New York State
Office of the Medicaid Inspector General

2012 Annual Report

Andrew M. Cuomo
Governor

James C. Cox
Medicaid Inspector General

Executive Summary

In 2012, the New York State (NYS) Office of the Medicaid Inspector General (OMIG) achieved significant results in several areas of Medicaid program integrity. Some of the highlights include:

Recovered Hundreds of Millions of Dollars – OMIG's recoveries for calendar year 2012 totaled more than $468 million in improperly expended Medicaid funds. This represents a growth of $58.2 million over the previous year.

Avoided Costs Creating Taxpayer Savings – OMIG avoided more than $2.4 billion in costs to the Medicaid program through proactive controls. These cost avoidance measures created taxpayer savings through various program initiatives, including the restricted recipient program and pre-payment reviews.

Set a New Record for the Number of Completed Investigations – In 2012, OMIG completed 4,400 Medicaid investigations, a new record for the agency. This was achieved by focusing resources on case processing and expedited investigations. As an example, OMIG completed 1,086 investigations of alleged prescription forgery.

Ended Program Participation for More Than 700 Providers Who Placed Beneficiaries or the Program at Risk – OMIG excluded 676 providers from participating in the Medicaid program, and 39 providers were terminated. These providers can no longer work in Medicaid-funded positions in health care-oriented businesses and organizations. OMIG also referred 64 providers to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU) for potential criminal prosecution.

Focused on New Close to Real-Time Tools and Processes – A new investigative tool was implemented: transportation street sweeps. These activities were a collaborative effort that resulted in the issuance of fines and summonses, as well as the seizure of vehicles.

Took Definitive Steps to Bar Providers' Participation in the Program – In 2012, OMIG denied enrollment or reinstatement to 168 providers, translating into $54.4 million in Medicaid cost savings. OMIG's decisive action meant that providers who should not participate in the program were prevented from gaining access to Medicaid recipients and Medicaid funding.

Worked with Law Enforcement to Strengthen Prosecutions for Fraud and Abuse – OMIG worked with MFCU and other local, state, and federal agencies on the Medicare Fraud Strike Force led by the United States Department of Justice (DOJ) to build better cases. These efforts led to 10 arrests, one guilty verdict, two guilty pleas, and six pre-trial diversion agreements of individuals alleged to have committed health care fraud against the Medicare and/or Medicaid programs. OMIG's work with other law enforcement agencies also yielded indictments and prosecutions.

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MESSAGE FROM THE MEDICAID INSPECTOR GENERAL

I am pleased to offer this Annual Report on behalf of the entire staff of the Office of the Medicaid Inspector General (OMIG) demonstrating our efforts to safeguard New York's Medicaid program. The diligence and dedication of the staff who work to help contain costs within the Medicaid program while improving health care access and quality is evident.

A focus for us in 2012 was fighting fraud within the Medicaid program, and we saw strong results. We completed 4,400 investigations in 2012 — a higher number of cases than in any one year in the history of the agency. We developed a new method to combat New York's drug diversion problem by performing drug inventory reviews at designated pharmacies. We also devoted resources to investigating transportation companies to ensure that Medicaid patients were being transported in safe vehicles by qualified drivers.

This year also marked OMIG's launch of its Business Line Teams (BLTs). A BLT is a group of executives, managers/supervisors, and employees with multidisciplinary backgrounds that evaluate program integrity within specific categories of service. It is a fresh approach that enables OMIG to coordinate efforts better, thereby enhancing accuracy, completeness, and overall effectiveness.

We dedicated significant resources in 2012 to nursing home audits, school supportive services, and managed care activities, and our strong financial recoveries in 2012 match or exceed totals from previous years. Total recoveries this past year were more than $468 million — an increase of $58.2 million over the previous year and the second highest since the agency was launched in 2006.

One of the priorities for OMIG is stopping overpayments before they happen. I am pleased to report that total Medicaid cost savings to taxpayers exceeded $2.4 billion for 2012. One important aspect of our cost savings was to end program participation for more than 700 providers who placed the program or its beneficiaries at risk. This process saved taxpayers $36.9 million last year.

This is my second year as Medicaid Inspector General. I am proud of the collaborative work being done in this agency, not only internally but with providers, managed care plans, beneficiaries, policymakers, and law enforcement partners. Through these cooperative and concerted efforts, we are working rigorously to safeguard one of Medicaid's primary directives: providing excellent health care at a cost that taxpayers can afford.

Sincerely,

James C. Cox

James C. Cox
Medicaid Inspector General

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OMIG Background

On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as a formal state agency. The legislation amended the Executive, Social Services, Insurance and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud, waste, and abuse in the State's Medicaid system. The statutory changes separated the administrative and program integrity functions, while still preserving the single state agency structure required by federal law. Thus, although OMIG remains a part of the NYS Department of Health (DOH), it is required by statute to be an independent office. The Medicaid Inspector General reports directly to the Governor.

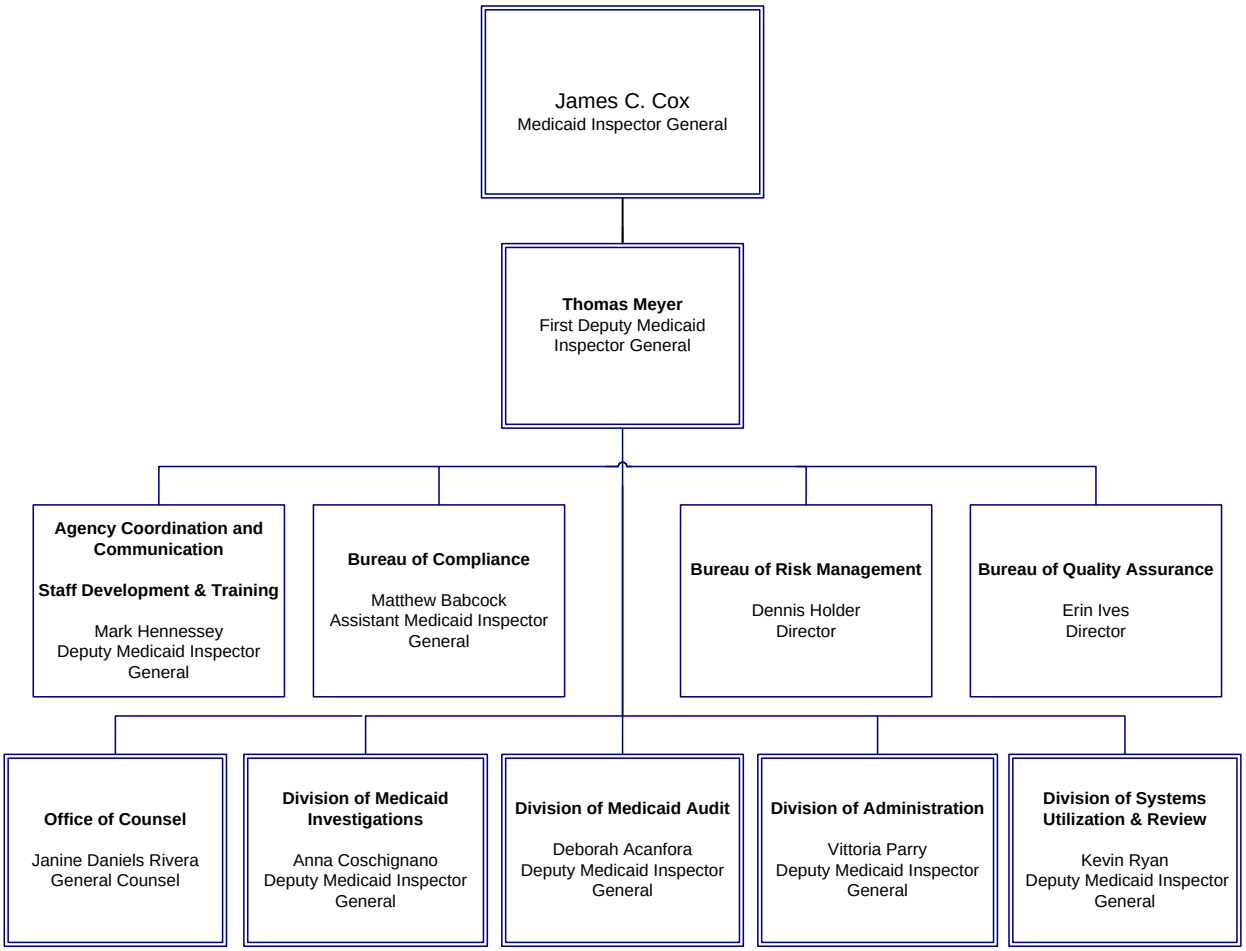
OMIG is charged with coordinating the work of fighting fraud, waste, and abuse in the Medicaid program. OMIG's mission requires that the agency perform its own reviews of the Medicaid program, while also working with other agencies which have either primary regulating authority or law enforcement powers. This means OMIG needs to understand Medicaid program regulations and guidance and use this knowledge to fight fraud and abuse and to recommend improvements to the program.

Mission Statement

The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care.

OMIG Organizational Chart

OMIG is headquartered in Albany. Certain headquarter responsibilities, as well as field office functions, are based in New York City (NYC). Regional offices are located in White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.



Executive Initiatives

New York State Medicaid Electronic Health Records Incentive Program

In 2009, the United States Congress included provisions in the American Recovery and Reinvestment Act allocating approximately $19 billion to provide incentives for the adoption of electronic health information technology (HIT) among Medicaid and Medicare providers. This is a federally funded project that will continue to pay incentives through 2021. During this time, OMIG will audit the adoption, implementation, upgrade, or meaningful use of certified Electronic Health Records (EHR) to identify and/or prevent improper Medicaid EHR Incentive payments and monitor for potential fraud, waste, and abuse.

Through the Medicaid EHR Incentive Program, eligible hospitals and health care practitioners in NYS can qualify for financial incentives to move from a paper-based system of maintaining patient records to a certified EHR. Providers can choose the type of EHR they wish to implement, but, the chosen system must be certified by the Office of National Coordinator for HIT as meeting required standards and specifications.

In 2012, OMIG developed and submitted an audit strategy which received approval from the federal Centers for Medicare and Medicaid Services (CMS). The audit strategy ensures that all statutory and regulatory requirements are met. OMIG staff initiated audits of 100 providers who received financial incentives for adoption, implementation, or upgrade of their EHR. The Medicaid provider's EHR systems must meet both a core set and a menu set of objectives that are specific to that type of provider (eligible professionals or eligible hospitals) in order to qualify for an incentive payment in their second and third year of participation. Starting in 2013, OMIG will also verify that providers are meeting meaningful use standards of the certified EHR systems.

Business Line Teams

OMIG launched Business Line Teams (BLTs) in 2012. A BLT is a group of executives, managers/supervisors, and employees with multidisciplinary backgrounds who evaluate program integrity within specific categories of service. The BLTs will enable OMIG to better coordinate efforts, thereby enhancing the accuracy, completeness, and overall effectiveness with which OMIG can achieve its mission.

While review work is coordinated on a business line basis, OMIG consists of nine core components:

- Division of Medicaid Audit
- Division of Medicaid Investigations
- Division of Surveillance and Utilization Review

- Division of Administration
- Office of Counsel
- Bureau of Compliance
- Bureau of Risk Management
- Bureau of Quality Assurance
- Agency Coordination and Communications

The BLTs cover the following categories of services:

- Managed Care
- Medical Services in an Educational Setting
- Home and Community Care Services
- Hospital and Outpatient Services
- Mental Health, Chemical Dependence, and Developmental Disabilities Services
- Pharmacy and Durable Medical Equipment
- Physicians, Dentists, and Laboratories
- Residential Health Care Facilities
- Transportation

Medicaid Redesign Team

NYS spends more than $50 billion annually to provide health care to over five million people in need of health insurance coverage. In 2011, to find ways to reduce costs and increase quality and efficiency in the Medicaid program, Governor Andrew M. Cuomo established the Medicaid Redesign Team (MRT). The purpose of the MRT was to develop recommendations for significant structural reforms to reduce costs and improve quality in the Medicaid program.

The Legislature approved 78 recommendations as part of the 2011-12 enacted Budget; these are in the process of being implemented. More information on the MRT, including its Phase 2 efforts and measures included in the 2012-13 enacted Budget, can be found at www.health.ny.gov/health_care/medicaid/redesign.

OMIG established, and continues to administer, two of the enacted Phase 1 proposals, MRT 102 (Centralize Responsibility for Medicaid Personal Injury and Estate Recovery), and MRT 154 (Enhance and Improve the State's Medicaid Program Integrity Efforts). The MRT 154 initiatives generated cost savings of $516 million in 2012. Cost savings are identified in Table 11.1 of the Operational Statistics portion of the Appendix at the end of this report.

MRT 102, Centralize Responsibility for Personal Injury and Medicaid Estate Recovery Process

MRT 102 gave OMIG statewide responsibility for making Medicaid recoveries from the estates of deceased beneficiaries, as well as from personal injury awards and settlements, for all NYS Medicaid beneficiaries whose cost of medical care was covered by Medicaid. The proposal enables OMIG to develop a State-centralized recovery process, as well as implementation of best practices statewide.

In 2012, OMIG, through its vendor, HMS, implemented the recovery process in 18 counties. Additionally, there are 11 counties in various stages of completion. The process included the use of standardized correspondence and procedures to initiate recoveries. The HMS process includes mailing of lien notices, questionnaires, asset research methods, lien filings, negotiations, and hardship determinations. Recoveries during 2012 were approximately $39 million.

