NEW YORK STATE

Office of the Medicaid Inspector General

OVERVIEW OF OMIG'S PROTOCOL AND AUDIT PROCESSES

MARCH 17, 2026

TODAY

- This presentation will focus on processes related to OMIG protocols as well as audits conducted of providers paid fee-for-service or paid by a Medicaid managed care plan.
- Agenda
  - Agency Overview
  - Audit Protocols
  - Audit Process
  - Best Practices
  - Questions

Please note: OMIG cannot comment on any specific audits or other open matters

AGENCY OVERVIEW

- The Office of the Medicaid Inspector General (OMIG) is an independent entity created within the New York State Department of Health to promote and protect the integrity of the Medicaid program in New York State

- **Our mission** is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

- In carrying out its mission, OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations

GUIDING PRINCIPALS

Maximize Medicaid Program Integrity

Preserve Medicaid Resources and Access to Care

Improve Awareness and Stakeholder Relationships

Strengthen Compliance and Encourage Self Disclosures

Promote Quality of Care

ANNUAL REPORT AND WORK PLAN

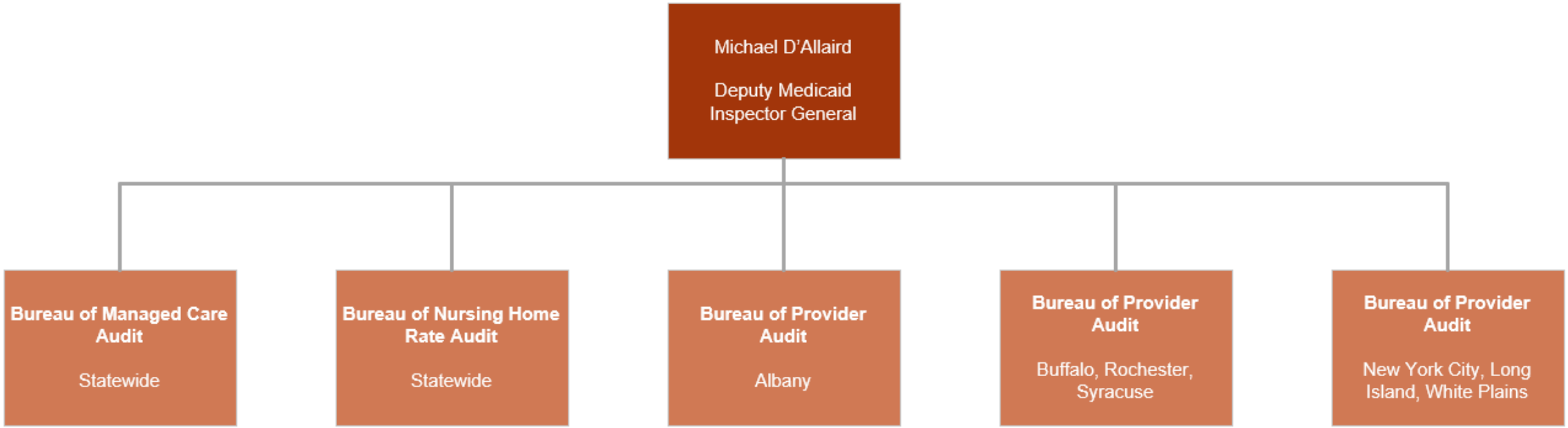
- 2024 Annual Report

https://omig.ny.gov/information-resources/annual-reports

- 2026 Work Plan

New York State Office of the Medicaid Inspector General 2026 Work Plan | Office of the Medicaid Inspector General

DIVISION OF MEDICAID AUDIT OVERVIEW



Office of the Medicaid Inspector General

Audit Protocols

AUDIT PROTOCOLS - OVERVIEW

- Protocols are "…working documents for auditors, used as guidelines in their efforts to identify violations of rules and regulations"
- Protocols summarize audit criteria in reference to rules and regulations governing specific program areas for a retrospective period of time.
- Protocols reflect a specified, previous period of time as OMIG audits are conducted retrospectively.

AUDIT PROTOCOLS – OVERVIEW (CONTINUED)

- Protocols are not rules imposed upon providers. Audit protocols are not used as a basis for disallowance of audited claims.
- Audit protocols are intended solely as guidance. Protocols are not a substitute for a review of the statutory and regulatory law.
- Pertinent rules and regulations established by the Department of Health and the Medicaid Program are cited in Audit Reports when a Medicaid overpayment is identified.
- Audits focus on criteria listed in protocols, but additional findings may be uncovered during the course of the audit.

WHEN/WHY IS A NEW PROTOCOL DEVELOPED?

- New service or benefit created under state or federal policy
- Expansion of existing program areas
- Emergence of new risk areas or program vulnerabilities
- OIG/AG/OSC recommendations or compliance mandates
- Change in billing structure or provider type (e.g. shifting from institutional to community-based settings)

WHEN/WHY IS A PROTOCOL UPDATED OR DISCONTINUED?

Reasons for audit protocol update

- New regulations or regulatory revisions
- New programmatic guidance or updates
- Addition or deletion of audit finding types
- New claims processing rules or edits
- Clarification of audit finding types (e.g. revision of audit finding type name)
- Events outside of our control (e.g. COVID-19 public health emergency)
- Expiration of applicable service dates

Reason for audit protocol discontinuance

- Service or program is no longer active or reimbursed
- Scope of audit protocol has been absorbed into another audit protocol

PROTOCOL UPDATES

- Audits in progress remain bound to the regulations and guidance that were active at the time the service occurred. When existing protocols are updated, there should be little to no impact to audits in progress.
- When protocols are updated, regulations and policies are included to cover all audits already in progress through the current policy at the time of the updated.
- Providers will be informed of protocol updates through official OMIG channels, including but not limited to the agency listserv, public website, Medicaid Updates, and social media channels.

