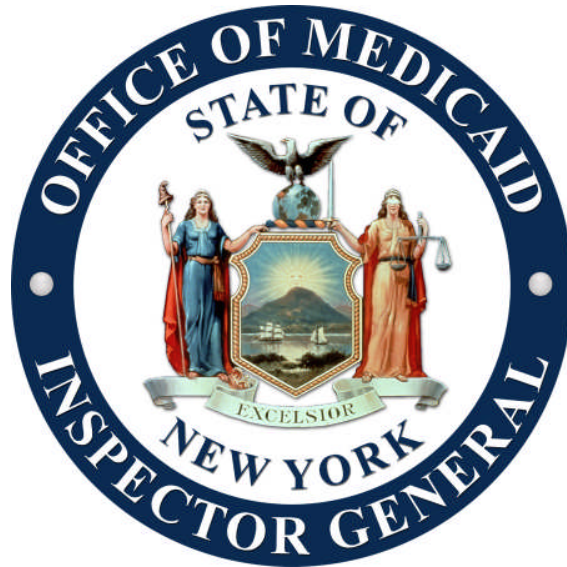


**New York State  
Office of the Medicaid Inspector General**



**SFY 2009-2010  
OMIG Medicaid  
Work Plan**

*David A. Paterson*  
**Governor**

*James G. Sheehan*  
**Medicaid Inspector General**

[www.omig.state.ny.us](http://www.omig.state.ny.us)

Fraud Hot Line: 1-877-87-FRAUD

**April 24, 2009**

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**STATEMENT FROM NEW YORK'S GOVERNOR  
DAVID A. PATERSON**

New York State's Medicaid program is the largest in the country, covering more than four million New Yorkers and costing more than \$45 billion annually. Since 2000, Medicaid enrollment has increased almost 50 percent and can be expected to increase further in a declining economy.

Our goal is to ensure that eligible New Yorkers are able to get and keep Medicaid coverage and that Medicaid buys quality, cost-effective care. Central to this goal is the work of the Office of the Medicaid Inspector General that is charged with preserving the integrity of the Medicaid program, preventing or detecting fraud, abuse or waste in the Medicaid system, and recovering improper payments. New York's efforts to control waste, fraud and abuse are leading the nation and serve as a role model for other states. We must continue our commitment to the integrity of the program that is critical to the health of so many New Yorkers.

## NYS OMIG 2009-2010 WORK PLAN

### INTRODUCTION

#### *AN OPEN LETTER FROM THE MEDICAID INSPECTOR GENERAL*

The Office of the Medicaid Inspector General (OMIG) plays a pivotal leadership role in the state's mission to eliminate and prevent fraud, waste and abuse in New York's Medicaid program.

Working closely with the Department of Health, the OMIG seeks to ensure the integrity of the Medicaid Program.

On behalf of my entire staff, I am pleased to present this, our second, OMIG work plan. This document is unique, since, to our knowledge, no other state Medicaid program integrity or enforcement agency publishes a detailed public summary of its intended areas of audit and investigative emphasis for the upcoming year. This work plan serves as a "road map" for the next year, reflecting OMIG's mission, developing competencies and carefully reviewing New York Medicaid expenditures and vulnerabilities. It also offers providers an opportunity to see the specific areas the OMIG will concentrate on during the next year.

This work plan represents the culmination of a comprehensive review and analysis of New York's Medicaid integrity effort. Every management-level employee throughout OMIG (most with help and advice from their staff) compiled an assessment of achievements for the current year, devised plans for the upcoming year, and made a personal presentation of the assessment and plan to the Inspector General and the deputy responsible for that particular area.

The work plan reflects guidance and input from the Department of Health (DOH) as well as the behavioral health agencies and the Office of Temporary Disability Assistance (OTDA) and is intended to give providers and the public a picture of OMIG's activities for the current fiscal year for planning and compliance. It is not intended to cover every OMIG initiative, investigation, or audit. OMIG will develop additional activities during this fiscal year beyond those described in this report.

The OMIG works closely with the Department of Health through the Office of Health Insurance Programs, which manages New York's Medicaid program, to assure the integrity and effectiveness of the Medicaid program. We also work with other components of the Department which have regulatory responsibility for individual and institutional providers.

We have also met with representatives of professional and institutional organizations, and included the results of those meetings. We will continue meeting with such organizations, since these exchanges provide our staff with valuable information concerning care delivery for the state's Medicaid enrollees, whether receiving acute care, long-term care services, primary care, mental health services, or chronic care in a day treatment program.

One of OMIG's additional key partners in protecting the New York State Medicaid program is the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General. Our office refers investigative findings to the MFCU for criminal and civil prosecution. One of my first goals as the MIG has been to enhance the communication and the overall relationship with the MFCU. I feel we have been successful in that effort over the past two-plus years, having collaborated with them on numerous projects important to both offices. For example, we have provided assistance to them in terms of implementing administrative remedies in their major



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home health care investigation known as “Operation Home Alone.” I look forward to leveraging the talents and expertise of both agencies in 2009 as we continue our joint interest in protecting the health and safety of Medicaid enrollees by pursuing failure of care investigations.

The Office of the State Comptroller (OSC) performs ongoing audits of Medicaid payments. In conjunction with these audits, the OSC performs analysis of Medicaid claims. These analyses have identified billing patterns that warrant further review and, in some cases, detailed reviews of provider records. The OSC’s findings are generally referred to the OMIG for audit purposes, and where necessary, recovery of overpayments.

From the time that the OMIG was created in November, 2006, the office has emphasized a new approach to program integrity, including:

- transparency and communication with health care providers
- identification of improper payments
- prevention and early detection
- communication with health care providers about the nature and causes of improper payments
- supporting development of effective internal compliance programs and controls
- effective use of data mining, data analysis, and data integration to use New York’s \$200 billion, four million covered lives and 60,000 provider data system to reduce costs and improve quality
- analysis and integration into practice of the best of current academic, advocacy, and oversight agency research and analysis of health care fraud, compliance, and program integrity

New York’s Governor and Legislature set significant financial goals for the OMIG in terms of fiscal recoveries. In 2006, New York State signed an agreement with the United States Department of Health and Human Services to repay health care modernization grants to New York with the state’s recovery of more than \$1.6 billion in fraud and abuse payments between October 1 2007 and September 30, 2011. Known as F-SHRP (for Federal-State Health Reform Partnership), this agreement contains strict requirements for the state to meet in terms of actual recoveries.

OMIG, the Department of Health, and the MFCU of the New York State’s Attorney General’s Office have collaborated to meet—and actually exceed—the first year goal of \$215 million (federal fiscal year 2008), but the out-year goals (\$322 million in FFY 2009, \$429 million in FFY 2010, and \$644 million in 2011) are ambitious and will be difficult to achieve.

For FY 2009-10, Governor David A. Paterson and the Legislature have established a goal of \$870 million in state-share recoveries and cost avoidances for OMIG—nearly three times the level assigned in 2006-07. To achieve this task, OMIG worked throughout the last year to develop accurate, reliable measures of cost avoidance, and developed new techniques to identify potential for cost avoidance in every part of the agency and the Medicaid program.

Given the financial expectations arising from F-SHRP and state budget goals, it is important that OMIG pay particular attention to its non-financial goals—to take steps to assure that providers are treated with fairness and respect and that health care professions and organizations assure that services are properly billed the first time. These issues are also addressed in this document.

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Finally, we urge every provider to review the “open letter to New York State health care providers” that will be posted on our Web site in May 2009. This letter identifies three priority areas which should be in every provider’s compliance work plan.

Protecting the integrity of the New York State Medicaid program is a daunting task. Preventing fraud, waste and abuse in the program is equally challenging. This work plan demonstrates that the staff of the OMIG has a clear path to addressing the challenges New York State faces over the next year.

## **EXECUTIVE INITIATIVES**

### **BUREAU OF ALLEGATIONS AND COMPLAINTS**

The Bureau of Allegations and Complaints (BAC) is under development to review and track all Medicaid provider-related allegations and complaints received by the Office of the Medicaid Inspector General. Experienced audit and investigative staff will apply a consistent review process to identify fraudulent and/or abusive situations which warrant further examination by a unit of OMIG or other New York State authorities.

During SFY 2009-10, the BAC will codify the policy and processes for reviewing and tracking all allegations and complaints into a written manual and provide case volume reports and case status updates on a designated schedule.

After testing the process for a period of six months, the BAC will conduct an extensive evaluation to identify potential improvements. At this time, efforts will focus on broadening the scope of the BAC to solicit allegations and complaints from beyond OMIG to include sources inside and outside state government across the state.

### **COMPLIANCE GUIDANCE**

In a continuing effort to promote integrity on the front end of provider processes, during the next year, the OMIG will publish compliance guidance for hospitals and managed care organizations. Additionally, the OMIG will convene advisory committees to solicit best practices to facilitate provider adoption and implementation of effective compliance programs that meet the requirements of § 363-d of the Social Services Law. The OMIG anticipates developing guidance documents focused on nursing homes, home care and Office of Alcoholism and Substance Abuse Services (OASAS) providers as the next phase of this endeavor.

Providers subject to Articles 28 or 36 of the Public Health Law or Articles 16 or 31 of the Mental Hygiene Law are statutorily mandated to maintain an effective compliance program. Providers covered by 18 NYCRR Part 521 will be required to have such programs in place within 90 days of OMIG's adoption of the final regulations. The OMIG will review provider compliance programs during the course of audits/investigations. Failure by providers to adopt and implement an effective compliance program will subject the provider to any sanctions or penalties permitted under state or federal laws or regulations including exclusion from the medical assistance program.

Compliance officers serve as the cornerstone of an organization's efforts in establishing, facilitating and coordinating effective compliance programs. A diligent and experienced compliance officer is integral to preventing illegal, unethical or improper conduct on the part of providers and their staffs and preserving the integrity and safeguarding the assets of the Medicaid program.

The OMIG appreciates the wide-ranging and vital responsibilities of compliance officers and the contributions they make to advance ethical behavior and exceptional care by New York State Medicaid providers. OMIG fully expects that compliance officers will be placed at senior management positions within organizations and be afforded the support and assistance of the governing board, the chief executive officer and fellow senior management, provided adequate resources (i.e., sufficient time, staff and budget), and granted access to relevant documents and

## NYS OMIG 2009-2010 WORK PLAN

other information necessary to effectively design, implement and monitor the compliance program.

Under state law and regulation, most health care providers organized other than as a sole proprietorship or general partnership are obligated to have a governing body with responsibility for setting policy, for assuring that processes and systems are in place to provide a reasonable assurance of compliance with governing law, and for exercising reasonable oversight over information and reporting systems on an ongoing basis to detect potential violations of law or corporate policy.

Where OMIG identifies a significant compliance or control weakness at a health care provider in the course of an audit, investigation, or match project, OMIG will inquire into the board's actions in assuring that compliance processes and systems are in place, and whether board members have exercised reasonable oversight over information and reporting systems.

In appropriate circumstances, OMIG will consider sanctions, including censure and/or exclusion against individual members of the governing body for significant failures to comply with their duties with respect to compliance and oversight.

### **CORPORATE INTEGRITY AGREEMENTS**

Although certain providers are obligated to adopt and implement effective compliance programs in accordance with Social Service Law § 363-d and Part 521 of the regulations, other than addressing the prescribed "elements," those providers are not obligated to follow any set process or include specific compliance provisions. In circumstances where a provider has failed or refused to meet their proscribed obligations, but where removal from the program would negatively impact access to services, the OMIG may consider imposing very specific integrity practices against a provider through the issuance of a corporate integrity agreement (CIA).

While utilized for some time by the Department of Health and Human Services Office of the Inspector General, CIAs have only recently been employed at the state level. We expect to implement this tool to a greater extent over the next year. Providers operating under OMIG CIAs will be subject to specific performance standards and reporting requirements and will be monitored by the OMIG and/or, in some cases, an independent external reviewer. Providers failing to meet conditions set forth in CIAs will face sanctions in the form of stipulated penalties and/or exclusion.

The OMIG intends to post executed CIAs on its Web site.

### **FOCUS ON ORDERING PHYSICIANS**

In the Medicaid program, physicians have two important roles. First, they provide services to Medicaid patients through examination, testing, diagnosis, and treatment for which they and/or their employers directly bill Medicaid.

The second role is to oversee and manage the care of their patients, i.e., to order services, tests, medicines, and devices, to supervise treatment plans for other services, and to make sure that the treatment the patient is receiving is most likely to result in the best outcome for the patient. Under many Medicaid program requirements, the treating physician approves and certifies to the medical necessity of the patient's treatment plan.

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The second role is as important, and significantly more expensive for the Medicaid program. Many physicians who are not even enrolled as providers in the Medicaid program (because they are employed by diagnosis and treatment centers, or have contractual relationships with managed care plans) order services and goods with a value in excess of \$1 million.

OMIG will review ordering physicians in order to determine:

- relationships between ordering physicians and providers of ordered goods and services;
- whether ordering physicians were properly licensed and not excluded from the Medicaid program at the time the services or goods were ordered;
- what happens to claims for ordered services when they are initially denied because of systems edits or claim denials (that is, whether claims are resubmitted using the provider number of a different ordering physician);
- which organizations appear to be using the services (by employment or contract) of excluded physicians, based upon denied claims;
- physicians who order goods or services in excess of \$75,000 per year and who have not enrolled in the Medicaid program; and
- physicians who ordered services or goods for patients, where there is no evidence of an existing physician-patient relationship, or no record to support for the order.

In appropriate circumstances, OMIG will seek recoveries of amounts paid from providers of services, or from ordering physicians, and sanctions.

### **AUDIT ASSESSMENT SURVEY**

As part of its continuous process improvement, internal controls and provider outreach initiatives, OMIG will conduct an audit assessment survey, which will be sent to providers within 30 days of the issuance of final audit reports. The survey is designed to solicit constructive feedback on OMIG's audit process and the interaction between OMIG staff and providers. The goal is to identify processes needing improvement, to enhance communication between the audit staff and the provider, and to minimize the disruption of business operations while maintaining a thorough review consistent with the focus of the audit. The survey will be voluntary and providers may remain anonymous. This new initiative is part of the OMIG's overall provider communications strategy and will be launched during the second quarter of 2009.

### **MARKETING AND ORDERING OF PRESCRIPTION DRUGS AND MEDICAL DEVICES**

New York State law authorizes physicians to prescribe Federal Drug Administration-approved drugs for both on-label (that is, consistent with the indications for which the drug is approved by the FDA) and off-label (that is, indications not approved by the FDA). Although prescription drugs can be beneficial to patients for some off-label uses, such use can also present significant risks.

OMIG will review the medical and scientific literature relating to the risk of potential adverse effects of off-label use of FDA-approved drugs. Where the literature suggests significant risk for certain patient demographic groups or patient diagnoses, OMIG will review Medicaid claims data to determine the extent of off-label use, the medical conditions of the patients for whom the drug

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was prescribed, the practice or institutional setting in which such uses occur, and the individual prescribers who have ordered the medications.

OMIG will also review information relating to the receipt by physicians in New York of payments from pharmaceutical and device manufacturers. Medicaid claims data will be reviewed to assess potential relationships between receipt of payments by physicians from pharmaceutical and device manufacturers and prescribing or device prescribing or use. OMIG will review conflict-of-interest disclosure information from physicians to determine whether the information obtained from pharmaceutical or device companies is consistent with that provided for IRS form 990, institutional review boards, hospital or university staff membership, and publications and presentations.

In appropriate cases, OMIG will review Medicare Part D data for dually-eligible patients to identify prescribers and the full extent of prescription medications provided to patients.

### **MONITORING NEW YORK STATE'S SHARE OF THE FEDERAL STIMULUS MEDICAID FUNDS**

On February 17, 2009 President Barack Obama signed the American Recovery and Reinvestment Act (ARRA), providing almost \$800 billion to stimulate the American economy. The ARRA consists of \$87 billion in fiscal relief through an increase in the Federal Medicaid Assistance Percentages (FMAP). New York's share of that funding, which includes funding for the state, counties, and the City of New York, is nearly \$11 billion over a 27-month period (\$1.9 billion in 2008-09, \$5.0 billion in 2009-10, and \$4.2 billion in 2010-11).

The ARRA highlights the need for a heightened level of accountability and transparency related to any funds that become available to states from the stimulus appropriations. The stimulus legislation has assigned the United States Government Accountability Office (GAO) with a range of responsibilities to help promote accountability and transparency. One of these recurring requirements includes bimonthly reviews of the use of funds by selected states and localities. New York State is one of the core group of 16 states that GAO will follow over the next few years to provide an ongoing longitudinal analysis of the use of funds under the ARRA.

The OMIG has commenced discussions with GAO representatives to determine OMIG's oversight responsibilities associated with New York's share of the federal Medicaid stimulus package. New York State is in the process of determining how and where the Medicaid stimulus funds will be allocated. Once these allocations are defined and the path of the stimulus funds is identified, OMIG will determine its role in monitoring these funds in relation to OMIG's core function of conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse with the goal of assuring integrity in the Medicaid program.

The OMIG looks forward to joining the collective accountability community and, where appropriate and consistent with the agency's mission, playing an important role in helping to ensure that the ARRA funds are spent properly and are meeting their intended purposes.

### **EXTERNAL COMMUNICATIONS**

The OMIG is committed to increasing visibility with its various constituencies, including the Governor's office, legislators and other policymakers, other state agencies, Medicaid providers

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and the general public. To that end, we have expanded outreach efforts on a variety of levels, and are focused on investigating new avenues of communication during 2009-10.

The OMIG values regular communication with providers, their associations and the associations of those professionals that represent the interests of providers, through audits, self-disclosures, compliance initiatives, etc. We will continue to conduct extensive outreach to promote OMIG's mission, discuss ongoing initiatives, and obtain constructive feedback. OMIG recognizes that many providers have established best practices, and we are interested in learning about those and sharing them with other providers with the hope of fostering high quality care and compliance throughout the healthcare industry.

### Web Site

The Web site ([www.omig.state.ny.us](http://www.omig.state.ny.us)) provides an outstanding outreach tool to all OMIG constituents. Not only does it contain background information on the office, it also features sections on:

- Agency regulations
- Annual reports
- Disqualified individuals
- Employment
- Final audit reports
- Payment Error Rate Measurement (PERM)
- Posting providers
- Presentations
- Press room
- Procurements
- Provider compliance
- Regulations
- Resources
- Self disclosure
- Subscribe to the OMIG list (a listserv feature that enables subscribers to automatically receive "breaking" news from OMIG as soon as it is ready to be posted on the Web site)

Additionally, consumers, providers or other observers may file a complaint about suspected fraud, waste or abuse directly through a link on the Web site. Both the 2008-09 and the 2009-10 work plans are posted, as is the 2009 budget testimony of Medicaid Inspector General, James G. Sheehan, as he appeared before a joint session of the New York State Legislature on February 2, 2009.

During the 2009-10 timeframe, the Web site will undergo a major renovation, including a graphic redesign. This will enable the OMIG to enhance the user-friendly aspects and interactivity of the site, as well as to improve the site's graphic attractiveness. The Public Information Office, in conjunction with Information Technology Office staff, are constantly re-evaluating the site and soliciting input from OMIG staff from across the state. Expected enhancements for 2009-10 will include:

- New layout for final audit reports to include provider category
- Addition of diagnosis related groups (DRG) pairings to assist hospitals in determining how their own DRGs compare to those of other hospitals of similar size

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- Investigating the feasibility of adding of other legal postings, which may include the results of administrative law judge (ALJ), including, but not limited to, hearings, appeals, and subpoena information
- Information about OMIG's senior staff and other contacts

### **External Outreach**

While the OMIG has responded to media inquiries concerning a number of issues throughout the past year, we have also initiated stories or appearances in electronic or print media during 2008-09. We track and monitor all media requests and who answers those inquiries, followed by maintaining an active news clipping file. Such media have included statewide public radio and television, New York City-based newspapers, political columns and trade publications focusing on specific aspects of OMIG's work. We will be proactive with the media in 2009-10 but also expect to answer inquiries that come into the office on both routine and more crisis-oriented matters.