MRT 154, Enhance and Improve the State's Medicaid Program Integrity Efforts

Medicare Coordination of Benefits with Provider Submitted Duplicate Claims

OMIG conducts reviews of claims approved and paid by Medicare for dual-eligible beneficiaries (i.e., beneficiaries with both Medicare and Medicaid coverage), that are also

submitted to Medicaid for payment. Potential duplicate claims are reviewed for possible edit enhancements, and recoveries are made when appropriate.

Effective December 2009, the NYS Medicaid program implemented an automated Medicare crossover process so that providers will no longer have to bill Medicaid separately for the Medicare deductible, coinsurance, or co-pay amounts for dual-eligible Medicare/Medicaid recipients covered by Medicare Parts A and B. These types of claims are now sent directly by Medicare to NYS Medicaid for processing and payment. In certain instances under this automated process both the provider submitted claim and the crossover claim can be reimbursed, if a separate claim is submitted directly by the provider to NYS Medicaid for a dual-eligible recipient. This is a problem because only one of the claims should be paid.

In 2010, OMIG started monitoring claims to observe how the new system was operating and if sufficient claim system edits were in place to catch any duplicate or questionable claims. OMIG identified a large volume of duplicate claims, and determined that providers were still submitting claims for dual-eligible beneficiaries directly to Medicaid. In 2011, OMIG submitted an MRT proposal which focused on eliminating and/or reducing the number of provider submitted claims associated with the automated Medicare crossover system. OMIG worked with DOH to modify claim system edits that identify and deny duplicate claims.

During 2012, the savings associated with the edit modifications suggested by OMIG resulted in $146.7 million in cost savings. OMIG continues to monitor the crossover system for duplicate Medicaid claims to identify and recover inappropriately paid claims from providers.

Certified Home Health Pre-claim Verification

DOH implemented new home health legislation in 2012 requiring Certified Home Health Agencies (CHHAs) billing Medicaid in excess of $15 million per year to use a verification organization to review and verify each service or item within a claim prior to submission to DOH. These verifications aid in reducing fraud, waste, and abuse, and increase visit and billing compliance at the provider level of home healthcare services. During 2012, each CHHA meeting the threshold billing amount selected a verification organization and implemented the process of electronic verification.

The verification organization generates conflict and exception reports, making the billing provider aware of billing errors before claims are submitted to Medicaid and other payers. The billing provider is then required to resolve these errors prior to submitting claims for payment. This process has resulted in a substantial savings to the Medicaid program.

In an effort to ensure that CHHAs resolve all conflicts and exceptions prior to submitting claims to Medicaid, OMIG began reviewing exception and conflict reports, as well as

supporting documentation, to ensure that exceptions and conflicts were resolved appropriately before billing. The Point of Service Unit has been working with the verification organizations to obtain access into their data systems through a portal. With access achieved, OMIG is able to more comprehensively assess the aggregate data and target our reviews toward areas which are anomalous or otherwise indicative of weak or lacking controls.

Compliance Activities

Adoption and implementation of a compliance program, meeting the requirements of New York State Social Services Law § 363-d and Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521, is required for certain providers to be eligible to receive Medicaid payments or submit claims for Medicaid services. Because of this requirement, the Bureau of Compliance's (BoC) approach when conducting reviews of providers' mandatory compliance programs is to take all reasonable steps to work with providers to assist them in meeting these compliance obligations. If providers are not meeting specific compliance requirements, BoC identifies the specific statutory or regulatory insufficiency, suggests resolutions, requires providers to submit plans of correction to address the insufficiencies, and monitors the providers' progress in resolving the insufficiency. BoC reserves the right to conduct unannounced follow-up reviews to confirm correction of the insufficiencies.

Providers who are required to have and maintain compliance programs must annually certify that their compliance programs meet all the statutory and regulatory requirements. OMIG actively oversees providers' performance through the certification obligation, use of computer databases, and direct outreach to providers who appear to have failed to meet the annual certification requirement.

Compliance Program General Guidance and Assistance

During 2012, BoC published *Compliance Program Guidance for General Hospitals (Guidance)* which focused primarily on hospitals and their compliance requirement. The *Guidance* was also announced as a guide that all Medicaid providers could use to assist in the development and operation of their compliance programs. The *Guidance* was BoC's premier publication for 2012. Other publications and presentations were made to provide direction and assistance to providers relative to the development and implementation of compliance programs that meet the statutory and regulatory requirements, as well as provide insight into how BoC assesses Medicaid providers' compliance programs. Among the more significant publications and presentations were the following:

- Compliance Alert 2012-01 – *Medicaid Provider Certification of its Compliance Program*;
- Updates to the BoC's observed provider compliance program Best Practices, Opportunities for Enhancement, and Insufficiencies;
- Webinar #15 – *OMIG's New Compliance Program Review Assessment Form and Compliance Program Review Process*;
- Webinar #16 – *Certification for December 2012: What Every Provider Needs to Know about Changes to the OMIG Certification Process*;
- University of Rochester 14th Annual Compliance Symposium;

- NYS Bar Association – *Corporate Integrity Agreements (CIAs) and Compliance Programs*; and,
- Compliance Program Assessment Form – updated to address more complete assessment of compliance elements and requirements.

BoC's dedicated telephone line and email address served as a main point of contact for compliance-related questions from providers, provider groups, and the public. During 2012, BoC received 215 calls via the dedicated telephone number and 266 emails directed to the dedicated email address. In response to a number of calls and emails, there were discussions with providers and representatives of providers on service bureaus and how providers should interact with service bureaus. BoC recommends that providers using service bureaus confirm that their service bureau is registered with DOH and inquire as to whether the service bureau is required to have a compliance program. If service bureaus are required to have a compliance program, providers were recommended to ask for a copy of the service bureau's annual certification receipt from OMIG.

In reviewing provider performance related to the annual December certification requirement, BoC has focused on providers who were paid in excess of $5 million by the State (e.g., non-managed care) under the Medicaid program. In a year-by-year comparison (2011 to 2012) of providers meeting the annual certification requirement, there was a 30 percent improvement in providers meeting the requirement in 2012. There was a 52 percent reduction in providers who never certified, but were required to. Although there are multiple reasons why the numbers have improved, BoC believes that education and outreach has had a major impact on the improvement, as well as the focus during 2012 compliance program assessments on providers that have never certified and were paid more than $5 million.

Compliance Program Effectiveness Reviews

During 2012, BoC initiated a total of 18 compliance program reviews of providers. This included on-site reviews and desk reviews of providers who were identified by BoC due to the provider's failure to meet the annual certification requirement, and through referrals from other OMIG units and other State agencies. Much of the work in the compliance program review area during the year included training new staff because experienced staff left the State's employ or were temporarily assigned to other State agencies. By the end of the calendar year, the new staff completed its training and began independent assignments.

Desk review assessments of providers who failed to certify identified multiple insufficiencies in their compliance programs. These providers were required to implement plans of correction to correct the insufficiencies. BoC will continue to work with many of those providers into calendar year 2013. During 2013, BoC will focus its desk reviews on providers who failed to meet their December 2012 certification requirement.

Corporate Integrity Agreement Enforcement

During 2012, one CIA expired by its terms with the provider satisfying all the requirements of the CIA. Prior to expiration, BoC conducted a compliance program review to assess the provider's compliance program. After BoC identified insufficiencies and the provider made improvements, BoC determined that the provider's compliance program met statutory and regulatory requirements.

Also in 2012, BoC helped to coordinate a joint MFCU, DOH, and New York State Education Department (NYSED) action against another provider under a CIA. The provider was allegedly engaged in the corporate practice of the profession of dentistry in violation of the State's Education Law, as well as other regulatory issues surrounding the provider's ongoing operation. MFCU ultimately negotiated a three-party agreement between MFCU, the provider, and OMIG, where the provider agreed to voluntarily leave NYS and the CIA would be suspended while the provider is out of the State. If the provider were to return to NYS, the CIA would be re-activated.

Active monitoring of providers' progress in meeting CIA deliverables continued during 2012. Although some CIA providers were found to be in breach of some of their CIA obligations, those failures were cured during the respective cure periods, so no penalties were assessed in 2012. The providers did make self-disclosures of overpayments identified as a result of their improved internal controls and oversight by their respective Independent Review Organizations.

Outreach and Educational Activities

As part of OMIG's statutorily-defined work, the agency offers educational presentations about the Medicaid program to providers and members of the public. As a component of that work in 2012, OMIG staff developed and presented educational sessions to a variety of outside consumer and professional trade association groups, including:

- Community Health Care Association of New York State
- Greater New York Hospital Association
- Healthcare Association of New York State
- Health Care Compliance Association
- Home Care Association of New York State
- LeadingAge New York State
- Long Term Care Community Coalition
- New York State Bar Association
- New York Health Information Management Association
- New York State Association of County Health Officials
- New York State Association of Health Care Providers
- New York State Health Facilities Association
- New York State Rehabilitation Association/New York State Behavioral Association
- New York Welfare Fraud Investigators Association
- United Cerebral Palsy

Additionally, for the first time in the agency's history, OMIG had a booth at the New York State Fair in Syracuse. Staffed for two weeks by various OMIG personnel, including one day by the Medicaid Inspector General, this booth provided a unique opportunity to speak directly with over 1,500 New Yorkers from across the State to address their concerns and ideas relating to Medicaid fraud, waste, and abuse.

OMIG also presented three educational webinars to members of the general public in 2012, offered free of charge, broadcast to an audience whose members were able to send in questions during the session. All webinars are posted on OMIG's website for later viewing and listening. Such educational opportunities assist providers in learning the latest developments in Medicaid program requirements and enable OMIG to reach a wide audience.

In 2012, OMIG made its presence known by utilizing the social media application Twitter for the first time (@NYSOMIG). The agency is exploring other forms of social media for use in the future.

Investigative Activities

OMIG uses an investigative process to detect and deter potential instances of fraud, waste, and abuse in the Medicaid program. This process includes activities which deter improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billings and services, and cooperating with numerous local, state, and federal partners to enhance enforcement opportunities.

Cases involving credible allegations of fraud or other illegal activities are forwarded to MFCU for pursuit of appropriate civil or criminal prosecution. OMIG has expanded its cooperative investigative efforts with MFCU as well as Health Care Fraud Task Forces in NYC, Albany, Syracuse, Rochester, and Buffalo.

Medicaid Fraud Allegations

The Bureau of Medicaid Fraud Allegations (BMFA) was established within OMIG to receive all allegations of potential fraudulent activity in the Medicaid program. The public and other State/federal entities report allegations to this centralized gatekeeper through a variety of methods including email, telephone, toll-free hotline (1-877-87-FRAUD), facsimile, OMIG's website (http://omig.ny.gov/) or U.S. mail. Allegations may be submitted confidentially or an individual can choose to identify themselves. BMFA consists of an investigator, medical professionals, and administrative staff who evaluate the allegations and refer them to the appropriate area within OMIG or to the appropriate outside agency if the allegation is not related to Medicaid.

BMFA can receive allegations of both provider and recipient fraud. Provider fraud can include: giving or receiving bribes or kickbacks, unacceptable medical and/or billing practices, misusing or abusing Medicaid services, falsifying records, or giving false information. Examples of recipient fraud can include: lending Medicaid identification cards to another person, forging or altering a prescription or fiscal order, using multiple Medicaid ID cards, intentionally receiving duplicative, excessive, contraindicated, or conflicting health care services or supplies, or re-selling items provided by the Medicaid program.

In 2012, BMFA received 3,197 allegations concerning Medicaid fraud, of which, 2,595 were transferred to the appropriate area in OMIG, as set forth in Table 1.1. BMFA closed 602 cases after a preliminary investigation.

Enrollment and Reinstatement Investigations

Enrollment and reinstatement staff screen providers prior to enrollment to enhance quality of care and regulatory compliance in the Medicaid program. OMIG conducts reviews of enrollment applications to identify fraudulent or abusive practices prior to enrollment, as well as to focus on applicants who are unqualified or whose poor quality of care would

present a danger to Medicaid recipients. On-site inspections and undercover operations are conducted, when needed, as part of the review, particularly in areas where licensing is not required, such as with durable medical equipment (DME) companies. Based on these investigations, applicants who do not meet the requirements of the Medicaid program may be denied enrollment. OMIG also reviews requests for reinstatement or removal from OMIG's List of Excluded Providers to determine whether excluded providers should be allowed to participate in the Medicaid program. Decisions are based, in part, on whether it is likely that the violations that led to the exclusion could reoccur if the individual is allowed to re-enroll in Medicaid.

In addition to pharmacies, DME companies, ambulette companies, laboratories, dentists, and dental groups, several new categories were added in 2012 to OMIG's list of providers that are reviewed prior to enrollment. Home health providers, personal care agencies, and nurse registries are now being reviewed with a focus on employees who provide services to see whether they have been sanctioned. Taxi/livery providers and optical establishments have also been added to the list and are being reviewed prior to enrollment.

Through front-end reviews, OMIG has identified owners of businesses applying to be Medicaid providers who are also Medicaid recipients. In cases where it is found that the owner/recipient may not have properly reported income, referrals are made to the New York City Human Resources Administration Bureau of Client Fraud Investigation (NYC HRA) or the appropriate Local Department of Social Services (LDSS).

In 2012, 168 providers were denied enrollment or reinstatement, resulting in $54.4 million in Medicaid cost savings, as reported in Table 11.1 within the Appendix. Cost savings occurs when a provider's application for enrollment or reinstatement in the Medicaid program is denied. The cost savings is considered to be the amount that is saved in a fiscal year by not enrolling an applicant into the provider type for which they applied.