HOW ARE AUDIT PROTOCOLS DEVELOPED?

PROTOCOL DEVELOPMENT PROCESS

Phase 1 – Draft Protocol and Approval

- OMIG subject matter experts review relevant laws, regulations, and guidance
- Initial protocol draft is developed by subject matter expert based upon research and program requirements
- Initial protocol draft is reviewed and approved by Provider Audit Bureau Director

Phase 2 – Program Agency Review

- Draft protocols are shared with the program agency for feedback
- OMIG and the agency collaborate to review and discuss proposed content.
- Revisions are made based on program agency input

PROTOCOL DEVELOPMENT PROCESS – CONTINUED

Phase 3 – Internal Quality Review

- Protocols undergo internal OMIG quality assurance review

Phase 4 – Stakeholder Review

- Draft protocols are shared with provider associations for feedback
- OMIG evaluates all comments and incorporates necessary revisions
- Final OMIG review is completed
- Final protocols are published on OMIG's website

PROVIDER FEEDBACK

- Stakeholders/relevant provider associations are afforded the opportunity to provide feedback on protocols as part of OMIG's protocol development process
- Provider Associations have discretion with how they may choose to comment. Comments may indicate perceived errors, discrepancies or disagreements with audit criteria, request that additional policy be referenced, and/or request that additional information be included or modified for clarity.

AUDIT PROTOCOL WEBPAGE

- OMIG's enhanced protocol webpage contains all current audit protocols, as well as archived audit protocols. Additionally, information on new protocols in development and targeted publication dates for existing protocol updates will be contained here.
- Audit Protocols can be found on OMIG's website at: https://omig.ny.gov/audit/audit-protocols

AUDIT PROTOCOLS

Department of Health (DOH) Project Type	For Service Dates	Published Date	Targeted Next Publication
Assisted Living Program (ALP) Protocol	01/01/2013 - 10/31/2025	12/26/2025	Pending
Certified Home Health Agency (CHHA) Episodic Payment Protocol	05/02/2012 – 07/12/2017	03/19/2019	2026
Certified Home Health Agency (CHHA) Protocol	-	06/26/2018	2027
Consumer Directed Personal Assistance Program Protocol	-	12/09/2020	2027
Dental Protocol	10/01/2012 - 07/02/2025	08/05/2025	Pending
Diagnostic & Treatment Center (DTC) Services Protocol	01/01/2018 - 02/05/2023	11/25/2024	2027
Durable Medical Equipment Protocol	04/01/2013 - 05/15/2025	08/20/2025	Pending
Early Intervention (EI) Program Protocol	04/06/2016 - 10/18/2021	03/30/2023	2027
Health Home (Adults) Protocol	01/09/2014 - 07/01/2019	05/31/2023	Q2 2026
Hospice Protocol	Prior to 08/31/2016	03/14/2019	Q1 2026
Hospital Outpatient Department (OPD) Emergency Room/Clinic Protocol	09/14/2015 - 03/31/2025	04/11/2025	2027
Hospital Outpatient Department (OPD) - Laboratory Protocol	09/14/2015 - 03/31/2025	04/11/2025	2027

NEW YORK STATE

Office of the Medicaid Inspector General

AUDIT PROCESS

PROVIDER AUDITS

BACKGROUND INFORMATION

- Audits are conducted pursuant to 18 NYCRR Part 517 and involve fiscal audits and reviews of a provider's claims, books, records, reports or other available documentation
- Additionally, OMIG has the legal authority to determine the amount of any overpayment to be recovered and/or as to whether other administrative actions apply, including but not limited to:
  - sanctions, such as censure, conditional or limited participation in the program, or exclusion (18 NYCRR Part 515)
  - monetary penalties (18 NYCRR Part 516); and/or
  - criminal referral
- Other relevant regulations include:
  - 18 NYCRR § 504.3 Duties of the provider
  - 18 NYCRR § 504.8 Audit and claim review
  - 18 NYCRR Part 518 Recovery and Withholding of Payments or Overpayments
  - 18 NYCRR Part 519 Provider Hearings

