicians Group	2
Podiatrist	1
Service Bureau	1
Therapist	1
Transportation	8
Total	**110**

Agency	2010
Commission on Quality of Care	2
Department of Justice	31
Health and Human Services (HHS-OIG)	3
Law Enforcement Agency	18
Local District Attorney	1
Local District Social Services	365
NYC HRA Bureau of Client Fraud Investigations	1,501
Off. for People with Developmental Disabilities	1
Off. of Prof. Discipline	12
Off. of Prof. Med. Conduct	4
Other DOH Unit (not OMIG)	5
Other Federal Agency	7
Other State Agency	7
Total	**1,957**

Audit Activities

Audits and reviews of Medicaid providers ensure compliance with applicable federal and state laws, regulations, rules and policies pertaining to the Medicaid program.

Fee-for-Service Audit Activities

OMIG conducts billing audits of provider services rendered to eligible recipients paid on a fee-for-service (FFS) basis. These audits focus on home health agencies, personal care agencies, diagnostic and treatment centers, hospitals, physicians and other health care providers. Additionally, OMIG is responsible for coordinating all Medicaid-related provider self-disclosure cases in accordance with the federal Affordable Care Act §6402. OMIG also conducts audits to determine the quality of care rendered to eligible recipients.

Pharmacy Projects

OMIG has initiated global audits of chain pharmacies that have multiple locations throughout New York and bill New York's Medicaid program. In 2010, OMIG initiated 18 pharmacy audits and finalized 19 audits, with identified overpayments totaling $3,773,455. Total recoveries in 2010 amounted to $535,010.

Out-of-State Pharmacy Audits

In 2010, the OMIG continued to review out-of-state pharmacies. These pharmacies provide high cost drugs via mail order that include: HIV drugs, blood products, human growth hormones, and drugs used to prevent respiratory viruses in high-risk infants. OMIG performed tests to substantiate costs, determine the appropriateness of the drugs billed and ensure that no unreported discounts were taken.

Outpatient Chemical Dependence Providers

OMIG conducts audits and pursues Medicaid payment recoveries of OASAS outpatient chemical dependence providers. OMIG auditors review clinical documentation to support the provision of patient-centered and clinically necessary services to demonstrate quality of care. During 2010, OMIG initiated seven outpatient chemical dependence audits and 18 were finalized with findings of $12,999,435. Recoveries totaled $2,713,509.

Outpatient Mental Health Services

The auditing, reviewing and recovery action by OMIG of outpatient mental health service providers licensed by the Office of Mental Health (OMH) remain integral to billing and documentation audit projects. During calendar year 2010, ten outpatient mental health audits

were initiated and 14 were finalized with total findings of $6,352,972. Total recoveries in 2010 amounted to $4,056,004.

Comprehensive Outpatient Programs/Community Support Programs

In 2010 OMIG, in conjunction with OMH, conducted audits of mental health providers who participate in the Comprehensive Outpatient Programs (COPS)/Community Support Programs (CSP). The amount of COPS reimbursement that a provider can receive is limited to a threshold amount and any COPS funding received in excess of that amount is considered an overpayment. In 2010 a OMH-COPS/CSP audit was initiated that included eight providers. Total recoveries amounted to $19,994,373.

Residential Habilitation, Medicaid Service Coordination and Day Treatment Services Programs

In 2010, OMIG initiated six audit projects related to services authorized by the Office for People with Developmental Disabilities (OPWDD). These projects include IRA (Individual Residential Alternative) residential habilitation, Medicaid service coordination and day treatment services programs. OMIG works in close partnership with OPWDD and the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) to enhance program integrity.

Hospital Outpatient Departments

Hospital outpatient department (OPD) billing audits continued in 2010. OPD audits include independent samples of emergency room/clinic services, referred ambulatory services and laboratory services. During 2010, OMIG initiated five OPD audits, with another six completed. Total recoveries amounted to $2,071,664.

Personal Care Services

In 2010, OMIG expanded its audit focus to include Personal Care providers located in the downstate region. As an educational tool for providers, audit protocols were developed and posted on OMIG's website in order to provide guidance to providers in the personal service care industry. OMIG audit staff collaborated with New York City Human Resources Association (HRA) staff to gather provider information specific to the five boroughs of New York City. During 2010, a total of 21 audits were initiated, with an additional four final audit reports issued with recoveries totaling $253,593.

Transportation

In 2010, transportation audit protocols were developed in conjunction with the Department of Health. Those protocols were then posted to the OMIG internet website.

During the reporting period, OMIG audits focused on the provision of ambulette transportation services. In 2010, 78 audits were finalized with recoveries of $436,023.

Audits have now expanded to include the review of taxi/livery transportation services for which audit protocols have been developed and made available to the public.
In August of 2010, oversight of transportation audits was transitioned to OMIG's County Demonstration Program. As such, transportation audits were conducted by the participating local (county) social services district, working in close collaboration with OMIG staff.

Traumatic Brain Injury

In 2010, eight audits of traumatic brain injury providers were finalized with total findings of $1,076,728. Recoveries related to these audits were $1,174,209.

School Supportive and Preschool Supported Health Services Programs

As part of the Compliance Agreement signed by New York State and the Centers for Medicare and Medicaid Services (CMS), OMIG was required in calendar year 2010 to audit every school district and county preschool provider that received at least $1 million in Medicaid reimbursement in calendar year 2009. There were 42 providers who met these criteria. OMIG was also required to audit 35 additional school districts and county preschool providers with total paid claims of less than $1 million in calendar year 2009.

The OMIG initiated 77 audits of School Districts, County Preschool Programs and § 4201 Schools (State supported schools for the Blind, Visually Handicapped and/or Hearing Impaired). OMIG finalized five of the audits and determined that the school districts and county preschool providers did provide the services for which they billed Medicaid, and they have a good understanding of the documentation standards required for Medicaid claiming.

Epogen Statewide Review/EPO Clinic Review

In 2010, OMIG finalized nine audits, with findings totaling $1,935,432 for the statewide review of claims submitted for Epoetin Alpha (Epogen) and Aranesp. These medications help decrease or eliminate the need for costly blood transfusions, and improve quality of life for patients who are chronically anemic.

Rate Based Audit Activities

Rate based audits review cost reports used to set rates for Medicaid providers. Examples of rate based entities include residential health care facilities and home health care providers.

Residential Health Care Facilities

Residential health care facilities (RHCFs) are reimbursed for covered services to eligible Medicaid recipients based on prospectively determined rates. Through 2009, the prospective

rates were comprised of two components - an operating component and a property/capital component.
These audits identify inappropriate or unallowable costs, services dropped by the RHCF but included in the reimbursement formula, rate appeal adjustments, and prior audit adjustments to property and operating costs that need to be carried over into subsequent rates (rollovers).

Activity in the chart below represents residential health care facility audits issued in 2010. As designated in the chart, OMIG issued 266 RHCF audits and identified $34 million in overpayments.

Audit Type	2010	
	Audits Issued	Findings (millions)
Base Year	15	$6.4
Dropped Services	22	8.4
Property	43	8.8
Rate Appeal	1	(-.9)*
Rollover	185	11.3
Total	**266**	**$34**

* Refund released to provider due to overcollection of funds related to 2010 stipulation agreements.

Base Year Audits

Reported base year costs, with appropriate inflation factors, are used for multiple years of reimbursement for the operating and property component until a new base year is set. For example, an audit of base year costs for three RHCFs identified the following disallowances:

- Expense not related to patient care
- Offset of rental income
- Unsubstantiated expense
- Working capital interest expense
- Offset of unrestricted investment income
- Mortgage interest expense
- Duplicate expense
- Direct assignment expense
- Non-entitlement to nursing adjustment add-on
- Return on average equity
- Sales tax

In 2010, these three audits identified overpayments totaling $4,018,787.

Dropped Services Audits

OMIG conducted audits of a RHCF's ancillary services – predominantly laboratory, radiology, physician and podiatry services - for the three years ending December 31, 2006. The audit identified ancillary services which, subsequent to the base year, were dropped, but the facility's Medicaid rates still included the cost of the ancillary services. Where Medicaid

is paying the outside fee-for-service provider in addition to the RHCF for the same ancillary services, duplicate reimbursement occurs. During 2010, the audits resulted in identification of overpayments of $2,745,590.