Pharmacy Investigations

Pharmacy investigations are conducted to identify kickback schemes, false claims, and quality of care issues. OMIG investigators also review early and auto refills in addition to performing inventory reviews of pharmacy billings and purchases. These investigations identify aberrant pharmacy and prescription practices including instances of billing for services not rendered, inaccurate data submissions on claims, duplicate billings, rendering unnecessary services, services rendered by unlicensed or excluded providers, and quality of care issues. In 2012, OMIG continued to conduct medication inventory reviews of pharmacies. During the review process, payments made for prescriptions billed to the NYS Medicaid program are compared with pharmacy inventory purchases to determine whether the pharmacy had purchased enough medication to fill the prescriptions that were claimed. OMIG has begun to expand the inventory review process to include managed care organizations (MCO) and law enforcement.

Pharmacy Verification Review Leads to Exclusion

A downstate pharmacy was excluded from the NYS Medicaid program based on findings from an inventory verification review initiated by OMIG. Investigators reviewed pharmacy claims and purchase orders for drugs purchased from seven wholesalers and determined that 16.43 percent of the Medicaid claims submitted by the pharmacy could not be supported by the wholesalers' purchase orders. The pharmacy and the supervising pharmacist were found to have submitted claims that could not be supported because the claims submitted to Medicaid exceeded the total drugs obtained. In addition, the pharmacy failed to provide documentation to show the drugs were purchased from registered sources. OMIG referred the provider to the MFCU for further investigation. OMIG issued a Notice of Agency Action, which resulted in an exclusion and restitution to the Medicaid program of $393,097.

Prescription Fraud

Forged prescriptions can lead to thousands of illegal pills and other drugs being disbursed into the community. Under DOH regulations, doctors are responsible for reporting to Medicaid and DOH's Bureau of Narcotics Enforcement (BNE) when prescription pads are lost or stolen. Pharmacies can unknowingly fill an altered or forged prescription when such incidents are not reported. Pharmacy providers are required to question such documents and contact the purported physician and appropriate authorities when they suspect fraud. When pharmacies or physicians fail to report or question suspect prescriptions, Medicaid may unwittingly pay for drugs dispensed to recipients who in turn may use them incorrectly or sell these drugs for cash.

Collaborative efforts between OMIG and BNE have allowed OMIG access to lost or stolen prescription pad reports. These reports, coupled with data mining techniques, use prescription serial numbers to reveal potentially forged prescriptions and dispensing discrepancies by pharmacies. Detecting forgeries early prevents additional prescriptions from being filled, keeps illicit drugs out of the community, and saves taxpayers money. In 2012, OMIG completed 1,086 forgery investigations. A breakdown of the forgery investigations can be found in Table 1.6 within the Appendix.

Recipient Investigations

Detecting eligibility fraud is challenging but integral to ensuring that only those persons meeting enrollment criteria receives Medicaid benefits. OMIG, in concert with its law enforcement partners, initiates investigations which result in civil actions, criminal prosecution, and restitution from recipients who fraudulently enroll and receive Medicaid benefits. OMIG has strong liaison relationships throughout the State with local law enforcement and district attorney (DA) offices, which aids in the investigation and prosecution of cases of fraud and abuse against the NYS Medicaid program. OMIG

completed 2,443 investigations involving enrolled recipients, as set forth in Table 1.3 within the Appendix. Additionally, 1,239 referrals were made to law enforcement and other State and federal agencies in 2012. Recipient referrals are shown in Table 1.10 within the Appendix.

Recipient Restriction Program

The Recipient Restriction Program (RRP) is a medical review and administrative mechanism conducted by a team of physicians, nurses and pharmacists who identify recipients who have received Medicaid funded services that are duplicative, excessive, or contraindicated. The team also investigates recipients who have allegedly engaged in abusive practices, such as prescription fraud or card lending. In order to promote coordinated medical care, reduce fraud, and save Medicaid dollars, recipients with indications of inappropriate utilization of Medicaid services are recommended for restriction to specific primary providers such as a physician/clinic, pharmacy, or a hospital. LDSSs and MCOs implement these restrictions.

As part of the MRT managed care expansion, DOH mandated that each MCO providing services to Medicaid and Family Health Plus members implement an internal restriction program to control potential fraud and abuse. OMIG has assumed an increasingly pivotal role in the oversight of the managed care recipient restriction programs and has been a resource and administrative liaison between the MCOs and LDSSs. OMIG assists the MCOs by reviewing each plan's policies and procedures to ensure compliance with current regulations and the managed care model contract, providing feedback, and granting approval to MCO restriction policies and procedures.

OMIG established a referral process for managed care members identified for possible inclusion into the MCO RRP. Additionally, OMIG developed and implemented a process to share restriction information with MCOs, allowing for the restriction to follow the member regardless of managed care enrollment status or specific plan membership. With OMIG's assistance, MCOs are able to implement and maintain restrictions while promoting the integrity of the NYS Medicaid program and providing quality care to their enrollees.

OMIG conducted 3,943 reviews, leading to 3,521 recommendations for restriction or referrals to MCOs. These recommendations included 355 cases involving prescription forgery. In 2012, the average monthly number of restricted recipients was more than 10,000. These restrictions resulted in improved quality of care for the recipient and a cost savings to the Medicaid program of more than $170 million. Savings associated with this project are found in the Cost Savings Activities table, Table 11.1, within the Appendix under "Recipient Restriction."

Referrals to Other Agencies

In accordance with the federal Affordable Care Act (ACA), OMIG refers credible allegations of fraud to MFCU for possible criminal prosecution. In 2012, preliminary findings from OMIG investigations led to 64 referrals to MFCU. While the majority of those referrals involved Medicaid providers, OMIG also referred seven non-enrolled providers, which can be seen in Table 1.8 within the Appendix. Additionally, OMIG issued 113 Notices of Immediate Agency Action, excluding individuals and entities from the Medicaid program as a direct result of MFCU prosecutorial activity. The summary of excluded providers can be found in Table 1.16 within the Appendix.

In addition to the referrals made to MFCU, OMIG works in close collaboration with NYC HRA and other LDSSs on recipient referrals. Recipients who may have unreported income and filed a fraudulent Medicaid application, loaned out their Medicaid card, or forged a prescription are referred for further investigation and appropriate action to NYC HRA and the appropriate LDSS. Such recipients may be arrested and ordered to pay restitution to the Medicaid program.

OMIG also shares its findings with professional licensing agencies such as the NYSED's Office of Professional Discipline (OPD) and DOH's Office of Professional Medical Conduct (OPMC). OPMC and OPD can take action on individuals who hold professional licenses. These actions are in turn reviewed by OMIG to determine whether a termination under 18 NYCRR §504.7(d) and/or an immediate sanction under 18 NYCRR 515.7(e) is warranted. The sanction may affect the individual's present or future participation in the Medicaid program.

Additionally, referrals are made to other legally authorized law enforcement agencies. OMIG's policy is to keep in contact with these agencies and follow-up on the progress of referred cases.

Table 1.9 within the Appendix shows 1,274 referrals to outside agencies in 2012. That total is made up of 614 referrals to NYC HRA of which 608 were recipients and six were providers. There were 362 referrals to LDSS, of which 361 were recipients and one was a provider. The remaining 298 cases were referred to various other law enforcement or licensing agencies.

Collaborations with Other Agencies

United States Department of Justice Medicare Fraud Strike Force

In 2012, OMIG's participation with the United States DOJ's Medicare Fraud Strike Force resulted in arrests, complaints, and indictments of individuals alleged to have committed health care fraud against the Medicare and/or Medicaid programs, as well as eventual criminal convictions.

An example of one of these successful prosecutions involved a NYS licensed proctologist who was found guilty of one count of health care fraud and five counts of health care false statements in Federal court after a two-week jury trial. The trial evidence showed that from January 2008 to January 2010, the provider defrauded Medicare and private insurance companies by billing for surgeries and medical services that were never provided. The provider was subsequently sentenced to 30 months in prison, three years supervised release, and forfeiture and restitution payment of $1.1 million. OMIG's role included, but was not limited to, conducting interviews, analyzing documents, surveillance, Russian translations, and assisting on searches and seizures.

Additionally, OMIG conducted various undercover operations to assist the DOJ Medicare Fraud Strike Force in furthering several of its cases. In 2012, OMIG's participation in these activities resulted in 10 arrests, one guilty verdict, two guilty pleas and six pre-trial diversion agreements.

Multiple Agency Collaboration Exposes Drug Diversion Ring

OMIG, the Federal Bureau of Investigation, Drug Enforcement Administration (DEA), NYC Police Department, and NYC HRA collaborated in a joint investigation of a primary care physician involved in an oxycodone distribution ring that distributed approximately 11,000 oxycodone pills purchased with close to $1 million in Medicaid funds. The physician was found guilty in the Southern District of New York of Conspiracy to Distribute a Controlled Substance and Conspiracy to Commit Health Care Fraud, and was subsequently sentenced to 36 months in prison and three years of supervised release. OMIG provided undercover staff and technical support as part of this investigation.

Pharmacy Investigations with MFCU Led to Significant Monetary Recoupments and Indictments

OMIG, working in concert with Special Investigators from MFCU, executed a search warrant at two pharmacy locations which resulted in the confiscation of millions of dollars of diverted HIV medications from wholesaler sources without pedigrees. OMIG spent several weeks reviewing evidence and offering expertise crucial to the investigation. The collaborative efforts of OMIG and MFCU enabled MFCU to reach a settlement agreement with the provider resulting in the collection of more than $9 million and obtain indictments against the former supervising pharmacist and others involved in the diversion. The investigation ultimately involved multiple agencies including OMIG, MFCU, the NYC Office of Special Narcotics Prosecutor, DEA, the US Food and Drug Administration and the United States Department of Health and Human Services, Office of the Inspector General (HHS OIG).

In another investigation, OMIG investigators discovered 47 unlabeled plastic bags containing a variety of drugs at a NYC pharmacy. OMIG referred the pharmacist, and the two pharmacies that he owned and operated, to MFCU. MFCU's investigation resulted in the pharmacist paying $1.2 million to the State to settle claims that he had billed Medicaid for drugs he purchased on the street and then sold to customers. In the settlement with MFCU, the pharmacist admitted to using black-market suppliers to purchase diabetes and HIV/AIDS medications, surrendered his pharmacist's license, and agreed to a ban that prohibits him from working in any pharmaceutical or health care job.

Joint Investigation of Drug Trafficking Ring Results in Recipient Arrest

A Medicaid recipient was sentenced to seven years in prison and five years post-release supervision, in accordance with a plea agreement. In October 2012, the recipient pled guilty to running a prescription drug trafficking ring together with his girlfriend and co-defendant, earning more than $75,000 in illegal drug sales. More than 6,000 oxycodone pills were obtained through scamming automobile insurance carriers, defrauding Medicaid and Medicare, and doctor shopping. OMIG investigators assisted in the long-term investigation including participation in the execution of the search warrant at the recipient's residence, assistance with drug retrieval, drug identification, calculating aggregate weights of the seized drugs, and contact with drug manufacturers.

County Collaborations Led to Medicaid Recoupments

A joint investigation was initiated when Schoharie County LDSS requested OMIG's assistance to obtain documentation on a recipient who was allegedly receiving benefits in Schoharie while living in Hempstead, New York. OMIG investigators issued an administrative subpoena to the NYS Thruway Authority requesting EZ Pass records for the recipient. The initial investigation was the beginning of collaboration between OMIG, Schoharie County LDSS, the Schoharie County Sheriff's Department, and the Schoharie County DA's Office, subsequently culminating in the arrests of seven recipients in 2012. All seven were charged with Welfare Fraud in the 5th Degree and Offering a False Instrument. In aggregate, they fraudulently received benefits totaling $10,324.

Forgery Investigation Led to Recipient Arrests

The Rochester Police Department referred a telephone complaint to OMIG from a pharmacist who suspected he had filled a forged prescription. OMIG verified the information with the prescriber and determined that the prescription was a forgery. Further investigation revealed that the recipient telephoned a local pharmacy and impersonated a doctor calling in a prescription for a patient, and later, presented the recipient's own Medicaid card and picked up the prescription for Tramadol. A review of the recipient's pharmacy claims identified numerous paid and denied claims for Tramadol, Oxycodone-Acetaminophen (Percocet), and Endocet, among others. In coordination with

the Rochester Police Department and the NYS Department of Financial Services, Insurance Division, the recipient was interviewed and admitted to being addicted to Percocet. The recipient was arrested and charged with Criminal Impersonation in the 1st degree.

OMIG and NYC Taxi and Limousine Commission Execute Field Operations

OMIG/TLC 19-A Stop Operations are cooperative efforts between OMIG and the NYC Taxi and Limousine Commission (TLC). Periodic operations are coordinated in advance by the two entities to target specific areas known to have Medicaid providers with a high number of ordered services for transportation. Certain Medicaid providers are stopped by TLC staff who seek paperwork from the driver, including NYS Driver's License, TLC License, van registration, and TLC base license during the field operations. At the same time, OMIG investigators interview the recipients. TLC issues summonses, seizes the vehicle, dispatches for another driver to take the vehicle and/or shuts down the base immediately, if an unacceptable practice, as defined by 18 NYCRR §515.2, or a practice contrary to TLC requirements is discovered. Based on analysis of claims data for the provider, OMIG may issue a Notice of Proposed Agency Action or refer the case to MFCU if a credible allegation of fraud exists, per 42 CFR 455.15.