AUDIT FLOW

Phase 1
Planning
Phase 2
Fieldwork
& Analysis
Phase 3
Reporting

PHASE 1: PLANNING

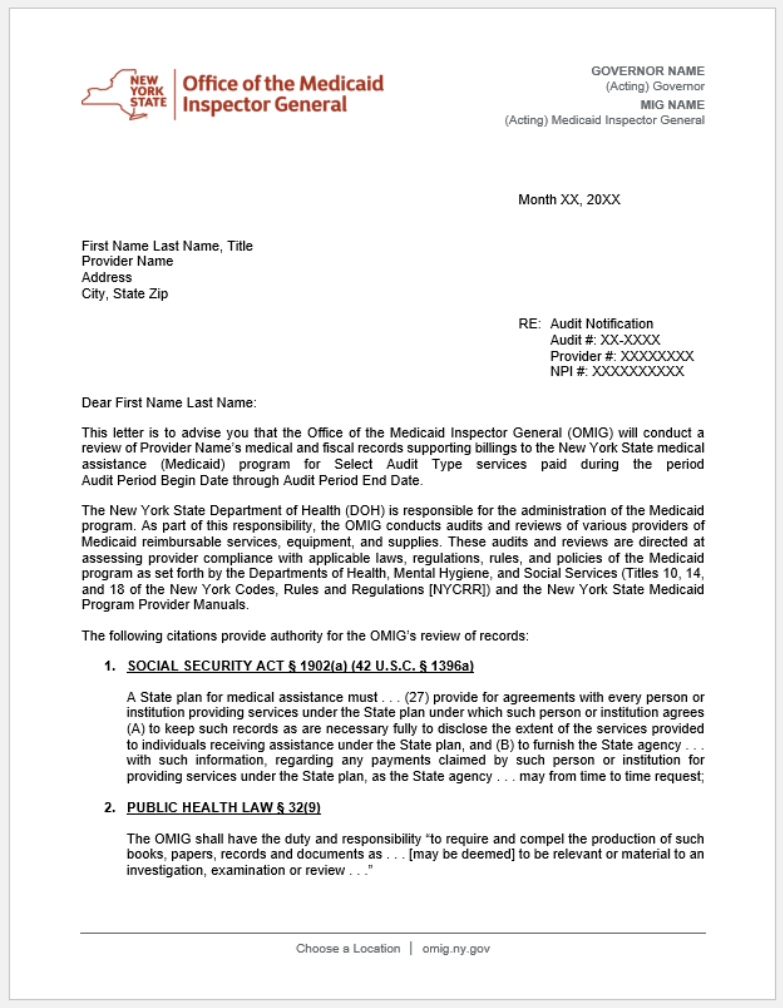
PLANNING

- Audit project areas are developed by the subject matter experts based on published protocols.

- Audits are selected and scheduled with regard to the OMIG Workplan and regional office staff availability.

AUDIT NOTIFICATION LETTER

- OMIG notification of intent to audit the provider for specified service type and audit period
- Informs provider of types of documents that will be requested during the audit
- Requests that certain documentation be made available at the entrance conference
- Informs provider to hold documents for the period under review until the audit is complete
- After letter is sent, audit supervisor calls provider to set date for the entrance conference



NEW YORK STATE | Office of the Medicaid Inspector General

GOVERNOR NAME
(Acting) Governor
MIG NAME
(Acting) Medicaid Inspector General

Month XX, 20XX

First Name Last Name, Title
Provider Name
Address
City, State Zip

RE: Audit Notification
Audit #: XX-XXXX
Provider #: XXXXXXXX
NPI #: XXXXXXXXXX

Dear First Name Last Name:

This letter is to advise you that the Office of the Medicaid Inspector General (OMIG) will conduct a review of Provider Name's medical and fiscal records supporting billings to the New York State medical assistance (Medicaid) program for Select Audit Type services paid during the period Audit Period Begin Date through Audit Period End Date.

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment, and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules, and policies of the Medicaid program as set forth by the Departments of Health, Mental Hygiene, and Social Services (Titles 10, 14, and 18 of the New York Codes, Rules and Regulations [NYCRR]) and the New York State Medicaid Program Provider Manuals.

The following citations provide authority for the OMIG's review of records:

1. SOCIAL SECURITY ACT § 1902(a) (42 U.S.C. § 1396a)

   A State plan for medical assistance must . . . (27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency . . . with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency . . . may from time to time request;

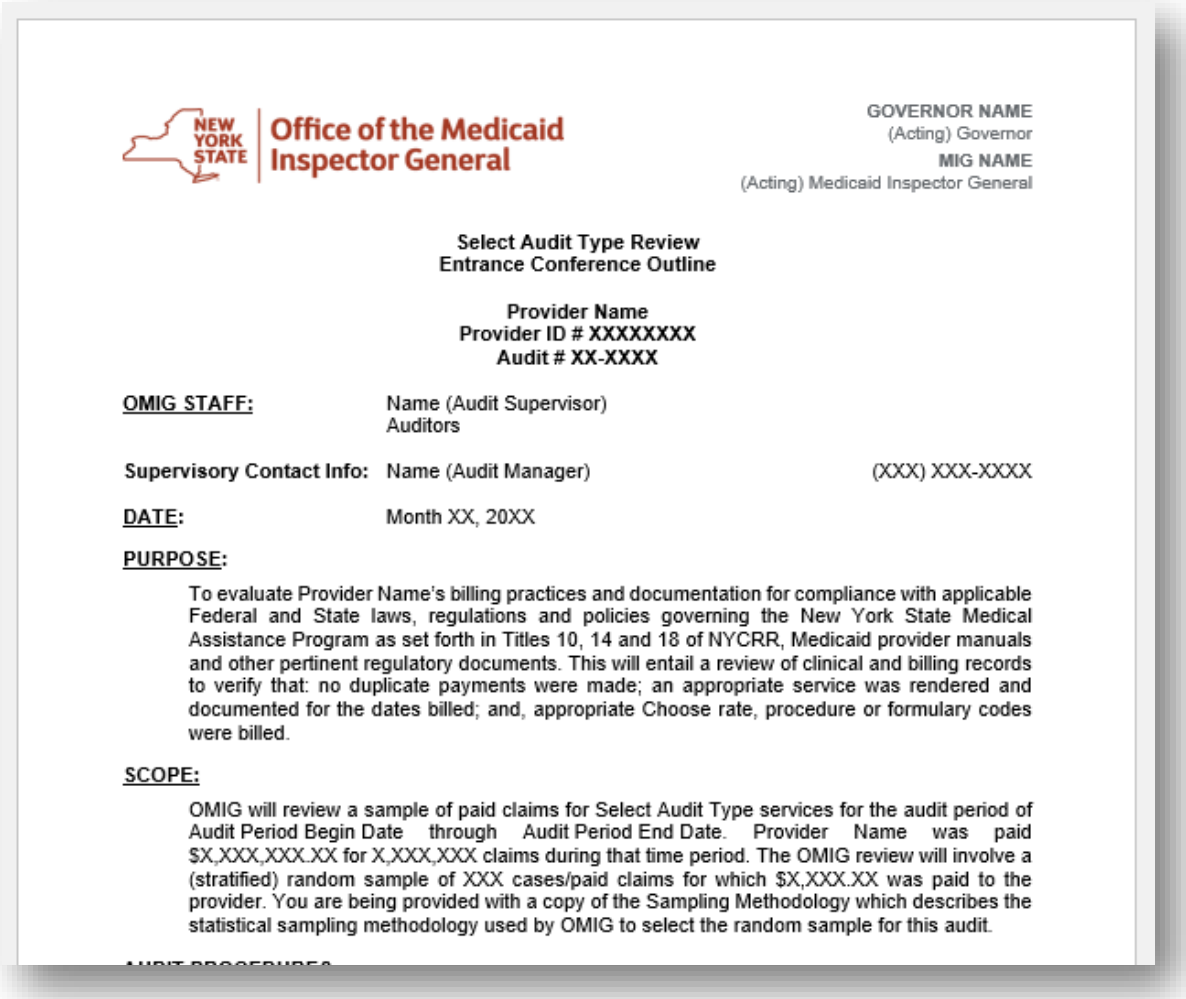
2. PUBLIC HEALTH LAW § 32(9)