Property Audits

Reported RHCF property costs are used as a basis for the property/capital component of the facility Medicaid rate on a two year lag basis. For example, property/capital audits of three facilities' costs identified significant issues, including:

- Unsubstantiated expense
- Mortgage interest and insurance expense disallowance
- Offset of investment income
- Movable equipment depreciation disallowance
- Duplicate expense
- Equipment rental/lease expense disallowance
- Non-patient care disallowance
- Mortgage amortization expense
- Non-allowable cost

These three audits identified overpayments totaling $3,042,637.

Rollover Audits

Base year operating costs are increased by an inflation factor and used as a basis for RHCFs Medicaid rates for subsequent years. During 2010, OMIG carried forward base year operating cost audit findings into subsequent rate years. The three largest Medicaid rollover facility audit finding impacts totaled $2,797,211.

Nursing Home – Bed Reserve Audits

The Medicaid program reimburses RHCFs for reserving a resident's bed on a per-day basis when a patient is transferred to a hospital, with the expectation that the patient will return to the facility within 15 days. In 2010 the OMIG continued to review bed reserve payments to assure that facilities were in compliance with Title 18 NYCRR § 505.9(d) requirements that the nursing facility's vacancy rate was equal to, or less than, five percent (5%) at the time the resident was temporarily discharged from the home, and that written documentation existed to support the expectation that the resident would return to the nursing home within 15 days of his/her transfer to the hospital.

In 2010, the OMIG finalized 14 audit reports that identified and recovered $3 million in overpayments. However, as a result of an adverse administrative hearing decision related to disallowances recovered based on the findings that some RHCFs did not have documentation to support the expectation that the resident would return to the nursing home within 15 days of their transfer to the hospital, OMIG refunded to five RHCF providers monies that were

previously collected. The current audit scope was also amended as a result of the decision and has since been reduced to a review of just the vacancy rate.

Managed Care Audit Activities

Managed care plans coordinate the provision, quality and cost of care for its enrolled members. In New York State, several different types of managed care plans participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care plans, primary care partial capitation providers, and HIV special need plans.

OMIG performs various match-based targeted reviews and audits of managed care organizations (MCOs), recovers overpayments, and submits/implements corrective action procedures that address system and programmatic issues/errors. OMIG also conducts audits of the records that support the Medicaid Managed Care Operating Reports (MMCOR) and the supporting documentation used as the basis for the Department of Health's negotiation of MCO premium rates.

In 2010, OMIG finalized 328 audits that identified $43.8 million in overpayments to managed care organizations.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

MCOs are required to void premium claims for any months where a managed care member is retroactively disenrolled, and the MCO was not at risk to provide services to the member during that time. In 2010, OMIG, in conjunction with DOH, continued to identify and review retroactive disenrollment of members on a quarterly basis. OMIG initiated 173 audits and finalized 148 with findings totaling $10,882,735, and recoveries of $10,688,841.

These retroactive disenrollment findings included those inappropriate capitated payments made on behalf of a single enrollee who receive multiple client identification numbers. The OMIG identifies the inappropriate claim payments and, working with the local social services districts corrects recipient eligibility and enrollment files, subsequently informs the MCOs to submit overpayment recoveries.

Capitation Payments for Deceased Managed Care Enrollees

Matching the New York State Medicaid database with vital statistics for New York State and New York City generates a list of Medicaid managed care enrollees and payments made on behalf of MCO enrollees who remain enrolled following the date of their death. As part of the agreement between New York State and the MCO, any capitation payment made on behalf of a deceased enrollee is recoverable from the MCO, and the local districts are informed to take appropriate action on behalf of any of the active cases/enrollees. In 2010, the OMIG finalized 53 audits that identified $3,060,470 in overpayments, and recovered $3,073,517.

Capitation Payments for Incarcerated Managed Care Enrollees

OMIG identifies capitation payments made to MCOs on behalf of enrollees who are shown to be incarcerated during the entire month they are covered by the capitation payment. In 2010, thirty-two audits were finalized that identified $1,335,018 in overpayments, of which $1,323,001 was recovered.

Supplemental Capitation Payments Made without Corresponding Encounter Data

In addition to monthly capitation payments, MCOs are entitled to supplemental newborn and capitation payments in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. The newborn supplemental capitation payment is paid under the newborn's recipient ID. The maternity supplemental capitation payment is paid under the mother's recipient ID. The MCO is required to submit birth/delivery encounter data to the DOH and is required to maintain evidence of such payments.

OMIG focused on reviewing submitted encounter data as well as other documentation to confirm payment was made to the hospital/birthing center. If the MCO cannot provide documentation to support the newborn/maternity billing, the MCO is requested to repay the supplemental payment. In 2010 the OMIG finalized 29 audits with $1,327,536 in findings. Due to an adjustment of an audit previously issued in 2009, the 2010 net recovery in this project area was reduced to $634,385.

In addition, OMIG finalized 21 audits identifying $2,534,068 in overpayments where a hospital inappropriately received a FFS Medicaid payment for a newborn enrolled in managed care and the MCO also received a supplemental newborn payment. For this project, $1,395,152 was recovered.

Family Planning Services

Under federal rules, managed care enrollees are entitled to receive family planning and reproductive health services from a fee-for-service Medicaid provider outside of the their MCO's provider network. If an enrollee receives the service outside of their plan's provider network, the MCO is responsible for repaying Medicaid for the fee-for-service payment made by Medicaid to the out-of-network provider. In 2010, OMIG finalized 27 audits that identified $10,915,701 in overpayments, and recovered $11,912,746.

Providers that are included in a MCO network are responsible for billing the MCO for any family planning services they provide to plan enrollees. OMIG identified instances where family planning services rendered by a network provider had been incorrectly billed to Medicaid fee-for-service. In 2010, the OMIG finalized 31 audits that identified $376,994 in overpayments; and recovered $577,793.

Managed Care – Incorrect Locator Code Designations

Each managed care enrollee is assigned a three digit number that identifies the enrollee's county of residence, termed the locator code. This code assures that the appropriate capitation and/or supplemental payment(s) are made to the MCO on the enrollee's behalf.

In 2010, the OMIG finalized five audits where the MCO received higher than appropriate capitation and supplemental payments as a result of incorrect and/or inaccurate identification of the enrollee's locator code, and recovered $14,713,357.

Fee for Service/GME Crossover

The inpatient hospital rate paid by Medicaid fee for service includes a component that reimburses teaching hospitals for graduate medical education (GME). When a beneficiary is enrolled in Medicaid managed care, inpatient hospital services are the responsibility of the health plan, however Medicaid fee for service makes a separate payment to the hospital for the GME. In 2010, OMIG initiated four audits of hospitals that billed for GME when they appeared to have also received Medicaid fee for service payments. No final reports were issued in 2010.

Summary of Audit Activities

2010 Audits				
Audit Dept.	**Audits Initiated**	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
Fee-for-Service Audit Total	331	542	$ 91,491,775	$ 59,586,257
Rate Audit	332	267	33,990,062	38,844,440
Managed Care	382	365	43,134,204	42,256,776
Total	**1,045**	**1,174**	**$ 168,616,042**	**$ 140,687,474**

Demonstration Program Activities

The purpose of the Medicaid Fraud, Waste, and Abuse County Demonstration Project (Project) is to partner with counties and New York City in an effort to detect fraud, waste, and abuse conducted by providers in the Medicaid program and recoup overpayments. Currently, 16 jurisdictions have an executed Memorandum of Understanding in place with the state; of which eleven counties and New York City are actively participating in the Project.

Since its inception, the County Demonstration Project has identified findings totaling more than $32.9 million. In 2010, there were $7,579,615 in findings and $7,318,335 in recoveries, which represents an approximate doubling of recoveries from that of 2009.

In 2010, the Project also embarked on its first joint audit venture between two local districts; Nassau and Suffolk counties. Together the two counties represented more than 95 percent of the Medicaid claims paid to a particular transportation provider servicing all of Long Island. By working together with an auditing firm with which each county has a contract, such a collaborative audit sends an important message to the Medicaid provider community that the counties are working together and in concert with OMIG to ensure the integrity of the Medicaid program.

Technology and Business Automation Activities

OMIG Technology and Business Automation activities all focus on using technology including data matches and front end payment controls to leverage state activities to improve program integrity. Detailed below are highlights of these activities from 2010.

Third Party Insurance Review Activities

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer before billing Medicaid. A significant amount of the State's Medicaid recoveries are the result of OMIG's efforts to obtain payments from private insurers responsible for services inappropriately reimbursed by Medicaid funds. Other insurance coverage, including Medicare and/or commercial insurance, should be identified during the enrollee's intake process at the local districts.