During 2012, two OMIG/TLC 19-A Stop Operations were conducted along major metropolitan thoroughfares. The first of these operations resulted in four summonses being issued to base operators for drivers or vans not being licensed, two summonses being issued to base owners for drivers or vans not being licensed, two summonses being issued to drivers for failure to produce a license or for not being licensed, and, one van was seized for operating in NYC without a van license. The second operation revealed four unlicensed or unqualified drivers, two unlicensed vehicles, missing paperwork and/or improper decals required to be displayed by TLC. TLC imposed $7,600 in fines, issued ten summonses, and seized the two unlicensed vehicles.

OMIG's Work with the Office of the State Comptroller (OSC) Results in Over a Million Dollars Returned to the NYS Medicaid Program

OSC initiated an audit on a hospital provider who filed for Chapter 11 bankruptcy and who, during that time, hired a third-party service bureau to review previously paid Medicaid claims to determine if additional revenues could be obtained through claim adjustments. OSC determined that many of the paid claims were incorrectly billed, resulting in erroneous claims. All data obtained in this audit was then referred to the OMIG to verify the claims, review reports received from the hospital's consultant, and confirm all amounts identified by OSC which would be returned to the Medicaid program. This collaboration between OMIG and OSC resulted in a Stipulation of Settlement that resulted in $1.4 million being returned to the Medicaid program.

Audit Activities

OMIG conducts audits of Medicaid providers are conducted with the goal of ascertaining whether providers adhere to applicable federal and state laws, regulations, rules, and policies pertaining to the Medicaid program.

Beginning in 2011 and continuing through 2012, OMIG's Division of Medicaid Audit and Office of Counsel began a process to review all fee-for-service (FFS) audit protocols. Audit protocols had been developed for each category of service, or program, audited by OMIG. The established review process includes the oversight agency responsible for the respective program. Subsequently, the audit protocols are shared with applicable provider associations for comment. OMIG provides clarification and education to the associations, based on their respective comments and concerns. Once the process of vetting the audit protocols is complete, they are posted on OMIG's website. This process has resulted in a reduction in the number of final audit reports issued to FFS providers in 2012; however, in 2013, OMIG anticipates a marked increase in the number of final audit reports issued.

Fee-for-Service Audit Activities

OMIG conducts billing audits of provider services rendered to eligible beneficiaries paid on a FFS basis. Examples of these audits include home health agencies, personal care agencies, diagnostic and treatment centers, hospitals, pharmacies, and other health care providers.

Certain FFS audit activities are highlighted below. Results of all FFS audit activities are listed in Tables 2.2–2.6 within the Appendix.

Comprehensive Outpatient Programs and Community Support Programs

OMIG audits payments to Comprehensive Outpatient Programs (COPS) and Community Support Programs (CSP) certified by the NYS Office of Mental Health (OMH). COPS overpayments are identified by calculating the amount of COPS reimbursement in excess of yearly threshold amounts set by OMH. These overpayments are subject to recoupment. Similarly, CSP payments in excess of a formulated reimbursement rate are also subject to recovery. OMIG issues audit reports for these recoveries based on OMH's calculations, and is also responsible for collecting recoveries of any identified overpayments. In 2012, OMIG and OMH finalized 26 COPS/CSP audits, with identified overpayments of $11.7 million and recoveries totaling $18.5 million.

Medicare Crossover Payment Matches

Effective December 2009, the NYS Medicaid program implemented an automated Medicare crossover process so that providers would no longer have to bill NYS Medicaid separately for the Medicare deductible, co-insurance or co-pay amounts for dual-eligible

Medicare/Medicaid beneficiaries covered by Medicare Parts A and B . These types of claims are now sent directly by Medicare to NYS Medicaid for processing and payment. This project identifies overpayments for claims submitted for dual-eligible beneficiaries that were processed prior to the implementation of the automated crossover system.

Before the automated system existed, providers who rendered services to dual-eligible beneficiaries were required to submit one claim to Medicare and one to Medicaid which showed the amount that Medicare had paid for the service. The Medicaid payment was calculated based on what Medicare approved and paid.

During 2012, OMIG performed a series of reviews to determine the accuracy of claims for deductibles and coinsurance for dual-eligible recipients which were processed prior to the implementation of the automated system. The purpose of these audits was to compare the amounts paid by Medicare Part B with the amounts reported on NYS's Medicaid system. Specifically, the amounts Medicare approved and paid were matched to the Medicaid claims, as were the coinsurance and deductible amounts. OMIG obtained Part B Medicare payment information (Medi-Medi data) from CMS through the contracted provider, Safe Guard Services. This review resulted in $1.5 million in identified overpayments.

County Demonstration Program Activities

Under the Medicaid Fraud, Waste, and Abuse County Demonstration Program (County Demonstration Program), OMIG partners with counties and NYC to detect Medicaid provider fraud, waste, and abuse and to recoup overpayments. Currently, 12 counties and NYC are actively participating in the County Demonstration Program. Audits initiated under the County Demonstration Program include pharmacy, transportation, and DME providers. With the finalization of pharmacy and transportation ambulette audit protocols during 2012, the amount of finalized audits and recoveries will increase in 2013. OMIG also expects additional counties to enroll in the demonstration program.

School Supportive and Preschool Supported Health Services Programs

As part of a 2009 compliance agreement entered into between NYS and CMS, OMIG was tasked, in calendar year 2012, to audit every school district and county preschool provider that received at least $1 million in Medicaid reimbursements in calendar year 2011. There were four providers - NYC plus three other providers - who met this criterion. OMIG was also required to audit 35 additional school districts and county preschool providers, with total paid claims of less than $1 million in calendar year 2011.

In 2012, OMIG initiated 38 audits of school districts, county preschool programs and schools defined under § 4201 of the NYS Education Law (state supported schools for the blind, visually handicapped, and/or hearing impaired). OMIG finalized 26 audits in 2012, identifying $2.35 million in overpayments (Tables 5.1 through 5.4).

Rate Based Audit Activities

Rate based providers are reimbursed by Medicaid using a daily rate that is calculated based on the costs submitted by the provider on its cost report. These reports are required to be submitted to DOH's Bureau of Long Term Care Reimbursement (BLTCR) on an annual basis. BLTCR then promulgates a daily rate for each provider. An example of a rate based provider reimbursed using this method is a residential health care facility (RHCF).

Rate audit activities are described below and the outcome of those activities are available in Tables 3.1–3.4 within the Appendix.

Capital Audits

The reported capital costs for RHCFs are used as a basis for the capital component of the nursing facility's Medicaid rate. OMIG's capital audits result in a variety of findings. Some examples of findings from capital audits are as follows:

- Working capital interest expense disallowances;
- Equity disallowances;
- Sales tax disallowances;
- Mortgage expense disallowances; and,
- Depreciation disallowances.

During 2012, 30 capital audits were completed, resulting in identification of overpayments of $10.2 million.

Base Year Audits

Base year audits examine the costs reported in the provider's base year. The reported base year costs are trended forward by an inflation factor and used as the basis for the operating portion of the rate for subsequent years until a new base year is established. Examples of the base year audit findings are as follows:

- Expense not related to patient care;
- Undocumented expense;
- Duplicated expense; and,
- Non-allowable expense.

During 2012, 13 base year audits were completed, resulting in identification of overpayments of $8.9 million.

Rollover Audits

The base year operating costs are used as the basis for rate calculations in subsequent years; therefore, changes from base year audits must be reflected in the subsequent years. Adjustments from base year audits must be integrated and carried forward in order to calculate the rates for years subsequent to the base year. The issuance of 21 rollover audits for 2012 resulted in identified overpayments totaling $2.3 million.

Patient Review Instrument

DOH's Division of Long Term Care utilized the patient review instrument (PRI) to calculate the nursing home rates. PRI was used to classify a nursing home's residents into the various resource utilization group categories to determine the facility's overall case mix index (CMI). CMI is used to adjust a nursing facility's operating component per diem rate to recognize the intensity of the services provided by the facility. Consequently, it is essential for PRIs to accurately reflect each resident's condition and functional ability. OMIG conducted reviews to determine the accuracy of PRIs used to calculate the December 2006 CMI. The CMI was used in the calculation of the 2006 through 2008 nursing home rates. In 2012, five PRI audits were finalized, identifying $3.2 million in overpayments.

Bed Reserve Audits

The Medicaid program reimburses RHCFs for reserving a Medicaid beneficiary's bed when that person leaves the facility on a temporary hospital or therapeutic leave of absence when certain conditions are met. OMIG continues to review bed reserve payments to assure that RHCFs are in compliance with Title 18 NYCRR §505.9(d), which addresses the eligibility and requirements to bill Medicaid for a reserved bed day. In 2012, OMIG finalized 14 audits that identified $3.7 million in overpayments.

Managed Care Audit Activities

As a result of MRT proposals, DOH established a goal to move most Medicaid populations into a care management system by April 2016. This system includes comprehensive managed care plans, HIV/AIDS special needs plans, and various long-term care plans, as well as, new plans that will need to be tailored to meet the needs of other transitioning populations, such as those with mental health and/or substance abuse issues.

Over the past year, the Medicaid population has continued to shift from FFS to managed care. As of December 2012, the comprehensive managed care population increased by nine percent over the past year and reached 3.3 million enrollees, while the managed long-term care population had a significant increase of 54 percent and includes more than 84,000 enrollees.

As this shift continues, OMIG must refocus its resources on monitoring the payments made to the MCOs as well as reviewing network provider's costs that are used to determine the managed care payment rates. To do this, OMIG will need to coordinate activities with DOH and develop work plans to address these new program integrity issues.

OMIG currently performs various eligibility/enrollment based reviews and audits of managed care plans to recover overpayments and correct system and program errors.

Highlights of managed care audit activities are described below, and the results of all such activities can be found in Tables 4.1–4.5 within the Appendix.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

When a capitation payment is inappropriately made due to eligibility errors or untimely eligibility file updates (i.e., death, incarceration, institutionalization, enrollees assigned more than one client identification number, or enrollees who have moved out-of-state, etc.), LDSS and/or the NYC HRA retroactively adjust the enrollee eligibility file and instruct the MCO to void the premium payments for any month where the MCO was not at risk to provide services. DOH and OMIG provide support to LDSS and NYC HRA in this process by generating and providing various reports and monitor the recovery process to ensure MCO returns the premiums. In 2012, through the combined efforts of OMIG, DOH, LDSS, and NYC HRA, 134 audits were finalized with $14.2 million in identified overpayments.

Capitation Payments for Incarcerated Managed Care Enrollees (Prison Match)

OMIG maintains a database containing the monthly updates for Medicaid individuals identified in the NYS Department of Corrections and Community Supervision, and the NYS Division of Criminal Justice Services. On an annual basis, OMIG matches this data against the premiums paid to MCOs in order to identify payments made for individuals who were incarcerated and not identified during the LDSS and NYC HRA retroactive disenrollment process. In 2012, OMIG finalized 26 audits, with identified overpayments of $2.3 million.

Recovery of Supplemental Newborn/Maternity Capitation Payments (No Reported Encounter Data)

A supplemental newborn/maternity capitation payment is an additional payment made to the MCO because costs associated with a delivery are not included in the monthly premium. This payment is made to the MCO after an enrollee gives birth and the MCO has paid the hospital for the delivery. OMIG analyzes encounter data reported by the MCO to determine if the supplemental newborn/maternity payment was appropriate. If no encounter data is reported for the delivery, OMIG requests documentation from the MCO to support the payment. In 2012, OMIG finalized 35 audits and identified overpayments of $1.7 million.

Family Planning Chargeback Services

Most MCOs include family planning and reproductive services in the benefit package offered to enrollees. Under federal rules however, the enrollee is entitled to receive these services from any FFS Medicaid provider. If an MCO enrollee chooses to go outside the MCO network, the servicing provider is compensated by Medicaid, and the MCO agrees, per contract, to reimburse Medicaid for the FFS payments made to the non-network provider. In 2012, OMIG finalized six audits and identified overpayments of $1.3 million.

Medicaid Payment Monitoring and Recovery Activities

OMIG payment monitoring and recovery activities focus on using technology, including data matches, and front-end payment controls, to leverage state activities to improve program integrity. Below are highlights of these activities from 2012, and detailed data can be found in Tables 7.1-8.5 and 10.1-11.1 within the Appendix.

Business Intelligence Activities

The Bureau of Business Intelligence (BBI) uses analytical tools and techniques, as well as knowledge of Medicaid program rules, to mine Medicaid claims data and identify improper claim conditions. These recovery projects are developed by BBI Claims Analysis and issued by BBI System Match and Recovery (SMR).

Dental Provider Activities

SMR continues to perform reviews on dental providers, examining combinations of procedure codes which should never happen, claims for residents of a skilled nursing facility which bears the responsibility for these claims, as well as consultations which did not follow Medicaid requirements when submitted. In 2012, 30 audits were finalized which identified $182,780 in overpayments.

In addition to the overpayments identified as part of the dental system matches, the claims of those dental providers receiving draft audit reports were analyzed and tracked to determine the effect on the future billing of the providers in the match. In 2012, cost savings associated with this project totaled $17.5 million.

Inpatient Crossover with Hospital Clinics and Emergency Room

The purpose of this system match is to identify separate clinic or emergency room billings for hospital inpatients who are covered for almost all services by an all-inclusive inpatient hospital rate. SMR issued 118 final audit reports to hospitals in 2012, which identified overpayments of $1.5 million in incorrect clinic and emergency room claims.