### **REVIEW OFF-LINE MEDICAID EXPENDITURES**

The Department of Health, which administers New York State's Medicaid program, and its fiscal agent, Computer Sciences Corporation, use the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay most of the claims submitted by providers who render services to Medicaid-eligible recipients.

Certain types of claims, however, require special processing or fall under MMIS limitations. These are handled outside MMIS and are referred to as "off-line" payments. Off-line Medicaid claims include, but are not limited to, payments to providers from public goods pools established to reimburse providers for services rendered to indigent persons, payments of Medicare insurance premiums on behalf of Medicaid recipients, and reimbursements to local governments and state agencies for off-line claims they have submitted for reimbursement.

The OMIG will review off-line Medicaid expenditures in New York State's Medicaid program by developing a comprehensive listing of off-line program and administrative expenses, the sources of these expenditures, and past and current internal and external audit activity. The review will establish the potential risk for each expenditure type after assessing the size of the expenditure and the extent to which the expenditures have been subject to prior audit activity. Those expenditure areas demonstrating high rates of risk will be incorporated into the OMIG audit work plan.

### **DIVISION OF MEDICAID AUDIT**

The Division of Medicaid Audit (DMA) professional staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and reduce the potential for fraud, waste and abuse.

Our field staff has a broad range of experience in health care programs. This affords the Division of Medicaid Audit the opportunity to organize and coordinate statewide projects to address the



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spectrum of Medicaid-covered services and the various program initiatives of the Department of Health (DOH), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse Services (OASAS). OMIG's professional staff performs audits and reviews of Medicaid providers augmented by outside contractors, and staff from the local districts through the County Audit/Investigation Demonstration Project.

The effects of the lack of regulatory controls and proper oversight authority have recently come to light in the home care industry in Dade County, Florida. According to published reports, Medicaid fraud had become an epidemic in this area where home health care clinics were opened with little or no regulation or accountability. This has led to the passage of a new law which strictly controls the authorization for such services and has established anti-fraud controls for all aspects of the operation of the clinics.

Pursuant to 42 USC § 1396(5), §§ 20, 34, and Article 5, Title 11 of the New York Social Services Law, and Chapter 436 of the Laws of 1997, DOH is the designated single state agency responsible for administering and supervising the Medicaid program in New York. That responsibility includes ensuring the quality of care within each facility, establishing the rates of payment to be paid to each facility for Medicaid-covered care (Public Health Law Article 28), validating the appropriateness of payments on delayed or denied claims, and the responsibility of assuring the accuracy of the promulgated rates of payment through the audit of cost reports (Social Services Law § 368-c). To carry out the latter responsibility, DOH conducts audits and reviews of various providers of Medicaid-reimbursable services.

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the state (Social Services Law § 365-a; 18 NYCRR Part 504). Satisfactory compliance with program rules and regulations is a condition of continued participation in the Medicaid program.

By choosing to participate as a Medicaid provider, a participant assumes responsibility for meeting all requirements as a prerequisite for receiving payment and maintaining continued status as an enrolled provider (18 NYCRR Parts 504, 515, 517 and 518). Enrollment as a provider, along with participation and submission of billings certifying compliance with those rules and regulations (18 NYCRR §§ 504.3 and 540.7(a) (8)), connotes acceptance of the contractual responsibilities.

DOH regulations (18 NYCRR Subchapter E) define the requirements for participation, as well as the rules, regulations and statutes of general applicability to the provider type in question. The rules governing the establishment of Medicaid rates by DOH are enumerated in 10 NYCRR Subpart 86-2.

### **AUDIT PROCESS**

The Medicaid program requires participating providers to maintain adequate records to support their billings to the program. Cost-based providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. This includes all underlying books, records and documentation that form the basis for the financial and statistical reports which the provider files with the Bureau of Long Term Care Reimbursement (BLTCR). The BLTCR is responsible for establishing the payment rates.

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Fee-for-service providers, who are paid in accordance with DOH-established rates, fees and schedules, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program. The provider must keep all records necessary to disclose the nature and extent of services furnished and the medical necessity of the service, including any prescription or fiscal order for the service or supply, for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.

OMIG's goal is to implement a system of paperless audits for rate-based provider audits. A team of auditors completed a pilot program in SFY 2008-09 regarding electronic work papers. OMIG chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. This program will be implemented in all rate-based provider audits during SFY 09-10. In conjunction with the implementation of TeamMate software, the OMIG has developed a training manual and outline for all rate-based provider audits, with the implementation process slated for completion by July 2009.

The Division of Medicaid Audit publishes its work plan to assist compliance offices in developing their own organization-specific audit and monitoring activities.

### **Selection of Audit Subject Areas, Providers and Methods**

The OMIG uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. We consider successful initiatives in Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program ideas and directives from the CMS Medicaid Integrity Program, which has federal responsibility for guiding and overseeing our work. We work closely with the Department of Health, the Department of Law and the Comptroller's offices in identifying program vulnerabilities.

We also receive recommendations for audits from the Department of Health and Human Services, Office of Inspector General (OIG), oversight agencies, newspaper articles and our hotline. An integral part of the selection process is a review of oversight agency survey reports or other provider reviews. We use this information to determine whether to perform an audit, and, if so, the type of audit. For example, we have the option of performing a documentation and coding audit or a clinical audit of fee-for-service providers, or a combination of those audit approaches.

### **Project Notification**

An on-site audit begins with an OMIG notification to the provider by sending out a project letter. In 2008, the OMIG revised the project letter to require providers to submit certain audit documentation to the OMIG within 30 days. This enables the OMIG to perform audit procedures prior to beginning the field audit. The information includes audited financial statements, tax returns, a list of related parties and selected analysis of work. In addition, we direct the provider to notify its outside accountants in writing, so that the OMIG can gain access to their workpapers.

We will require a copy of provider tax returns and information on its corporate compliance program. We will also review enrollment records and require copies of current annual certifications.

### **Entrance Conference**

The OMIG conducts an on-site entrance conference with each individual provider to discuss the nature and extent of the audit. For rate-based audits, we discuss specific issues to be addressed

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based on pre-audit reviews of documents. For fee-for-service audits, we are able, in certain instances, to give providers the specific date of service or cases under review. In other instances, we will give the provider sample selections periodically during field work which may include ranges of dates of service.

### Statistical Sampling

Information obtained from statistical sampling is now generally accepted. Accounting firms, national healthcare consulting firms, the Department of Health and Human Services, and the Office of the Inspector General (OIG) have historical uses of statistical sampling for audit purposes. In many instances, statistical sampling allows an audit of an account to be conducted that would otherwise be too voluminous or complex to audit in its entirety. Some of the sampling techniques generally used by auditors, including the OMIG, are as follows:

- **Population or sampling frame**—the entire set, made up of individual elements, under consideration: In the context of third-party insurer audits, the population might be the set of all claims made over a certain period of time or the set of all recipients of medical care.
- **Sampling unit**—the individual elements that comprise the population or sampling frame: In the case of an insurer audit, the sampling unit might be the insurance recipient or the individual insurance claim or transaction.
- **Probability sample**—a sampling procedure in which the probability that any member of the population will be included in the sample is known in advance: For example, in a simple random sample, each member of the population has an equal chance of being included in the sample. Valid estimation procedures require probability samples.
- **Random sample**—a group of sampling units from a population where each unit has an equally likely chance of being independently selected from the population or sampling frame.
- **Sampling procedure or technique**—the method used to select units for inclusion in a probability sample, for instance, choosing every tenth unit (systematic sampling), or using a random number table.
- **Estimator**—the mathematical rule by which an estimate of some population characteristic is calculated from the sample results.
- **Estimate**—the value obtained by applying the estimator to the random sample, and projecting it to the larger population: A point estimate is an estimate in which a single number is used as an estimate of a population characteristic. An interval estimate is one in which the estimate is given as a confidence interval within which the population characteristic will lie with a certain confidence level.
- **Unbiased**—an estimator is unbiased if the average value of the estimate, taken over all possible samples, is exactly equal to the true population value.
- **Confidence interval, confidence level**—the confidence interval is the range of values in which a population characteristic will lie with a given level of certainty (confidence level, expressed in percent). For example, we might be “95 percent confident” that the mean of a

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sampling frame is between two values, X1 and X2, which are the upper and lower bounds of the confidence interval.

The OMIG uses the services of a recognized statistician to assist in the development of sampling techniques and analysis and identification of the results of a statistical sample.

### **Audit Field Work**

The OMIG's standard document requests include audit financial statements, tax returns, related parties and access to the workpapers of independent certified public accountants. This information will facilitate our review and, at times, enable us to reduce our procedure. We will review the provider's compliance plans, interview the compliance officer and, as necessary, inspect auditing, monitoring and compliance committee reports. Additionally, we will review enrollment records and annual certification for paper and electronic submission of claims.

The OMIG is streamlining the audit process based on comments from trade associations and providers. Our goal is to share our preliminary findings, including work papers during field work. We believe this will resolve any differences before an exit conference.

The OMIG has incorporated into its audit process a review of medical necessity for services rendered to eligible recipients and billed to the Medicaid program. The purpose of the medical necessity review is to determine if services are reasonable and necessary, and, therefore, reimbursable through Medicaid. Focusing on clinical documentation, OMIG clinical staff has the requisite training needed to make clinical determinations as to the appropriateness of the services provided to Medicaid recipients.

The OMIG will, as part of field work, give the provider preliminary findings, including workpapers to resolve, if possible, and audit findings.

### **Exit and Draft Reports**

Upon completion of a field audit, the OMIG will conduct an exit conference with the provider to discuss preliminary findings. Afterward, the OMIG will issue a draft audit report that will identify any proposed recoupment and the basis for the action. The provider has 30 days to respond to the draft audit report. If the provider fails to reply within that time frame, the OMIG will issue a final report. If the provider objects to the draft audit report, the OMIG will consider the provider's response, including any supporting documentation, before issuing a final audit report.

The provider has 60 days after receiving the final audit report to request an administrative hearing. If granted, the administrative hearing will be limited to only those matters contained in the provider's objection to the draft audit report. The provider has the option, after the hearing decision, to undertake an Article 78 proceeding if the provider disagrees with the hearing decision.

## **ADULT DAY HEALTH CARE**

Adult day health care (ADHC) is a community-based long term care program that provides comprehensive health care services in a congregate day setting. ADHC is designed to meet the health care needs of chronically-ill, frail elderly and disabled adults who require certain primary, preventative, diagnostic, therapeutic, rehabilitative or palliative services. Currently, 12,000 New Yorkers receive ADHC services in 168 programs statewide.

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The ADHC program assesses a registrant's needs and designs an individualized care plan that is developed and implemented by an interdisciplinary team of medical professionals, including the registrant's personal community physician. ADHC provides nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. ADHC provides services according to the assessed needs of the registrant and range from monitoring, observing and maintaining an individual's health status to aggressive interventions and utilization of resources.

### **Clinical Audit**

The OMIG intends to expand its review of ADHC billings for compliance with Medicaid billing requirements. As part of this review, the OMIG will inspect the education, certification and licensure of staff providing ADHC services. These audits will be directed at determining whether providers are in compliance with ADHC billing and payment requirements. The rules governing ADHC audits and operations are contained in 10 NYCRR Parts 425, 713 and Subpart 86-2.

### **Rate Audit**

The Medicaid rate for an ADHC program is computed on the basis of allowable costs, as reported by the associated residential health care facility, and the total number of visits by ADHC residents, for which services were delivered pursuant to 10 NYCRR Section 86-2.9, subject to a maximum daily rate.

Medicaid computes ADHC rates for programs that do not have adequate cost experience, based upon annual budgeted allowable costs. Budgeted costs are not subject to audit. Effective April 1, 2007, when an ADHC program achieves an occupancy rate of 90 percent or more for a calendar year, the ADHC rates are based upon actual expenses and are subject to audit.

Our 2008 ADHC audit experience identified several issues such as excess accruals, unallowable costs and lack of supporting documentation for cost allocations. The OMIG will expand reviews of ADHCs focusing on these areas.

## **ASSISTED LIVING FACILITIES**

The assisted living program (ALP) is an entity approved to operate pursuant to section 485.6(n) of the Social Services Law. The ALP is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator (18 NYCRR § 494.2).

The OMIG's historical review of ALP providers identified documents and coding issues. In addition, we have identified through data mining activities a variety of goods and services billed to Medicaid by other providers that were included in the ALP payment rate. Per 18 NYCRR § 505.5(d) (1) (iii), Medicaid will not pay for any items furnished to a facility or organization when the cost of these items is included in the facility's rate. The OMIG will expand its audits of ALPs focusing on documents and coding issues. In addition, we will review goods and services billed to Medicaid that are included in the ALP payment rate.

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### **CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM**

The purpose of the Consumer-Directed Personal Care Assistance Program (CDPAP) is to allow chronically-ill and/or physically disabled individuals receiving home care services under the Medicaid program greater flexibility and freedom of choice in obtaining such services while reducing administrative costs. The popularity of CDPAP has led to increased expenditures in recent years. In general, local social service districts enter into a contract with providers to provide CDPAP to consumers. The OMIG will target selected CDPAP providers for compliance with the responsibilities identified in the local district contracts. The OMIG will also ensure that the consumers of service are adhering to contractual and program responsibilities.

### **COUNTY AUDIT/INVESTIGATION DEMONSTRATION PROJECT**

The Medicaid Fraud and Abuse County Demonstration (County Demo) was authorized by Chapter 58 of the Laws of 2005, created to further New York State's efforts to combat fraud, waste and abuse in the Medicaid program by enlisting the assistance of local districts to become agents of the state in post-payment provider accountability.

To date, 15 counties and the five boroughs of the City of New York are enrolled in the initiative. As of March, 2009, 77 audits are in process or completed, with an estimated total recovery value of \$24.7 million.

During SFY 2009-10, the OMIG anticipates the following actions to improve the operation and outcomes of the program:

- Establish fiscal reporting requirements for the program
- Identify and seize opportunities for process improvement within OMIG
- Draft programmatic guidelines for the program
- Negotiate 2009-10 work plans, including timelines, with county participants and, where applicable, their contractors
- Create a communication strategy
  - Establish participant access to a shared OMIG server as a repository for documents transmitted electronically
  - Create a quarterly newsletter
  - Conduct bi-monthly conference calls
- Provide additional training to participant counties in specialty audit areas.
- Publicize successes
- Evaluate the cost effectiveness of the program

The OMIG anticipates that the completion of the activities outlined will result in a greater number of high quality final audits being processed in a careful yet expeditious manner.

### **CROSSOVER PAYMENT MATCHES**

The OMIG is considering a number of match projects to identify potential overpayments for claims for recipients who have dual eligibility for Medicare and Medicaid. Information identified

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by the Office of the State Comptroller, along with payment information from the Medi-Medi project, will be utilized to detail the inappropriate payments. The initial reviews will involve physician, durable medical equipment (DME), and laboratory payments. The reviews will be expanded to inpatient hospital and other areas as the projects are developed.

### **DIAGNOSTIC AND TREATMENT CENTERS**

In prior audits, the OMIG identified significant documentation, coding and medical necessity issues of diagnostic and treatment centers (D&TC) services. The OMIG will expand its review of Medicaid payments for services provided by D&TC to determine compliance with applicable rules and regulations found in 10 NYCRR and 18 NYCRR. A key component of the review will be to determine the appropriateness of payments for physical, speech, and occupational therapy services and HIV primary care services.

In addition, the OMIG's review will determine whether the services were rendered by an unqualified practitioner. The OMIG will also review D&TC compliance with Medicaid conditions of participation. Claims for payment will be reviewed to ensure that they were submitted within 90 days from the date of service.

Prior audits have found significant problems with the reviews of plans of care for rehabilitation services not being completed on a timely basis, no explanation of benefits (EOB) for Medicare/third party health insurance (TPHI)-covered services and insufficient documentation for the rate code billed.

### **DURABLE MEDICAL EQUIPMENT AND SUPPLIES**

The OMIG will review durable medical equipment (DME) and other supply claims submitted by selected providers to determine compliance with 18 NYCRR § 505.5. The OMIG will review a sample of payments to ensure that the equipment and/or supplies were properly authorized, products delivered, and the claim amount falls within Medicaid payment guidelines. The OMIG will focus on items dispensed to institutional residents and the accuracy of Medicare coinsurance claims. The OMIG will use system matches to identify claims for institutional residents and for inappropriate claims for dual-eligible (i.e., those who are covered by both Medicare and Medicaid) recipients. The OMIG will also conduct medical reviews of high ordering DME physicians to support the need for the DME and to determine if the targeted providers had seen and treated the recipients on the date of service or during the six month period prior to the DME date of service.

### **EARLY INTERVENTION**

Counties in New York State provide a vast array of early intervention services to children between birth and three years of age. The counties contract for the early intervention services with providers in the community. The providers submit bills to and are paid by the counties for the services rendered to eligible recipients. The counties, in turn, bill third-party insurance, Medicaid and state early intervention funds for such services. The Medicaid claim information indicates that the counties are the Medicaid provider of record, not the community providers. Our analyses of medical claims, by recipient, indicate that some children may be receiving excessive daily services. Further, a small sample of claims reviewed by early intervention audit staff has identified a lack of documentation to support community provider claims to counties.

The OMIG will audit early intervention services and will stratify provider claims contracting with the county and sample claims for contractors providing most of the services. The OMIG will turn

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audit findings over to the counties for the purpose of recouping inappropriate payments. These would be the first significant audits of early intervention services conducted by other than early intervention staff. If OMIG audits of the largest providers reveal significant findings, the audit plan will be turned over to the county to audit additional providers. The purpose of these reviews is to ensure that contractors are following Medicaid requirements for providing services.

### **FREESTANDING AMBULATORY SURGERY SERVICES**

The Medicaid program reimburses ambulatory surgery centers a higher payment rate than it does if the same services were to be performed in a physician's private office. If the service is performed in an ambulatory surgery center, it must be justifiable for reasons of patient safety and administration of anesthesia. The OMIG will review physician and ambulatory surgery center medical charts to ascertain if documentation demonstrates that the procedure needed to be performed in an ambulatory surgery setting. Reimbursement methodology for ambulatory surgery is found in 10 NYCRR § 86-4.40. Ambulatory surgery is defined in 10 NYCRR §§ 405.20, 709.5 and 755.1.

### **HOME HEALTH SERVICES**

#### **Adult Home Setting**

The Medicaid program reimburses a certified home health care agency (CHHA) for services to eligible recipients in a variety of settings, but not for recipients residing in adult homes. The OMIG has initiated data mining activities to identify CHHA billings for services to recipients residing in adult homes and will recover payments from the CHHA for services to recipients residing in adult homes.

#### **Certified Home Health Agency - Rate**

The OMIG will conduct audits of CHHA cost reports to verify per-visit and hourly rates calculated for the various ancillary disciplines in accordance with 18 NYCRR Part 517 and Subparts 86-1. With an emphasis on both high Medicaid utilization and rate caps, the OMIG will review direct patient costs, overhead costs, related party costs, Medicaid patient visits, total visits and related hours. The OMIG will validate the direct costs through inspection of invoices and payroll records, and will verify cost-allocated statistics for reasonableness. Lastly, patient visits and hours will be verified against supporting patient logs and/or census data to ensure proper reporting.

#### **Claims Audits**

The OMIG will review home health agency (HHA) claims to determine whether the claims meet the criteria outlined in 18 NYCRR § 505.23, Article 36 PHL, and in 10 NYCRR Article 7. This review determines if the services were provided, ordered by a qualified practitioner in a timely manner, adequately documented, third-party coverage was pursued, and the personnel met all regulatory requirements.