Pre-Payment Insurance Verification Cost Savings Activities

New York has been successful in identifying other insurers who should have paid for services instead of billing Medicaid. These pre-payment insurance verification activities have resulted in cost savings to the state's Medicaid program of approximately $1.11 billion**.**

Third Party Recovery Activities

FFS Third Party Recovery – The primary objective is to identify and maximize private insurance and Medicare coverage. This enables the state to recover Medicaid funds.

Managed Care Third Party Recovery – The State and Managed Care (MC) plans now share responsibility for the collection of third party revenues, pursuant to respective MC contracts. This is generating additional cash recoveries.

During the past year, OMIG, through its vendor HMS, initiated 5,634 third party reviews, with recoveries totaling $193,606,492.

Home Health Care Demonstration Project

OMIG continues to work with CMS and the States of Connecticut and Massachusetts under a pilot demonstration project that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were inadvertently submitted to and paid by the Medicaid agencies.

This demonstration project replaces previous Third Party Liability (TPL) audit activities of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This is an administrative savings in resources for the home health agencies (HHA), as well as the regional home health intermediary (RHHI) and for the participating states. During 2010, this project recovered $91,928,268.

Business Intelligence Activities

Staff within OMIG's Bureau of Business Intelligence provide data related services to support the agency's mission, but also engages in provider analysis through Systems Match and Recovery (SMR) activities. SMR activities identify overpayments made to providers by performing data match reviews and then collecting the overpayments identified by each match. During 2010, SMR initiated a total of 1,095 provider reviews with recovery activity totaling $14,348,391. Some of the specific highlights and areas of focus for 2010 are outlined below.

PCAP Reviews

The Prenatal Care Assistance Program is a comprehensive prenatal care program for Medicaid eligible women. OMIG reviewed clinic services to ensure appropriate and to ensure that all ancillary testing covered by the PCAP rate was not billed separately to Medicaid. The PCAP system match covering 2006-2008 recovered $4,220,565 from 146 PCAP providers.

OB-Gyn Reviews

As a result of the PCAP review, OMIG became aware of improper billings by physicians for obstetrical and delivery services. Physicians incorrectly bill an all-inclusive "global" delivery rate for PCAP clinic patients, when prenatal and a post partum services are already paid in the PCAP clinic rate. The system match was sent to 234 physicians or physician groups and recovered $1,299,777.

Chemotherapy Reviews

The chemotherapy clinic rate is a specialty rate developed for the higher cost of specialized staff and equipment required to serve individuals receiving cancer treatment. The rate code also allows facilities to bill clinic administered drugs separately. While the rate was established for the treatment of cancer, providers can apply to expand the usage to hematology and anemia treatments through an appeal to the DOH. For the first time in 2010, OMIG developed a review to determine if the chemotherapy rate was used for diagnosis not covered in the clinic's agreement with DOH. As a result of the review, $1 million was recovered from 32 providers.

Dental Reviews

OMIG developed a dental matching project which identified inappropriate dental services for edentulous (toothless) patients, consultation procedures without referring provider information and dentist services billed fee-for-service for recipients living in skilled nursing facilities where these services are included in the skilled nursing facility rate. This project included 274 providers and identified $9 million in inappropriate services. An initial group of 41 audits was issued in 2010, with the balance issued in early 2011.

General Clinic Reviews

This review identifies ancillary testing ordered at clinic visits billed under the all-inclusive general clinic rate in hospital-based clinics. Ancillary services are included in the threshold clinic rate and should not be billed fee for service for registered patients of the clinic, even if performed on days following the clinic visit. The new APG outpatient payment methodology in December 2008 eliminated the general clinic rate for hospital-based clinics. The general clinic matching project encompasses 252 providers and resulting in recoveries of $1.8 million.

Deceased Recipients Reviews

Prior to December 2009, OMIG identified fee-for-service Medicaid claims billed for deceased recipients. Vital statistics information received from the Department of Health and verified on the Social Security database was used to identify a recipient's date of death. In 2010, approximately $877,000 was recovered from these efforts. Closer attention to these improper claims appears to be causing a positive change in provider billing behavior, as the number of providers included in the review decreased from 296 in the initial review in December 2009 to 154 in the December 2010 review.

System Edits

Edits are one of the most effective tools, and the first line of the defense, the OMIG uses to prevent fraud, waste, and abuse. Edits are automated controls built into eMedNY to help ensure the proper payment of all Medicaid claims. Developed collaboratively by staff of OMIG, the Department of Health, and the Department's fiscal agent, edits aid in controlling fraud, waste, and abuse as identified by audits and investigations, and serve to meet budgetary goals.

For 2010, eMedNY system edits that were modified or created by OMIG resulted in approximately $129 million in cost avoidance. During this time period OMIG also reviewed the processing logic for 39 system edits and recommended improvements for 28 edits.

Other Initiatives

During 2010, there were a number of initiatives that the OMIG worked on, in conjunction with the Department of Health to enhance system editing and to identify inappropriate payments. These initiatives include working collaboratively with other external partners as well. OMIG obtained suspended license data from the Department of Motor Vehicles to identify ambulette drivers with inactive licenses, which is a violation of the New York State Vehicle and Traffic Law. The Department of Health's Bureau of Narcotics Enforcement provided serialized prescription data, and lost and stolen prescription information to ensure that Medicaid paid only for properly prescribed medication and that only properly authorized prescribers are prescribing medication. The Department of Health participated in the electronic prescribing (e-prescribing) initiative by recommending steps for authenticating and certifying providers/prescribers, regulating intermediaries, establishing accountability and audit trails for electronic prescriptions, and laying the groundwork for the authority for state monitoring and auditing.

Prepayment Review Activities

Prepayment reviews use capabilities within the Medicaid claims processing system to review some, or all, of the claims for providers of interest. Using this capability, OMIG staff are able to monitor and review the claiming of providers who demonstrate aberrant, unacceptable or inappropriate billing practices. Prepayment review can be used as a compliance tool, a deterrent to a specific activity and as a powerful fraud deterrent tool.

In 2010, staff reviewed over 2,700 providers, including pharmacies, outpatient clinics, diagnostic and treatment centers, durable medical equipment providers, physical therapists, and transportation providers. Cost savings resulting from these reviews totaled $9,284,578. As a result of these prepayment reviews, 1,564 providers were placed on medical prepayment review, 10 providers were investigated further for potential fraud, or reviewed further for inappropriate paid claims and 18 recipients were referred to the Recipient Restriction Program.

Improvement of Provider Submissions

At the request of OMIG, Computer Sciences Corporation, the State's fiscal agent, expanded the functionality of the prepayment review process. For example, edit criteria can now be set to deny claims if a provider uses invalid prescription serial numbers and bypass codes. A total of 304 providers were placed on review for this issue and resulted in a 65 percent decrease in submissions of claims with invalid information.

Identifying Duplicate DME and Clinic Payments for Managed Long Term Care (MLTC) Recipients

Medical supplies and dental services are benefits covered by MLTC plans. Data analysis identified duplicate DME medical supply and clinic dental claims being paid for MLTC recipients. As a result of the OMIG's analysis, DOH modified the eMedNY scope of benefits file to prevent future payments of medical supply and clinic dental services for MLTC recipients. Annual cost avoidance realized from these system modifications is nearly $1.5 million.

Identifying DME Providers Submitting Claims with No Diagnosis Code

OMIG identified 349 providers billing for DME codes with no Diagnosis Code on the claim/order. Effective October 1, 2009, DOH required the diagnosis code is a minimum requirement for all DME orders. Denied claims for this project totaled $478,545 in 2010.

Cardswipe Program Activities

The OMIG designates providers, based on various criteria, to become a mandatory "swiper" as part of the Cardswipe program. The swipe is accomplished using a standard device (terminal) which is similar to those used commercially to process credit cards. For designated providers, the terminal is supplied to the provider at no cost and the provider is required to swipe the recipient's Medicaid card in a substantial number of instances at the point of service.

Mobile Card Swipe Terminal Expansion Project

In 2010, OMIG started testing a new expansion project to allow private duty nurses and non-emergency transportation carriers to swipe Medicaid identification cards with wireless cardswipe terminals at the point of service.

The mobile expansion program began its rollout in late summer of 2010 after discussions with officials from provider associations, patient advocates and individual providers. By the end of 2010, there were 24 providers in the mobile program.