Physician Services in OMH Clinics

Physicians provide services to Medicaid recipients in a variety of settings. In the provision of ambulatory care for recipients with mental illness, the costs of routine physicians' services are included in the facility's rate or fee, and should not be billed separately. Only the licensed OMH program is eligible to seek and receive Medicaid reimbursement for the services provided under the auspice of the licensed program. Physicians or other licensed clinicians, regardless of how they are engaged by the OMH licensed program, may not seek separate Medicaid reimbursement for services provided by the OMH licensed outpatient

program. This match identified services which were inappropriately billed separately. In 2012, 28 final reports were issued with identified overpayments of $1 million.

General Clinic - Ambulatory Patient Groups Review

This match looked at the Ambulatory Patient Groups (APG) payment methodology in hospital outpatient settings and emergency departments. Ancillary services are included in the APG payment and should not be billed separately. In 2012, 67 final reports were issued identifying overpayments in the amount of $845,810.

Edit 1141

The Edit 1141 Pre-payment Review (PPR) affords OMIG the opportunity to review provider submitted Medicaid claims before they are paid or denied. PPR uses Edit 1141 in the eMedNY system as a tool to detect, monitor, and deter the submission of inappropriate claims by enrolled Medicaid providers who demonstrate possible unacceptable or inappropriate billing practices. Once a provider is placed on PPR, claims transactions are manually reviewed prior to any payment being made. In conjunction with this function, staff will contact providers and request information necessary to support the submitted claims. Based on the review of the provider's documentation, claims will be paid or denied. As a result of these in-depth pre-payment reviews, providers can be referred for further investigation and/or administrative action.

For calendar year 2012, cost savings for PPR-Medical was $2,206,034. The total cost savings for PPR-dental activities was $879,591.

Provider Self-Disclosures

OMIG operates the statewide mandatory self-disclosure program for all Medicaid providers regardless of the types of services provided to beneficiaries. OMIG encourages providers to investigate and report matters that involve possible fraud, waste, abuse, or inappropriate payments through self-review, compliance programs, and internal controls.

OMIG's self-disclosure unit, in concert with its vendor, HMS, provides efficient, user-friendly methods for providers to refund Medicaid payments to DOH. OMIG created a process for submissions to include disclosure reasons, financial impact to the Medicaid program, and corrective measures undertaken to prevent the error from reoccurring. Providers can use the traditional method of disclosing directly to OMIG staff, or they can utilize the OMIG/HMS Provider Overpayment Reporting Terminal (PORTal), which was developed as a single point of entry for all OMIG/HMS reviews. HMS developed the PORTal to assist in the overpayment recovery process.

OMIG's self-disclosure activities identified $20.6 million in overpayments in 2012.

Third-Party Insurance Review Activities

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

Pre-Payment Insurance Verification Cost Savings Activities

The NYS third-party liability vendor, HMS, obtains rosters of insured individuals from many insurance carriers across the country. HMS matches these rosters against Medicaid beneficiaries enrolled in NYS in an effort to identify those beneficiaries who have additional insurance coverage. Once identified this information is added to eMedNY so that medical services are first billed to the other insurance, leaving Medicaid as the payer of last resort. In 2012, these pre-payment insurance verification activities resulted in cost savings to the State's Medicaid program of approximately $1.1 billion, as shown in Table 11.1 within the Appendix.

Third-Party Recovery Activities

OMIG, through its vendor, HMS, maximizes reimbursement of Medicaid expenditures through recovery of funds from third-party insurers. HMS recoveries can come from providers who adjust their claims to include third-party monies, or they can come directly from the insurance companies through direct billing of the Medicaid claims.

HMS also seeks recovery of encounter based claims for MC recipients. These recoveries are pursued directly from the third-party insurer.

During the past year, OMIG initiated 3,979 third-party reviews, with recoveries of more than $128 million.

Home Health Care Demonstration Project

OMIG continues to work with CMS to finalize recoveries under this demonstration project. During this project OMIG's vendor, the University of Massachusetts, utilized 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 Medicaid. During 2012, this project identified $139.3 million in recoveries.

This demonstration project has now been replaced with a more traditional approach of individually reviewing claims from home health agencies for every dual-eligible Medicaid

claim the State has possibly paid in error. This process is much more labor intensive and is expected to yield fewer recoveries.

Medicaid Recovery Audit Contractor

ACA requires Medicaid agencies to contract with a Recovery Audit Contractor (RACs) to identify and recover overpayments. HMS has been designated as the NYS Medicaid RAC.

During 2012, HMS identified and recovered approximately $55.6 million in inappropriate Medicaid expenditures. The bulk of these recoveries were from payment integrity reviews resulting from analysis of the Medicaid paid claims data.

HMS performs data mining algorithms on the Medicaid database to identify potential areas of recovery. They then develop an Improper Payment Scenario Development Request (IPSDR) for each initiative. This document includes the overpayment scenario, methodology used to identify the finding, and the pertinent state and federal regulations. The IPSDR is approved by OMIG staff prior to implementation. In 2012, these projects included inappropriately billed vaccines for children and inappropriately billed graduate medical education payments to medically managed detoxification providers.

Overpayments associated with these projects can be tracked and reported through the PORTal that was developed by HMS. This process allows for validation of overpayment at the time of data mining and notifies providers via mail and electronically via the PORTal. This process places more emphasis on provider compliance and program oversight as each overpayment is reviewed at the claim level.

Administrative Actions

Sanctions – Terminations & Exclusions

Sanctions that can be imposed on a provider by OMIG include censure, exclusion, termination, or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3). In 2012, OMIG conducted investigations and imposed discretionary exclusions based upon:

- NYSED actions, such as license surrender, suspension and revocation, for Medicaid and non-Medicaid providers;
- actions taken by OPMC involving professional misconduct and physician discipline actions, including suspensions, revocations, surrenders, and consent agreements;
- felony indictments and convictions of crime relating to the furnishing or billing for medical care, services, or supplies;
- correspondence received from the federal HHS OIG; and/or,
- OMIG's internal enrollment files and eMedNY data, which provides relative ownership information to determine affiliations of excluded providers.

Thirty-nine terminations and 676 exclusions were issued during 2012. The Restricted and Excluded Individuals or Entities list contains 4,804 Medicaid and non-Medicaid provider exclusions, and the list of Terminated Individuals or Entities has 1,158 entries. These lists are updated daily (except holidays and weekends) and are available to the public on OMIG's website, www.omig.ny.gov.

Under ACA's program integrity provisions, Section 6501 requires states to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare, or another Medicaid state plan, or Children's Health Insurance Plan on or after January 1, 2011. In order to help states identify those providers whose billing privileges have been revoked, CMS established a secure web-based portal that allows states to share information regarding terminated providers. New York was the first state to utilize this site, as OMIG staff worked with CMS to successfully use the system. In 2012, 307 providers were uploaded into the database.

Administrative Hearings and Article 78 Proceedings

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

In 2012, OMIG received a total of 62 requests seeking to challenge the agency's final determination. Over the course of 2012, 50 cases in which administrative hearing was requested were subsequently resolved by Stipulation of Settlement, 13 hearing requests were withdrawn, and seven hearing decisions were issued.

Article 78 of the Civil Practice Law and Rules is the main procedural vehicle to challenge final administrative agency actions in New York. Article 78 actions must be commenced in Supreme Court within four months of a final adverse administrative agency decision. A total of 19 Article 78 proceedings were filed during 2012.

In 2010, OMIG began to file judgments in an effort to recover outstanding Medicaid overpayment dollars pursuant to Social Services Law section 145-a. In calendar year 2012, OMIG obtained five judgments totaling $3.5 million against delinquent providers.

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2012. OMIG's work this year demonstrates that NYS remains the national leader in promoting and protecting the integrity of the Medicaid program. As OMIG ends another year of operation and reports on its varied achievements and accomplishments, the agency recognizes that much remains to be done. OMIG looks forward to strengthening the agency's partnerships with other state agencies, expanding provider compliance education efforts, and increasing the level of transparency in the agency's operations.

Appendix

2012

Acronym List

ACA – Affordable Care Act

APG – Ambulatory Patient Groups

BBI – Bureau of Business Intelligence

BLT – Business Line Teams

BLTCR – Bureau of Long Term Care Reimbursement

BMFA – Bureau of Medicaid Fraud Allegations

BNE – Bureau of Narcotics Enforcement

BoC – Bureau of Compliance

CHHA – Certified Home Health Agency

CIA – Corporate Integrity Agreement

CMI – Case Mix Index

CMS – Centers for Medicare and Medicaid Services

COPS – Comprehensive Outpatient Programs

CSP – Community Support Programs

DA – District Attorney

DEA – Drug Enforcement Administration

DME – Durable Medical Equipment

DOH – Department of Health

DOJ – Department of Justice

EHR – Electronic Health Records

FFS – Fee-for-service

HHS OIG – United States Department of Health and Human Services Office of the Inspector General

HIT – Health Information Technology

IPSDR – Improper Payment Scenario Development Request

LDSS – Local Department of Social Services

MCO – Managed Care Organization

MFCU – Medicaid Fraud Control Unit

MRT – Medicaid Redesign Team

NYC – New York City

NYC HRA – New York City Human Resources Administration

NYC TLC – New York City Taxi and Limousine Commission

NYCRR – New York Codes, Rules and Regulations

NYS – New York State

NYSED – NYS Education Department

OMH – Office of Mental Health

OMIG – Office of the Medicaid Inspector General

OPD – Office of Professional Discipline

OPMC – Office of Professional Medical Conduct

OSC – Office of the State Comptroller

PORTal – Provider Overpayment Reporting Terminal

PPR – Prepayment Review

PRI – Patient Review Instrument

RAC – Recovery Audit Contractor

RHCF – Residential Health Care Facility

RRP – Recipient Restriction Program

SMR – System Match and Recovery

2012 Operational Statistics

As required by Public Health Law §35(1), the following Appendix of Operational Statistics provides information about the audits, investigations, and administrative actions, initiated and completed by OMIG.

OMIG initiates audit collections when it has been determined that a provider has submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made. Amounts reported in the attached appendices represent the value of issued final audit reports, self-disclosures, and cost savings activities. Recovery amounts are achieved by receipt of cash, provider withholds, and voided claims. The recovery amounts may be associated with overpayments identified in earlier reporting periods. Identified overpayment and recovery amounts reflect total dollars due to the Medicaid program.

Investigative Activities

2012 Investigation Activities by Source and Region

Table 1.1			
Bureau of Medicaid Fraud Allegations			
Manner of Receipt	**Investigative Activities Received**	**Investigative Activities Closed**	**Investigative Activities Transferred**
Correspondence	10	0	10
Email	782	89	693
Fax	65	12	53
Hotline	1,384	320	1,064
Internal	157	5	152
Internet	283	53	230
Telephone	306	72	234
US Mail	210	51	159
Totals	**3,197**	**602**	**2,595**

Table 1.2						
Investigations by Subject Type and Regions Summary						
	Downstate		**Upstate**		**Totals**	
Subject Type	**Opened**	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Enrolled Provider	479	444	631	1,006	1,110	1,450
Enrolled Recipient	57	31	1,729	2,412	1,786	2,443
Non Enrolled Individual	40	33	278	258	318	291
Non Enrolled Provider	130	58	73	90	203	148
Totals	**706**	**566**	**2,711**	**3,766**	**3,417**	**4,332**

Table 1.3						
Enrolled Recipients						
Initial Source	**Downstate**		**Upstate**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	4	3	437	457	441	460
Bureau of Narcotics Enforcement (BNE)	0	0	13	2	13	2
Drug Enforcement Agency (DEA)	0	0	2	7	2	7
Enrolled Recipient	0	0	77	87	77	87
Federal Department of Homeland Security (DHS)	0	0	0	2	0	2
Federal Bureau of Investigation (FBI)	0	1	0	0	0	1
General Public (Non-enrolled)	1	0	395	436	396	436
Health and Human Services (HHS)	10	1	8	4	18	5
Law Enforcement	3	0	17	12	20	12
Local District Social Services	3	0	19	14	22	14
Managed Care Plans	1	11	71	66	72	77
NYS Department of Financial Services	0	0	3	0	3	0
NYS Department of Health (DOH)	2	0	24	17	26	17
NYS Office of Health Insurance (OHIP)	1	0	3	23	4	23
NYS Office of Temporary and Disability Act (OTDA)	0	0	14	17	14	17
NYS Office of Attorney General	1	1	0	0	1	1
NYS Office of the Inspector General	0	0	2	2	2	2
Non-Enrolled Provider	0	0	1	39	1	39
Non-Enrolled Recipient	0	0	4	10	4	10
OMIG Audit	1	0	3	3	4	3
OMIG Bureau of Payment Controls and Monitoring (BPCM)	0	0	1	1	1	1
OMIG Div. of Technology and Business Automation	0	0	2	1	2	1
OMIG Division of Medicaid Investigations (DMI)	27	12	537	1,046	564	1,058
OMIG Executive	0	0	0	1	0	1
Provider	3	2	96	165	99	167
Total	**57**	**31**	**1,729**	**2,412**	**1,786**	**2,443**