   The OMIG shall have the duty and responsibility "to require and compel the production of such books, papers, records and documents as . . . [may be deemed] to be relevant or material to an investigation, examination or review . . ."

Choose a Location | omig.ny.gov

PHASE 2: FIELDWORK & ANALYSIS

ENTRANCE CONFERENCE: WHAT IT IS



NEW YORK STATE | Office of the Medicaid Inspector General

GOVERNOR NAME
(Acting) Governor
MIG NAME
(Acting) Medicaid Inspector General

Select Audit Type Review
Entrance Conference Outline

Provider Name
Provider ID # XXXXXXXX
Audit # XX-XXXX

OMIG STAFF: Name (Audit Supervisor)
Auditors

Supervisory Contact Info: Name (Audit Manager) (XXX) XXX-XXXX

DATE: Month XX, 20XX

PURPOSE:

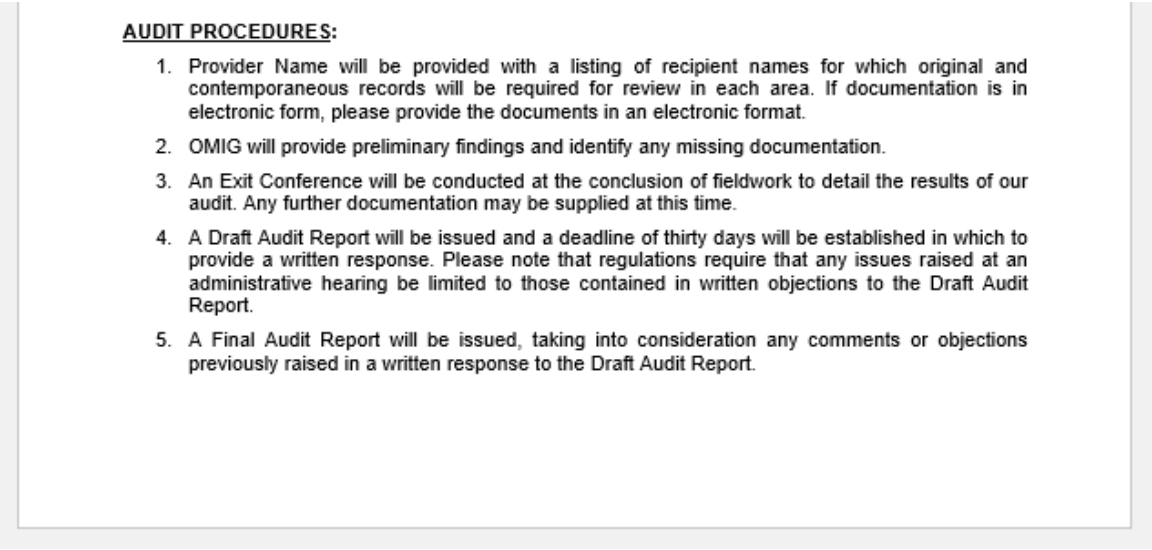
To evaluate Provider Name's billing practices and documentation for compliance with applicable Federal and State laws, regulations and policies governing the New York State Medical Assistance Program as set forth in Titles 10, 14 and 18 of NYCRR, Medicaid provider manuals and other pertinent regulatory documents. This will entail a review of clinical and billing records to verify that: no duplicate payments were made; an appropriate service was rendered and documented for the dates billed; and, appropriate Choose rate, procedure or formulary codes were billed.

SCOPE:

OMIG will review a sample of paid claims for Select Audit Type services for the audit period of Audit Period Begin Date through Audit Period End Date. Provider Name was paid $X,XXX,XXX.XX for X,XXX,XXX claims during that time period. The OMIG review will involve a (stratified) random sample of XXX cases/paid claims for which $X,XXX.XX was paid to the provider. You are being provided with a copy of the Sampling Methodology which describes the statistical sampling methodology used by OMIG to select the random sample for this audit.

- Purpose
  - Evaluate billing practices and documentation for compliance with laws, regulations and policies
- Scope
  - Program area
    - Specific Category of Service (COS) and Rate/Procedure Codes
  - Universe and Sample Information
    - Number of Claims
    - Paid Amounts