Landline Expansion Project

During 2010, almost 800 additional pharmacy providers were added to the landline program for a total of 1,556 providers, resulting in cost avoidance totaling $181.3 million.

OMIG is actively working with providers and local districts to assist in raising the awareness of the program requirements for cardswipe providers and for recipients to present their card.

Post and Clear Activities

The Post and Clear Program is a set of enhanced controls designed to ensure that Medicaid claims for ordered services are actually ordered by the provider indicated on the claim. Provider's selected for the program must electronically 'post' their orders to the Medicaid claims processing system. This establishes a record of the care, services or supplies ordered by the provider, and enables the OMIG to verify that the order has been requested by the ordering physician before paying a provider who submits a claim for furnishing the service.

At the end of calendar year 2010, there were a total of 241 providers designated as posters. For 2010, the Post and Clear program created cost savings totaling $48.6 million.

Interagency Coordination Activities

Program integrity cannot be achieved without close, coordinated work with the agencies that directly regulate the provision of Medicaid funded services. During 2010, OMIG worked to improve its coordination with other agencies. Listed below is an overview of this coordinated activity.

Department of Health

The Department of Health (DOH) acts as the single State Agency for administration of the Medicaid program. DOH has coordinated with OMIG in developing a number of processes, both systems edits and hands-on utilization reviews which help to detect and prevent fraud and abuse. These activities are undertaken because of DOH's commitment to maintaining Medicaid for those who need it. Listed below are examples of DOH and OMIG's collaborations on program integrity:

Strengthening Claims Payment Processes

During calendar year 2010, DOH engaged in significant efforts to support the prevention, detection and investigation of Medicaid fraud and abuse. Throughout 2010, the monthly "Deceased Beneficiary" report was generated and forwarded to OMIG for follow-up. The Medicare Cross-over project, which was implemented in 2009, created the capability to process Medicare Cross-over claims received directly from the Medicare Coordination of Benefits Contractor (COBC) rather than from providers of service. During 2010, additional edits were installed and modifications were made to further strengthen controls within the eMedNY Claims Processing System.

During calendar year 2010, there were 30 edit status changes, 23 edits to deny, while 2 edits were set to pend. One hundred and thirteen (113) evolution projects were implemented during the calendar year, including 9 projects requested by OMIG. In addition to implementing DOH policies and budget initiatives, 31 projects involved areas of potential fraud, waste or abuse, including approximately 22 which created or modified processing edits. Among these were enhancements to Capturing Dispensing Pharmacists Identification on Electronic Pharmacy Claims, Editing Servicing Providers Profession Codes for Non-Recognized Practitioners, Modifying Edit 0705 for Exact Duplicate Crossover Claims, and Denying Providers the Ability to Change Date and Time Stamps on Card Swipe Terminals. In addition, a project was created to modify the edits for 1141/1142 to enhance the Provider on Review process for easier detection of fraud or abuse. Under the direction of the OHIP, Computer Sciences Corporation (CSC) referred 20 cases of potential fraud, waste and abuse to OMIG. OHIP and CSC staff also worked with OMIG to support many fraud and abuse initiatives, including their efforts to retrieve claims, payment, and MEVS data from eMedNY.

Ensuring Provider and Service Integrity

DOH conducted over 779,478 pended claim reviews, resulting in over $87 million in cost avoidance.

These activities dis-enrolled 1,863 providers due to expired licenses and 659 deceased providers. Another 804 providers withdrew their enrollment applications due to failure to comply with all documentation requirements.

There were 35 dental and 5 medical providers referred to OMIG for further investigation relative to potential fraud, waste and abuse. There were also 349 fee-for-service enrollment applications pended to OMIG for final determination.

Office of Temporary and Disability Assistance

The Office of Temporary and Disability Assistance (OTDA) is responsible for supervising programs that provide assistance and support to eligible families and individuals. In 2010, OTDA served as a referral source for State and Federal agencies for the Medicaid portions of data matches the agency conducts. OMIG and OTDA collaborated on review processes listed below.

PARIS Match (Public Assistance Reporting and Information System)

OTDA submitted all active recipients of Temporary Assistance (TA), Supplemental Nutrition Assistance Program (SNAP), and Medicaid to the Federal government quarterly for the purpose of matching New York State recipients to those also receiving assistance in other states. When OTDA receives the file back, the "Medicaid only" matches were separated and forwarded to the Department of Health so they could be disseminated to the local districts at their discretion. OMIG also received a copy of this information.

Prison Match

The Department of Correctional Services and the Division of Criminal Justice Services each submitted a file to the OTDA Bureau of Information Technology (BIT) monthly to match jailed inmates to those receiving assistance. BIT does matches for all program areas and initiates an auto close process for all single-person cases. The Medicaid only multiple-person cases, and all other auto close exceptions, are sent to the Department of Health to be disseminated to the local districts at their discretion. OMIG uses this information as a selection tool.

Veterans

OTDA also receives a veteran's match from the Federal government. All active public assistance recipients are matched against a comprehensive veterans file. This match yields individuals that are eligible to be shifted from Medicaid to VA benefits, thereby saving Medicaid dollars.

Office of Alcoholism and Substance Abuse Services

OASAS plans, develops and regulates the state's system of chemical dependence and gambling treatment agencies in order to improve the lives of New Yorkers. OMIG and OASAS have worked together to create a true program integrity partnership. In 2010, OASAS conducted eight Quality Services Reviews (QSR) of "high-risk" Medicaid providers. Providers who rank "high" or "extreme" through a Medicaid Risk Assessment are selected for QSR prior to the expiration of their Operating Certificate. QSRs focus on excessive services indicators outlined in OASAS regulations as well as other regulatory requirements that relate to the quality of treatment services.

OASAS APG Implementation and OMIG protocols

OASAS worked extensively with advocacy groups, providers and other stakeholders to determine the services that will be reimbursed under APGs, and identify the appropriate payments assigned to each service. Agency APG implementation began on October 1, 2010 for hospital-based outpatient clinics with implementation in hospital-based opioid treatment programs beginning on January 3, 2011. Freestanding outpatient clinics and freestanding opioid treatment programs began on July 1 and July 4, 2011, respectively. OMIG committed to working with OASAS to develop appropriate audit protocols relative to the APG implementation period.

OASAS Referrals to OMIG

OASAS efforts resulted in two referrals to OMIG. Both referrals were based on regulatory violations and questionable Medicaid billing practices. In the case of one of the referrals, OMIG took action in collaboration with OASAS' suspension of the provider's Operating Certificates, with intent to revoke. In 2010, based on concerns identified through OASAS' monitoring activities and receipt of fraud allegations, an additional provider was referred to OMIG. Results of these activities are ongoing.

Office of Mental Health

Office of Mental Health oversees services for people in New York State with the need for mental health services. Some of OMIG and OMH's collaboration is in part recounted in the OMIG "Audit Activities" section regarding COPS payments. Other highlights of collaboration are noted below.

Self Disclosures to OMIG based on OMH Posting of Information

Some OMH regulated providers made self-disclosures to OMIG after OMH provided guidance originally generated by OMIG. OMH's website included a link to OMIG's instructions regarding self-disclosures. OMH's website includes a Medicaid Fraud and Abuse Notification, a notification to contractors with information regarding the Federal and New York State False Claims Acts, as well as other federal and state laws that aid in

preventing fraud, waste, and abuse. This is a great example of how even simple agency coordination can improve provider practices.

OMH Monitoring of Excluded Providers

OMH has also enhanced its protocols to monitor staff to identify any persons who are excluded providers as a result of Medicaid sanctions. Prospective employees are reviewed against excluded provider lists prior to making an offer of employment. Additionally, the agency's entire payroll is compared on a bi-weekly basis to the excluded provider data bases maintained by the OMIG and two federal departments. During 2010, that process identified 2 persons, out of over 17,000 employees, who were listed as excluded providers. Since billings to Medicaid for patient care or administrative service are not permitted for excluded individuals, OMH self-disclosed those findings to OMIG, and made appropriate restitution.

Office for People With Developmental Disabilities

Office for People With Developmental Disabilities (OPWDD) is charged with making sure that people who with developmental disabilities are provided the services that they need. OPWDD's goal is to help people with developmental disabilities live richer lives.

OPWDD has been successful in implementing a comprehensive Medicaid accountability system which includes billing standards, regular communication and training for providers on these standards, field reviews that audit against the standards, routine desk reviews of Medicaid paid claims to identify inappropriate claims, and special targeted Medicaid field reviews based on eMedNY data analyses. In 2010 OPWDD worked closely with the OMIG in all Medicaid accountability areas. This successful partnership has enabled the OPWDD to maximize the agency's effectiveness in preventing and detecting Medicaid fraud, waste, and abuse.