Table 1.4						
Providers (Enrolled & Non-Enrolled)						
Initial Source	**Downstate**		**Upstate**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	44	42	69	92	113	134
Bureau of Narcotics Enforcement (BNE)	0	4	1	0	1	4
CQC	0	0	1	1	1	1
CSC Fraud Unit	2	10	0	10	2	20
Drug Enforcement Agency (DEA)	0	0	1	1	1	1
Enrolled Recipient	51	46	140	184	191	230
Federal Bureau of Investigation (FBI)	2	2	0	1	2	3
General Public (Non-enrolled)	67	50	100	121	167	171
Health and Human Services (HHS)	19	37	4	3	23	40
Law Enforcement	4	5	5	4	9	9
Local District Social Services	6	7	7	12	13	19
Managed Care Plans	22	26	38	38	60	64
NYS Department of Financial Services	0	1	2	2	2	3
NYS Department of Health (DOH)	17	11	14	27	31	38
NYS Department of Taxation and Finance	0	0	7	7	7	7
NYS Education Department	0	3	1	4	1	7
NYS Office for People with Dev Disabilities (OPWDD)	1	1	1	1	2	2
NYS Office for the Aging	0	0	2	2	2	2
NYS Office of Health Insurance (OHIP)	5	13	18	74	23	87
NYS Office of Attorney General	66	7	13	8	79	15
NYS Office of the Inspector General	2	8	1	1	3	9
NYS Office of the State Comptroller	1	11	1	3	2	14
Non-Enrolled Provider	3	2	5	6	8	8
Non-Enrolled Recipient	0	4	1	4	1	8
OMIG Audit	20	28	29	46	49	74
OMIG Bureau of Compliance	0	0	0	1	0	1
OMIG Bureau of Payment Controls and Monitoring (BPCM)	1	9	4	1	5	10
OMIG Div. of Technology and Business Automation	0	2	1	1	1	3
OMIG Division of Medicaid Investigations (DMI)	200	124	157	342	357	466
OMIG Executive	1	0	1	3	2	3
Provider	68	38	79	88	147	126
Safe Guard Services (SGS)	7	11	0	6	7	17
Shop/CVR/Comp Target	0	0	0	1	0	1
Total	**609**	**502**	**703**	**1,095**	**1,312**	**1,597**

Table 1.5						
Non-Enrolled Individuals						
Initial Source	**Downstate**		**Upstate**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	1	0	36	34	37	34
CQC	0	0	0	1	0	1
Drug Enforcement Agency (DEA)	0	0	2	0	2	0
Enrolled Recipient	1	1	106	103	107	104
Federal Department of Homeland Security (DHS)	0	0	2	1	2	1
General Public (Non-enrolled)	3	1	70	62	73	63
Health and Human Services (HHS)	1	0	1	1	2	1
Law Enforcement	5	0	2	1	7	1
Local District Social Services	0	1	5	4	5	5
Managed Care Plans	1	21	11	11	12	32
NYS Department of Financial Services	0	0	1	0	1	0
NYS Department of Health (DOH)	5	3	1	1	6	4
NYS Office for People with Dev Disabilities (OPWDD)	0	0	0	3	0	3
NYS Office of Health Insurance (OHIP)	0	0	0	1	0	1
NYS Office of the Attorney General	6	0	1	2	7	2
NYS Office of the Inspector General	1	0	0	0	1	0
Non-Enrolled Provider	0	0	0	1	0	1
Non-Enrolled Recipient	0	0	7	3	7	3
OMIG Audit	2	3	10	9	12	12
OMIG Division of Medicaid Investigations (DMI)	6	0	4	3	10	3
OMIG Executive	0	0	0	1	0	1
Provider	8	4	20	17	28	21
Total	**40**	**34**	**279**	**259**	**319**	**293**

Table 1.6						
Forgery Investigations by Source and Region						
Initial Source	**Downstate**		**Upstate**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	0	0	10	18	10	18
Bureau of Narcotics Enforcement (BNE)	0	0	13	1	13	1
Enrolled Recipient	0	0	3	6	3	6
General Public (Non-enrolled)	0	0	7	11	7	11
Law Enforcement	0	0	3	2	3	2
Local District Social Services	0	0	4	6	4	6
Managed Care Plans	0	8	12	9	12	17
NYS Department of Health (DOH)	3	0	0	0	3	0
NYS Office of Health Insurance Programs (OHIP)	0	0	1	1	1	1
NYS Office of the Attorney General	1	1	0	0	1	1
Non-Enrolled Recipient	0	0	0	1	0	1
OMIG Division of Medicaid Investigations (DMI)	1	3	459	972	460	975
Provider	0	1	25	46	25	47
Total	**5**	**13**	**537**	**1,073**	**542**	**1,086**

Table 1.7						
All Investigation Types						
Initial Source	**Downstate**		**Upstate**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	49	49	542	587	591	636
Bureau of Narcotics Enforcement (BNE)	0	4	14	2	14	6
CQC	0	0	1	2	1	2
CSC Fraud Unit	2	10	0	10	2	20
Drug Enforcement Agency (DEA)	0	0	5	8	5	8
Enrolled Recipient	52	52	323	376	375	428
Federal Department of Homeland Security (DHS)	0	0	2	3	2	3
Federal Bureau of Investigation (FBI)	2	3	0	1	2	4
General Public (Non-enrolled)	71	53	565	621	636	674
Health and Human Services (HHS)	30	38	13	8	43	46
Law Enforcement	12	8	24	17	36	25
Local District Social Services	9	9	31	30	40	39
Managed Care Plans	24	63	120	116	144	179
NYS Department of Financial Services	0	1	6	2	6	3
NYS Department of Health (DOH)	24	17	39	45	63	62
NYS Department of Taxation and Finance	0	0	7	7	7	7
NYS Education Department	0	3	1	4	1	7
NYS Office for People with Dev Disabilities (OPWDD)	1	1	1	4	2	5
NYS Office for the Aging	0	0	2	2	2	2
NYS Office of Health Insurance (OHIP)	6	13	21	98	27	111
NYS Office of Temporary and Disability Act (OTDA)	0	0	14	17	14	17
NYS Office of Attorney General	73	8	14	10	87	18
NYS Office of the Inspector General	3	8	3	3	6	11
NYS Office of the State Comptroller	1	14	1	3	2	17
Non-Enrolled Provider	3	2	6	47	9	49
Non-Enrolled Recipient	0	5	12	17	12	22
OMIG Audit	23	38	42	58	65	96
OMIG Bureau of Compliance	0	0	0	1	0	1
OMIG Bureau of Payment Controls and Monitoring (BPCM)	1	9	5	2	6	11
OMIG Div. of Technology and Business Automation	0	2	3	2	3	4
OMIG Division of Medicaid Investigations (DMI)	233	147	698	1,394	931	1,541
OMIG Executive	1	1	1	5	2	6
Provider	79	46	196	272	275	318
Qui Tam	0	4	0	0	0	4
Safe Guard Services (SGS)	7	11	0	6	7	17
Shop/CVR/Comp Target	0	0	0	1	0	1
Total	**706**	**619**	**2,712**	**3,781**	**3,418**	**4,400**

2012 Investigative Referrals

Table 1.8	
DMI Referrals to MFCU	
Provider Type	**2012**
Clinical Psychologist	1
Dental Groups	2
Dentist	4
Diagnostic & Treatment Center.	1
Enrolled Provider	1
Home Health Agency	6
Long Term Care Facility	3
Medical Appliance Dealer	1
Multi-Type	2
Multi-Type Group	2
Nurse	4
No Provider Type	4
Non Enrolled Provider	7
Pharmacy	7
Physician	9
Therapist	3
Therapy Group	1
Transportation	6
Total	**64**

Table 1.9	
DMI Referrals to Outside Agencies	
Agency	**2012**
Commission on Quality of Care	1
Department of Justice	1
Health and Human Services (HHS-OIG)	1
Law Enforcement Agency	233
Local District Attorney	14
Local District Social Services	362
Managed Care Plans	2
NYC HRA Bureau of Client Fraud Investigations	614
OMIG Business Intelligence Unit	2
Office of Professional Discipline	12
Office of Professional Medical Conduct	3
Other DOH Unit (not OMIG)	3
Other Federal Agency	4
Other State Agency	22
Total	**1,274**

Table 1.10	
DMI Recipient Referrals to Outside Agencies	
Agency	**2012**
Law Enforcement Agency	232
Local District Attorney	14
Local District Social Services	361
NYC HRA Bureau of Client Fraud Investigations	608
Other Federal Agency	3
Other State Agency	21
Total	**1,239**

Table 1.11	
DMI Forgery Referrals to Outside Agencies Recipients Only	
Agency	**2012**
Law Enforcement Agency	45
Local District Attorney	1
Local District Social Services	27
NYC HRA Bureau of Client Fraud Investigations	268
Total	**341**

2012 Investigative Financial Activities by Region and Provider Type

Table 1.12		
Number of Reports	**Final Actions**	**Recoveries**
6	$ 1,866,740	$ 1,616,554

Table 1.13						
2012 Investigative Financial Activities						
Provider Type	**Final Actions**		**Total**	**Number of Reports**		**Total**
	Notice of Agency Action (NOAA)	**Stipulation**		**NOAA**	**Stipulation**	
Dentist	$ 1,586	$ 0	**$ 1,586**	2	0	**2**
Hospital	0	1,460,503	**1,460,503**	0	1	**1**
Long Term Care Facility	10,812	0	**10,812**	1	0	**1**
Pharmacy	393,097	0	**393,097**	1	0	**1**
Physician	742	0	**742**	1	0	**1**
Total	**$ 406,237**	**$1,460,503**	**$ 1,866,740**	**5**	**1**	**6**

Table 1.14				
2012 Investigative Financial Recoveries				
Provider Type	**Downstate**	**Upstate**	**Upstate Western**	**Total Recoveries**
Dental Groups	$ 0	$ 0	$ 7,994	**$ 7,994**
Dentist	4,063	1,586	0	**5,649**
Diagnostic & Treatment Center	26,838	0	0	**26,838**
Hospital	1,460,503	0	0	**1,460,503**
Long Term Care Facility	49,429	0	0	**49,429**
Multi-Type	43,692	0	0	**43,692**
Pharmacy[1]	(67,445)	7,951	0	**(59,494)**
Physician	0	15,900	742	**16,642**
Transportation	22,623	42,678	0	**65,301**
Total	**$ 1,539,703**	**$ 68,115**	**$ 8,736**	**$ 1,616,554**

[1] Investigative recoveries lowered due to identification of overpayments received by OMIG from the provider necessitating a refund in 2012

2012 Sanctions – Exclusions & Terminations

Table 1.15	
Sanctions By Type	
Exclusion Type	**Number of Actions Total**
Exclusion – 18 NYCRR 515	676
Termination – 18 NYCRR 504.7	39
Grand Total	715

Table 1.16			
Excluded Providers Summary			
Allegation Source	**Exclusion 18 NYCRR 515**	**Termination 18 NYCRR 504.7**	**Number of Actions Total**
HHS	196	0	196
Medicaid Fraud Control Unit	113	0	113
OMIG	256	2	258
Office of Professional Medical Conduct	40	8	48
SED	71	29	100
Grand Total	**676**	**39**	**715**

2012 Enrollment and Reinstatement Activities

Table 1.17	
Enrollment Applications Received	
Application Type	**2012 Review Totals**
711 Orthopedic Shoe Review	7
New Enrollment Review	727
Ownership Change Application	246
Reinstatement	50
Removal from Exclusion List	105
Total	**1,135**

Table 1.18	
Enrollment Applications Dispositions	
Disposition	**2012 Totals**
Approved	879
Closed on initial review	3
Denied	168
Substantiated	3
Withdrawn	20
Total	**1,073**

2012 Summary of Audit Activities

Table 2.1				
2012 Audits Statewide				
Audit Department	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Fee-for-Service Audit Total	569	226	$ 11,745,032	$ 27,288,358
Rate Audit	100	91	29,566,502	27,478,982
Managed Care	412	230	20,178,003	22,204,787
Medicaid in Education	38	26	2,350,061	1,608,073
County Demonstration Program[2]	4	3	(3,473,845)	666,850
Total	**1,123**	**576**	**$ 60,365,753**	**$ 79,247,050**

2012 Fee-for-Service Audits by Project Type and Region

Table 2.2				
2012 Upstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	0	1	$ 3,528	$ 0
Dentist	0	0	0	3,900
Diagnostic & Treatment Center[3]	0	0	(300,065)	(57,939)
Duplicate Clinic Match	5	3	48,386	2,353
Medicaid EHR Incentive Program	20	0	0	0
MRT-154-8	22	23	123,264	132,069
Medicare Crossover	3	4	211,611	29,348
OASAS[4]	0	1	(149,298)	(23,212)
OMH	0	1	0	178,697
OMH Rehabilitation	6	1	0	0
OMH-COPS Recon Project	49	14	5,916,940	7,100,131
OPWDD[5]	0	0	(650,424)	153,491
OPWDD-IRA Res Hab	5	0	0	0
Personal Care	0	1	0	0
Pharmacies	6	1	0	0
Physician Reviews	0	0	0	7,028
TBI[6]	0	0	(68,909)	42,658
Transportation Ambulette	0	0	0	7,064
Total	**116**	**50**	**$ 5,135,033**	**$ 7,575,588**

[2] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to 2011 final audit and a revised final audit in 2012 related to a 2011 final audit
[3] Audit overpayments identified/overpayments recovered lowered due to a stipulation issued in 2012 related to a 2010 final audit
[4] Audit overpayments identified/overpayments recovered lowered due to a stipulation issued in 2012 related to a 2010 final audit
[5] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to a 2011 final audit
[6] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to a 2011 final audit