#### **Medical Surpluses**

These are situations where patients qualify for Medicaid after they have incurred monthly medical bills that exceed a predetermined excess income amount. In some counties, the responsibility for applying the excess income is assigned to specific CHHA providers who are



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required to bill the net of the patient's monthly liability. The OMIG's review will analyze billing for affected recipients to ensure that CHHA billings were submitted as applicable, net of the patient's monthly liability.

### **HOSPICE SERVICES**

The OMIG will review Medicaid payments to hospice providers to determine compliance with 10 NYCRR § 86-6, and Sections 792, 793, and 794. A medical record review will be completed to determine whether the services were properly authorized, appropriately provided and documented, and if third-party coverage was pursued. Auditors will review personnel records to verify that provider staff met all regulatory, educational, and medical and experience requirements along with a documentation review to determine whether the recipient met the criterion of being terminally ill with a life expectancy of approximately six months or less. Additionally, the OMIG will perform data match analyses to identify potential overlapping billing for duplicate services.

### **HOSPITALS**

#### **Ambulatory Surgery Services**

The OMIG will review ambulatory surgical services provided in hospitals. The Medicaid program reimburses ambulatory surgery centers a higher payment rate than if the same services were performed in a private physician's office. If the service is performed in an ambulatory surgery center, it must be for reasons of patient safety and administration of anesthesia. The OMIG will review physician and ambulatory surgery center medical charts to ascertain if documentation justifies that the procedure was performed in an ambulatory surgery setting. Reimbursement methodology for ambulatory surgery is found in 10 NYCRR § 86-4.40. Ambulatory surgery is defined in 10 NYCRR §§ 405.20, 709.5 and 755.1.

#### **Credit Balances**

The OMIG uses an outside contractor to review hospital credit balances for patient accounts receivable with credit balances where Medicaid is the primary payor. The OMIG has initiated credit balance audits of hospital medical accounts receivable with credit balances where Medicaid is the secondary payor. As part of our review, we will obtain from a hospital a listing of patient accounts receivable with credit balances where Medicaid is the secondary payor. We will select a stratified statistical sample of claims for inspection and analysis purposes.

#### **Duplicate Clinic Claims Audit**

The OMIG has identified, through data mining activities, Medicaid clinic rate code billing combinations, billed by hospital outpatient clinics and diagnostic and treatment centers, which constitute duplicate payments. The services were billed on the same date of service for the same recipient. This analysis identified 206 facilities with \$5.2 million in inappropriate billings for the four years through December 31, 2007. Areas to be reviewed include rate codes in the HIV, CHAP, PCAP, OASAS and OMRDD specialties. The OMIG's efforts in this area prior to 2004 resulted in a near 100 percent recovery rate. The OMIG will issue reports to affected providers requesting repayment for the service which constitutes a duplicate payment.

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### **Fee-for-Service Payments When Patient Enrolled in Medicaid Managed Care**

In 2008, the OMIG's data mining activities identified Medicaid fee-for-service (FFS) payments to providers when the Medicaid recipient was enrolled in a Medicaid managed care plan. This resulted in significant findings and recoveries. The OMIG will expand the review of Medicaid fee-for-service payments in instances where the Medicaid beneficiary was enrolled in managed care. The OMIG will focus on those providers with historical billing issues in this area, not only to recover overpayment, but also to identify gaps in the provider's compliance program.

### **Hospital Newborn Fee-for-Service – Managed Care Crossover Payments**

In phase I, the OMIG will identify instances where both the hospital received a Medicaid payment while the newborn was enrolled in managed care and the MCO received a supplemental newborn capitation payment (KICK) indicating the hospital was either eligible for or did receive a payment from the managed care organization (MCO) related to the newborn's birth.

In phase II, the OMIG will identify instances in which the hospital received a Medicaid payment while the newborn was enrolled in managed care and the MCO received a capitation payment in the month of delivery indicating the hospital was eligible to receive payment from the MCO related to the newborn's birth.

In each phase, when confirmed, the hospital will be required to repay Medicaid. These reviews comply with 18 NYCRR §540.6(e), which addresses the responsibility of providers to seek reimbursement from liable third parties before billing Medicaid directly for payment.

### **Ninety-Day Billing Exception Codes**

The Medicaid program requires a provider to submit claims for services to eligible recipients within 90 days from the date of discharge or service. Claims submitted after 90 days are denied unless the provider submits a 90-day exception code on the claim.

The OMIG's data mining activities identified numerous inaccuracies where claims were submitted after 90 days with invalid exception codes. For example, claims for outpatient hospital services were submitted with exception code 10 (administrative delay in prior authorization process). No prior authorization is required for outpatient services. The OMIG will expand the review of Medicaid payments for claims submitted by providers after the date of discharge or for services utilizing exception codes. Generally, the review period will cover July 1, 2003 through December 31, 2005.

The OMIG will select a sample of claims submitted with exception codes and request the hospital to provide the underlying documentation to support late claim submission.

### **Payment for Medicare Coinsurance and Deductibles**

The OMIG has identified instances where providers are billing Medicaid for Medicare coinsurance and deductible amounts that are suspect. Through data mining, the OMIG has identified billings where a Medicare-approved amount in excess of the deductible is billed with a zero fill in the Medicare-paid field. The OMIG will request from providers documentation of the Medicare claims, denials and payments by Medicare and a refund, where appropriate.

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In addition, the OMIG has also identified instances where the Medicare deductible has already been met for a patient and subsequent billings are made for the deductible amount. The OMIG will initiate reviews of these claims for credit balances and recovery initiatives.

The OMIG will continue to review and recover provider billings where the Medicare-approved amounts appear excessive or duplicative.

### **Physician and Hospital Financial Relationships**

New York State covers unacceptable practices under 18 NYCRR § 515.2(b) (5) Bribes and Kickbacks. This is an area on which the OMIG has not focused in prior years; however, because of recent self disclosures, we believe it is time to review hospital/physician financial relationships.

The OMIG is currently reviewing hospital cost report information with respect to physician payments for direct patient care, administrative services and rental of hospital space for private offices. We will use this information to identify hospitals for review purposes. The focus of these audits will be:

- Excess payments for direct care services
- Administrative payments for undocumented or unnecessary services
- Below market-rate rental of office space
- Physician practice subsidies

Our reviews will include minutes of boards of director meetings, outside auditor work papers, inspection of contracts and related documents, corporate structures, financial transactions and interviews of hospital operational personnel and physicians and, where necessary, their employees.

### **Review of DRG Coding**

The Medicaid program reimburses hospitals for covered inpatient services on a prospective payment system based on diagnosis related groups (DRGs). The OMIG has identified certain DRG code pairings that impact hospital payments for inpatient services. The OMIG will focus on the following DRG code pairings:

<u>DRG</u>	<u>Description</u>
014	Stroke with infarct
832	Transient Ischemia
089	Simple pneumonias pleurisy—simple, complex older than 17 with clinical complications
541	Simple pneumonia and other respiratory disorders excluding bronchitis act
127	Heart failure and shock
544	Congestive heart failure and cardiac arrhythmia with major clinical complications
370	Cesarean section with clinical complications
650	High risk cesarean section with clinical complications

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627	Neonatal birth wt > 2499 grams without significant or procedure, with major problem
628	Neonatal birth wt > 2499 grams, without significant or procedure with minor problem
853	Percutaneous cardiac procedure with drug eluting stent with acute myocardial infarction
854	Percutaneous cardiac procedure with drug eluting stent without acute myocardial infarction

### **HUMAN IMMUNODEFICIENCY VIRUS SERVICES**

The OMIG will review Medicaid payments for HIV and AIDS-related services provided by diagnostic and treatment centers (D&TC) and designated AIDS centers (DAC) to determine compliance with applicable rules and regulations found in 10 NYCRR and New York State AIDS Institute policy directives.

#### **Case Management Services**

HIV/AIDS case management is a process which assists HIV-infected or high-risk persons who are Medicaid-eligible to gain access to necessary services in accordance with goals contained in a written case management plan. New York State DOH AIDS Institute community follow-up program standards and 18 NYCRR § 505.16 provide details of the regulatory requirements for HIV/AIDS case management services. The OMIG will review providers rendering case management services to ensure that procedural requirements for the provision of services are met and that those services have been billed correctly. This will include an examination of supporting documentation for the units of service billed.

#### **Drug Resistance Testing**

Medicaid covers HIV drug resistance testing when clinically indicated, up to a maximum of three genotypic and phenotypic tests, in any combination, per year. This is an issue that the OSC identified. The OMIG has initiated data mining activities to identify laboratories that billed Medicaid for more than three covered tests per year.

#### **Pre-Test Counseling**

DOH guidelines generally limit billing for HIV pre-test counseling visits to two visits per recipient per year. In certain cases, DOH will allow payment for more than two visits a year. The provider must have adequate medical record documentation to support the billing of more than two HIV pre-test counseling visits per recipient, per year. OSC also identified this as an issue for the OMIG to monitor.

The OMIG has initiated data mining activities to determine those providers who submitted more than two HIV pre-test counseling visits per recipient, per year. The OMIG will inspect providers' underlying medical record documentation to ascertain compliance with medical record documentation requirements.

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### LABORATORY SERVICES

#### **Independent Laboratories**

The OMIG will review Medicaid payments for selected independent laboratories to assess compliance with 18 NYCRR § 505.7. The OMIG will select a sample of claims and review the underlying documentation such as physician orders and test results to ascertain compliance with Medicaid regulations. In addition, the OMIG will focus on tests performed on recipients who were residents of facilities where the laboratory tests are included in the rate, or unbundled laboratory services, or where the recipient did not have Medicare or another form of third-party insurance coverage.

#### **Payment for Medicare Coinsurance and Deductibles**

The Medicare program reimburses providers for laboratory services to dual-eligible recipients based on Medicare's fee schedule, not subject to coinsurance or deductibles. The OMIG has identified laboratories that have billed Medicaid for coinsurance and deductibles related to dual-eligible recipients.

The OMIG will review Medicaid payments for dual-eligible recipients (Medicare-Medicaid) for selected hospital-based and independent laboratories to assess compliance with 18 NYCRR §505.7. We will review a sample of Medicaid claims to determine if the Medicare program was billed for a covered laboratory test and the propriety of coinsurance and deductible amounts billed to Medicaid.

### MANAGED CARE

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 (9); prepaid health service plans (14); managed long-term care plans (17); primary care partial capitation providers (3); and HIV special need plans (3). The Medicaid managed care policy and billing procedures are generally found and referenced to the contract sections found in the Medicaid managed care/Family Health Plus contract. The managed care contract describes the responsibilities and agreements established between a managed care organization and the New York State Department of Health (Medicaid).

#### **Capitation Payments Made When Enrollees are Institutionalized in a Skilled Nursing Facility**

The OMIG intends to review data matches where a monthly capitation payment was paid for a period following the month in which an enrollee was institutionalized in a skilled nursing facility. We will identify and make fiscal recoveries of Medicaid managed care capitation payments for months subsequent to the enrollee's date of institutionalization where the local social services district failed to facilitate the recovery. The fiscal recovery for institutionalized enrollees is described in the Medicaid managed care and family health plus model contract, Section 3.6.

#### **Compliance Review of Medicaid Managed Care and Family Health Plus Contracts**

The OMIG intends to review procedures and policies of two MCOs and their contracted network providers to assure the organization is in compliance with all provisions of the Medicaid managed care and Family Health Plus contract, into which the MCO entered with DOH.

### **Family Planning Chargeback to Managed Care Organizations**

As a result of significant recoveries in this area over the past year(s), the OMIG will continue to identify claims in relation to family planning criteria as set forth by the Division of Managed Care pursuant to the managed care contract, Appendix C, Part I, Section 2a, "Free Access to Services for MMC Enrollees," specifically, free access to family planning and reproductive health services. In instances where the enrollee has chosen to go outside the health plan network for family planning services, those claims are identified on an annual basis and are recoverable from the managed care organizations as stated in the managed care contract, Appendix C, Part II, and Section 2b. A report of all claims for each MCO will be forwarded to the New York State Division of Managed Care for reconciliation with the managed care plans. When reconciliation is completed, the OMIG will then forward a remittance advice to each MCO for payment of the agreed-upon amount.

### **Family Planning Chargeback to Managed Care Organization Network Providers**

MCO network provider contracts outline services to MCO enrollees and the methodology to bill the MCO for such services. In 2007, the OMIG successfully identified and recovered payments where MCO network providers inappropriately billed Medicaid directly for MCO-covered services provided to Medicaid managed care enrollees. The OMIG in 2009-10 will again determine if claims submitted by MCO network providers should have been paid by the MCO and not Medicaid. This review is in compliance with 18 NYCRR § 540.6(e), which addresses the responsibility of providers to seek reimbursement from liable third parties before billing Medicaid directly for payment.

### **Improper Multiple Client Identification Numbers for One Enrollee Payments**

In prior OMIG audits of enrollee payments to MCOs, the OMIG identified payments for the same patient with multiple client identification numbers (CINs). Through data mining activities, we will identify MCOs receiving multiple monthly capitation payments for the same enrollee. The OMIG will request that the MCO review the claim(s) in question and take the following action: reimburse Medicaid where the payment was not appropriate, or if the MCO believes the claim(s) to be correct, provide case record documentation to support the claim. The fiscal recovery for multiple CINs is described in the Medicaid managed care and Family Health Plus model contract, Section 3.6 (SDOH Right to Recover Premiums).

### **Improper Retroactive Supplemental Security Income Capitation Payments**

In 2008, the OMIG's review of retroactive Supplemental Security Income (SSI) capitation payments to MCOs resulted in significant findings and recoveries. The OMIG will continue to review SSI-related enhanced capitation payments made to MCOs. The Medicaid managed care contract, Section 10.29, Prospective Benefit Package Change for Retroactive SSI determinations (MMC Programs), states that, despite the fact that enrollment status may be changed using retroactive dates, MCOs may not bill capitation payments retroactively to a listed date of SSI eligibility, only prospectively from the date the plan is notified via the roster of the status change. Our review will focus on MCO billing adjustments for Medicaid managed care enrollees where enrolled status changed retroactively to "SSI" or "SSI-related."

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### **Payments for Deceased Enrollees**

In prior year data mining activities, we identified capitated payments to MCOs after the date of death of recipients. The fiscal recovery for deceased enrollees is described in the Medicaid managed care and Family Health Plus model contract, Section 3.6 (SDOH Right to Recover Premiums).

### **Payments for Incarcerated Enrollees**

The OMIG receives a Prison Match Report monthly from the NYS Office of Temporary and Disability Assistance, produced in collaboration with the Department of Corrections and the Division of Criminal Justice Services. The match lists individuals who had been eligible for assistance under the Office of Temporary Disability Assistance (OTDA) and/or Medicaid at the time of their incarceration.

As a result of successful recoveries in 2008 related to this match, we will again determine which individuals were enrolled in Medicaid managed care at the time of incarceration where the monthly capitation payments continued after the member was incarcerated and the LDSS failed to facilitate the recovery. We will notify each MCO of capitation payments made to them for incarcerated members for any time period following the month of incarceration. We will request that the MCO either void the claims or provide documentation supporting their right to the capitation payment. The fiscal recovery for incarcerated enrollees is described in the Medicaid managed care and Family Health Plus model contract, Section 3.6 (SDOH Right to Recover Premiums).

### **Prior to Date of Birth Payments**

The Medicaid managed care contract states that the capitation rate for a newborn will begin as of the month following certification of the newborn's eligibility and enrollment, retroactive to the first day of the month in which the child was born. In each year, the OMIG identified inconsistencies where MCOs billed a capitation payment for the month prior to the newborn's birth month. The OMIG will not only focus on recovery of such overpayments, but also on gaps in the MCO operating system that allow inappropriate claim submissions.

### **Recovery of Capitation Payments for Retroactive Disenrollment Transactions**

The Medicaid managed care and Family Health Plus model contract, Section 8.2, requires MCOs to void premium claims for any months of retroactive disenrollment where the MCO was not at risk for the provision of benefit package services during that month. The OMIG will continue to identify and review retroactive disenrollment of beneficiaries on an annual basis to ensure that the MCO repays/voids capitation payments when the MCO was not at risk for the provision of benefit package services during any month.

### **Review of Reported Costs by Managed Long Term Care Organizations**

A managed long term care organization's (MLTCO's) final rate is determined by using multiple factors. The OMIG intends to initiate reviews of reported costs submitted by the MCOs that are used by the DOH in finalizing a MCO capitated rate, and determine the accuracy of the information reported. This review will include, but not be limited to, an analysis of related party costs and administrative expenses reported in the MCO cost report submission.

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### **Review of Reported Costs by MCO Plan Companies**

The MCO final rate is determined using multiple factors, one of which is reported operational costs used by the plan. The OMIG will review the reported costs submitted by the plans and used by the DOH in finalizing a MCO rate, and determine the accuracy of the information reported. The review of reported costs will include but will not be limited to: electronic analysis of the MCO's reported paid claims confirming reported medical costs were incurred and paid in compliance with provider contracts; an analysis of the reporting and propriety of third-party recoveries; a review of the appropriateness and allocation of direct and indirect administrative costs; an analysis of related party transactions and contracted expenses; and a review of the accuracy of incurred but not reported (IBNR) accruals by product line.

### **Supplemental Capitation Payments Made Without Corresponding Encounter Data**

MCOs are entitled to a supplemental newborn capitation payment (paid under the newborn's recipient ID) and a supplemental maternity capitation payment (paid under the mother's recipient ID) in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. The MCO must maintain on file evidence of such payments. Additionally, the MCO is expected to submit birth/delivery encounter data to the DOH. Based on successful recoveries in this area over the past year, the OMIG will continue to target supplemental newborn and maternity capitation payments to MCOs focusing on encounter data and other documentation to support payment. If the MCO cannot provide documentation to support the newborn/maternity billing, we will request repayment of the supplemental capitation payment. This policy is described in the Medicaid managed care and Family Health Plus contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments).

### **Supplemental Newborn and Maternity Payment Errors**

The OMIG will continue to review newborn and maternity supplemental capitation payments and identify instances where incorrect payments appear to exist based on recipient file demographic information. In the past, some of these scenarios have included more than one newborn payment for the same enrollee, billing for both supplemental payments under the same recipient, and billing for a delivery when the enrollee is under 10 years of age or over 50 years old. The OMIG is developing claim edits to prevent these occurrences. The policy is described in the Medicaid managed care and Family Health Plus contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments).

### **Supplemental Payments to Federally Qualified Health Centers with No Encounter Data**

Federal law 42 U.S.C. § 1396a (bb) (5) (A) requires states to make supplemental payments to a federally qualified health center (FQHC) pursuant to a contract between the FQHC and the MCO for the amount, if any, that the FQHC's prospective payment system (PPS) rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC. The OMIG will focus on the supplemental payments made to FQHCs to assure that the FQHC had an executed contract with the Medicaid beneficiaries' MCO, and, that the FQHC provided a billable service prior to billing Medicaid.



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### MEDICAID IN EDUCATION

The Center for Medicare and Medicaid Services (CMS) has issued rule changes that have a direct impact on Medicaid in education claiming requirements. The American Recovery And Reinvestment Act of 2009 extended the moratorium in place delaying implementation of several of these new rules until June 30, 2009.

As an extension of the rule changes and ongoing discussions with CMS, the OMIG will implement pre-payment and continue post-payment claim reviews. Pre-payment reviews will focus on early identification of potential claiming problems, as well as to target providers for post-payment review. Post-payment review includes monitoring all payments to providers, comparing billing trends among providers and scheduling on-site audits.

### OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS)

The mission of OASAS is to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery. In achieving this, OASAS works with providers and addictions professionals to assure delivery of the highest quality services and to ensure a strong return on taxpayers' investment in the State's programs and services. OASAS conducts several activities to help providers strengthen their management/governance capacities and control systems, while moving toward a "gold standard" of services. Such on-going efforts include the following:

- In 2008, OASAS established an administrative/regulatory relief workgroup to assist providers in increasing patient care by reducing paperwork and providing regulatory relief. Paperwork has been streamlined through regulatory revisions, model case record forms, guidance documents, and face-to-face consultation with providers while facilitating regulatory compliance and quality patient care.
- OASAS continued support and expansion of the New York State Board Training Consortium's Training Series, intended to instruct board members of affiliated not-for-profit agencies on their important governance responsibilities. In 2008, OASAS worked with the OMIG and others to help develop a new training module on Medicaid accountability and related compliance issues in order to help not-for-profit providers become "audit-ready." OASAS hopes to build on this resource in 2009-10 and provide additional guidance to providers on Medicaid compliance planning and other governance issues.
- OASAS promotes fiscal accountability and sound financial management through the development of *Administrative and Fiscal Guidelines for OASAS-Funded Providers*. These *Guidelines*, to be issued in 2009, will articulate minimum standards and identify recommended practices designed to ensure that public funds are properly managed and accounted for in OASAS-funded programs.
- OASAS continues to collaborate with the OMIG and other audit agencies to reinforce effective and consistent fiscal management and compliance. For SFY 2008-09, OASAS compliance enforcement activities resulted in \$6.6 million in Medicaid cost avoidance savings.

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- OASAS has developed a new OASAS quality services review (QSR) protocol designed to assess the provision of quality patient-centered care and clinically necessary services. QSRs consider indicators outlined in the excessive services regulations [Part 822.11(k)], as well as other regulatory requirements that relate to the clinical necessity and quality of treatment services. Providers identified as “high” or “extreme” through an OASAS Medicaid risk assessment, and other providers delivering high units of service, may be selected for review. The protocol also includes pre-review coordination with OMIG in order to select a statistically relevant sample of patient records for review.
- Additionally, OASAS and provider representatives are developing the OASAS scorecard which, for the first time, will collect and display all relevant program performance indicators for all program sites, counties, and New York State as a whole. The scorecard for treatment services providers will be available in 2009 and will engage the field; build on current efforts; and focus on core service outcomes. It will provide a comprehensive, relevant view of performance and will be instrumental in driving system improvements.

Within this framework, OASAS supports the OMIG’s efforts to prevent and investigate Medicaid fraud, waste and abuse in the chemical treatment dependence system and to improve the quality of chemical dependence care for all patients.

### **Chemical Dependence Inpatient Rehabilitation Services - Clinical**

The OMIG will continue a statewide review of Medicaid payments for chemical dependence inpatient rehabilitation providers to determine if providers claimed reimbursement in accordance with 14 NYCRR § 818. Prior OMIG audits identified significant non-compliance with applicable regulations relating to missing progress notes and treatment plans.

### **Chemical Dependence Inpatient Rehabilitation Services - Rates**

OASAS inpatient rehabilitation providers are reimbursed for services by the Medicaid program through a prospective per diem payment rate system. The OMIG will conduct audits of providers’ promulgated rates to determine compliance with 14 NYCRR § 841. The reviews will focus on identifying inappropriate and unallowable costs included in the promulgated rates of free-standing OASAS inpatient chemical dependence rehabilitation providers and recovering the Medicaid overpayments.

### **Ninety-Day Billing Exception Codes**

The Medicaid program requires a provider to submit claims for services to eligible recipients within 90 days from the date of discharge or service. Claims submitted after 90 days are denied unless the provider submits a 90-day exception code on the claim.

OMIG data mining activities identified numerous inaccuracies where claims were submitted after 90 days with invalid exception codes. For example, claims for services were submitted with exception code 10, (delay the prior authorization process). No prior authorization is required for such services. The OMIG will expand its review of Medicaid payments for claims submitted by providers after the date of discharge or services utilizing exception codes. Generally the review period will cover July 1, 2003 through December 31, 2005.

OMIG will select a sample of claims submitted with the exception codes and request the provider to submit underlying documentation to support late claim submission.

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### **Outpatient Chemical Dependence Services**

The OMIG will review Medicaid payments for outpatient chemical dependence services to determine if providers claimed reimbursement in accordance with 14 NYCRR § 822. Medicaid reimbursement is available for outpatient chemical dependence services provided in hospital-based or freestanding clinics. The OMIG will conduct reviews of providers that receive the largest amounts of Medicaid reimbursement for these services. Prior OMIG audits identified significant non-compliance with regulations, such as missing treatment plans and missing signatures on treatment plans. The OMIG also identified significant non-compliance with regulations limiting the number of participants for outpatient group therapy services. Additionally, the OMIG will focus on the medical necessity of services rendered to Medicaid recipients and will also consider if the services were clinically excessive. The OMIG will also conduct audits or investigations of OASAS providers who are found to be providing excessive services through OASAS reviews and are referred to the OMIG by OASAS.

### **OFFICE OF CHILDREN AND FAMILY SERVICES**

The Bridges to Health and the Home and Community-Based Services Medicaid Waiver Programs provide services not otherwise available through other programs to children with complex medical conditions who are in foster care or in the custody of the Division of Juvenile Justice and Opportunities for Youth. The program consists of three waivers administered as a single program:

- For children with severe emotional disturbances
- For children with developmental disabilities
- For children with medical fragility

The services are rendered by not-for-profit voluntary authorized agencies known as health care integration agencies (HCIAs) and subcontracted qualified waiver service providers (WSPs).

The Office of Children and Family Services (OCFS) has implemented a comprehensive quality management system for the waiver program used to determine if the waiver program operates in accordance with its design, meets statutory and regulatory requirements, achieves desired outcomes and identifies opportunities for improvement. The quality management program includes standards for the provision of services and billing of Medicaid. In addition, OCFS will provide ongoing communication and training for HCIAs and WSPs on those standards, and conduct provider audits using those standards.

The OCFS Office of Audit and Quality Control (AQC) has prepared an audit program which the OMIG is currently reviewing. AQC will revise the audit program as necessary based on input received from the OMIG. Once the audit program is finalized, AQC will begin field audits of all HCIAs and WSPs. The field audits will include testing that could result in a financial recovery such as supporting documentation for Medicaid billings and recipient eligibility, and testing that could result in non-financial compliance findings such as documentation of the waiver enrollment process or provider qualifications and training.

### **OFFICE OF MENTAL HEALTH**

The New York State Office of Mental Health (OMH) has as its mission to promote the mental health of New Yorkers. Of particular focus for OMH is mental health service provision for adults with serious mental illness and children with severe emotional disturbances.

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OMH's policy is to refer all matters relating to suspected Medicaid fraud, waste and abuse to the OMIG as such cases are identified.

### **Clinic Restructuring**

OMH has undertaken a multi-year initiative to restructure the way in which the state delivers and reimburses publicly-supported mental health services. The goal is to develop a system of quality care that responds to the individual needs of adults and children and delivers care in appropriate settings.

Clinic restructuring represents the first phase of this transformation process. Parallel initiatives are tackling the many challenges facing support services for children, rehabilitation and support services for adults, inpatient services, and the treatment of co-occurring disorders in both mental health and substance abuse clinics. The key elements of clinic restructuring include the following:

- **A redefined and more responsive set of clinic treatment services and greater accountability for outcomes.** “Clinic” is defined as a level of care with specific services. These services should enhance consumer engagement and support quality assessment and treatment. Clinic treatment should be part of a coordinated and accountable system of recovery and resiliency, which includes other Medicaid-reimbursable and non-Medicaid specialty services, such as case management, day and vocational services.
- **Redesigned Medicaid clinic rates and phase-out comprehensive outpatient programs (COPs).** Medicaid payment rates will be based on the efficient and economical provision of services to Medicaid clients. OMH will establish peer groups for payment, and payments will be comparable for similar services delivered by similar providers across service systems. Payments will also include adjustments for factors that influence the cost of providing services. The new system will eliminate rate add-ons such as COPs. OMH is committed to integrating clinic restructuring with DOH’s new outpatient reimbursement methodology called ambulatory patient groups (APGs), which will replace New York’s current “threshold visit” methodology for reimbursement.
- **HIPAA-compliant procedure-based payment systems with modifiers to reflect variations in cost.** The federal Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Act requires the use of a HIPAA-compliant billing system. Billing codes for clinic services will be HIPAA-compliant with modifiers to reflect differences in resources and related costs (e.g., service location, night and weekend hours, language other than English, among other factors).
- **Provisions for indigent care.** The New York State Constitution gives the state a special responsibility to care for “persons suffering from mental disorder or defect and [for] the protection of the mental health of the inhabitants.” Assuring access to outpatient clinic services is essential to meeting this objective while also reducing the demand for other high cost services such as inpatient care. Currently, OMH clinics receiving COPs payments are required to serve all clients regardless of ability to pay. As part of restructuring, OMH will work to develop a comprehensive strategy for funding mental health outpatient services for the uninsured.

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- **Standards of care.** OMH recently released standards of care for clinic treatment. These guidelines are a first step in articulating the basic tenets of good clinical care and accountability. These fundamentals of care should be occurring in all clinics now, as well as in our redesigned clinic of the future.

### **Continuing Day Treatment Reimbursement Methodology**

As part of the New York State Office of Mental Health's financial management plan relating to the 2008-09 state budget, the level of Medicaid reimbursement for continuing day treatment (CDT) programs was reduced, effective January 1, 2009. To implement this reduction, OMH issued emergency regulations effectuating this reduction from January 1 through March 31, 2009. The enacted 2009/10 budget included a temporary restoration of the previously reduced funding for non-Article 28 CDTs, effective from April 1, 2009 through June 30, 2010.

Effective April 1, 2009, the regulation also provided for a change in the reimbursement methodology for CDTs, from one based upon hours of attendance to a modified threshold rate, designed to more closely correlate the amount of reimbursement to the level of services received. CDT programs have historically been reimbursed for visits in durations of one, two, three, four, or five hours. At least one service per visit must be provided, regardless of the duration of the visit. While Article 31 and Article 28 CDT programs are licensed under the same regulations, they have been reimbursed differently. Article 31 providers have been paid rates based on daily visit duration and the individual consumer's cumulative CDT use during a calendar month. Article 28 providers have been reimbursed based on a "threshold" visit, as long as the visit is at least one hour in duration.

The new reimbursement methodology entails changing Medicaid reimbursement for CDT programs to "half-day" and "full-day" visits. Reimbursement for a full-day visit requires a minimum of four hours of attendance and the provision of at least three services. Reimbursement for a half-day visit requires a minimum of two hours of attendance, and the provision of at least one service. This methodology will apply to both Article 31 and Article 28 providers. Article 31 CDT programs will continue to have three rate tiers, with different rates for half-days and full-days based on the cumulative monthly hours of attendance totaling 1 through 40 hours, 41 through 64 hours, and 65 plus hours. This is equivalent to the current three-tier rate structure based on five-hour days. Article 28 CDT programs will have different half-day and full-day rates with two tiers reflecting cumulative monthly hours of attendance of 1 through 40 hours, and 41 plus hours. For both Article 31 and Article 28 CDT programs, all crisis, collateral, group collateral and pre-admission services that meet the regulatory minimums for program attendance and service provision will now be reimbursed as half-day visits, without regard to actual duration of attendance. These hours will not be counted toward the monthly cumulative hours for purposes of determining which rate tier to assign regular visits.

### **Community Residence Rehabilitation Services**

The OMIG will review payments made for rehabilitative services provided to residents, both child and adult, of community-based residential programs in accordance with 14 NYCRR § 593. OMH licenses these programs for adults with mental illness and children and adolescents with serious emotional disturbances. The OMIG is focusing on Medicaid recipients residing in community residences. Rehabilitative service providers will be reviewed for compliance with regulations relating to service authorization requirements. In addition, the OMIG will assess provider adherence to program documentation and staffing requirements.

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### **Case Management Services**

Case management is a process which assists persons eligible for Medicaid to gain access to necessary services in accordance with goals contained in a written case management plan. 18 NYCRR § 505.16 provides details of the regulatory requirements for case management services. The OMIG will review providers of case management services to ensure that the procedural requirements for service provision are met and that those services have been billed correctly and have supporting documentation for the claimed units of service.

### **Ninety-Day Billing Exception Codes**

The Medicaid program requires a provider to submit claims for services to eligible recipients within 90 days from the date of discharge or service. Claims submitted after 90 days are denied unless the provider submits a 90-day exception code on the claim.

The OMIG data mining activities identified numerous inaccuracies where claims were submitted after 90 days with invalid exception codes. For example, claims for administration services were submitted with exception code 10 (delay the prior authorization process). No prior authorization is required for such services. The OMIG will expand its review of Medicaid payments for claims submitted by providers after the date of discharge or services utilizing exception codes. Generally our review period will cover July 1, 2003 through December 31, 2005.

The OMIG will select a sample of claims submitted with the exception codes and request that the hospital provide underlying documentation to support late claim submission.

### **OMH COPS–Managed Care Recoveries**

The MCO submits an encounter to DOH for those services paid by the MCO to a network provider, and the comprehensive outpatient program services (COPS) supplemental payment is subsequently billed on a fee-for-service (FFS) basis by the network provider who rendered the service. A COPS-only payment is made if the MCO-enrolled recipient received a covered service from a medical health provider within the MCO network; in that case, the MCO is required to submit encounter data to DOH. The OMIG will match COPS supplemental payments with MCO encounter information. If the network provider cannot provide documentation that a managed care service was provided, the OMIG will recover the COPS payment.

### **COPS/CSP-Overpayment Recoveries**

The OMIG and the OMH performed a review of mental health providers who received COPS/CSP (community support programs) overpayments for the four years ended November 31, 2005. COPS are supplemental payments in addition to the provider's Medicaid rate. The amount of COPS reimbursement that a provider can receive is limited to a threshold amount and any COPS received in excess of that amount can be recouped. CSP payments in excess of a formulated reimbursement rate are also subject to recovery. Recoveries of COPS and CSP overpayments will be for the period of local fiscal year (LFY) 2002/3-2004/5 for New York City providers and county year (CY) 2003-2005 for the rest of the state.

### **Outpatient Services**

The OMIG will review Medicaid payments for outpatient mental health services to determine if providers claimed reimbursement in accordance with 14 NYCRR §§ 587 and 588. This review

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will include clinic, continuing day treatment, partial hospitalization, and intensive psychiatric rehabilitation program. Prior OMIG audits identified significant non-compliance with regulations relating to treatment plans and program documentation requirements. Additionally, the OMIG will identify instances where a pharmacological service was billed (unbundled) by providers as a separate procedure and instances where unlicensed physicians were approving treatment plans.

### **Prepaid Mental Health Plan**

The OMH monitors the Prepaid Mental Health Plan (PMHP) through a governing body that includes two members of the commissioner's cabinet, the physician medical director for adult services, the director of state operations finance, a representative of the OMH counsel's office, key members of the state facility program operations staff, and representatives for recipient/consumers and component facility administration.

The governing body convenes quarterly to review the operation of PMHP, including specific data regarding fiscal and operational issues. Enrollment patterns, service use, and available service options for consumers are reviewed to strengthen the quality of comprehensive mental health treatment and recovery services that are available and delivered at state psychiatric center outpatient service sites throughout New York State.

### **OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITY**

The Office of Mental Retardation and Developmental Disabilities (OMRDD's) audit plan for 2009 includes 124 Medicaid field audits to evaluate voluntary agencies' compliance with Medicaid documentation requirements and to recover funds when appropriate. These reviews will be in addition to desk reviews of claims by OMRDD staff and other investigations/audits conducted when Medicaid overpayments are either self disclosed by the voluntary agencies or reported to OMRDD by external sources. In addition, OMRDD staff will be conducting audits of its own Developmental Disabilities Services Offices (DDSOs) to ensure that appropriate documentation is maintained. OMRDD will also be providing extensive training to voluntary agency staff relative to Medicaid billing and documentation requirements. Workforce reductions may impact on OMRDD's ability to complete its audit work plan for 2009-10.

The desk reviews planned for 2009 will include reviews which can be performed through analysis of billing data available through the Department of Health's eMedNY system to determine compliance with rules, regulations and policies. During 2009, OMRDD expects to initiate several new desk reviews to determine billing compliance for the Home and Community Based At-Home Residential Habilitation Service as the billing unit and reimbursement structure recently changed.

In addition, the OMIG will work collaboratively with OMRDD in the following areas:

- Consistency between the OMIG and OMRDD audit tests through the use of a protocol that is agreed-upon by both agencies.
- OMIG will carefully weigh the appropriate balance between audit standards which must require recovery of overpayments and other audit standards for which program integrity, quality of care and continuity of services would be better served by viewing such standards as primarily opportunities for provider quality improvement without the need for fiscal recovery.
- The continuation of ongoing sharing of audit findings and self-disclosure information between the OMIG and OMRDD.

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- Training on regulatory interpretation for both OMIG and OMRDD staff.

### **Case Management Services**

Case management is a process which assists persons eligible for Medicaid to gain access to necessary services in accordance with goals contained in a written case management plan. 18 NYCRR § 505.16 provides details of the regulatory requirements for case management services. The OMIG will review providers of case management services to ensure that the procedural requirements for the provision of services are met and that those services have been billed correctly and have supporting documentation for the units of service billed.

### **Ninety-Day Billing Exception Codes**

The Medicaid program requires a provider to submit claims for services to eligible recipients within 90 days from the date of discharge or service. Claims submitted after 90 days are denied unless the provider submits a 90-day exception code on the claim.

Our data mining activities identified numerous inaccuracies where claims were submitted after 90 days with invalid exception codes. For example, claims for OMRDD services were submitted with exception code 10 (delay the prior authorization process). No prior authorization is required for such services. The OMIG will expand the review of Medicaid payments for claims submitted by providers after the date of discharge or services utilizing exception codes. Generally, the review period will cover July 1, 2003 through December 31, 2005.

The OMIG will select a sample of claims submitted with the exception codes and request the underlying documentation to support late claim submission.

## **OUT-OF-STATE PROVIDERS**

In 2008, New York State paid approximately \$290 million to out-of-state providers for 35 different types of medical service. The OMIG will focus on payments to out-of-state providers for ambulatory surgery, inpatient hospital services, laboratory services and skill nursing facilities.

### **Ambulatory Surgery**

In 2008, New York State reimbursed out-of-state providers for \$4 million in ambulatory services. The OMIG will review physicians and ambulatory surgery center medical chart documentation to determine if the procedure needed to be performed in an ambulatory setting. In our review of ambulatory surgery claims submitted by out-of-state providers, we will determine if the services were provided in a clinic setting.

### **Inpatient Services**

The OMIG will focus on the highest billers and determine if payments were made at the lowest amount in accordance with 18 NYCRR § 527.1. The state reimbursed out-of-state inpatient hospital providers approximately \$43 million in the 2008 calendar year.

The OMIG will review hospital inpatient medical chart documentation to determine if it supports the DRG coding for services.



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### **Laboratory Services**

In 2008, New York State reimbursed out-of-state providers \$12 million for laboratory services. The OMIG will review claims to ensure that all tests were ordered, the results were available and compliant with Medicaid billing regulations. This includes reviewing payments made for dual-eligible recipients.

### **Nursing Home Audits**

In 2008, New York State reimbursed out-of-state providers \$140 million for nursing home services. Residents are sent out of state, as necessary, for specialized care, such as traumatic brain injury, ventilator and specialized pediatric care, and, to a lesser degree, for geographic proximity to a patient's home. Medicaid payments to out-of-state residential health care facilities (RHCF) are determined by the New York State Department of Health's, Bureau of Long Term Care Reimbursement by utilizing the host state's Medicaid rate, along with a per diem add-on for ancillary services not included in the host state's rate. The OMIG will review the propriety of the rate calculation for out-of-state RHCFs, including verification of the Medicaid rate paid by the host state. The OMIG will verify propriety of add-on ancillary services.