OPWDD audit function transitions to OMIG

As of October 1, 2010 all activities related to Medicaid audits, other than routine desk reviews of paid Medicaid claims, were transferred to OMIG. In order to continue achieving the same level of overall success in maintaining Medicaid integrity and at the same time ensure that agencies do have the resources to provide services to OPWDD's individuals, it is essential that OMIG continue to consult with OPWDD relative to regulatory requirements for OPWDD programs, the interpretations thereof, and the development of new audit protocols. OPWDD and OMIG staff will continue to meet on a quarterly basis to discuss the status of OPWDD referrals to the OMIG and the OMIG's referrals to OPWDD, as well as any other relevant issues that may impact the agencies.

Office of Children and Family Services

The Office of Children and Family Services (OCFS) serves New York's public by promoting the safety, permanency and well-being of our children, families and communities. In 2010, OCFS achieved results by setting and enforcing policies, building partnerships, and funding and

providing quality services. In 2010, OCFS and OMIG worked to improve interagency relations with good results.

Bridges to Health

The Bridges to Health (B2H) Home and Community-Based Medicaid Waiver program was phased into statewide operation over a three-year period beginning January 1, 2008. Calendar year 2010 was the third year of the B2H phase-in period and during that year, the Office of Children and Family Services's (OCFS) Office of Audit and Quality Control (AQC) performed audits of four B2H Health Care Integration Agencies (HCIAs).

OCFS and OMIG Collaboration

AQC's audits identified instances of Medicaid billing errors, which were not unexpected given the recent implementation of the B2H program and the myriad requirements the HCIAs were required to learn. AQC found no evidence that any of the errors constituted Medicaid fraud. AQC's audits resulted in the voiding of Medicaid claims which were identified as lacking sufficient supporting documentation, as well as recommendations to the HCIAs for improvements to their internal controls for the detection and prevention of future errors. In 2010 OMIG presented at OCFS's Bridges to Health workgroup and committed to working with OCFS to address program shortcomings in its approach to auditing this field.

Commission on Quality of Care and Advocacy for Persons with Disabilities

The Commission's duties cover a broad spectrum of oversight mandates regarding Medicaid and non-Medicaid funded programs, as required by Section 45.07 of the New York State Mental Hygiene Law. During the 2010 calendar year, the Commission worked on or completed four investigations which directly involved Medicaid fraud and abuse. Over the course of 2010, CQC and OMIG shared information on these investigations and will continue their joint efforts to investigate and uncover fraud and abuse in the Medicaid system. These investigations are described below, with the exception of one investigation which remains ongoing therefore details can not be reported at this time.

Guest House Community Services

Guest House is a not-for-profit corporation located in Peekskill, New York providing services to individuals with developmental disabilities. The Commission's investigation found that Guest House's executive director embezzled more than $300,000 in federal Medicaid funds. The former director recently pled guilty to the charges and faces up to ten years in jail and a fine of twice the gross gain from the offense. He entered his plea in White Plains federal court, admitting his involvement in covering up the diversion to himself of $132,000 in Medicaid checks that were payable to Guest House. In addition, the investigation found that he had used another $168,000 in Guest House funds for personal expenditures, including the use of a Guest House debit card to withdraw cash from ATMs in Kenya. The Commission also found that Guest House inappropriately

billed Medicaid more than $800,000 for services that could not be properly documented. The case was referred to OMIG who is currently in the process of recouping the disallowed amount. The former director was also excluded from the Medicaid program.

Multi-Functional Family Services

Multi-Functional is a not-for-profit corporation located in Brooklyn, New York that provides services to individuals with developmental disabilities. The Commission received a complaint alleging that the agency was falsifying documents and that services were being provided by unqualified staff. In December 2010, the Commission referred its findings to OMIG recommending that more than $640,000 be disallowed because the agency failed to comply with Medicaid documentation requirements. OMIG has sent the agency a draft report seeking to recoup the funds.

UCP North Country

UCP North Country is a not-for-profit located in Watertown, New York which provides services to individuals with developmental disabilities. In 2010, the Commission, working collaboratively with OMIG, investigated a complaint alleging that Service Coordination services were being billed to Medicaid but not provided. The joint investigation found that one of the agency's service coordinators, was claiming that he was providing service coordination when in actuality he was working at another unrelated job. Based on the investigation, UCP North terminated the service coordinator and repaid the Medicaid program $100,000. The former service coordinator was referred to the Jefferson County District Attorney's Office where the case is still pending.

Administrative Actions

Administrative Hearings and Article 78 Proceedings

A final determination by the OMIG that seeks to recover overpayments, impose a sanction, impose a penalty, or some combination of all these actions gives rise to administrative hearing rights. The OMIG's final determinations are issued by way of a Final Audit Report or Notice of Agency Action. Both notices, regardless of format, are subject to administrative review and, if necessary, judicial review.

In 2010, a total of 90 requests were received by OMIG, seeking to challenge the final determination of the OMIG. Over the course of 2010, 49 cases where an administrative hearing was requested were subsequently resolved by stipulation of settlement, four hearing requests were withdrawn, and three hearing decisions were issued. A total of 18 Article 78 proceedings were filed during 2010.

In 2010, OMIG began to file judgments in an effort to recover outstanding Medicaid overpayment dollars. Over the course of the year, the OMIG has obtained judgments totaling $10,116,742 against delinquent providers, pursuant to Social Services Law section 145-a.

Sanctions – Terminations & Exclusions

Sanctions include: censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3). OMIG conducted investigations and imposed discretionary exclusions during this time period based upon:

- New York State Education Department actions such as license surrender, suspension and revocation, for Medicaid and non-Medicaid providers
- actions taken by the Office of Professional Medical Conduct (OPMC) involving professional misconduct and physician discipline actions including suspensions, revocations, surrenders and consent agreements
- correspondence received from the Department of Health and Human Services
- OMIG's internal enrollment files and eMedNY data which provided relative ownership information to determine affiliations of excluded providers

Seventy-eight (78) terminations and 861 exclusions were issued during 2010. The Restricted and Excluded Individuals or Entities contains 6,266 Medicaid and non-Medicaid provider exclusions. The list of Terminated Individuals or Entities has 2,553 entries; and there are 89 providers on the list of providers who have been censured under the provisions of 18 NYCRR 515.7(f). These lists are available to the public on OMIG's web site www.omig.ny.gov.

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2010. OMIG's work this year demonstrates that New York remains the leader in promoting and protecting the integrity of the Medicaid program. As OMIG ends its fourth year of operation and reports on its varied achievements and accomplishments, the agency recognizes that much remains to be done. OMIG is excited as it approaches a fifth year of operation and looks forward to strengthening the agency's partnerships with other state agencies, expanding provider compliance education efforts, and increasing the level of transparency in the agency's operations.

Appendix

2010

Appendix – 2010 Operational Statistics

As required by Public Health Law §35(1), the following Appendix of Operational Statistics provides information about the audits, investigations, and administrative actions, initiated and completed by the Office of the Medicaid Inspector General. Additionally, and as required by the Law, this Appendix includes details about those activities initiated and completed covering the outcome, region, source of complaint and total dollar values identified and collected.