ENTRANCE CONFERENCE: WHAT IT IS

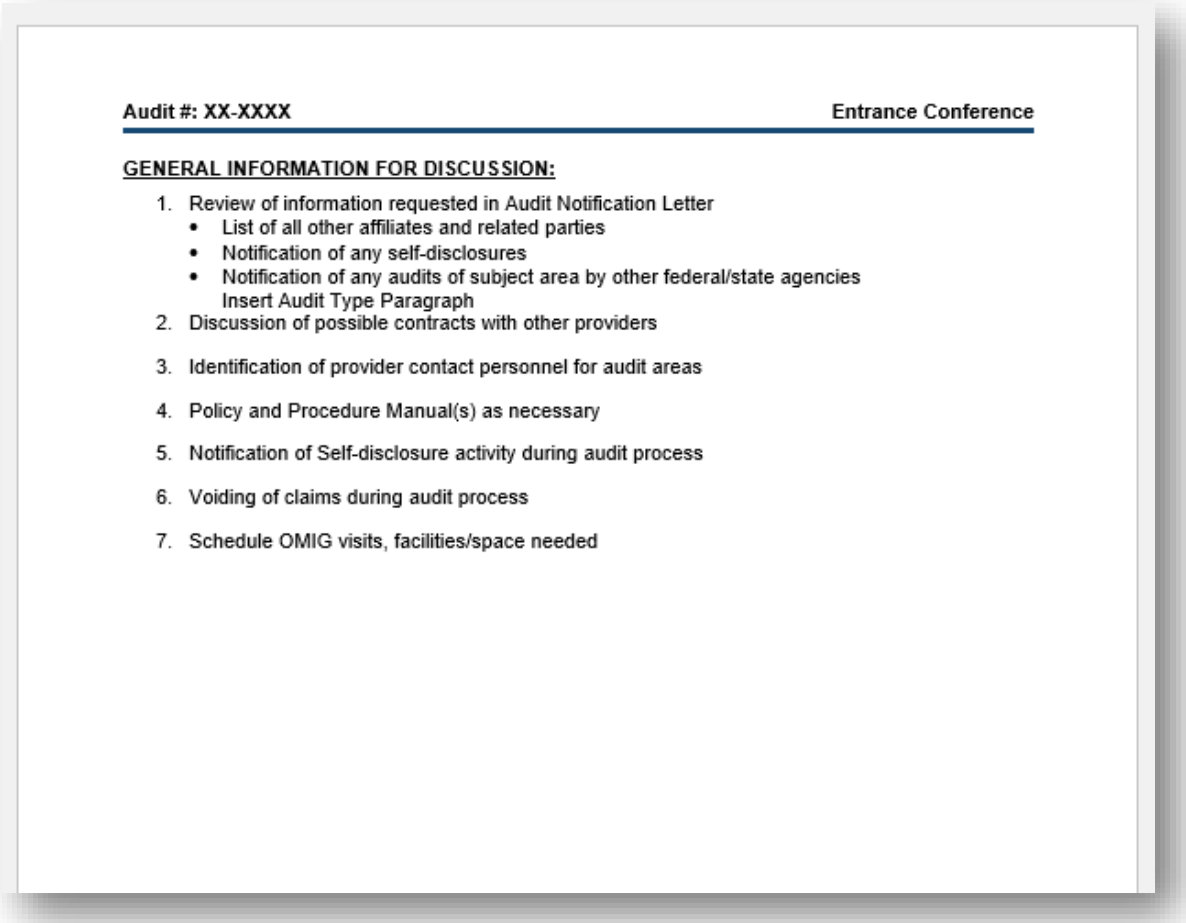


AUDIT PROCEDURES:

1. Provider Name will be provided with a listing of recipient names for which original and contemporaneous records will be required for review in each area. If documentation is in electronic form, please provide the documents in an electronic format.
2. OMIG will provide preliminary findings and identify any missing documentation.
3. An Exit Conference will be conducted at the conclusion of fieldwork to detail the results of our audit. Any further documentation may be supplied at this time.
4. A Draft Audit Report will be issued and a deadline of thirty days will be established in which to provide a written response. Please note that regulations require that any issues raised at an administrative hearing be limited to those contained in written objections to the Draft Audit Report.
5. A Final Audit Report will be issued, taking into consideration any comments or objections previously raised in a written response to the Draft Audit Report.

- Audit Procedures
  - List of recipients in sample
  - Complete record of audit period
  - Electronic vs. paper records
- Logistics
  - Provider staff to contact for medical/billing/personnel records requests and questions
  - No voiding of claims within the scope of the audit period

ENTRANCE CONFERENCE: WHAT IT IS



Audit #: XX-XXXX **Entrance Conference**

GENERAL INFORMATION FOR DISCUSSION:

1. Review of information requested in Audit Notification Letter
   - List of all other affiliates and related parties
   - Notification of any self-disclosures
   - Notification of any audits of subject area by other federal/state agencies
   Insert Audit Type Paragraph
2. Discussion of possible contracts with other providers
3. Identification of provider contact personnel for audit areas
4. Policy and Procedure Manual(s) as necessary
5. Notification of Self-disclosure activity during audit process
6. Voiding of claims during audit process
7. Schedule OMIG visits, facilities/space needed

- Documentation Requested in Engagement Letter
  - List of affiliate and related parties
  - Operating Certificates
  - Notification of Self-disclosures
  - Notification of any audits of subject area by other federal/state agencies
- Answer questions

ENTRANCE CONFERENCE

IMPACT

- The Entrance Conference must be scheduled by OMIG within 60 days of the audit notification letter.
  - Providers can ask for an extension, but OMIG gets one extension via a formal written notice of 60 days.
  - The Entrance Conference once executed, holds the regulatory period open from the date the provider was notified of OMIG's intent to audit until the end of the audit. Providers need to keep documents until the process is complete.
  - To ensure the integrity of the audit, the specific dates of service are not shared with the provider until fieldwork is complete
  - The Entrance Conference Outline is provided to allow the provider a reference as to what we are doing and how.
  - If there are questions about the audit, this is the time to ask.

ENTRANCE CONFERENCE

THE START OF THE AUDIT

- Auditors will already know the dates of service under review
  - The random sample is generated prior to the start of the audit.
  - Audit team will share initial list identifying which recipient files need to be made available. Additional lists will be shared as the audit progresses.
- Review of the document set with the provider and audit team.
  - This allows for the audit team to understand how the records are maintained and limit the interactions about what documents needed.

FIELDWORK

RECORD REVIEW

- Auditors will request original and complete records
- To ensure the integrity of the audit, the specific date of service is not shared with the provider until fieldwork is complete
- Audit staff reviews the randomly selected sample of claims and supporting documentation from the provider.
- As appropriate, any missing documentation of other questions/issues with what is being reviewed will be communicated to the provider.
- Allowed claims or any with preliminary findings are recorded as the fieldwork progresses.