### **PAYMENT ERROR RATE MEASUREMENT PROJECTS**

New York State is part of the CMS review of medical claims to determine a national payment error rate for the Medicaid program, known as the Payment Error Rate Measurement (PERM) project. The OMIG is responsible for the Medicaid fee-for-service and Medicaid managed care universe submission, as well as the medical review portion of the Medicaid fee-for service sample. The Office of Health Insurance Programs (OHIP) has responsibility for the Medicaid and the State Child Health Insurance Plan (SCHIP) eligibility portion of the PERM project as well as the review of the SCHIP managed care claims. Fifteen other states and the District of Columbia are also working with CMS to determine the extent of improper Medicaid payments by reviewing between 820 and 1,000 claims for review purposes.

The state provided CMS with a universe of paid claims for each quarter in the 2008 federal fiscal year. The OMIG stratified the claims and selected them at random. Any claim paid during the period has a chance to be selected.

The OMIG will monitor the CMS contractor claim review for fee-for-service payments and managed care capitation payments. To assist CMS contractors, the OMIG will contact providers to encourage appropriate documentation for each claim sampled, follow up with providers in the event that additional documentation is needed, perform medical and payment reviews and dispute any CMS review contractor findings with which New York State disagrees. Disputes may occur if the state disagrees with the clinical assessment of the documentation provided. Disputes may also occur when the state disagrees with the way in which CMS contractors applied laws, regulations or policies.

The dispute processes for the PERM project contain stringent time constraints. To dispute an error with CMS review contractors, states are allowed only 10 business days. To dispute an error with CMS, states are allowed only five business days. States are only allowed to appeal to CMS if they have first appealed the claim with the review contractor. These timeframes are non-negotiable and necessitate the review of the claims by OMIG prior to an error being assessed.

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PERM review is scheduled at three-year intervals. Between cycles, the OMIG will use the PERM model to continuously perform random sampling of Medicaid claims.

### **PERM-PLUS PROJECT**

The OMIG will use PERM samples to collect information that might not be required as part of the project, but which is useful to the OMIG in identifying potential threats to the integrity of the Medicaid program. OMIG staff will look at each sample payment as it relates to the overall billing pattern of the provider, the utilization pattern of Medicaid recipients and the health care relationships between the client, the provider and other health care providers dealing with the client and the sampled provider.

### **PAYMENTS FOR PERSONAL CARE AIDE SERVICES**

The OMIG will audit providers receiving Medicaid reimbursement for PCA services, an industry that involves program expenditures of approximately \$2.5 billion annually over the last three calendar years. OMIG audits will ensure adherence with 18 NYCRR § 505.14, 10 NYCRR § 766, and the New York State Medicaid program policy manual guidelines. A sample of randomly selected paid claims will be examined to ensure that services were rendered in accordance with the patient's plan of care; the agency had sufficient documentation to substantiate billed services; appropriate documentation was maintained in patient and personnel-related records; supervision was provided as required; and claims for payment were submitted in accordance with New York State laws, department regulations and the provider manuals for personal care services. Particular attention will be given to audit procedures to ensure that PCA services were actually performed as billed. The scope of the reviews will entail examining the role of local social service districts (counties) which play a vital role in the programmatic and oversight process.

### **PHARMACY AUDITS**

The OMIG conducts pharmacy audits to ensure provider compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid program. OMIG will verify that prescriptions were properly ordered by a qualified practitioner, the pharmacy has sufficient documentation to substantiate billed services, appropriate formulary codes were billed, patient-related records contain the documentation required by the regulations and claims for payment were submitted in accordance with department regulations and appropriate provider manuals. The OMIG's audits include various types of pharmacies, including retail chain pharmacies, long-term care pharmacies, specialty pharmacies, infusion pharmacies and other retail (non-chain) pharmacies by location.

#### **Global Pharmacy Audit**

The OMIG will conduct a global review of one pharmacy chain for services provided to eligible recipients. As part of this review, the OMIG will select a statistically valid random sample of claims from the statewide universe of Medicaid payments. OMIG offices throughout the state will be responsible for gathering pharmacy chain documents for each sample selection. As part of this review, the OMIG will seek the assistance of the pharmacy chain's corporate compliance offices to assure timely submission of documents for audit purposes.

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### **Pharmacy Audits—Out of State**

The OMIG has identified five out-of-state pharmacies with high-dollar Medicaid reimbursements located in Pennsylvania, New Jersey, and Tennessee. Total New York State Medicaid payments from 2004 through 2008 for these providers range from \$57.9 million to \$206.3 million. The drugs billed include HIV drugs, blood products, human growth hormones, and Synagis for children. The OMIG will determine if the pharmacies are in compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid program. In addition, the OMIG will perform tests to ensure that proper purchases are made to substantiate costs and appropriateness of the drugs billed and that no unreported discounts have been taken.

### **Infusion Specialty Pharmacies**

The OMIG will pursue audits of infusion and specialty pharmacies, which generally have higher-dollar Medicaid reimbursements than retail pharmacies. Infusion and specialty pharmacies differ from retail pharmacies in the types of drugs they dispense. The majority of orders for services are received electronically (telephone, fax, computer), and the pharmacies also dispense auxiliary supplies along with the ordered drugs. The OMIG will review for non-compliance with emphasis on missing documentation (especially for auxiliary supplies), inaccurate claim submissions (drug, strength, quantity), and bypassing system edits (60-day edits).

### **Long-Term Care Pharmacies**

Long-term care pharmacies will also undergo audits for their compliance with regulations governing the Medicaid program. Orders received by these pharmacies typically resemble inpatient multi-drug orders rather than traditional prescriptions. The OMIG will review ordering information and compare that to the claim information, with an emphasis on incomplete order information (e.g., quantity and refills). The OMIG will also review whether Medicaid is being properly credited for unused medications of nursing home patients.

### **Other Areas of Interest**

In recent years, some pharmacies have been providing drugs at lower prices than their usual and customary charges. These pharmacies are charging a “special” price for 30-day and 90-day supplies of generic drugs. In addition, some are providing free generic antibiotics during the winter and spring months. Other pharmacies are charging a “membership fee” in order for their customers to obtain low-cost pricing. The OMIG is in the process of identifying such pharmacies and the special pricing that is being offered to customers. The OMIG will, among other things, examine claims paid to ensure that the prices charged to the general public are also reflected in the amounts billed to the Medicaid program.

## **PHYSICIANS AND DENTISTS**

### **Dental**

The OMIG reviews the maximization of dental provider billings involving all dental services within the scope of the Medicaid program. The OMIG targets providers based on specific, conflicting and over-utilized procedure codes identified through staff peer review and complaints involving individual providers. In 2008 and 2009, the OMIG concentrated on such procedures as denture repairs vs. placement of new dentures and basic dental procedures such as cleanings, fillings and X-rays on totally edentulous (i.e., no teeth) patients. The OMIG has also investigated

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placement of substandard and unnecessary stainless steel and other pre-formed crowns involving children. Additionally, the OMIG considers completion of excessive dental procedures (i.e., fillings, extractions, root canals and post/core procedures) billed on a per visit basis.

The OMIG has also investigated substandard record keeping (e.g., medical histories, dental exams, and non-diagnostic X-rays).

### **High-Ordering Providers**

The OMIG routinely analyzes goods and services ordered by physicians using a variety of techniques, including data mining, in an effort to identify areas of audit purposes. Through this process, the OMIG has identified certain physicians who appear to have ordered excessive goods and services such as drugs, home health care, hospice, DME and transportation. In order to ascertain the propriety and medical necessity of goods and services ordered by physicians, the OMIG will inspect the physician's patient medical records to determine if adequate documentation exists to support ordered goods and services, including medical necessity.

The OMIG intends to send letters to high-ordering physicians alerting them to their ranking when compared to other physicians. Also, the OMIG will be monitoring their ordering practices. If the trends continue, we will initiate an audit of the physician's medical records.

### **Teaching Anesthesiologists**

The Medicare program permits concurrent supervision of residents. The Medicaid program does not permit concurrent supervision of residents. Medicare and Medicaid programs reimburse physicians for two categories of units:

- Base units for the specific procedure
- Time units related to time spent by the physician on the procedure

Medicaid regulations allow anesthesiologists in teaching hospitals to be paid when they are involved in a procedure with medical residents, but require that the anesthesiologist must be present during induction and emergence. The OMIG will review teaching anesthesiologists claims to assure compliance with 10 NYCRR § 405.13.

### **PRIVATE DUTY NURSING SERVICES FOR MEDICAID RECIPIENTS**

The OMIG will target private duty nursing service claims where the service provider's earning exceed \$100,000, identify and seek recoveries where nurses are providing long-term health care services without proper supporting documentation. As part of the review, the OMIG will focus on the paid claims with straight time of more than 16.5 hours as well as their adherence to Social Security Act 1902 (42USC 1396a), 18 NYCRR § 504.3 and Public Health Law Section 32 (9). In addition, the OMIG will refer all excessive billings to the Division of Medicaid Investigations (DMI).

### **RECORD RETENTION**

Providers must attest to compliance with all rules, regulations, policies, standards, fee codes and procedures as set forth in Title 18 of the New York State Codes, Rules and Regulations of and other publications of the Department of Health, including provider manuals and other official bulletins by signing a claims certification statement. This includes the requirement that all records

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that support provision of care and payment will be maintained for a period of six years from the date of payment. As part of its audit, the OMIG will ask the provider and/or the individual attesting to this provision what controls were in place to ensure that records would be maintained for the required period.

The OMIG has found that some providers—or their representatives—sign the claim certification statement without ensuring that conditions exist that will result in records being maintained for the full six years from date of payment. In those cases, the OMIG may choose to impose a sanction or a penalty.

### **RESIDENTIAL HEALTH CARE FACILITIES**

Residential health care facilities (RHCs) are reimbursed for covered services to eligible recipients based on prospectively determined rates. Through 2008, the prospective rates were comprised of two components:

- an operating component
- a property/capital component

The operating component was based on the 1983 reported costs of the RHC, or the first full year of operation, whichever was later, or on a more current basis to reflect, among other events, a change of ownership or construction of a new facility.

Approximately 40 percent of the RHCs operating in New York State have reimbursement rates based on 1983 operating costs. The remaining 60 percent are based on more recent operating costs. The property/capital component is based on costs reported in each year with a two-year time lag, with the exception of mortgage expense, which is based on rate year costs.

Legislation passed in 2006 to rebase the 2009 operating component of the Medicaid rate to the year 2002, takes effect retroactively to April 1, 2009. Effective April 1, 2010, the method used to reimburse nursing homes for services to Medicaid patients will be revised to use a regional base price with adjustments for nursing home-specific costs based on 2007 costs.

For the state fiscal year 2009-2010, the OMIG plans to conduct Medicaid rate audits in the following areas.

#### **Bed Reserve Audits**

The Medicaid program reimburses RHCs on a per-day basis when patients are transferred to a hospital, with the expectation that the patient will return to the facility within 15 days. Due to substantial findings over the past year, the OMIG will continue to perform audits of nursing homes in the area of reserved bed day billings. The audit scope will include a review of 18 NYCRR § 505.9(d) requirements that the nursing facility's vacancy rate was equal to or less than five percent at the time the resident was temporarily discharged from the home, and that written documentation exists to support the expectation that the resident would return to the nursing home within 15 days when discharged from a hospital.

## **Rate Audits**

### **Base Year**

Since the same reported costs, with appropriate trend factors, are used for multiple years of reimbursement for the operating component until a new base year is set, the OMIG will review new base years approved by the Bureau of Long Term Care Reimbursement. The OMIG's audits will focus on inappropriate and unallowable costs included in the RHCf rates. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

The OMIG will conduct a risk assessment and perform audits of the new base year costs for RHCfs that are rated as "high risk" by the OMIG.

### **Dropped Ancillary Services**

The Medicaid rates for residential health care facilities include various ancillary services as contained in their base year costs. The OMIG will review whether RHCfs are providing the ancillary services included in their Medicaid per diem rate and whether any changes in billing have occurred. Some RHCfs have elected to change the method of billing regarding ancillary services—for example, an outside fee-for-service provider bills Medicaid directly for the ancillary services as opposed to the RHCf doing the billing itself.

In cases where RHCfs have discontinued providing services included in their Medicaid rate, the OMIG will reduce their per diem rate accordingly and recover related Medicaid overpayments. Where Medicaid is paying the outside fee-for-service provider in addition to the RHCf for the same ancillary services, duplicate reimbursement occurs. As required by 10 NYCRR § 86-2.27, RHCfs are required to notify the Department of Health when any previously offered service is deleted, which may lead to a drop in a particular RHCf's rate because an ancillary service is no longer available.

### **Medicaid Rate Part B Carve Out**

Medicaid rates for nursing facilities include billable rates for Medicaid patients who are not eligible for Medicare Part B service reimbursement, as well as rates for those who are eligible. The difference between the non-eligible and eligible rates is called the "Part B carve-out." The OMIG is currently developing an approach to systematically capture the Part B reimbursement associated with Medicaid patients through data gathering and computer matches with the Centers for Medicare and Medicaid Services (CMS), the federal department responsible for oversight of the Medicare and Medicaid programs. Once the computer match process is developed and tested, the OMIG plans to audit the Part B carve out for facilities with 2002 base rate years or later. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517, and 518 provide the OMIG with the authority to conduct such audits.

### **Notice of Rate Changes (Rollovers)**

Reported base year operating costs are increased by an inflation factor (also known as a "trend" factor) and used as a basis for RHCf Medicaid rates for subsequent years. The OMIG intends to carry forward base year operating costs audit findings into rate year 2008 and adjust Medicaid rates accordingly.

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### **Property/Capital Cost Audits**

Reported RHCF property costs are used as a basis for the property/capital component of the RHCF Medicaid rate. The OMIG will review each RHCF property cost component of their promulgated rate and, where appropriate, audit the underlying costs that determined the capital component. This may include mortgage refinancing. OMIG audits will make appropriate adjustments to the rates and recover applicable Medicaid overpayments. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

### **Rate Appeals**

Residential health care facilities file rate appeals to contest their Medicaid rates as the result of a number of factors, including computational errors, additional costs, methodology issues, new services, new renovation projects, new base years, among other issues. The OMIG will review rate appeals that have been approved by the Department of Health's Bureau of Long Term Care Reimbursement and, where indicated, audit underlying costs associated with those appeals to determine the appropriateness of each appeal issue. OMIG audits will make proper adjustments to the rates and recover applicable Medicaid overpayments. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

### **Temporary Staffing Costs**

Through December 31, 2006, the Medicaid program permitted nursing home rates to be rebased if the facility was sold to another party. The OMIG identified a number of nursing homes with substantial increases to their operating component attributable to the transfer of most employees to a temporary staffing agency.

As part of the base year audits, the OMIG will focus on facilities using temporary staffing agencies for significant numbers of employees. This review will include the contract with the temporary staffing agency, documented invoices for staffing and the previous owner's payroll records. The OMIG will also determine whether the owner or the nursing home has any interest in the temporary staffing agency, and whether the temporary staffing agency is a related party or an affiliate of the facility. In appropriate circumstances, the OMIG will review the involvement of consultants and professionals in the temporary staffing agency arrangement and its reporting on cost reports.

## **Claim Audits**

### **Patient Review Instrument – Clinical Audit**

The number of a nursing home's residents classified in the various resource utilization group (RUG-II) categories determines the facility's overall case mix index (CMI) and thus significantly influences its per diem Medicaid reimbursement rate. Consequently, it is essential for each resident's condition and functional ability to be assessed accurately. This is accomplished by means of the patient review instrument (PRI). The PRI was utilized through December 2006 to calculate the nursing home rate.

The Department of Health's Bureau of Long Term Care Reimbursement (BLTCR) utilizes PRIs to adjust a nursing facility's operating component per diem rate to recognize intensity of services. The OMIG will examine the propriety of the preparation of the PRIs as they affect the nursing facility's case-mix index portion of its per diem rate of reimbursement. The last case-mix index

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calculated by the DOH's BLTCR for 2006 will be used for the 2007 and 2008 rates, per PHL § 2808-2-b (a) (v).

### **NAMI Project**

A patient's net available monthly income (NAMI) equals his or her income which is available to offset the cost of care after all deductions. The OMIG will inspect the nursing home's admission and patient account records to assure that NAMI was properly reported and offset to per diem Medicaid rates. We will select a few nursing homes covered by the White Plains region and conduct reviews on a sample basis. If substantial findings exist, we will convert this into a statewide computer match project.

### **SELF DISCLOSURES**

The law which establishes the OMIG requires that all providers who are required to maintain an effective compliance program make timely disclosure and repayment of overpayments obtained from Medicaid, as an aspect of an effective compliance program. The OMIG has developed a self-disclosure protocol, which allows providers to make their disclosures to the OMIG, and explains how those disclosures will be addressed. The OMIG has done extensive outreach to communicate this process to the various provider, medical and legal associations, and has posted necessary forms and instructions on the OMIG's Web site. Through this process, providers who identify internal billing or operational issues that might affect their right to Medicaid reimbursement come forward and disclose the parameters of the problem and its potential Medicaid financial impact. The OMIG determines that the issue is a true disclosure (not the result of audit or investigation), validates the parameters described and works with the provider for repayment, which may include extended repayment terms and/or forgiveness of some accrued interest.

As a result of self-disclosures received, the OMIG is expanding its audit program to: examine all inclusive hospital clinic rates that were modified to remove physician costs from the rate and allow the physician costs to be billed separately; audit home care providers to ensure Medicaid is not being billed for travel time for aides providing home care services; audit renal care providers to ensure Medicaid is not being billed for services that are all inclusive in Medicare rates; audit teaching hospitals medical education rates, which include Medicaid funding, to ensure only qualified residents are included in the program.

### **TRANSPORTATION**

The OMIG has taken an analytical approach to transportation reviews by concentrating on high ordering transportation providers as well as on the transportation providers themselves. With the assistance of OMIG nursing staff, we intend to focus increased audit efforts on the ordering providers. Physicians, methadone maintenance, pharmacies and adult day health care providers are just a few of the high-ordering providers that the OMIG plans to review in conjunction with transportation audits.

### **Ninety-Day Billing Exception Codes**

The Medicaid program requires a provider to submit claims for services to eligible recipients within 90 days from the date of discharge or service. Claims submitted after 90 days are denied unless the provider submits a 90-day exception code on the claim.



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The OMIG's data mining activities identified numerous inaccuracies where claims were submitted after 90 days with invalid exception codes. The OMIG will expand its review of Medicaid payments for claims submitted by providers after the date of service utilizing exception codes. Generally, the review period will cover July 1, 2003 through December 31, 2005.

The OMIG will select a sample of claims submitted with the exception codes and request that the transportation company provide the underlying documentation to support late claim submission.

### **Transportation – Billing for Inpatients**

The OMIG, as a result of prior successful recoveries in this area, will again initiate audits of transportation services billed to Medicaid when the recipient was a hospital inpatient. The audit scope will include a review of the transportation company records to support the transportation service was provided, as well as validation that the company's drivers met the required regulations to escort and bill for the transportation of Medicaid recipients. Providers will be asked to explain, in writing, how the entity billed for a patient who was an inpatient at the time, and what compliance and oversight measures the provider has put in place to prevent a recurrence.

### **Transportation – Non-emergency Ambulance**

The OMIG will review Medicaid claims for non-emergency ambulance procedure codes to ensure that the Medicaid recipient is in need of services that can only be administered by an ambulance, and further, that the ambulance had the appropriate equipment and personnel to meet the needs of the recipient.