Table 2.3				
2012 Downstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Ambulatory Surgery	0	0	$ 0	$ 32,712
Credentials	0	0	0	752
DME and Orthopedic Shoe Vendor[7]	0	0	(153,719)	295,499
Death Match	0	0	0	51,508
Diagnostic and Treatment Center[8]	0	2	(1,368,155)	1,208,115
Duplicate Clinic Match	33	0	0	137,510
Exception Codes	0	1	924	0
HIV/AIDS	0	0	0	19,584
High Ordering Providers	0	0	60,146	286,420
Hospice	0	1	2,300,000	2,300,000
Hospital Inpatient	0	1	392,219	392,219
Laboratories	0	1	0	0
Medicaid EHR Incentive Program	50	0	0	0
MRT-154-8	91	99	604,816	649,379
Medicare Crossover	0	14	1,319,767	712,620
OASAS	0	0	0	1,058,872
OMH[9]	0	0	(1,644,553)	210,364
OMH – Outpatient	0	0	0	61,057
OMH-COPS Recon Project	104	9	4,456,043	8,723,744
OPWDD - Day Hab	1	0	0	0
OPWDD – PreVoc	1	0	0	0
OPWDD - SEMP	1	0	0	0
OPWDD - Day Tx	3	1	0	0
OPWDD-IRA Res Hab	5	0	0	37,040
OPWDD - MSC	2	0	0	0
Ob/Gyn Services	0	0	0	30,317
PCAP	0	0	0	195
PERM	0	2	508,843	508,843
Pharmacies	2	0	0	210,852
Physician Reviews	0	1	279,682	404,404
Transportation Ambulette[10]	0	0	(38,531)	(38,531)
Total	**293**	**132**	**$ 6,717,482**	**$ 17,293,475**

[7] Audit overpayments identified lowered due to stipulation agreements issued in 2012 related to 2009 final audits
[8] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to a 2008 final audit
[9] Audit overpayments identified lowered due to stipulation agreements issued in 2012 related to a 2006 and a 2010 final audit
[10] Audit overpayments identified/recovered lowered due to a stipulation agreement issued in 2012 related to a 2010 final audit

Table 2.4				
2012 Western Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	1	0	$ 0	$ 0
DME and Orthopedic Shoe Vendor	0	0	0	13,055
Diagnostic and Treatment Center[11]	0	0	(385,754)	(188,549)
Duplicate Clinic Match	5	3	4,124	2,257
Hospital Outpatient Department	1	0	0	0
Medicaid EHR Incentive Program	30	0	0	0
MRT 154-8	24	21	57,553	43,295
OASAS[12]	0	0	(205,264)	(157,222)
OMH	0	0	0	62,603
OMH Rehabilitation	1	2	73,105	73,105
OMH-COPS Recon Project	60	3	1,375,944	2,684,485
OPWDD-Ira Res Hab	11	0	0	0
OPWDD-MSC	4	0	0	0
Pharmacies[13]	8	0	(84,292)	65,228
TBI[14]	0	0	(433,833)	(8,173)
Total	**145**	**29**	**$ 401,583**	**$ 2,590,084**

Table 2.5				
2012 Out-of-State Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Ambulatory Surgery[15]	0	0	$ (785,476)	$ (346,446)
Diagnostic and Treatment Center	1	0	0	0
Hospital Inpatient	0	0	215,301	138,261
MRT 154-8	14	15	61,107	37,392
Total	**15**	**15**	**$ (509,068)**	**$ (170,793)**

[11] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2011 final audit
[12] Audit overpayments identified/recovered lowered due to a stipulation issued in 2012 related to a 2010 final audit
[13] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2009 final audit
[14] Audit overpayments identified/recovered lowered due to a stipulation issued in 2012 related to a 2011 final audit
[15] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2009 final audit

Table 2.6				
2012 Statewide Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	1	1	$ 3,528	$ 0
Ambulatory Surgery[16]	0	0	(785,476)	(313,734)
Credentials	0	0	0	752
DME and Orthopedic Shoe Vendor[17]	0	0	(153,719)	308,555
Death Match	0	0	0	51,508
Dentist	0	0	0	3,900
Diagnostic and Treatment Center[18]	1	2	(2,053,974)	961,628
Duplicate Clinic Match	43	6	52,511	142,121
Exception Codes	0	1	924	0
HIV/AIDS	0	0	0	19,584
High Ordering Providers	0	0	60,146	286,420
Hospice	0	1	2,300,000	2,300,000
Hospital Inpatient	0	1	607,521	530,480
Hospital Outpatient Department	1	0	0	0
Laboratories	0	1	0	0
Medicaid EHR Incentive Program	100	0	0	0
MRT 154-8	151	158	846,740	862,135
Medicare Crossover	3	18	1,531,378	741,969
OASAS[19]	0	1	(354,562)	878,438
OMH[20]	0	1	(1,644,553)	451,664
OMH Outpatient	0	0	0	61,057
OMH Rehabilitation	7	3	73,105	73,105
OMH-COPS Recon Project	213	26	11,748,927	18,508,360
OPWDD[21]	0	0	(650,424)	153,491
OPWDD – Day Hab	1	0	0	0
OPWDD – PreVoc	1	0	0	0
OPWDD – SEMP	1	0	0	0
OPWDD-Day Tx	3	1	0	0
OPWDD-IRA Res Hab	21	0	0	37,040
OPWDD-MSC	6	0	0	0
Ob/Gyn Services	0	0	0	30,317
PCAP	0	0	0	195
PERM	0	2	508,843	508,843
Personal Care	0	1	0	0
Pharmacies[22]	16	1	(84,292)	276,080
Physician Reviews	0	1	279,682	411,432
TBI[23]	0	0	(502,742)	34,485
Transportation Ambulette[24]	0	0	(38,531)	(31,467)
Total	**569**	**226**	**$ 11,745,032**	**$ 27,288,358**

[16] See footnote number 15 on page A17 of the Appendix
[17] See footnote number 7 on page A16 of the Appendix
[18] See footnote numbers 3, 8, and 11 on pages A15, A16, and A17 of the Appendix
[19] See footnote numbers 4 and 12 on pages A15 and A17 of the Appendix
[20] See footnote number 9 on page A16 of the Appendix
[21] See footnote number 5 on page A15 of the Appendix
[22] See footnote number 13 on page A17 of the Appendix
[23] See footnote numbers 6 and 14 on pages A15 and A17 of the Appendix
[24] See footnote number 10 on page A16 of the Appendix

2012 Rate Audits by Type and Region

Table 3.1				
2012 Upstate Region Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	1	0	$ 0	$ 0
Data Warehouse	0	0	0	211,959
PRI	0	1	2,024,150	1,287,621
Skilled Nursing – Base Year	1	3	897,435	1,128,243
Skilled Nursing – Dropped Services	0	2	512,164	663,069
Skilled Nursing – Capital[25]	10	5	(58,881)	1,072,427
Skilled Nursing – Rollovers	4	3	46,651	263,314
Total	**16**	**14**	**$ 3,421,519**	**$ 4,626,633**

Table 3.2				
2012 Downstate Region Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	29	14	$ 3,667,132	$ 2,608,421
Clinic – D and T	1	0	0	0
Data Warehouse	0	0	0	18,391
Personal Care	6	0	0	0
PRI	0	4	1,215,627	820,290
Rollover – Sales Tax	3	2	8,495	13,853
Skilled Nursing – Base Year	2	5	5,596,801	2,548,164
Skilled Nursing – Dropped Services	0	2	96,007	96,007
Skilled Nursing – Capital	13	13	7,639,430	8,459,332
Skilled Nursing – Rollovers	10	11	1,447,896	1,547,657
Transportation	0	0	0	1,744
Total	**64**	**51**	**$ 19,671,388**	**$ 16,113,859**

[25] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2010 final audit

Table 3.3				
2012 Western Region Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	1	0	$ 0	$ 0
HHC	0	1	535,548	535,548
Medicare Part B	0	1	0	0
Skilled Nursing – Base Year	0	5	2,443,334	2,571,624
Skilled Nursing – Dropped Services	0	0	0	13,414
Skilled Nursing – Capital	10	12	2,651,906	2,372,014
Skilled Nursing – Rate Appeal	2	0	0	0
Skilled Nursing - Rollovers	7	7	842,807	1,245,891
Total	**20**	**26**	**$ 6,473,595**	**$ 6,738,491**

Table 3.4				
2012 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	31	14	$ 3,667,132	$ 2,608,421
Clinic – D and T	1	0	0	0
Data Warehouse	0	0	0	230,350
HHC	0	1	535,548	535,548
Medicare Part B	0	1	0	0
Personal Care	6	0	0	0
PRI	0	5	3,239,777	2,107,911
Rollover – Sales Tax	3	2	8,495	13,853
Skilled Nursing – Base Year	3	13	8,937,570	6,248,030
Skilled Nursing – Dropped Services	0	4	608,171	772,490
Skilled Nursing – Capital	33	30	10,232,455	11,903,773
Skilled Nursing – Rate Appeal	2	0	0	0
Skilled Nursing - Rollovers	21	21	2,337,354	3,056,862
Transportation	0	0	0	1,744
Total	**100**	**91**	**$ 29,566,502**	**$ 27,478,982**

2012 Managed Care and Provider Review Audits by Type and Region

Table 4.1				
2012 Upstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Death Match	8	0	$ 0	$ 58,433
Family Plan Chargeback/MCO	6	1	6,624	260,240
Locator Code	0	1	57,547	57,547
Mat/Kick	0	2	9,396	9,396
Multiple CIN	0	1	43,219	43,219
No Reported Encounter Data	14	10	239,892	219,763
Prison Match	6	7	764,953	764,953
Retroactive Disenrollments	42	33	3,349,516	3,349,398
Newborn FFS-MC Crossover	20	0	0	0
Total	**96**	**55**	**$ 4,471,147**	**$ 4,762,949**

Table 4.2				
2012 Downstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
FFS-GME Crossover	0	2	$ 36,298	$ 13,971
FQHC FFS/MC Crossover	1	0	0	0
Death Match[26]	25	0	0	(95,672)
Duplicate Payments	0	1	1,658	1,658
Family Plan Chargeback/FFS	4	5	32,824	150,430
Family Plan Chargeback/MCO	15	3	1,264,135	3,571,426
Locator Code	0	3	403,707	1,015,603
Mat/Kick	0	6	34,224	34,224
Multiple CIN	1	1	4,044	5,620
No Reported Encounter Data	24	16	1,461,798	402,669
Prior DOB Payments	4	4	8,842	8,464
Prison Match	13	12	1,204,030	796,442
Retroactive Disenrollments	85	67	6,947,542	7,205,110
Newborn FFS-MC Crossover	47	0	21,974	21,974
Misclassified Patient Discharges	7	0	0	0
Total	**226**	**120**	**$ 11,421,076**	**$ 13,131,919**

[26] Audit overpayments recovered lowered due to identification of overpayments received by OMIG from the provider necessitating a refund in 2012

Table 4.3				
2012 Western Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
FQHC FFS/MC Crossover	2	0	$ 0	$ 0
Death Match	6	0	0	2,814
Family Plan Chargeback/MCO	6	2	58,597	58,597
No Reported Encounter Data	11	9	30,248	30,154
Prior DOB Payments	3	3	15,698	15,560
Prison Match	7	7	293,231	292,397
Retroactive Disenrollments	38	34	3,911,279	3,910,397
Newborn FFS-MC Crossover	14	0	0	0
Misclassified Patient Discharges	1	0	0	0
Total	**88**	**55**	**$ 4,309,053**	**$ 4,309,919**

Table 4.4				
2012 Out-of-State Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Newborn FFS-MC Crossover	2	0	$ 0	$ 0
Total	**2**	**0**	**$ 0**	**$ 0**

Table 4.5				
2012 Statewide Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
FFS-GME Crossover	0	2	$ 36,298	$ 13,971
FQHC FFS/MC Crossover	3	0	0	0
Death Match[27]	39	0	0	(34,425)
Duplicate Payments	0	1	1,658	1,658
Family Plan Chargeback/FFS	4	5	32,824	150,430
Family Plan Chargeback/MCO	27	6	1,329,357	3,890,263
Locator Code	0	4	461,254	1,073,150
Mat/KICK	0	8	43,620	43,620
Multiple CIN	1	2	23,990	48,838
No Reported Encounter Data	49	35	1,731,938	652,587
Prior DOB Payments	7	7	24,541	24,024
Prison Match	26	26	2,262,213	1,853,792
Retroactive Disenrollments	165	134	14,208,337	14,464,905
Newborn FFS-MC Crossover	83	0	21,974	21,974
Misclassified Patient Discharges	8	0	0	0
Total	**412**	**230**	**$ 20,178,003**	**$ 22,204,787**

[27] See footnote number 26 on page A21 of the Appendix

2012 School Supportive and Preschool Supported Health Services Programs Audits by Type and Region

Table 5.1				
2012 Upstate Region Medicaid in Education Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP*	3	2	$ 50,041	$ 50,041
SSHSP**	9	6	393,642	430,125
Total	**12**	**8**	**$ 443,683**	**$ 480,166**

Table 5.2				
2012 Downstate Region Medicaid in Education Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	2	0	$ 0	$ 0
SSHSP	4	5	270,045	33,537
Total	**6**	**5**	**$ 270,045**	**$ 33,537**