AUDIT OBJECTIVE

WERE THE SERVICES RENDERED BY THE PROVIDER IN COMPLIANCE WITH MEDICAID RULES, REGULATIONS AND POLICIES?

Correct Dates Billed

Appropriate Rate or Procedure Codes

Records Contained the Documentation Required

In Accordance with Regulations and Provider Manuals

Claims for Medicaid Reimbursable Services

AUDIT OBJECTIVE

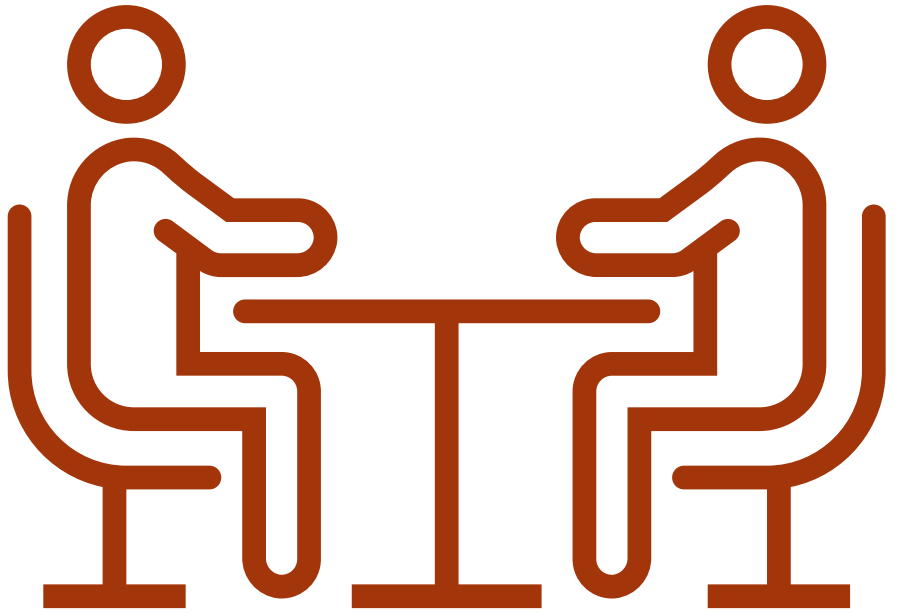
- Auditors will validate the randomly selected sample of claims.
- Inventory the documents
- Apply the legal and programmatic policy
- Compile the results and report them accurately.

PERSONNEL REVIEW

- Auditors will compile a list of staff who provided services on sample dates. For these employees, OMIG may request:
  - Documentation of required training
  - Documentation of health requirements
  - License numbers or other credentials
  - Criminal history record checks (if applicable)
  - Payroll documentation for sampled services dates

STAFF INTERVIEWS

- Auditors may interview provider's clinical, billing, and compliance staff as needed during the fieldwork
- Copy of policy and procedures may be requested



CONCLUSION OF FIELD WORK

PRE-EXIT CONFERENCE

- Prior to end of field work, auditors will inform provider of any missing/incomplete documentation
- Findings are preliminary at this point
- Provider is given the opportunity to respond with additional documentation

NEXT STEPS

- This is ***not*** the exit conference; exit conference will be scheduled at a later date and will be the formal presentation of the audit findings to the provider
- This is an opportunity to discuss documents that are missing and the next steps in the process.

PHASE 3: REPORTING

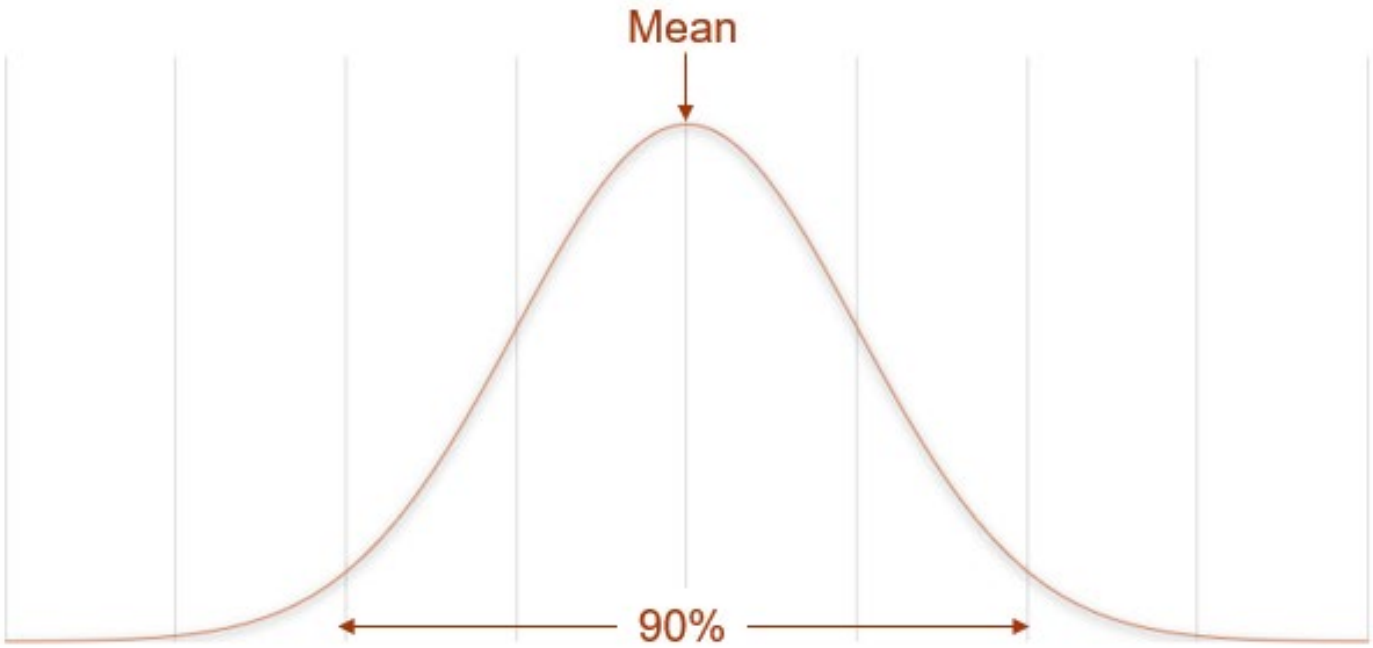
REPORTS

- Exit Conference Summary
- Draft Audit Report
- Final Audit Report
- Summation Letter