### **Claim Review**

The OMIG will review fee-for-service claims and supporting documentation of selected transportation providers. The Department of Health regulation, 18 NYCRR Section 504.8, allows the department to examine a provider's adherence to established department policy and procedures, as well as their conduct relative to unacceptable practices. The OMIG will review transportation provider compliance with regulations governing the program as stated in 18 NYCRR Section 505.10.

### **Vehicle Information**

The OMIG will review the driver license and vehicle license plate numbers reported in Medicaid claims by transportation providers who use ambulettes to transport patients. If such numbers are found to be invalid or if the vehicle number as reported is not licensed by the appropriate authorities (New York City Taxi and Limousine Commission, for example), or if the driver as reported is not appropriately licensed (19A certified, for example), OMIG will seek to recover the payments associated with such claims.

## **WAIVER PROGRAMS**

### **Home and Community-Based Services (HCBS)–Medicaid Waiver for Individuals with Traumatic Brain Injury**

The OMIG will expand its review of traumatic brain injury (TBI) providers. Medicaid HCBS waiver programs allow states to provide alternative services for individuals who would otherwise

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require care in nursing homes. The OMIG will examine documentation in support of TBI claims to determine compliance with the *HCBS/TBI Waiver Provider Manual*.

Prior audits have identified several payment issues such as the lack of documentation for services billed, billing for TBI provider services not included in the service plan, billing for more hours than documented, and service plans not being updated on a timely basis. In addition, the OMIG determined that several provider staff did not have the requisite qualification to render services.

The OMIG will also review Medicaid payments for claims submitted by TBI providers 90 days after the date of service. Medicaid regulations require that claims for payment of services be submitted within 90 days of the date of service to be valid unless the claim is delayed due to circumstances outside the control of the provider.

### **Home and Community-Based Services Waiver-Services Provided Under § 1915(c) of the Social Security Act**

The purpose of the waiver is to decrease the risk of institutionalization by providing such services as day habilitation, residential habilitation, respite, and family education and training. Any waiver service provided to a participant must be included in the participant's service plan along with the amount, frequency and duration of each service. The OMIG will review Medicaid payments to providers to determine if services provided to individuals with developmental disabilities were in accordance with § 1915(c) approved waiver agreements and 18 NYCRR Parts 624, 633, 635, 636, 686 and 671. The OMIG will conduct audits and reviews of residential habilitation providers identified by OMRDD that did not pass a phase I review for instances of non-compliance with requirements for ICF/MR level of care determinations and individualized service plans.

### **Long Term Home Health Care Program Waiver (LTHHCP)-Home and Community-Based Services**

The waiver programs allow states to provide alternative services for individuals who would otherwise require care in a nursing home. LTHHCP providers supply a coordinated plan of services to ill or disabled persons in the individual's home, the home of a responsible adult, or an adult care facility (other than a shelter for adults). Although the program services persons of all ages, it most frequently provides services to the frail elderly. Participants in the program must be medically-eligible for placement in a hospital or residential health care facility for an extended period of time if such a program were unavailable. Medical eligibility is determined by the New York State Long Term Care Placement Form Medical Assessment Abstract (DMS-1) form or its successor.

Prior audits of LTHHCP providers found that the comprehensive assessments were not completed on timely basis. The OMIG will expand its review of LTHHCP providers focusing on timely completion of comprehensive assessments.

### **Long Term Home Health Care Program-Rates**

The OMIG will conduct audits of LTHHCP cost reports submitted for LTHHCP to verify per-visit and hourly rates calculated for the various ancillary disciplines in accordance with 18 NYCRR Part 517 (Provider Audits) and Subpart 86-5 (LTHHCP). With an emphasis on both high Medicaid utilization and rate caps, the OMIG will review direct patient costs, overhead costs, related party transactions, Medicaid patient visits, total visits and related hours. Where appropriate, direct costs will be verified to the necessary supporting documentation (invoices, payroll records, trial balance accounts, etc.). Statistics will be reviewed for reasonableness to

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ensure that indirect costs are properly allocated. In addition, patient visits and hours will be verified to the supporting patient logs and/or census data to ensure proper reporting.

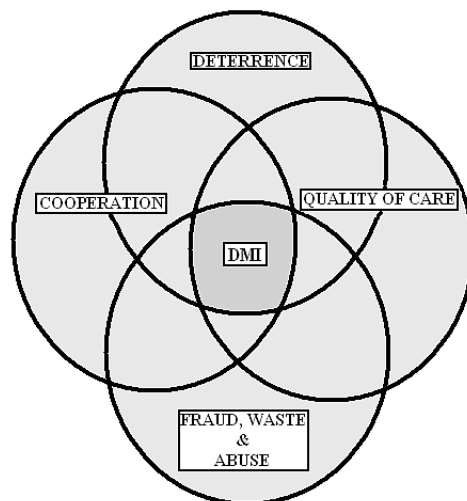
### **DIVISION OF MEDICAID INVESTIGATIONS**

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

The Provider Investigations Unit, Undercover Shopper Unit, Enrollment and Reinstatement Unit, Provider Exclusions and Censures Unit, Surveillance and Utilization Review System Unit, Medi-Medi Project, Prescription Forgery Project, Recipient Fraud Unit, and Recipient Restriction Program all focus on four main areas that address the integrity of the Medicaid program:

- Fraud, waste, and abuse,
- Cooperation with other entities,
- Deterrence, and
- Quality of care.

Although DMI is divided into specific units, matters addressed by DMI impact every section of the division and the OMIG. Cases may begin in one unit but frequently involve several other units, since unraveling the complexities within the Medicaid system that can lead to fraud and deceit requires an overarching theory of investigation. Tracking providers to recipients then to providers and to other recipients helps DMI find those who seek to defraud the Medicaid program.



Any patient could be a DMI undercover investigator. Recipient and provider records are scrutinized through surveillance, forensic accounting of subpoenaed bank records and billings,

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medical record reviews, witness testimony, site visits, immediate demands for records, and computerized analysis.

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

Unlawful or improper behavior also results in adverse administrative actions. Such actions against providers include excluding or terminating, censuring, imposing penalties, or suspending privileges for a specified period of time. Recipients abusing the program are restricted to a single provider.

The OMIG notifies other governmental agencies including the Office of Professional Medical Conduct (OPMC), the Bureau of Narcotic Enforcement (BNE), State Education Department (SED) and the Health and Human Services' Office of Inspector General (HHS OIG), when appropriate.

After DMI identifies improper provider billing practices, the OMIG's Division of Medicaid Audit commences an additional review resulting in recoupment and systemic improvements.

### **PROVIDER INVESTIGATIONS UNIT**

Uncovering schemes and deceptive practices saves New York State's Medicaid program millions of dollars. DMI conducts investigations into dental care, medical care, pharmaceuticals, and transportation providers to identify fraud, waste, and abuse.

Fraudulent Medicaid billing practices include billing for services not rendered, manipulating payment codes to inflate reimbursement, submitting inaccurate data on claims, rendering unnecessary services, and duplicate billings. Upcoding (i.e., billing for more intensive services than those that were actually rendered), unbundling, dispensing medication to deceased recipients through auto-refill programs, accepting payment from another provider, and sharing reimbursement paid by the Medicaid program as a result of referring a patient to another provider are defined as illegal activities and are investigated and referred for criminal and civil action.

Unlicensed or excluded providers may not treat, order, or bill for services rendered to Medicaid recipients. DMI identifies providers who were previously removed from the Medicaid program or who lost their professional license and takes appropriate action against them. As is true for the general population, Medicaid recipients should never be treated by unlicensed practitioners.

DMI also investigates business arrangements and relationships that violate federal health care anti-kickback statutes or the statutory limitation on self-referrals by physicians. DMI is investigating matters involving enrollment and marketing schemes, prescription "shorting" (i.e., not including the proper number of pills in a prescription), kickbacks, factoring, and general health care fraud.

Experience shows that some nursing facilities, rehabilitation centers, and other health care settings implement schemes to defraud the Medicaid program while failing to meet minimum standards of care. DMI will identify providers that bill for medically unnecessary services and for services either not rendered, not rendered as prescribed, or for care that is so deficient that it

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constitutes a “failure of care.” DMI also investigates excessive services provided by dentists and dental clinics.

Investigators appear at provider locations unannounced to conduct credential verification and reviews (CVRs) to review records, documentation, premises and internal systems, for the purpose of verifying employee records, state and local regulations, credentials, and licensing.

DMI routinely investigates allegations of fraud and abuse related to transportation carriers who are also Medicaid providers. As Medicaid providers, health transportation carriers are required to comply with Article 19A of the New York State Vehicle and Traffic Laws and Department of Motor Vehicle’s (DMV) regulations. OMIG works closely with DMV to enforce these laws and regulations helping to meet a common goal of detecting fraud and protecting Medicaid recipients and other consumers.

In New York City, DMI cooperates with the Taxi and Limousine Commission to track each Medicaid provider’s ambulettes with global positioning system devices to detect fraud and ensure appropriate billing.

The CVR program and on-site inspections are increasing the OMIG’s exposure to enrolled providers, thereby improving relationships with providers who may see and report questionable practices. DMI also receives tips from concerned citizens who report misconduct through the hotline, internet, or local districts. DMI sends tens of thousands of explanation of medical benefits (EOMB) forms to recipients to verify that they have actually received the services billed by providers.

DMI investigators and auditors ensure that Medicaid claims submitted by and paid to providers are accurate, appropriate, and in compliance with applicable Medicaid rules and regulations. They select a multi-year period for review and analyze billing codes and procedures using a statistically valid random sample of claims.

Investigators determine whether any billings should be disallowed and, if so, the value associated with those inappropriate charges. They review documentation and determine whether disallowances exist in the sample. An automated statistical program cites overpayments and projects them across the universe for that sample. Based on these analyses, investigators create notices of proposed agency action, when appropriate.

Financial reviews and concurrent investigations often reveal program issues and weaknesses. The OMIG recommends program and policy changes such as modifying pertinent procedure codes, rewording citations in the Medicaid manual, and issuing Medicaid updates to alert providers about compliance matters.

Investigators are trained in the art of identifying deceptive behavior, uncovering complex financial schemes and auditing, interviewing uncooperative witnesses, Medicaid and health care fraud, and investigating complex computer forensic information. Investigators speak and read multiple languages, including English, French, Russian, Ukrainian, Mandarin Chinese, Spanish and Portuguese, and use those talents to leverage their varied law enforcement backgrounds. OMIG investigators receive training in the latest law enforcement techniques from subject matter experts and consult regularly with auditors, and investigators from other entities to share and compare trends observed during investigations.

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Developing relationships with other local, state and law enforcement agencies provides economies of scale to combat Medicaid fraud. DMI is a member of New York Health Care Fraud Taskforces and works with the Federal Bureau of Investigation, Drug Enforcement Administration, United States Department of Health and Human Services Office of Inspector General, New York State Attorney General Medicaid Fraud Control Unit, Office of the New York State Comptroller, Commission on Quality of Care and Advocacy for Persons with Disabilities, New York State Education Department, Office of Professional Discipline, Office of Professional Medical Conduct, Bureau of Narcotic Enforcement, State Insurance Fund, New York State Insurance Department, Workers' Compensation Board Inspector General, local district attorney's offices, and the special investigation units of numerous health insurance providers.

### **THE UNDERCOVER SHOPPER UNIT**

The Undercover Shopper Unit serves as the OMIG's "eyes and ears" on the street. Undercover investigators, known as "shoppers," identify fraud and assist other investigators in confirming the existence of fraud. Shoppers receive services from Medicaid providers; they are equipped with pseudonyms, Medicaid cards to match the pseudonyms, and surveillance equipment to accurately record the provider's conduct during "shops." The provider's subsequent claims are reconciled with the investigator's written report. Differences between the evidence obtained by the undercover investigator and the provider's claims receive additional scrutiny.

Shops are conducted randomly or as directed based on information gleaned from various targeting tools such as Provider SURS, EOMB results, the hotline and anonymous complaints. Information provided by Enrollment Audit Review (EAR) Unit and provider fraud investigations are also used to direct shops. During SFY 2008-2009, DIE undercover investigators conducted thousands of shops and will maintain or exceed the number of shops in 2009-10.

Some shops identified enrolled pharmacies and durable medical equipment (DME) providers that billed for services and products dispensed by other non-enrolled pharmacies or DME providers. Providers may not claim that they provided services when in fact another entity provided said services. This is not permitted under the program and constitutes an unacceptable practice, false filing, and potential fraud. Both enrolled and non-enrolled providers who participate in such schemes face exclusion or termination from the Medicaid program.

Undercover shopping is an excellent tool for discovering everything from quality of care issues to billing problems to systemic fraud. The unit's findings have resulted in arrests, prosecutions, exclusions, terminations, and penalties. Numerous other entities rely on the undercover shopper unit to assist in their investigations.

Prior to 2009, shoppers had been used only in the fee-for-service arena. Thirty-six counties and the five boroughs of New York City have mandatory managed care programs. The managed care arena presents unique challenges in finding instances of fraud, waste and abuse. However, DMI is coordinating with county departments of social services and managed care providers to discover and help to prevent fraud and abuse in this area. Undercover investigators test the quality of care provided to beneficiaries whose Medicaid coverage is provided under the mantle of managed care. During SFY 2009-2010, the Undercover Shopper Unit will expand its upstate footprint to further the OMIG's mission to preserve the integrity of the Medicaid program.

### **ENROLLMENT AND REINSTATEMENT UNIT**

The Enrollment and Reinstatement Unit (EAR) thoroughly reviews provider enrollment and reinstatement applications to determine if applicants should be enrolled into the Medicaid

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program. These front-end reviews help ensure that potentially abusive providers and those unable to provide high quality care are identified before they are enrolled or reinstated. This results in cost savings to the Medicaid program. In addition, front-end denials deter other providers from even attempting to enroll.

Experience shows that some pharmacies, laboratories, transportation providers and DME providers commit fraud against the Medicaid program. EAR determines if applications contain false, misleading or inaccurate information. On-site investigations, undercover staff, background checks, exclusion records and corrective actions taken, sanction databases and other sources are used to gather information and assist in determining whether a provider should be permitted to service this vulnerable community.

Ownership changes are screened to determine if a sale was legitimate, if excluded individuals are purchasing businesses, or if providers undergoing audits or investigations are selling their business. Non-arm's-length transactions will be discovered and referred to the exclusion unit and the New York State Department of Tax and Finance when appropriate.

Practitioners are required to enroll in the Medicaid program if they order more than 4,500 services or more than \$75,000 in a 12-month period. EAR identifies practitioners who reach these levels of activity and fail to enroll. The Provider Investigation Unit is notified when there appears to be identity theft and a license number is being used by another practitioner.

Other units within the OMIG are notified when abuses or unacceptable practices are discovered during an EAR review. This results in audits, investigations, and exclusions. Pharmacies are currently being excluded based on evidence obtained during joint investigations with the shopper unit. EAR coordinates with the Edit 1141 (pre-payment review) Unit when providers are enrolled but limited to certain services to ensure that services outside of the limited area are not reimbursed.

The unit coordinates its efforts with the MFCU, the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), OPMC and OPD, the Board of Pharmacy, the New York State Department of Transportation and other state and local agencies, as well as staff within the DOH and OMIG. As an example, providers seeking reinstatement in Medicaid must first be reinstated by Medicare. EAR works with CMS to coordinate reinstatement efforts for qualified providers. EAR also acts as the liaison between the OMIG and the DOH/OHIP Bureau of Provider Enrollment.

Within the next fiscal year, EAR expects to review approximately 700-900 applications. Historically, more than 15 percent of all applications result in denials. EAR expects that by increasing undercover shopper coordination, more fraud will be discovered and therefore, the number of exclusions will increase.

### **PROVIDER EXCLUSIONS UNIT**

To protect the integrity of the Medicaid program and recipients from health care professionals who pose a risk, the OMIG excludes individuals and entities from participating in the Medicaid program. Action is taken against individuals and entities for program-related criminal indictments, convictions, patient abuse or neglect, licensing board disciplinary actions or for having engaged in any practices considered unacceptable under the Medicaid program. Under certain circumstances, a lesser action is censure. The OMIG utilizes a consistent and fair approach to ensure a just outcome and does not make these life-altering decisions lightly.

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Censured providers are always monitored to ensure integrity in the Medicaid program. These providers are considered high-risk and the particular underlying issue that led to the censure is scrutinized along with other areas that are traditionally abused.

Various federal, state and local agencies provide information used to determine whether to exclude. The OMIG will increase the speed at which criminal indictments, convictions, licensing board and administrative actions are forwarded from the agencies to remove providers who defraud the system or provide poor quality of care at a more rapid pace. Out- of-state providers who are licensed in New York and are excluded by other states are considered for exclusion in the New York State Medicaid program.

DMI identifies providers to potentially exclude by maintaining a cooperative relationship with all district attorneys in New York State, conducting internet searches that reveal Medicaid and health care-related arrests and information concerning ongoing investigations conducted by other agencies, and reviewing actions taken against health care professionals by the United States attorneys. Furthermore, providers who engage in conflicts of interest are considered for exclusion; two examples of conflicts of interest are physicians prescribing drugs produced by companies that have the same physician on retainer or payroll and physicians related to another provider from which they order services.

Office of Professional Medical Conduct (OPMC) and the State Education Department (SED) provide consent orders on cases where they took action. The OMIG will obtain the full investigative file and consider the underlying facts to make an independent decision on whether exclusion is warranted. Clinical experts consult with the exclusion specialists, as appropriate.

Enrolled transportation providers that subcontract to non-enrolled providers violate the Medicaid rules. The enrollment process is vigorous to protect the recipients and integrity of the program. Transportation providers who skirt the system and subcontract services to non-enrolled personnel or entities will be considered for exclusion.

Individual providers are often fired after being excluded from the Medicaid program. Tracking excluded providers to determine where they are working after being excluded ensures that providers are not permitted to wrongfully gain from the Medicaid program and service the state's most vulnerable population. DMI will compare payroll and employment records at random and the largest health care-related providers to the exclusion list. The OMIG Web site lists excluded providers, and health care organizations employing an excluded practitioner may result in having to deal with administrative sanctions.

### **PROVIDER SURVEILLANCE AND UTILIZATION REVIEW SYSTEM UNIT**

The Provider Surveillance and Utilization Review (PSURS) is staffed with a certified coder and medically trained experts such as nurses and a dental hygienist who utilize complex computerized queries to compare providers to their peers. Their constant scrutiny monitors providers enrolled in the Medicaid program and targets providers for further investigation.

The PSURS staff has vast clinical, hospital, administrative and claims review experience. They have extensive computer data mining capabilities and provide a unique skill set to detect fraud, waste and abuse in providers that render and order services for Medicaid recipients. They conduct comprehensive reviews on providers who are identified as outliers for potential aberrant practices, including improper billing, ordering or quality-of-care issues.



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The PSURS unit also provides data mining, medical review and analysis for investigative staff and frequently works on joint investigations within the OMIG, and with the New York State Attorney General's MFCU, the Office of Professional Medical Conduct (OPMC), the State Board of Education, the Bureau of Narcotics Enforcement, and other government agencies.

Excessive and inappropriate billing by some providers for patients with infectious diseases, specifically, HIV and AIDS, are a recognized area for potential fraud, waste, and abuse. The unit will concentrate additional efforts into this area to protect this vulnerable population and cooperate with the provider and recipient fraud investigation units to ensure that resources are dedicated to those in need and not those who seek to obtain medication and treatment fraudulently.

To combat steering and fraud, newly enrolled pharmacies and enrolled pharmacies are scrutinized to determine whether certain providers are cooperating to wrongfully bill the Medicaid program. Also, early and automatic refills have traditionally been areas for abuse and are examined carefully.