Table 5.3				
2012 Western Region Medicaid in Education Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	3	4	$ 691,306	$ 691,306
SSHSP	17	9	945,027	403,064
Total	**20**	**13**	**$ 1,636,333**	**$ 1,094,370**

Table 5.4				
2012 Statewide Medicaid in Education Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	8	6	$ 741,347	$ 741,347
SSHSP	30	20	1,608,714	866,726
Total	**38**	**26**	**$ 2,350,061**	**$ 1,608,073**

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

2012 Medicaid Fraud, Waste, and Abuse County Demonstration Program Audits by Type and Region

Table 6.1				
2012 Upstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Pharmacies[28]	0	0	$ (1,199,766)	$ 18,566
Total	**0**	**0**	**$ (1,199,766)**	**$ 18,566**

Table 6.2				
2012 Downstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME and Orthopedic Shoe Vendors	0	0	$ 0	$ 63,086
Pharmacies[29]	0	2	(636,567)	221,920
Transportation[30]	0	0	(1,637,512)	363,279
Total	**0**	**2**	**$ (2,274,079)**	**$ 648,285**

Table 6.3				
2012 Western Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Pharmacies	4	1	$ 0	$ 0
Total	**4**	**1**	**$ 0**	**$ 0**

Table 6.4				
2012 Statewide County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME and Orthopedic Shoe Vendors	0	0	$ 0	$ 63,086
Pharmacies[31]	4	3	(1,836,333)	240,485
Transportation[32]	0	0	(1,637,512)	363,279
Total	**4**	**3**	**$ (3,473,845)**	**$ 666,850**

[28] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to a 2011 final audit
[29] Audit overpayments identified lowered due to a stipulation agreement issued in 2012 related to a 2011 final audit
[30] Audit overpayments identified lowered due to a revised final audit issued in 2012 related to a 2011 final audit
[31] See footnote numbers 28 and 29 on this page
[32] See footnote number 30 on this page

Medicaid Payment Monitoring and Recovery Activities

2012 Systems Match Recoveries by Type and Region

Table 7.1				
2012 Upstate Region Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	12	14	$ 132,383	$ 132,383
DME Crossover – Medicaid with Medicare Detail[33]	0	0	(160)	17,867
Dental[34]	0	1	(571)	(571)
General Clinic	23	13	54,291	48,387
Home Health	17	11	59,668	29,249
Inpatient Crossover/Clinic/ER	27	28	202,581	286,108
OB/Gyn	0	0	0	150
Partial Hospitalization	0	1	1,925	44,808
Physician – Place of Service	0	2	1,206	12,332
Physician Services in OMH Clinics	7	4	106,624	98,517
Transportation	40	0	0	0
Total	**126**	**74**	**$ 557,947**	**$ 669,230**

Table 7.2				
2012 Downstate Region Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	10	15	$ 89,696	$ 94,135
Ancillary/Same Day Clinic Visit	0	0	3,655	3,655
Chemotherapy[35]	0	0	(360,081)	(351,221)
DME Crossover – Medicaid with Medicare Detail	0	1	163,914	201,902
Deceased Recipients	0	1	21,239	40,097
Dental	7	15	68,488	269,455
Duplicate Clinic Payments	0	0	7,990	269,536
General Clinic	42	29	647,087	524,945
Home Health	45	19	215,879	144,100
Inpatient Crossover/Clinic/ER	50	49	1,115,713	1,103,009
Inpatient/Ancillary/Laboratory	0	0	1,937	1,937
NAMI	0	2	68,860	68,860
OB/Gyn	0	0	0	2,134
Partial Hospitalization	0	2	35,045	41,780
Physician – Place of Service	0	2	7,573	36,116
Physician Services in OMH Clinics	22	18	769,632	52,132
Podiatrists	0	0	1,239	4,288
Radiology	0	0	0	924
Transportation	74	2	29,575	0
Total	**250**	**155**	**$ 2,887,441**	**$ 2,507,784**

[33] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2011 final audit
[34] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2011 final audit
[35] Audit overpayments identified/recovered lowered due to stipulations issued in 2012 relating to 2010 final audits and a 2011 final audit

Table 7.3				
2012 Western Region Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	15	14	$ 71,132	$ 71,132
DME Crossover – Medicaid with Medicare Detail	0	4	89,850	20,722
Dental	7	8	80,421	83,847
General Clinic	50	25	144,431	113,421
Home Health	10	4	22,141	10,344
Inpatient Crossover/Clinic/ER	39	41	260,784	300,663
OB/Gyn	0	0	0	716
PAC & PAS	0	0	7,447	3,723
Physician – Place of Service	1	5	322,572	3,335
Physician Services in OMH Clinics	6	5	153,855	53,307
Radiology[36]	0	0	(287)	(287)
Transportation	24	0	0	0
Total	**152**	**106**	**$ 1,152,346**	**$ 660,923**

Table 7.4				
2012 Out-of-State Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME Crossover – Medicaid with Medicare Detail	0	3	$ 63,755	$ 12,359
Dental	4	6	34,442	364,000
OB/Gyn[37]	0	0	(13,999)	7,660
Physician – Place of Service	0	0	0	60,337
Physician Services in OMH Clinics	2	1	1,687	0
Transportation	21	0	0	0
Total	**27**	**10**	**$ 85,885**	**$ 444,356**

[36] Audit overpayments identified/recovered lowered due to a stipulation issued in 2012 related to a 2010 final audit
[37] Audit overpayments identified lowered due to a stipulation issued in 2012 related to a 2010 final audit

Table 7.5				
2012 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	37	43	$ 293,211	$ 297,650
Ancillary/Same Day Clinic Visit	0	0	3,655	3,655
Chemotherapy[38]	0	0	(360,081)	(351,221)
DME Crossover – Medicaid with Medicare Detail	0	8	317,359	252,850
Deceased Recipients	0	1	21,239	40,097
Dental	18	30	182,780	716,731
Duplicate Clinic Payments	0	0	7,990	269,536
General Clinic	115	67	845,810	686,753
Home Health	72	34	297,689	183,693
Inpatient Crossover/Clinic/ER	116	118	1,579,077	1,689,779
Inpatient/Ancillary/Lab	0	0	1,937	1,937
NAMI	0	2	68,860	68,860
OB/Gyn[39]	0	0	(13,999)	10,659
PAC & PAS	0	0	7,447	3,723
Partial Hospitalization	0	3	36,970	86,587
Physician – Place of Service	1	9	331,351	112,120
Physician Services in OMH Clinics	37	28	1,031,799	203,956
Podiatrists	0	0	1,239	4,288
Radiology[40]	0	0	(287)	638
Transportation	159	2	29,575	0
Total	**555**	**345**	**$ 4,683,621**	**$ 4,282,291**

[38] See footnote 35 on page A25 of the Appendix
[39] See footnote 37 on page A26 of the Appendix
[40] See footnote 36 on page A26 of the Appendix

2012 Self Disclosure Audits by Provider Type and Region

Table 8.1				
2012 Upstate Self Disclosure Audits				
Provider Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Capitation Provider	3	0	$ 0	$ 0
Child Care Institution	1	0	0	0
Diagnostic and Treatment Center[41]	4	1	(79,409)	361,612
Home Health Agency	27	28	4,243,929	4,389,876
Hospital	8	4	175,313	24,115
Long Term Care Facility	6	2	64,537	12,968
Medical Appliance Dealer	1	1	4,516	4,516
Multi-Type	13	5	425,872	193,300
Nurse	1	0	0	0
Other	2	0	0	0
Transportation	1	1	7,774	31,346
Total	**67**	**42**	**$ 4,842,532**	**$ 5,017,733**

Table 8.2				
2012 Downstate Self Disclosure Audits				
Provider Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Capitation Provider	4	0	$ 0	$ 0
Child Care Institution	5	2	112,582	60,105
Dentist	1	1	1,060	1,060
Diagnostic and Treatment Center	23	15	1,693,870	690,479
Home Health Agency	35	28	2,454,314	2,090,982
Hospital	11	10	1,092,535	1,178,043
Laboratory	0	1	1,127,155	1,127,155
Long Term Care Facility	12	12	1,024,142	876,977
Multi-Type	25	18	5,571,884	5,477,217
Multi-Type Group	5	1	199,975	343,262
Pharmacy	1	0	0	0
Physicians Group	12	5	435,147	54,262
Transportation	0	1	1,128,906	1,275,185
Total	**134**	**94**	**$ 14,841,570**	**$ 13,174,727**

[41] Audit overpayments identified lowered due to a revised stipulation issued in 2012 related to a 2005 stipulation

Table 8.3				
2012 Western Self Disclosure Audits				
Provider Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Capitation Provider	2	0	$ 0	$ 0
Child Care Institution	1	1	7,049	7,049
Diagnostic and Treatment Center	7	4	147,574	136,925
Home Health Agency	18	15	255,510	504,835
Hospital	7	6	80,775	177,105
Long Term Care Facility	7	7	185,674	66,952
Multi-Type	15	10	195,687	930,385
Nurse	1	1	8,770	0
Physicians Group	1	2	15,076	15,076
Transportation	0	1	29,116	23,420
Total	**59**	**47**	**$ 925,231**	**$ 1,861,747**

Table 8.4				
2012 Out-of-State Self Disclosure Audits				
Provider Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Hospital	2	1	$ 3,837	$ 23,470
Medical Appliance Dealer	1	0	0	0
Multi-Type	1	0	0	90
Total	**4**	**1**	**$ 3,837**	**$ 23,559**

Table 8.5				
2012 Statewide Self Disclosure Audits				
Provider Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Capitation Provider	9	0	$ 0	$ 0
Child Care Institution	7	3	119,632	67,154
Dentist	1	1	1,060	1,060
Diagnostic and Treatment Center	34	20	1,762,035	1,189,016
Home Health Agency	80	71	6,953,753	6,985,694
Hospital	28	21	1,352,460	1,402,732
Laboratory	0	1	1,127,155	1,127,155
Long Term Care Facility	25	21	1,274,353	956,897
Medical Appliance Dealer	2	1	4,516	4,516
Multi-Type	54	33	6,193,442	6,600,991
Multi-Type Group	5	1	199,975	343,262
Nurse	2	1	8,770	0
Other	2	0	0	0
Pharmacy	1	0	0	0
Physicians Group	13	7	450,223	69,337
Transportation	1	3	1,165,796	1,329,950
Total	**264**	**184**	**$ 20,613,170**	**$ 20,077,764**

2012 Business Line Team Projects

Table 9.1				
2012 Business Line Team Projects[42]				
Business Line Team	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Managed Care	421	230	$ 20,178,008	$ 22,204,786
Medical Services in an Educational Setting	38	26	2,350,061	1,608,073
Home and Community Care Services	167	111	7,412,649	7,806,574
Hospital and Outpatient Services	439	235	3,020,626	7,724,163
Mental Health, Chemical Dependence, and Developmental Disabilities Services	290	63	10,241,262	20,453,698
Pharmacy and Durable Medical Equipment[43]	23	14	(1,338,133)	1,126,176
Physicians, Dentists, and Laboratories	36	68	5,413,845	3,545,671
Residential Health Care Facilities	156	157	30,681,718	28,084,177
Transportation[44]	160	5	(480,672)	1,728,806
Activities Relating to Multiple Business Lines	212	196	10,049,925	10,941,532
Total	**1,942**	**1,105**	**$ 87,529,284**	**$ 105,223,656**

[42] Business Line Team Projects officially commenced in May 2012
[43] Audit overpayments identified lowered due to stipulations issued in 2012 related to a 2011 final audit
[44] Audit overpayments identified lowered due to a revised final audit issued in 2012 related to a 2011 final audit

Third-Party Liability Recoveries

Table 10.1		
2012 Third Party Liability Recoveries		
Activity Area	**Amount**	
HMS – Third Party Liability	$	128,165,587
HMS – Casualty & Estate		39,336,487
HMS – RAC		55,564,425
UMASS		139,346,751
Self-Disclosed TP Health Insurance		979,123
Total	**$**	**363,392,373**

Cost Savings Activities

Table 11.1		
2012 Cost Savings Activities		
Activity Area	**Amount**	
Card Swipe Program/ Post & Clear Program	$	30,373,501
Clinic License Verification		19,831,467
Dental System Match		17,594,033
Edit 102 – Service Date prior to Birth Date		164,263
Edit 1141 – Dental Activities		879,591
Edit 1141 – Medical Activities		2,206,034
Edit 1236/1238 - Order/Servicing/Referring Provider #		7,997,209
Edit 1344 – Transportation Claims		858,760
Edit 1357 – Provider ID/Service ID are the same		4,904,806
Edit 760 – Suspected Duplicate, Covered by Inpatient		2,640,069
Edit 903 – Ordering/Referring Provider Number Missing		18,953,040
Edit 927 – Transportations Claims		2,347,381
Edit 939 - Ordering Provider Excluded Prior to Order Date		10,084,399
Edit 941/944 – Practitioner Claims		11,496
Enrollment and Reinstatement		54,487,535
Exception and Conflict Report		369,527,175
Exclusions/Terminations – Internal		12,100,996
Exclusions/Terminations – External		24,838,819
High Ordering Physicians		298,713,801
Managed Care Locator Code		28,849,174
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims		146,710,216
Pharmacies License Verification		11,399,054
Pre-Payment Insurance Verification Commercial		1,128,088,875
Pre-Payment Insurance Verification Medicare		38,513,604
Recipient Restriction		171,254,338
Serialized Prescription Program Edits		38,671,015
Transportation Crossover Edit		122,318
Total	**$**	**2,442,122,969**