Investigations

2010 Investigations by Source and Region

Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
Anonymous	104	21	389	223	493	244
Bureau of Narcotics Enforcement (BNE)	11	2	2	0	13	2
CSC Fraud Unit	9	11	18	11	27	22
DOH	14	18	82	47	96	65
Drug Enforcement Agency (DEA)	0	0	2	0	2	0
Enrolled Recipient	68	39	216	135	284	174
Federal Bureau of Investigation (FBI)	18	23	5	3	23	26
Federal Department of Homeland Security (DHS)	0	0	2	1	2	1
General Public (Non-enrolled)	56	184	419	440	475	624
Health and Human Services (HHS)	165	6	3	1	168	7
Law Enforcement	0	5	0	2	0	7
Local District Social Services	20	6	58	44	78	50
Managed Care Plans	55	3	53	35	108	38
Non-Enrolled Provider	7	7	13	5	20	12
Non-Enrolled Recipient	13	6	50	36	63	42
SED	7	5	4	1	11	6
OPWDD	1	3	4	2	5	5
OHIP	21	34	116	39	137	73
OTDA	0	0	10	8	10	8
NYS Office of the Attorney General	70	7	21	153	91	160
NYS Office of the Inspector General	6	0	1	0	7	0
NYS Office of the State Comptroller	0	1	13	0	13	1
NYS Workers' Compensation Board	0	1	0	1	0	2
OMIG Audit	39	32	25	19	64	51
OMIG Bureau of Payment Controls and Monitoring	19	44	11	6	30	50
OMIG DMI	323	337	1,639	1,274	1,962	1,611
OMIG Executive	1	3	7	6	8	9
Other	0	0	0	4	0	4
Provider	53	15	213	96	266	111
Qui Tam	0	2	0	0	0	2
Safe Guard Services (SGS)	0	1	1	2	1	3
Unknown	1	0	31	0	32	0
Total	**1,081**	**816**	**3,408**	**2,594**	**4,489**	**3,410**

2010 Investigative Financial Activities by Region and Provider Type

2010 Investigative Financial Activities[1]						
Provider Type	Penalties/Restitution		Total	Number of Reports		Total
	Notice of Agency Action (NOAA)	Stipulation		NOAA	Stipulation	
Optician	$ 0	$ 38,000	**$ 38,000**	0	1	**1**
Pharmacy	1,836,848	974,383	**2,811,231**	1	2	**3**
Transportation	851,602	(175,444)[2]	**676,157**	1	1	**2**
Total	**$ 2,688,449**	**$ 836,939**	**$ 3,525,388**	**2**	**4**	**6**

2010 Investigative Financial Recoveries					
Provider Type	Downstate	Upstate	Upstate Western	Out-of-State	Total Recoveries
Dentist	$ 7,348	$ 0	$ 0	$ 0	**$ 7,348**
Diagnostic & Treatment Center	236,782	0	0	0	**236,782**
Long Term Care Facility	126,000	0	0	0	**126,000**
Medical Appliance Dealer	0	440	0	0	**440**
Optician	67,217	0	0	0	**67,217**
Pharmacy	2,635,092	2,145	3,532	6,768	**2,647,537**
Physician	443,506	3,582	0	0	**447,088**
Transportation	74,942	532	0	318	**75,792**
Total	**$ 3,590,887**	**$ 6,699**	**$ 3,532**	**$ 7,086**	**$ 3,608,204**

[1] This recovery category has been renamed to more accurately define oversight activities undertaken by the Division of Medicaid Investigations that result in financial findings and recoveries.

[2] Penalty amount lowered due to a stipulation agreement issued in 2010 related to a 2006 final agency action.

Audits

2010 Fee-for-Service Audits by Project Type and Region

2010 Downstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	0	0	$ 0	$ 73,558
Death Match[3]	0	0	(13,264)	(7,622)
Dentist	0	0	0	108,119
Diagnostic and Treatment Center	6	12	1,995,130	4,025,474
DME and Orthopedic Shoe Vendor	0	1	2,378	585,677
EPO/Aranesp Statewide Review	0	4	515,086	366,534
EPOGEN Clinic Review	0	3	1,025,313	1,026,614
Exception Codes[4]	1	16	(443,588)	(62,076)
HHC – Long Term	1	0	0	0
High Ordering Providers	0	0	10	73,922
Hospital Outpatient Department	1	0	0	1,835,966
Laboratories	2	0	0	0
Nursing Reviews	0	1	0	0
OASAS	0	9	12,127,374	1,499,918
Ob/Gyn Services	0	0	0	341,122
OMH	0	5	4,720,106	2,334,321
OMH – Outpatient	0	0	0	60,951
OMH-COPS	1	49	15,392,908	10,258,713
OPWDD	2	1	265,109	97,306
PCAP	0	0	0	13,627
PERM	0	1	43,391	43,391
Personal Care	11	1	46,704	46,704
Pharmacies	0	4	3,588,080	122,329
Physician Reviews	0	0	0	28,438
PRI	0	1	0	0
Radiology	0	0	0	3,123
Self Disclosure	100	82	23,899,563	8,039,281
SNF-PRI/MDS	1	1	1,055	1,055
Traumatic Brain Injury (TBI)	0	1	82,263	82,263
Transportation	0	18	203,781	186,394
Total	**126**	**210**	**$ 63,451,398**	**$ 31,185,101**

[3] Audit findings/recoveries lowered due to a stipulation agreement issued in 2010 related to a 2009 final audit.

[4] Audit findings/recoveries reduced due to issuance of a revised final audit report in 2010 necessitating a refund of monies to the provider.

2010 Upstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Diagnostic and Treatment Center[5]	4	3	$ (266,590)	$ 356,939
DME and Orthopedic Shoe Vendor	0	1	92,435	92,435
Exception Codes	0	3	0	95,423
Hospital Inpatient	1	0	0	0
Hospital Outpatient Department	4	6	2,875,756	235,698
Nursing Reviews[6]	0	1	0	(12,373)
OASAS	7	7	731,515	878,187
Ob/Gyn Services	0	0	0	9,993
OMH	9	6	708,869	151,655
OMH Rehabilitation	1	0	0	0
OMH-COPS	0	6	2,732,397	2,790,356
OPWDD	3	0	0	0
Personal Care	9	1	4,820	4,820
Pharmacies	2	5	68,887	71,981
Physician Reviews	0	0	0	27,445
PRI	1	0	0	0
Self Disclosure	61	48	3,472,070	2,985,869
SNF-PRI/MDS	0	0	0	1,739,155
TBI	5	6	864,538	692,485
Transportation	3	28	42,370	44,621
Total	**110**	**121**	**$ 11,327,068**	**$ 10,164,688**

[5] Audit findings reduced due to issuance of a revised final audit report in 2010. Original audit report was issued in 2009.

[6] Audit recoveries lowered due to refund released to provider as a result of cancelling a withhold in 2010 that was originally started in 2009.

2010 Western Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Dentist	0	2	$ 2,300,000	$ 2,300,000
Diagnostic and Treatment Center	1	1	67,938	67,938
DME and Orthopedic Shoe Vendor	0	1	0	16,983
Duplicate Clinic Match	0	74	861,538	780,323
EPO/Aranesp Statewide Review	0	1	190,596	190,596
EPOGEN Clinic Review	0	1	204,437	204,437
Exception Codes	0	2	245,775	245,775
HIV/AIDS	1	0	0	0
Laboratories	0	1	46,061	46,061
Nursing Reviews	0	1	0	0
OASAS	0	2	384,147	512,461
Ob/Gyn Services	0	0	0	23,827
OMH	1	3	923,997	1,570,028
OMH Rehabilitation	3	0	0	0
OMH-COPS	0	21	7,562,409	6,941,679
OPWDD	1	0	0	0
Other	0	0	0	790
PCAP	0	0	0	149,579
Personal Care	1	2	202,069	261,577
Pharmacies	12	10	116,488	340,701
Physician Reviews	0	1	41,063	0
PRI	0	1	27,451	27,451
Self Disclosure	63	48	1,323,832	2,415,656
TBI	3	1	132,927	399,461
Transportation	1	31	777,093	205,008
Total	**87**	**204**	**$ 15,407,822**	**$ 16,700,332**

2010 Out-of-State Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	0	1	$ 1,046,987	$ 1,389,900
DME and Orthopedic Shoe Vendor	0	0	0	216
Exception Codes	0	2	0	0
Laboratories	1	2	261,122	142,017
Pharmacies	4	0	0	0
Self Disclosure	3	1	378	378
Transportation	0	1	0	0
Total	**8**	**7**	**$ 1,308,487**	**$ 1,532,511**

2010 Statewide Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	0	1	$ 1,046,987	$ 1,463,458
Death Match[7]	0	0	(13,264)	(7,622)
Dentist	0	2	2,300,000	2,408,119
Diagnostic and Treatment Center	11	16	1,796,478	4,450,351
DME and Orthopedic Shoe Vendor	0	3	94,813	695,311
Duplicate Clinic Match	0	74	861,538	780,323
EPO/Aranesp Statewide Review	0	5	705,682	557,130
EPOGEN Clinic Review	0	4	1,229,750	1,231,052
Exception Codes[8]	1	23	(197,813)	279,122
HHC-Long Term	1	0	0	0
High Ordering Providers	0	0	10	73,922
HIV/AIDS	1	0	0	0
Hospital Inpatient	1	0	0	0
Hospital Outpatient Department	5	6	2,875,756	2,071,664
Laboratories	3	3	307,183	188,078
Nursing Reviews[9]	0	3	0	(12,373)
OASAS	7	18	13,243,036	2,890,565
Ob/Gyn Services	0	0	0	374,942
OMH	10	14	6,352,972	4,056,004
OMH Outpatient	0	0	0	60,951
OMH Rehabilitation	4	0	0	0
OMH-COPS	1	76	25,687,715	19,994,373
OPWDD	6	1	265,109	97,306
Other	0	0	0	790
PCAP	0	0	0	163,206
PERM	0	1	43,391	43,391
Personal Care	21	4	253,593	313,102
Pharmacies	18	19	3,773,455	535,010
Physician Reviews	0	1	41,063	55,883
PRI	1	2	27,451	27,451
Radiology	0	0	0	3,123
Self Disclosure	227	179	28,695,843	13,441,184
SNF-PRI/MDS	1	1	1,055	1,740,209
TBI	8	8	1,076,728	1,174,209
Transportation	4	78	1,023,244	436,023
Total	**331**	**542**	**$ 91,491,775**	**$ 59,586,257**

[7] See footnote number 3 on page A3 of the Appendix.
[8] See footnote number 4 on page A3 of the Appendix.
[9] See footnote number 6 on page A4 of the Appendix.