EXIT CONFERENCE

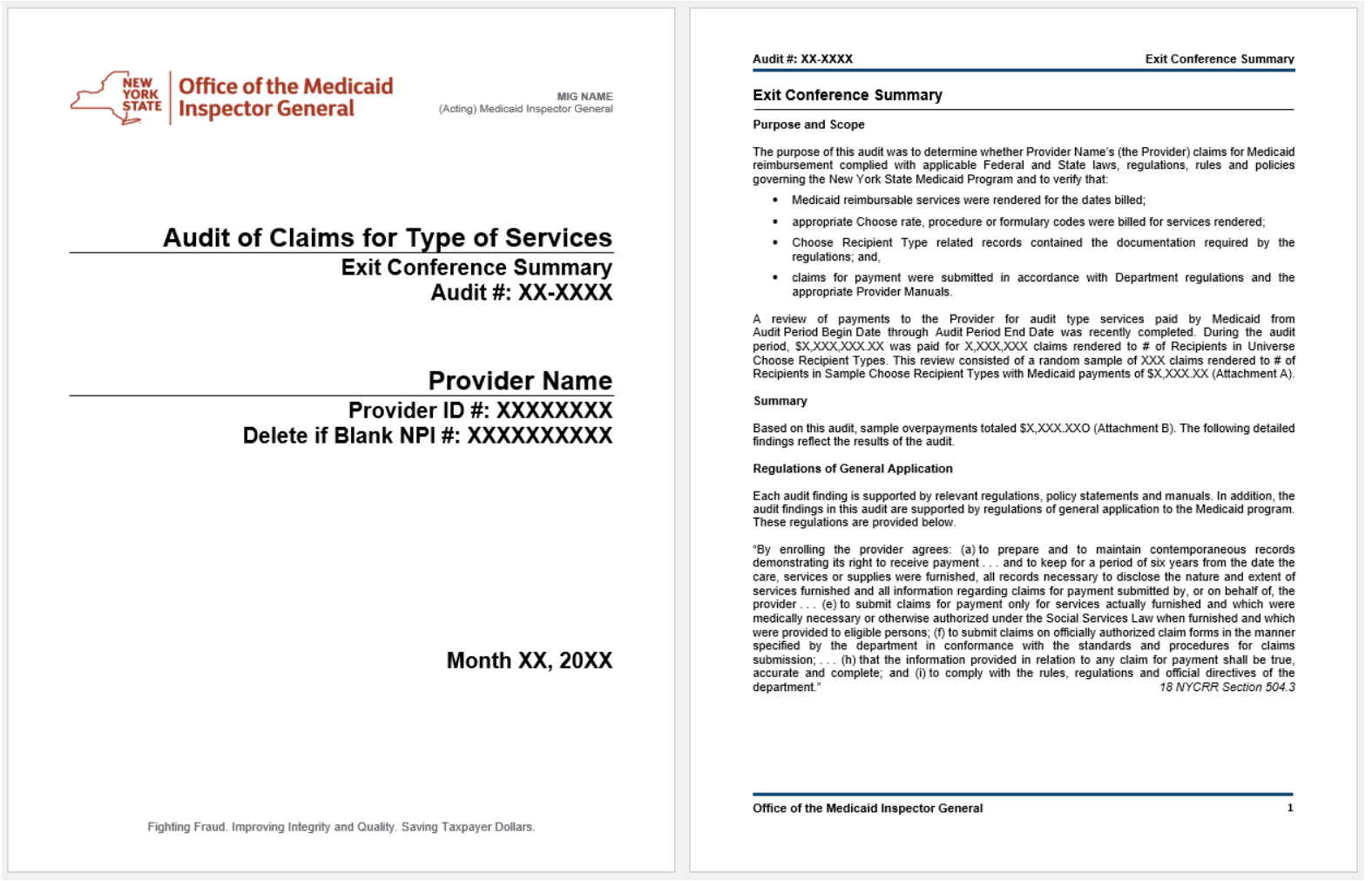
- Provider receives Exit Conference Summary prior to meeting
- Provider also receives data through secure file transfer:
  - List of random numbers used to generate the sample
  - Claim detail information for the universe of claims for the audit period
  - Claim detail information for the claims in the sample
- Present audit finding details
- Additional documentation/information may be presented
- Explain process
  - Draft Audit Report
  - Final Audit Report
  - Rights to an Administrative Hearing
- Answer questions

EXIT CONFERENCE



- The disallowed amounts in the sample are projected over the sampling frame (universe of claims)
  - Point estimate
  - Lower confidence limit

EXIT CONFERENCE SUMMARY



NEW YORK STATE | Office of the Medicaid Inspector General

MIG NAME
(Acting) Medicaid Inspector General

Audit of Claims for Type of Services

Exit Conference Summary
Audit #: XX-XXXX

Provider Name

Provider ID #: XXXXXXXX
Delete if Blank NPI #: XXXXXXXXXX

Month XX, 20XX

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars.