Long-term and newly enrolled physicians and outpatient clinics are tested against their peers for provided and ordered services. Upcoding, surges in claims or ordered services, improper disease management, inappropriate treatment, and overlapping providers on similar dates of service for the same diagnosis are indicators of fraud and will be investigated.

Dentists treating recipients in a private practice and/or dental clinics are studied by a trained dental hygienist. Unbundling claims, rendering treatment without radiographic support, and servicing patients excessively are subjected to the same analysis and investigative measures as other providers. Records are examined to ensure that recipients are treated well and the quality of care meets the professional standard.

### **MEDI-MEDI PROJECT**

Some individuals are eligible for both Medicare and Medicaid. In these instances, Medicaid remains the payor of last resort; Medicare must be billed first, then Medicaid should be billed once Medicare has paid its share of the patient's costs. Providers servicing this population may submit inconsistent claims to each program, thereby fraudulently and illegally increasing their revenue stream. The Medi-Medi Project identifies fraud, waste, and abuse in cases where claims are filed with Medicare and Medicaid.

Through the Medi-Medi Project, the New York Medicare Medicaid Data Analysis Center (NMMDAC) team of data analysts and investigators analyze Medicare and Medicaid data. Comparing both sets of data ensures that the claims submitted to Medicaid correspond with claims submitted to Medicare. As a result of this analysis, aberrant practices involving both Medicare and Medicaid are reviewed as joint investigations.

Providers who commit fraud against either Medicaid or Medicare are more likely to defraud both programs. Providers excluded from either Medicare or Medicaid for substandard care or fraud will be investigated by the other program.

In 2008-09, the CMS contractor for Medi-Medi provided on-site Medicare 101 and Medi-Medi training to more than 200 OMIG staff. This training explained the services covered by Medicare and how to best request information on dual-eligible recipients that will help to identify fraudulent practices.

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In 2009-10, the Medi-Medi Program will focus on clinical psychologists treating residents in long-term care facilities, J codes billed to Medicare that are billed as NDC (National Drug Code) codes to Medicaid, analyzing APG (ambulatory patient group) codes related to emergency room visits, and reviewing durable medical equipment diabetic supply issues.

### **PRESCRIPTION FORGERY PROJECT**

Recipients submitting forged prescriptions to enrolled pharmacies lead to thousands of illegal pills and drugs being disbursed into the community. Recipients may alter valid prescriptions or obtain lost or stolen prescription pads. Under DOH regulations, doctors are responsible for reporting when prescription pads are lost or stolen. Some enrolled pharmacies unknowingly fill altered or forged prescriptions; others might fill potentially altered or forged prescriptions without question, while other pharmacies question such documents and contact the purported physician and appropriate authorities when they suspect fraud.

When pharmacies or physicians fail to notify Medicaid or the Bureau of Narcotics Enforcement (BNE) about lost or stolen prescription pads or suspected fraud, Medicaid may unwittingly pay the enrolled pharmacies when they dispense these drugs to recipients. The drugs are either sold for cash to other people or wrongly used by the recipient. The integrity of the Medicaid program and the prescription pad system is violated while the community is placed at risk.

Forgeries are identified through responsible providers who properly report suspected fraud. BNE shares lost and stolen prescription data with the OMIG. Using data mining techniques to find prescription serial numbers may reveal forged prescriptions and dispensing discrepancies by pharmacies.

This data mining follows timelines to identify the exact date and time prescription forms may have been taken from a provider. Through this process, the OMIG can recognize prescription forgeries early and limit the forgery to a specific geographic region. By rapidly intercepting forgeries before they spread to outlying communities, the DMI saves tax dollars and protects the public. Some prescribers are referred to the PSURS Unit to determine if they are likely to be involved in conspiring with recipients to obtain medication for use or sale.

Sometimes forgeries are identified without the physician's reporting lost or stolen prescription forms when OMIG investigators compare drugs dispensed to the prescribing physician's known practice. As an example, it would be unusual and probably inappropriate for a podiatrist to prescribe HIV medications. Such a proactively discovered fraud may reveal other recipients who are using forged prescriptions.

DMI reports issues to the local district fraud investigators who obtain the evidence necessary for a successful case. Recipients are referred for prosecution and placed on restriction such that they are permitted only to access one physician and one pharmacist. Further, physicians who fail to report lost or stolen prescriptions are considered for adverse administrative action. Pharmacists who knowingly dispense drugs based on forged prescriptions are referred for prosecution.

Detecting forgeries early prevents additional prescriptions from being filled and thereby keeps illicit drugs out of the community and saves taxpayers money.

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### **RECIPIENT FRAUD UNIT**

Recipients who defraud the Medicaid program by “doctor shopping,” fraudulently enrolling in, or abusing the program are violating the law and are referred for criminal prosecution. In addition, DMI seeks penalties and other adverse administrative remedies, including restricting the recipient to one specific doctor or pharmacy.

Recipients abusing the program often partner with a provider who enables the fraud. The Recipient Fraud Unit teams with the Provider Fraud Unit to locate such providers and then identifies other potential recipients who might also be defrauding the program. These providers write prescriptions for recipients who may not necessarily need those drugs. Ordering treatment or pharmaceuticals for those who do not need them is not only a waste of money but also places the recipient’s health at risk. Identifying these providers is an important role of this unit.

The Recipient Fraud Unit focuses on particularly high-use recipients and the providers servicing them. After identifying a high-use recipient, the unit reviews all services provided or ordered by that recipient’s physician, clinic, or other members of that practice or clinic. All prescriptions written for specific medications, such as oxycodone or oxycontin, are reviewed and followed to the servicing pharmacy. The unit notices trends in prescribing patterns for each provider and patterns for recipients for a “doctor shopping” to obtain narcotics and other prescription drugs. After locating “doctor shopping” recipients and providers with questionable prescribing practices, the unit expands its analysis to other providers within the geographic area.

Detecting eligibility fraud is challenging but integral to ensuring that those receiving Medicaid benefits meet the enrollment criteria. Civil action, criminal prosecution, and restitution are initiated against recipients who fraudulently enroll and receive Medicaid benefits. Medicaid is only for those who meet strict, state-established financial eligibility requirements. Enrolled recipients who do not meet the requirements set by the program will be discovered and prosecuted.

Reports of suspected fraud are rapidly investigated to establish the validity of an allegation. After triaging the complaint, the unit coordinates with the local district to obtain relevant evidence and prosecute the recipient when appropriate. The unit will continue to identify vulnerability in the Medicaid program and orchestrate appropriate ways to strengthen its integrity.

New York State does not currently have a centralized enrollment system; each local social services district interprets current regulations and policies. The Recipient Fraud Unit will conduct outreach and training programs to the local districts to increase prosecutions, identify weaknesses in the Medicaid application process and coordinate consistent regulations and policy interpretation. In 2009-10, newsletters will be sent to every commissioner of social services, county executive, and district attorney identifying patterns observed throughout New York citing best practices used to combat fraud.

The unit has relationships with the 58 local departments of social services and the Office of Temporary and Disability Assistance, Department of Taxation and Finance, and the Department of Labor (DOL). Intercommunication between OTDA, DOL, and the Department of Tax and Finance builds multi-layered prosecutions. Recipients defrauding Medicaid often also steal unemployment insurance and temporary assistance from New York State. Further, recipients who fraudulently enroll in Medicaid are referred for criminal tax fraud investigation and prosecution.

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### **RECIPIENT RESTRICTION PROGRAM (RRP)**

Duplicative, excessive, contraindicated or conflicting health care services, drugs or supplies often indicate that the Medicaid program is not being used efficiently. Federal and state regulations allow the OMIG to limit a recipient's access to Medicaid-funded services when that recipient commits fraud, waste, or abuse. A team of physicians, nurses and pharmacists recommends restricting a recipient to one primary physician, clinic, inpatient hospital, pharmacy, dentist or dental clinic, podiatrist, or DME vendor.

Through an internal review process, the OMIG identified the Recipient Restriction Program as not having optimized its potential ability to shape recipient behavior and save taxpayer dollars. To address that issue, the unit was reorganized this year, resulting in increased oversight and efficiency.

Referrals from the Recipient and Provider Fraud Units, local districts, or other agencies automatically initiate a full review of a recipient's health care plan. Specialized computer programming identifies recipients who may be abusing the Medicaid system by obtaining questionably unnecessary or excessive services. The Medicaid information for these recipients is thoroughly reviewed by a team of physicians, nurses and pharmacists, who make recommendations about whether to restrict a recipient to one primary-care physician, clinic, inpatient hospital, pharmacy, dentist or dental clinic, podiatrist, or durable medical equipment vendor. Local districts implement the restrictions for a two-year period. After two years, a case is reevaluated and the restriction is continued for three- and six-year periods, if warranted.

DMI specialists train and instruct local district staff and work with numerous law enforcement entities and groups that suggest recipients for restriction. During State Fiscal Year 2008-09, an average of 8,000 recipients were restricted at any given point, resulting in great cost savings and improved quality of care for recipients.

While seeking to optimize the Medicaid program, recipients who engage in fraud uncover providers who conspire and encourage illegal or dangerous behavior. After locating the providers, DMI is better positioned to investigate that provider's other patients. Accordingly, the unit cooperates with all divisions within the OMIG and numerous outside agencies.

### **DMI UNIT INTEGRATION**

Each unit inside DMI independently and collaboratively addresses fraud, waste and abuse, cooperates with other entities, deters improper behavior, and improves the quality of care.

The Provider Fraud Unit uncovers schemes and deceptive practices in the Medicaid program. It conducts investigations into entities and people providing dental care, medical care, pharmaceuticals, and transportation services, to identify fraud, waste, and abuse committed by employees, owners, facilities, and all Medicaid-enrolled and non-enrolled providers for fraudulent Medicaid billing practices.

The Undercover Shopper Unit identifies fraud and assists other investigations in confirming the existence of fraud. Shoppers receive services from Medicaid providers and reconcile the services and claims to identify fraudulent billing practices.

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The Enrollment and Reinstatement Unit reviews applications of certain categories of providers that historically commit fraud against the Medicaid program to determine whether a provider should be permitted to service this vulnerable community.

The Provider Surveillance and Utilization Review System Unit detects fraud, waste and abuse in providers who render and order services for Medicaid recipients. Comprehensive reviews are conducted on providers that are identified as outliers for potential aberrant practices including improper billing, ordering or quality-of-care issues.

The Recipient Fraud Unit combats doctor shopping, fraudulent enrollment, and abuse in the Medicaid program. Recipients abusing the program often partner with a provider who enables the fraud. The Recipient Fraud Unit teams with the Provider Fraud Unit to locate the providers and then identifies the other recipients who may also be defrauding the program.

The Recipient Restriction Program identifies situations in which the Medicaid program is not used effectively. It uncovers providers who conspire and encourage a recipient's illegal behavior. After locating the providers, the Provider Fraud Unit is better positioned to investigate that provider and the Recipient Fraud Unit investigates the provider's other patients.

In addition to working collaboratively inside DMI, the units also collaborate with other areas inside the OMIG and numerous outside agencies. Only with the cooperation and assistance of these other entities can government successfully fight or prevent potential criminal fraud committed against the Medicaid program.

Any patient could be a DMI undercover investigator. Recipient and provider records are constantly scrutinized through surveillance, forensic accounting of subpoenaed bank records and billings, medical record reviews, witness testimony, site visits, immediate demands for records, and computerized analysis. Providers and recipients conducting illegal activities are forwarded to the Deputy Attorney General for Medicaid Fraud Control, United States Attorney, the Deputy Attorney General for Medicaid Fraud Control, or local district attorneys for civil or criminal prosecutions resulting in substantial confinement and restitution.

Unlawful or improper behavior also results in adverse administrative actions. Adverse administrative actions against providers include excluding or terminating, censuring, imposing penalties, or suspending privileges for a specified period of time. Recipients found to be abusing the program are restricted to a single provider for their own protection.

Solving the problem of fraud and deceit requires each individual unit to cooperatively leverage its expertise to find those who would defraud the Medicaid program. The Division of Medicaid Investigation is the OMIG's eyes and ears on the street and protects the integrity of the Medicaid program.

Improving quality of care for Medicaid recipients and saving taxpayer money are the overarching themes of DMI's mission. Investigators and specialists recognize and remember that the most vulnerable population relies on them to police the program and ensure that only qualified and reputable providers treat them. Culling the unqualified and disreputable from the program protects the recipients and prevents the taxpayers from paying for unnecessary or poor quality services.

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### **FALSE CLAIMS ACT/QUI TAM RECOVERIES**

In 2007, the State of New York passed the New York False Claims Act (FCA) that mirrors the provisions of the Federal FCA with respect to whistleblower protections and the ability of whistleblowers to share in the proceeds of recoveries made as a result of their disclosure of information to the Attorney General for the State of New York as a FCA filing.

Such actions, also known as *qui tam*, allow private citizens to file a lawsuit in the name of the United States Government charging fraud by government contractors and others who receive or use government funds. The whistleblower then shares in any money recovered. Congress enacted the federal law to identify and prosecute government procurement and program fraud and recover revenue lost as a result of that fraud.

False Claims Act whistleblower actions are an important part of OMIG's efforts to encourage effective compliance programs and disclosure of overpayments by providers. Whistleblower actions which are supported by credible evidence should receive timely and appropriate review and investigation.

The OMIG is particularly interested in two kinds of whistleblower cases; First, those in which the whistleblower can demonstrate that the issues which are the basis of the action was raised internally through a health care providers' existing compliance program, and not addressed. Secondly, those cases where a whistleblower raised the issues which are the basis of the action and was retaliated against by the employer or other employees. Where the facts support the conclusion that the provider failed to address issues raised through the compliance program, or that there was retaliation against the whistleblower, OMIG will use its administrative penalty and exclusion authority in addition to any monetary remedy in the False Claims case.

The Office of the Medicaid Inspector General works closely with the Attorney General and with federal authorities to review and analyze allegations, participate in the decision to intervene in the case, and then to assist in the investigation of those allegations, and to participate in the litigation or settlement process.

## **DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION**

### **BUREAU OF BUSINESS INTELLIGENCE (BBI)**

The Bureau of Business Intelligence will continue to support the data needs for OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert services consultants.

#### **Data Mining**

A number of procurements and relationships are currently being explored:

#### **Desktop Graphical User Interface Tool**

Following a successful pilot project, the OMIG, Office of Health Insurance Programs (OHIP), Office of Mental Retardation and Developmental Disabilities (OMRDD) and Office of Mental Health (OMH) are working together to procure a data tool that presents ease-of-use through a graphical user interface, yet allows the user to make complex queries and effortlessly drill down

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into increasing levels of detail. Unfortunately, this process has been delayed as each agency has had to deal with the state budget crisis. At this time, we are firming up plans and estimate that the product will be purchased in August of 2009.

### **Link Analysis Software**

The OMIG conducted a pilot project using IBM Entity Analytics Software (EAS) which specializes in resolving entity relationships (e.g., identity attributes) from disparate data sources. Using a partial set of data, it uncovered numerous instances of duplicate recipients in our enrollment file. Based on the sample, we estimate that more than 22,000 duplicate enrollments remain on file. The OMIG has since purchased the tool and is scheduled to procure the necessary integration services by May of this year. Once procured, we estimate a three-month engagement to complete the duplication process, a match of vital statistics information to recipients and providers and a match of exclusion data with providers and business associates.

### **Provider Sanction Matches**

The OMIG has hired a company called Verisys to augment our ability to match providers against national sanction information. Though OMIG currently matches against federal sanction data, many gaps exist in the processes for transferring data from states to the federal level. Verisys has invested in many data feeds to states, and we are serving as a pilot site for their ability to find additional providers who have been previously sanctioned. Verisys is currently assessing OMIG provider information, and we expect preliminary results in the spring of 2009.

### **Employee Sanction Matches**

The OMIG is working with OMRDD, OMH, OASAS and DOH to develop controls, processes and matching to ensure that all of their state and contract staff have not previously been sanctioned. Initial runs have been completed with OMIG, OMRDD, OMH, and OASAS staff. One match has been made which resulted in an employment termination. OMIG will work with DOH to complete its run and will schedule periodic runs with all four agencies in the future.

### **Statistics-Based Data Mining**

The OMIG is seeking to augment its growing data mining capabilities with additional expertise in the area of statistical data mining. As a specialized area of background, education and experience, the OMIG will procure the services from the commercial market. The OMIG plans to develop a competitive bidding process to seek these services and expects to select a vendor by the end of 2009.

### **System Match Recovery Unit (SMR)**

Specific matches scheduled to be performed during state fiscal year 2009-10 are:

#### **Inpatient Clinic/ER Crossover**

This project will identify hospital-based clinic and emergency room claims paid for a date of service that coincides with a recipient's inpatient hospital stay.

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### **Deceased Recipients**

The unit will identify claims for service dates subsequent to a recipient's date of death. This process uses data from vital statistics to match against Medicaid recipient files to determine those recipients who have recently died.

### **General Clinic**

This project will identify laboratory and referred ambulatory services delivered in relation to a clinic visit but billed separately. Ancillary services are included in the threshold clinic rate and should not be billed separately.

### **Radiology**

The inpatient hospital rate includes the technical component. Radiologists billing for inpatients are entitled only to the 40 percent professional component. This project identifies claims that include the technical component.

### **Products of Ambulatory Care (PAC)**

This match identifies fee-for-service ancillary testing and physician services included in the PAC rates.

### **Prenatal Care Assistance Program (PCAP)**

This match addresses billing issues for Medicaid clients who receive prenatal care services.

### **Physician Office Visits**

This project identifies claims submitted by physicians for office visits that were actually performed in a clinic setting. The OMIG will seek to recoup the difference in fees for these services.

### **OB/GYN**

The billing OB/GYN physicians are reviewed for duplicate delivery billing, physician billings for PCAP patients, and global delivery charges for PCAP patients. Physician services are included in the PCAP rate. Physicians serving PCAP patients are entitled to delivery-only charges, and not the global fees which include ante-partum care.

## **BUREAU OF INFORMATION TECHNOLOGY SERVICES (BITS)**

### **Redesign the OMIG Internet**

The current OMIG Internet site will be revamped to improve the overall clarity and navigation of the site. The OMIG will continue to expand the content included in the site. This project will be conducted in conjunction with OMIG's public information staff.



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### **OMIG Surveys**

The OMIG is committed to monitoring the quality of service provided as part of our ongoing improvement process. To assist the OMIG in meeting this goal, the BITS will integrate survey capability into its Web site and list service (i.e., automated mailing) capabilities.

### **BUREAU OF PAYMENT CONTROLS AND MONITORING**

#### **MEDICAID SYSTEMS CONTROL AND REVIEW UNIT**

##### **Edit Monitoring**

Unit staff will continue to monitor and review edit statuses to ensure that they are set properly, while remaining effective and relevant for maintaining program integrity.

##### **Edits**

Unit staff will continue to work with OMIG staff as well as staff from the Department of Health, Office of Health Insurance Programs, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services and CSC, the Medicaid fiscal agent, to develop new system edits and combination edits to reduce fraud, waste and abuse within the Medicaid program. SFY 2009-10 initiatives include:

Staff will continue to analyze the combination edit tables to identify edit combinations that are no longer working as intended or to identify opportunities for new edit combinations.

The unit will review each existing system edit. This review will initially consist of a review of edits that are currently set to “pay” to identify opportunities to change the edit setting to “deny.” We will also review each edit to determine if there are claims types that are not included in the edit logic, but should be. This will allow us to deny additional claim types as part of each edit, if relevant.

The unit will monitor denied claims on a weekly basis. Monitoring will be focused on identifying surges in claims hitting edits and Medicaid providers with an unusual amount of denied claims. This may be an indicator of a provider “gaming the system” in an attempt to identify weaknesses in the claims processing system.