2010 Rate Audits by Type and Region

2010 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Clinic D&T	0	0	$ 0	$ 10,000
Home Health Care (HHC)	1	0	0	0
HHC Long Term	2	0	0	0
Medicare Crossover	4	0	0	0
Medicare Part B	1	0	0	0
Rollover-Sales Tax	4	3	86,609	85,394
Skilled Nursing Facility Audits	146	112	14,243,647	16,499,588
Transportation	0	0	0	12,383
Total	**158**	**115**	**$ 14,330,256**	**$ 16,607,365**

2010 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
HHC	0	1	$ 0	$ 0
Medicare Crossover	1	0	0	0
Rollover – Sales Tax	1	1	13,917	13,917
Skilled Nursing Facility Audits	59	52	9,341,916	10,578,703
Transportation	0	0	0	1,614
Total	**61**	**54**	**$ 9,355,833**	**$ 10,594,234**

2010 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
HHC	1	0	$ 0	$ 0
HHC Long Term	1	0	0	0
Skilled Nursing Facility Audits	111	98	10,303,973	11,642,661
Transportation	0	0	0	180
Total	**113**	**98**	**$ 10,303,973**	**$ 11,642,841**

2010 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Clinic – Diagnostic and Treatment	0	0	$ 0	$ 10,000
HHC	2	1	0	0
HHC Long Term	3	0	0	0
Medicare Crossover	5	0	0	0
Medicare Part B	1	0	0	0
Rollover – Sales Tax	5	4	100,526	99,311
Skilled Nursing Facility Audit	316	262	33,889,536	38,720,952
Transportation	0	0	0	14,177
Total	**332**	**267**	**$ 33,990,062**	**$ 38,844,440**

2010 Managed Care and Provider Review Audits by Region and Type

2010 Downstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve[10]	0	15	$ (3,184,141)	$ (3,962,430)
FFS-GME Crossover	4	0	0	0
Death Match	38	31	2,311,031	2,308,739
Family Plan Chargeback/FFS	12	24	362,664	545,168
Family Plan Chargeback/MCO	28	15	10,022,811	10,595,115
Locator Code	0	1	2,419,083	2,419,083
No Reported Encounter Data	20	16	683,052	198,100
Prior to Date-of-Birth Payments[11]	0	0	0	(406)
Prison Match	16	16	901,200	889,183
Rate Audit	2	0	0	0
Retroactive Disenrollments	87	74	6,397,077	6,270,811
SSI Retroactive Billings	0	1	151,749	151,749
Newborn FFS-MC Crossover	0	18	2,529,198	1,390,282
Underweight Babies	2	0	0	0
Total	**209**	**211**	**$ 22,593,724**	**$ 20,805,394**

2010 Upstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Clinic – FQHC	0	1	$ 4,430	$ 4,430
Death Match	11	11	584,880	584,880
Family Plan Chargeback/FFS	2	2	1,934	17,658
Family Plan Chargeback/MCO	11	5	632,919	987,541
Locator Code	0	2	8,162,012	8,162,012
No Reported Encounter Data	7	6	428,670	333,631
Prior to Date-of-Birth Payments[12]	0	0	0	(546)
Prison Match	7	7	308,759	308,759
Retroactive Disenrollments	38	33	2,002,798	2,002,798
Underweight Babies	1	0	0	0
Total	**77**	**67**	**$ 12,126,402**	**$ 12,401,163**

[10] Audit findings/recoveries for 2010 include three stipulation agreements resulting from an adverse administrative hearing decision which necessitated the reversal of 2008 audit findings, and subsequent adjustment to finalized audit amounts and refunds being issued to providers in 2010.

[11] Audit recoveries reduced due to identification overpayments received by the OMIG from a provider necessitating a refund in 2010.

[12] See footnote number 11 on this page.

2010 Upstate Western Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	0	0	$ 0	$ 728,900
Death Match	12	11	164,559	179,898
Family Plan Chargeback/FFS	4	5	12,395	14,968
Family Plan Chargeback/MCO	13	7	259,972	330,090
Locator Code	0	2	4,132,262	4,132,262
No Reported Encounter Data	8	7	215,814	102,654
Partial Capitation Plan Rate Overpayment	2	2	1,016,285	1,016,285
Prison Match	9	9	125,059	125,059
Retroactive Disenrollments	47	41	2,482,860	2,415,233
Newborn FFS-MC Crossover	0	3	4,870	4,870
Total	**95**	**87**	**$ 8,414,077**	**$ 9,050,218**

2010 Statewide Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	0	15	$ (3,184,141)	$ (3,233,530)
Clinic – FQHC	0	1	4,430	4,430
FFS-GME Crossover	4	0	0	0
Death Match	61	53	3,060,470	3,073,517
Family Plan Chargeback/FFS	18	31	376,994	577,793
Family Plan Chargeback/MCO	52	27	10,915,701	11,912,746
Locator Code	0	5	14,713,357	14,713,357
No Reported Encounter Data	35	29	1,327,536	634,385
Partial Capitation Plan Rate Overpayment	2	2	1,016,285	1,016,285
Prior to Date-of-Birth Payments	0	0	0	(952)
Prison Match	32	32	1,335,018	1,323,001
Rate Audit	2	0	0	0
Retroactive Disenrollments	172	148	10,882,735	10,688,841
SSI Retroactive Billings	0	1	151,749	151,749
Newborn FFS-MC Crossover	0	21	2,534,068	1,395,152
Underweight Babies	3	0	0	0
Total	**382**	**365**	**$ 43,134,204**	**$ 42,256,776**

2010 Medicaid in Education Reviews by Region and Type

2010 Downstate Region Medicaid in Education Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
PSHSP*	2	0	$ 0	$ 0
SSHSP**	9	0	0	0
Total	**11**	**0**	**$ 0**	**$ 0**

2010 Upstate Region Medicaid in Education Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
PSHSP	5	1	$ 0	$ 0
SSHSP	22	1	0	0
Total	**27**	**2**	**$ 0**	**$ 0**

2010 Western Region Medicaid in Education Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
PSHSP	9	1	$ 0	$ 0
SSHSP	30	2	0	0
Total	**39**	**3**	**$ 0**	**$ 0**

2010 Statewide Medicaid in Education Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
PSHSP	16	2	$ 0	$ 0
SSHSP	61	3	0	0
Total	**77**	**5**	**$ 0**	**$ 0**

*Pre-School Supportive Health Services Program
**School Supportive Health Services Program

Medicaid Fraud, Waste, and Abuse Demonstration Program

2010 Downstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendors	3	7	$ 398,783	$ 116,843
Pharmacies	84	33	2,120,976	3,002,164
Transportation	14	3	2,379,813	36,581
Total	**101**	**43**	**$ 4,899,572**	**$ 3,155,587**

2010 Upstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendors	0	1	$ 18,751	$ 12,640
OASAS	0	0	0	3,342
Pharmacies	9	20	1,444,890	1,737,516
Physician Reviews	5	0	0	0
Transportation	4	1	0	0
Total	**18**	**22**	**$ 1,463,641**	**$ 1,753,498**

2010 Western Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendors	1	1	$ 1,373	$ 1,373
OMH[13]	0	0	(230,695)	237,339
Pharmacies	25	17	1,445,724	2,170,538
Transportation	2	0	0	0
Total	**28**	**18**	**$ 1,216,402**	**$ 2,409,250**

2010 Statewide County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendors	4	9	$ 418,907	$ 130,856
OASAS	0	0	0	3,342
OMH[14]	0	0	(230,695)	237,339
Pharmacies	118	70	5,011,590	6,910,217
Physician Reviews	5	0	0	0
Transportation	20	4	2,379,813	36,581
Total	**147**	**83**	**$ 7,579,615**	**$ 7,318,335**

[13] Audit findings lowered due to a stipulation agreement issued in 2010 related to a 2008 final audit.