The unit will track edit averages and edit summaries to identify spikes in the number of claims hitting various edits. The OMIG plans to use this information to identify opportunities to create new edits or tighten the logic on existing edits.

##### **New Data Sources**

Staff will continue to identify new opportunities to obtain external data which will help in identifying inappropriate Medicaid payments. New or evolving data source efforts include the following:

Staff will continue to work with the New York State Education Department (SED) on license edit issues.

Staff members are working with OHIP enrollment to get an automated feed from the SED Pharmacy License Board. Once completed, the OMIG expects to be able to identify pharmacy

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establishments without valid licenses, per SED. We can then subject Medicaid claims from these providers to our existing license editing process.

The OMIG will implement a joint project with the DOH to increase the processes related to matching Medicaid enrollment information with death records from DOH vital statistics and New York City vital statistics. We will use this information to determine if Medicaid claims are being paid for deceased Medicaid recipients and providers.

OMIG has an agreement with the New York State Department of Motor Vehicles (DMV) to obtain driver's license information which will assist in identifying individuals who are transporting Medicaid recipients with suspended licenses. This information will enhance the OMIG's ability to edit ambulette claims.

OMIG has an agreement with the New York City Taxi and Limousine Commission (TLC) to obtain origin/destination information on ambulettes in New York City that is being captured by global positioning system (GPS) devices. We may be able to use this information to match trip information to Medicaid claims to identify claims that are not supported by a corresponding trip. In addition, there may be opportunities for the OMIG's DMI staff to work cooperatively with the TLC on joint investigations of Medicaid transportation providers in New York City.

### **Point-of-Service Controls Unit**

The cardswipe program is designed to enforce and verify the presence of the Medicaid recipient at the point of service. It also offers providers a quick, automated process to determine the current eligibility of the Medicaid recipient.

One of the major initiatives will focus on more effective monitoring and compliance. The unit will create a comprehensive set of standard procedures and protocols which will define the OMIG's expectations, monitoring and communications, and potential resulting actions for non-compliance. The OMIG expects that 85 percent of each provider's transactions will be swiped.

The OMIG will make a major expansion of the use of cardswipe machines. The new machines will be portable and will be initially rolled out to individual home health providers and transportation (ambulette) providers. Another key feature of this initiative will be the swiping at the time the service is begun and at the time the service is completed. Affected providers will receive detailed information as the plan moves forward and the rollout begins.

### **Post and Clear Program**

The post and clear program implements a set of checks and balances, ensuring that an ordering provider posts an order and a billing provider clears the order before the claim will be paid. This check ensures that stolen and forged orders (e.g., prescriptions) will not be paid unless the order has been posted. Focuses for the Post and Clear Program this fiscal year include:

- providers who are not enrolled and should be (orders exceed 4,500 claims totaling more than \$75,000). Staff will identify these providers and work with OHIP's provider enrollment staff to get them properly enrolled.
- an overall expansion of the providers on post and clear. Candidate providers will be established through a combination of factors; including high ordering practices, having

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lost/stolen scripts, comparison of drugs to diagnosis, and specialty not matching the orders.

Currently, more than 17,500 non-enrolled providers order services for Medicaid recipients (managed care, nurse practitioners, registered physician assistants and physicians). These providers submitted \$278.9 million ordered services in 2008. Staff will look into some of the ordering and billing behaviors surrounding these providers.

### **Prepayment Review Unit**

The review activities of the Prepayment Review Unit differ from traditional auditing activities. Staff review and adjudicate claims on a prepayment basis, allowing more flexibility to react to issues on an *ad hoc* basis. Prepayment review allows us to build editing criteria into the claims processing system.

The expected outcomes from prepayment review activities include: generation of cost savings through cost avoidance, referral of providers for formal audit or investigation, provider education and behavior modification, and possible fine or exclusion of providers for unacceptable billing and medical practices.

In the upcoming fiscal year, the Prepayment Review Unit will continue reviewing dental and pharmacy providers. New areas of concentration will include:

- Analysis and review of upcoding of ambulatory patient groups (APG) for clinic claims to maximize Medicaid reimbursements;
- Analysis of potentially inappropriate billing practices arising from new budget initiatives implemented in 2008 (e.g., smoking cessation program, asthma counseling, and payment of patient counseling fee to pharmacies);
- Potential misuse of National Provider Identification (NPI) as a prescriber ID;
- Inappropriate billing practices by laboratories; and
- Durable medical equipment (DME) providers dispensing adult diapers.

## **BUREAU OF THIRD-PARTY LIABILITY**

The Bureau's primary mission is to maximize cost avoidance and third party recoveries from all sources to ensure Medicaid is payer of last resort. Unit managers (Third-Party Liability and Home Health) oversee several contracts to accomplish this objective.

### **THIRD PARTY LIABILITY UNIT**

#### **Medicaid Match and Recovery Contract - HMS**

The primary objective is to identify and maximize private health insurance and Medicare coverage. This enables the state and local governments to achieve cost avoidance savings and/or recover Medicaid funds. The contractor is expected to perform comprehensive third party identification and post payment recovery reviews. The current and projected scope of work is as follows:

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### **Pre-payment Insurance Verification**

This activity is the foundation of our cost avoidance efforts. By identifying third-party coverage and updating the third-party file on eMedNY prior to payments made by Medicaid, claims are rejected until third party resources are utilized.

Liabile third parties are added to the eMedNY database after matching Medicaid recipient files with commercial insurance, Medicare, military and any other available third-party files. Identified and verified third-party client/carrier specific eligibility information is provided to the front-end of the state payment system for categories of service including major medical, dental, prescription drug and optical claims

### **Third Party Retroactive Recovery Projects**

A comprehensive periodic retroactive recovery process is in place as a primary component of OMIG's efforts for recovery of Medicaid expenditures.

The recovery process utilizes many sources such as; known third-party liability (eMedNY) that has been identified through various means including local district input, matching with the Social Security Administration and the contracted third-party file matches (commercial insurance companies, military carriers, State and federal files and input from employers, etc). The updated third-party file is matched against the eMedNY claims extract file to identify claims for which potential or verifiable third party liability exists.

The claims are separated into rate-based claims and fee-based claims. Rate-based claims are primarily for inpatient and clinic services and are printed with insurance information on review letters that are sent to providers. The review letter instructs providers to bill the insurance carrier and submit to the contractor within 90 days, - documentation of a denial or indicate they have voided/adjusted the Medicaid claim

Fee-based claims (i.e., practitioner, laboratory and pharmacy claims) with potential third-party coverage are directly billed to the insurance carriers by the contractor.

In addition to Medicaid, the current contract includes third-party recovery for the New York State Elderly Prescription Insurance Coverage (NYS EPIC) program.

### **Payment Integrity**

The unit will continue its payment integrity initiatives of claims for skilled nursing facilities, hospice and credit balance reviews. Other areas under development are Medicare (Part B, Part D and durable medical equipment regional carriers (DMERC) direct billing analysis.

This initiative will also review potential duplicate payments, overpayments and any third-party or other related payment discrepancies identified through the additional forensic analysis of provider or direct billing denials that may have resulted in inappropriate Medicaid payments.

### **New Initiatives**

Several new initiatives to be developed and implemented are:

- We will look to begin work in two areas that were historically a local district responsibility - estate recovery and accident & casualty recovery.

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- The state's enactment of legislation required in the DRA of 2005 will require that health insurers provide coverage, eligibility and claims data necessary to identify potentially liable third-party insurers. This will provide the OMIG with new data matching opportunities with employers' self-funded health plans, third party administrators and pharmacy benefit managers.
- Managed care (MC) plans are currently responsible for the collection of third-party revenues pursuant to respective MC contracts. These recoveries must be reported on MC cost reports and our review of the last three years revealed nominal recoveries reported. Accordingly, the OMIG is proposing to conduct these third party recovery activities.

### **HOME HEALTH UNIT**

#### **Home Health Care Demonstration Project – UMASS**

The federal Center for Medicare and Medicaid Services (CMS) has been working with Connecticut, Massachusetts, and New York under a pilot demonstration project that uses 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 review activities of individually gathered Medicare claims from home health agencies for every dual-eligible Medicaid claim the state has possibly paid in error. This represents an enormous savings in resources for home health agencies, as well as the regional home health intermediaries, and for the participating states.

The demonstration includes an educational component to improve the ability of all parties to make appropriate coverage determinations in the first instance; and an audit sample drawn from each project year's universe of dual-eligible home health claims paid by Medicaid that the state believes should have been paid by Medicare. The sample results are extrapolated to the universe of claims in determining a Medicare settlement payment for each FFY. Reconsideration appeals and arbitration procedures are included in the project to resolve cases where the states and CMS disagree on Medicare's denial of coverage. Subsequent payments are made after final determinations on disputed cases are resolved.

In addition, based on demonstration findings, the OMIG continues to develop a Medicare/Medicaid overlapping payment review of the top providers with high utilization cost to the Medicaid program.

#### **Medicare Maximization Project - CMA**

Working with the legal staff, the OMIG is developing settlement offers for the Medicare Maximization Project for FFY93 through FFY97. The offer informs of the restitution and programmatic action required as a result of the Center for Medicaid Advocacy (CMA) review of dual-eligible claims for the home care services paid during the above referenced fiscal years.

### **OFFICE OF COUNSEL**

The Office of Counsel (OC) to the Office of the Medicaid Inspector General (OMIG) promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

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In addition to providing day-to-day internal legal advice and support to the OMIG, the OC coordinates the OMIG's role in the prevention, detection and investigation of Medicaid fraud, waste and abuse. The OC is also responsible for developing new and modifying existing regulations relating to the OMIG's activities, including but not limited to, the recovery of improperly expended medical assistance (Medicaid) funds. Further, the OC provides general legal services to the OMIG, including advice and support regarding the OMIG's programs and operations, and representation at administrative hearings and in litigation matters relating to Medicaid fraud, waste and abuse. Work planned for FY 2009/2010 includes the following focus areas:

### **Administrative Decision-Making**

The OC will continue to review appeals of Notices of Immediate Agency Action submitted by individuals and providers that are excluded from participation in the Medicaid program pursuant to 18 NYCRR § 515.7. Such reviews result in final determinations of the agency that affirm, reverse or modify in whole or in part the determination to exclude.

### **Bureau Support**

The OC will continue to provide legal advice and support to all divisions, bureaus and offices within the OMIG on new and existing initiatives. The OC's major initiatives for FY 2009-10 include, but are not limited to:

- working with and providing assistance as necessary to Legislative and Intergovernmental Affairs in reviewing and drafting legislation;
- providing assistance to the Human Resource Management Group in the area of labor relations and management-related issues;
- working with the Collections Management Group to restructure and strengthen OMIG's policies and procedures associated with collection initiatives, including bankruptcy-related issues;
- assisting Financial Management with the contract review process;
- developing training materials and sessions for OMIG staff on a variety of topics, such as: the administrative hearing process, how to testify at administrative hearings, service of process and subpoenas, and Medicaid policy implication reports.

As part of the OMIG's ongoing efforts to foster provider compliance, the OC will continue to work with executive staff in the overall effort to develop compliance program guidance specific to particular types of providers. Lastly, any initiatives of the Medicaid Inspector General and/or the First Deputy Medicaid Inspector General that call for legal advice, support and/or assistance will become the priority of OC staff.

### **Creation and Revisions of Regulations**

The OC continues to work closely with the Governor's Office of Regulatory Reform (GORR) to revise current regulations and promulgate new regulations to accomplish the OMIG's statutory mission. The OMIG published a proposed comprehensive regulatory agenda, in the *The New York State Register*, on January 7, 2009. The regulatory agenda included proposing new regulation Part 521 to Title 18 NYCRR (Provider Compliance Programs), which implements New York Social Services Law §363-d, mandating provider compliance programs. This regulation was formally submitted to the Department of State as a Notice of Proposed

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Rulemaking and published in *The State Register* on January 14, 2009. The 45-day public comment period ended on March 2, 2009. The OC is in the process of reviewing the comments and preparing the assessment of public comment for this rulemaking.

The OC has also amended 18 NYCRR Part 516 (Monetary Penalties), effective February 25, 2009. The amendment to Part 516 increases monetary penalties for violations of the Medicaid program rules and policies, conforming the regulation to the recent changes to the governing statute, Social Services Law 145-b. The OC is currently in the process of amending Title 18 NYCRR Parts 515, 518, and 519 and continues to work with OMIG staff on initiatives to develop, implement and amend regulations relating to such areas as Medicaid program integrity, quality of care and other policy-related issues.

### **Hearings and Litigation**

The OC will continue to represent the OMIG in administrative hearings in which individuals and/or organizational providers appeal sanction and/or overpayment determinations issued by way of a Notice of Final Agency Action or Final Audit Report. The OC's involvement in this area primarily involves representing the interests of the OMIG as reflected in the final determination at the administrative hearing. This includes preparing witnesses to testify in the proceeding, making opening statements before the administrative law judge to summarize what the case will show and what evidence will be presented, cross-examining appellants and their witnesses, making timely objections during the administrative hearing, gathering, reviewing and submitting into evidence all of the necessary and supporting documentation that supports the final determination, preparing a closing brief, and creating a record for the administrative law judge that both explains and supports the action taken.

The OC will continue to provide legal support to the Office of the Attorney General in its representation of the OMIG in judicial proceedings. Within the last year, OC attorneys have appeared in court along with the Assistant Attorney General assigned to the case. The OC will continue to provide such assistance, in addition to assisting in providing research and preparation of documents submitted to the courts.

In the case of administrative hearings and litigation, assistance by the OC may also involve the negotiation of settlements, and the review of the final determination prior to issuance, to ensure consistency and compliance with governing rules and regulations.

## **DIVISION OF ADMINISTRATION**

### **BUREAU OF COLLECTIONS MANAGEMENT**

The Bureau of Collections Management (BCM) is responsible for the recovery of overpayments and penalties as identified by the Divisions of Audit; Technology and Business Automation; and Medicaid Investigations.

The primary goal of the BCM is to establish a proactive approach to collections to enable accounts to be liquidated in an expeditious manner. Accounts that have no collection activity for a defined period are put on notice and, if necessary, referred to the Office of Attorney General's Civil Recovery Unit for further action.

BCM activities focus on providing administrative and resource support to meet OMIG's collection needs and may include coordination with the Department of Health Fiscal Management

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Group (FMG); New York State Office of the Attorney General; other State Agencies; as well as Medicaid providers and their representatives.

### **RECOUPMENT OF OVERPAYMENT PROTOCOL**

In order to expedite the recoupment of overpayments and minimize the disruption in New York State cash flow, including the obligation to repay the Federal government its proportionate share within 60 days of discovery, the OMIG has established a recoupment of overpayment protocol. The process works as follows:

#### **Repayment**

Within 20 days from the date of the final report/notice, allowing five days for mailing of the final report, the provider will be expected to make full payment; or choose to enter into a repayment agreement with the OMIG. If the repayment period exceeds 90 days from the date of the final report, the amount to be recouped may include interest. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15 percent withhold after 20 days until the agreement is established.

The OMIG may require financial information from the provider to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request, or a 50 percent withhold will be imposed. OMIG acceptance of the repayment agreement is based on the provider's repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if the unpaid balance is not repaid as agreed.

#### **Default Withhold**

If within 20 days, the provider fails to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50 percent of the provider's Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law.

#### **Adjustment Due Provider**

If the provider receives an adjustment in its favor while owing funds to the state, such adjustment will be applied against the amount owed.

#### **Notice**

The OMIG will provide notice to the provider no later than 5 days after the withholding of any funds.

### **ASSESSMENT OF INTEREST PROTOCOL**

In accordance with 18 NYCRR § 518.4, the protocol for assessment of interest on overpayments is:



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### **Interest Assessment**

There are two periods for interest assessment: (a) from the date of overpayment to the date of notice of audit findings (pre-final interest); and (b) from the date of notice of audit findings to the date of repayment (post final interest). Interest on overpayments will be assessed as follows:

#### **From the date of overpayment to the date of notice of audit findings (pre-final interest):**

Interest will be assessed beginning on the date of overpayment through the date of the final report/notice. The rate of interest will be the prime rate and the interest calculation will adjust with any change to the prime rate over the period for which interest is calculated. If an audit sample/projection is used to calculate an overpayment, interest will be charged from the end of the audit period to the date of the report/notice of audit findings.

For a case with a draft report/notice, the interest will be calculated for both the low and mid points from the end of the audit period to the date of the draft report/notice. The draft report/notice language will include a statement that interest will be adjusted through the date of the final report/notice. The final report/notice will include interest for both the low and mid points from the end of the audit period to the date of the final report/notice. If an individual date(s) of payment is used to calculate an overpayment (for example, a data match listing overpayments for individual dates of service, instead of a sample/projection audit), interest will be charged from the individual date(s) of payment to the date of the report/notice of audit findings.

For cases with a draft report/notice, the interest will be calculated from the individual date(s) of payment to the date of the draft report/notice. The draft report/notice language will include a statement that interest will be adjusted through the date of the final report/notice. The final report/notice will include interest from the individual date(s) of payment to the date of the final report/notice.

**From the date of notice of audit findings to the date of repayment (post final interest):** If full repayment is made within 90 days of the date of the final report/notice, no post final interest will be assessed. If full repayment is not made within 90 days of the date of the final report/notice, recoveries of amounts due are subject to interest charges at the prime rate plus two percentage points beginning on day 91. Such interest will be collected by FMG upon referral of the case/collection from the OMIG. Medicaid checks issued to the provider will be reduced by the designated withhold percentage or fixed weekly amount until the liability has been repaid. The interest shall be posted and accumulated on a weekly basis, and collection of the interest assessed shall commence after the principal amount owed has been fully repaid. Interest shall be collected in the same manner and at the same rate of Medicaid check reduction as the related liability.

## Appendix A

### Glossary of Abbreviations

ADHC	Adult day health care
ALP	Assisted living programs
AQC	Office of Audit and Quality Control
BLTCR	Bureau of Long Term Care Reimbursement
BMA	Bureau of Medicaid Audit
CDT	Continuing day treatment
CDPAP	Consumer-directed personal assistance program
CHHA	Certified home health agency
CIN	Client identification number
CMA	Center for Medicaid Advocacy
CMS	Center for Medicare and Medicaid Services
COPS	Comprehensive outpatient programs services
CQC	Commission on Quality of Care
CSP	Community support programs
D&TC	Diagnostic and treatment center
DMA	Division of Medicaid Audit
DME	Durable medical equipment
DMI	Division of Medicaid Investigations
DOH	Department of Health
DRG	Diagnosis-related group
DSH	Disproportionate hospital share payments
EAR	Enrollment Audit Review
FFY	Federal fiscal year
FQHC	Federally qualified health center
FWA	Fraud, waste and abuse
HCBS	Home and community-based services
HHA	Home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IMD	Institutions for mental disease
LDSS	Local social services district
LTHHCP	Long-term home health care program
MCO	Managed care organization
MFCU	Medicaid Fraud Control Unit
MICSA	Medicaid insurance community service agency
MLTC	Managed long term care organizations
MMIS	Medicaid Management Information Systems
MUT	Medicaid utilization threshold program unit
NMMDAC	New York Medicare Medicaid Data Analysis Center
NYCRR	New York Code of Rules and Regulations
OASAS	Office of Alcoholism and Substance Abuse Services
OCFS	Office of Children and Family Services
OHIP	Office of Health Insurance Programs
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
OMRDD	Office of Mental Retardation and Developmental Disabilities

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OOC	Office of Counsel
OTDA	Office of Temporary Disability Assistance
PERM	Payment Error Rate Measurement
PHL	Public Health Law
PMPH	Prepaid mental health plan
PPS	Prospective Payment System
SSI	Supplemental Security Income
TBI	Traumatic brain injury
TOA	Threshold override application