[14] See footnote number 13 on this page.

Technology and Business Automation

2010 Systems Match Recoveries by Region and Type

2010 Downstate Region Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	1	$ 1,372	$ 1,372
Chemotherapy	26	25	974,703	969,442
Deceased Recipients	188	274	677,039	747,025
Dental	16	6	50,750	108,893
DME/SNF	39	36	174,524	120,778
DME Crossover – Medicaid with Medicare Detail	30	7	1,330,248	23,957
Duplicate Clinic Payments	6	3	1,472,446	572,289
General Clinic	39	82	499,913	889,329
Hemodialysis	0	2	0	46,639
Home Health	108	112	446,393	443,044
Home Health – Nursing Home	0	1	5,081	5,081
Inpatient Crossover/Clinic/ER	0	4	392,802	831,714
Inpatient/Ancillary/Laboratory	34	28	71,801	71,801
NAMI	0	5	112,821	86,267
Non-affiliated Inpatient/Clinic/ER	0	4	142	18,080
OB/Gyn	80	77	793,699	726,416
PAC & PAS	11	4	263,576	112,889
Partial Hospitalization	17	4	179,120	26,804
Prenatal Care Assist Program (PCAP)	1	14	1,107,517	3,400,529
Physician – Place of Service	0	34	401,187	670,856
Radiology	0	50	234,075	263,602
Voluntary Refunds	7	7	678,036	679,934
Total	**602**	**780**	**$ 9,889,157**	**$ 10,816,741**

2010 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Chemotherapy	3	3	$ 36,926	$ 36,926
Deceased Recipients	13	26	57,769	59,391
Dental	2	0	0	0
DME/SNF	8	7	29,971	29,971
DME Crossover – Medicaid with Medicare Detail	17	0	0	0
General Clinic	18	58	525,151	234,199
Home Health	25	26	74,438	74,985
Inpatient Crossover/Clinic/ER	0	1	3,087	10,930
Inpatient/Ancillary/Lab	18	13	43,443	39,366
NAMI	0	1	33,915	5,653
Non-Affiliated Inpatient/Clinic/ER	0	3	0	2,044
OB/Gyn	45	43	225,729	151,029
PAC & PAS	5	3	42,148	9,857
Partial Hospitalization	8	3	110,151	40,145
PCAP	0	6	364,321	530,623
Physician – Place of Service	0	3	25,042	39,780
Radiology	0	26	87,931	142,022
Total	**162**	**222**	**$ 1,660,023**	**$ 1,406,921**

2010 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Chemotherapy	3	3	$ 17,702	$ 1,978
Deceased Recipients	8	10	7,314	7,314
Dental[15]	7	1	0	(8,874)
DME/SNF	5	5	12,209	12,209
DME Crossover – Medicaid with Medicare Detail	19	1	1,147	1,147
General Clinic	33	80	657,486	764,214
Home Health	18	15	42,282	40,292
Home Health – Nursing Home	0	2	0	1,054
Inpatient Crossover/Clinic/ER	0	1	1,572	1,572
Inpatient/Ancillary/Lab	20	13	43,283	45,026
NAMI[16]	0	2	0	(25,465)
OB/Gyn	60	57	291,022	282,847
PAC & PAS	6	2	2,420	915
Partial Hospitalization	5	3	48,864	25,197
PCAP	2	6	182,113	289,413
Physician – Place of Service	0	5	66,109	73,270
Radiology	0	19	42,253	181,638
Voluntary Refunds	2	1	4,452	4,452
Total	**188**	**226**	**$ 1,420,226**	**$ 1,698,199**

[15] Audit recoveries lowered due to refund released to provider as a result of a stipulation agreement issued in 2010 related to a 2009 final audit.

[16] Audit recoveries reduced due to a stipulation agreement issued in 2010, and provider bankruptcy necessitating the write-off of identified overpayments.

2010 Out-of-State Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Deceased Recipients	23	31	$ 69,505	$ 63,492
Dental	16	0	0	0
DME/SNF	24	23	96,286	81,456
DME Crossover – Medicaid with Medicare Detail	30	1	26,459	14,686
General Clinic[17]	0	32	139	(3,476)
Inpatient Crossover/Clinic/ER	0	1	1,211	1,211
Inpatient/Ancillary/Lab	1	1	1,773	1,773
Managed Care Death Match	0	0	0	2,465
OB/Gyn	49	49	190,222	139,485
Other	0	1	0	0
Physician – Place of Service	0	6	58,072	60,573
Radiology	0	11	26,482	64,867
Total	**143**	**156**	**$ 470,149**	**$ 426,530**

[17] Audit recoveries reduced due to amendments in audit parameters necessitating issuance of a revised audit report and refund to provider.

2010 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	1	$ 1,372	$ 1,372
Chemotherapy	32	31	1,029,330	1,008,345
Deceased Recipients	232	341	811,627	877,221
Dental	41	7	50,750	100,019
DME/SNF	76	71	312,990	244,415
DME Crossover – Medicaid with Medicare Detail	96	9	1,357,854	39,789
Duplicate Clinic Payments	6	3	1,472,446	572,289
General Clinic	90	252	1,682,689	1,884,266
Hemodialysis	0	2	0	46,639
Home Health	151	153	563,113	558,322
Home Health – Nursing Home	0	3	5,081	6,134
Inpatient Crossover/Clinic/ER	0	7	398,673	845,427
Inpatient/Ancillary/Lab	73	55	160,300	157,965
Managed Care Death Match	0	0	0	2,465
NAMI	0	8	146,737	66,454
Non-Affiliated Inpatient/Clinic/ER	0	7	142	20,124
OB/Gyn	234	226	1,500,672	1,299,777
Other	0	1	0	0
PAC & PAS	22	9	308,143	123,661
Partial Hospitalization	30	10	338,135	92,147
PCAP	3	26	1,653,951	4,220,565
Physician – Place of Service	0	48	550,410	844,478
Radiology	0	106	390,741	652,128
Voluntary Refunds	9	8	682,488	684,386
Total	**1,095**	**1,384**	**$ 13,417,644**	**$ 14,348,391**

Third Party Liability Recoveries

Activity Area	2010
HMS	$ 193,606,492
UMASS	91,928,268
Self-Disclosed TP Health Insurance	2,177,973
Total	**$ 287,712,733**

Cost Savings Activities

Activity Area	2010
Card Swipe Program/ Post & Clear Program	$ 232,828,664
Clinic License Verification	20,127,526
Duplicate Clinic/Nursing Home Claim Editing	222,329
Edit 102 – Service Date prior to Birth Date	98,758
Edit 1141 – Dental Activities	1,621,603
Edit 1141 – Medical Activities	9,284,578
Edit 1236/1238 - Order/Servicing/Referring Provider #	6,698,580
Edit 1344 – Transportation Claims	1,526,173
Edit 1357 – Provider ID/Service ID are the same	4,183,692
Edit 748 – DME Denied Claims	105,549
Edit 760 – Suspected Duplicate, Covered by Inpatient	2,807,579
Edit 903 – Ordering/Referring Provider Number Missing	28,641,440
Edit 939 - Ordering Provider Excluded Prior to Order Date	8,975,665
Edit 941/944 – Practitioner Claims	136,706
Enrollment and Reinstatement	58,766,757
Exclusions/Terminations – Internal	9,189,572
Exclusions/Terminations – External	8,841,570
High Ordering Physicians	25,806,920
Hospice Audit – Jacob Perlow	6,981,712
Medicaid Payments for Deceased Recipients	298,234
Pharmacy Claims – Credits for Prescriptions	98,429,992
Pharmacies License Verification	19,093,081
Pharmacy Prior Authorization (Serostim)	52,314,772
Pre-Payment Insurance Verification Commercial	897,534,399
Pre-Payment Insurance Verification Medicare	218,099,026
Recipient Restriction	151,623,959
Serialized Prescription Program Edits	36,498,919
Transportation Crossover Edit	218,642
Total	**$ 1,900,956,437**