Exit Conference Summary

Purpose and Scope

The purpose of this audit was to determine whether Provider Name's (the Provider) claims for Medicaid reimbursement complied with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate Choose rate, procedure or formulary codes were billed for services rendered;
- Choose Recipient Type related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with Department regulations and the appropriate Provider Manuals.

A review of payments to the Provider for audit type services paid by Medicaid from Audit Period Begin Date through Audit Period End Date was recently completed. During the audit period, $X,XXX,XXX.XX was paid for X,XXX,XXX claims rendered to # of Recipients in Universe Choose Recipient Types. This review consisted of a random sample of XXX claims rendered to # of Recipients in Sample Choose Recipient Types with Medicaid payments of $X,XXX.XX (Attachment A).

Summary

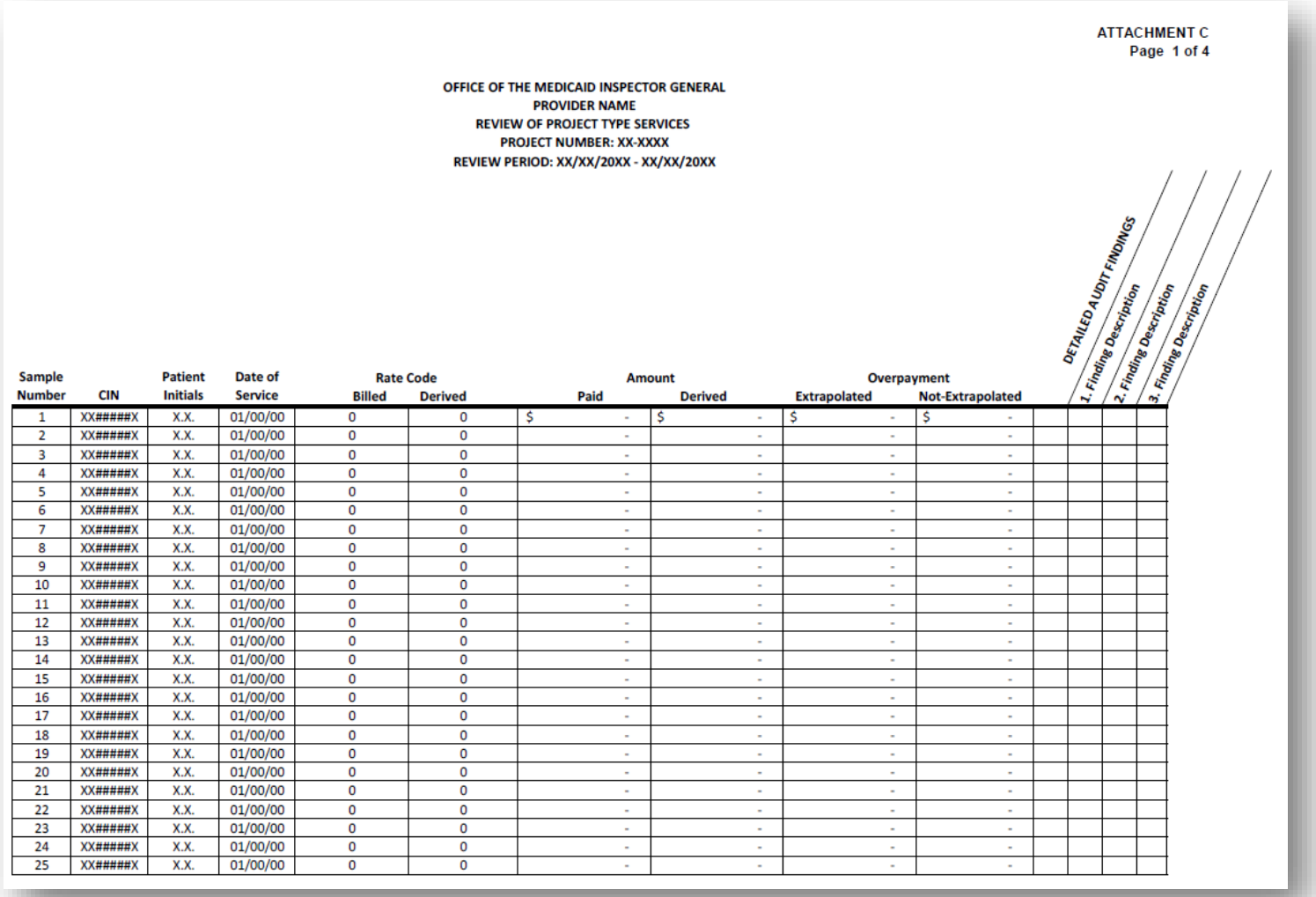
Based on this audit, sample overpayments totaled $X,XXX.XXO (Attachment B). The following detailed findings reflect the results of the audit.

Regulations of General Application

Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid program. These regulations are provided below.

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*

ATTACHMENT C



ATTACHMENT C
Page 1 of 4

OFFICE OF THE MEDICAID INSPECTOR GENERAL
PROVIDER NAME
REVIEW OF PROJECT TYPE SERVICES
PROJECT NUMBER: XX-XXXX
REVIEW PERIOD: XX/XX/20XX - XX/XX/20XX

Sample Number	CIN	Patient Initials	Date of Service	Rate Code		Amount		Overpayment		DETAILED AUDIT FINDINGS			
				Billed	Derived	Paid	Derived	Extrapolated	Not-Extrapolated	1. Finding Description	2. Finding Description	3. Finding Description	
1	XX######X	X.X.	01/00/00	0	0	$ -	$ -	$ -	$ -				
2	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
3	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
4	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
5	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
6	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
7	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
8	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
9	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
10	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
11	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
12	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
13	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
14	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
15	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
16	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
17	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
18	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
19	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
20	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
21	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
22	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
23	XX######X	X.X.	01/00/00	0	0	-	-	-	-				
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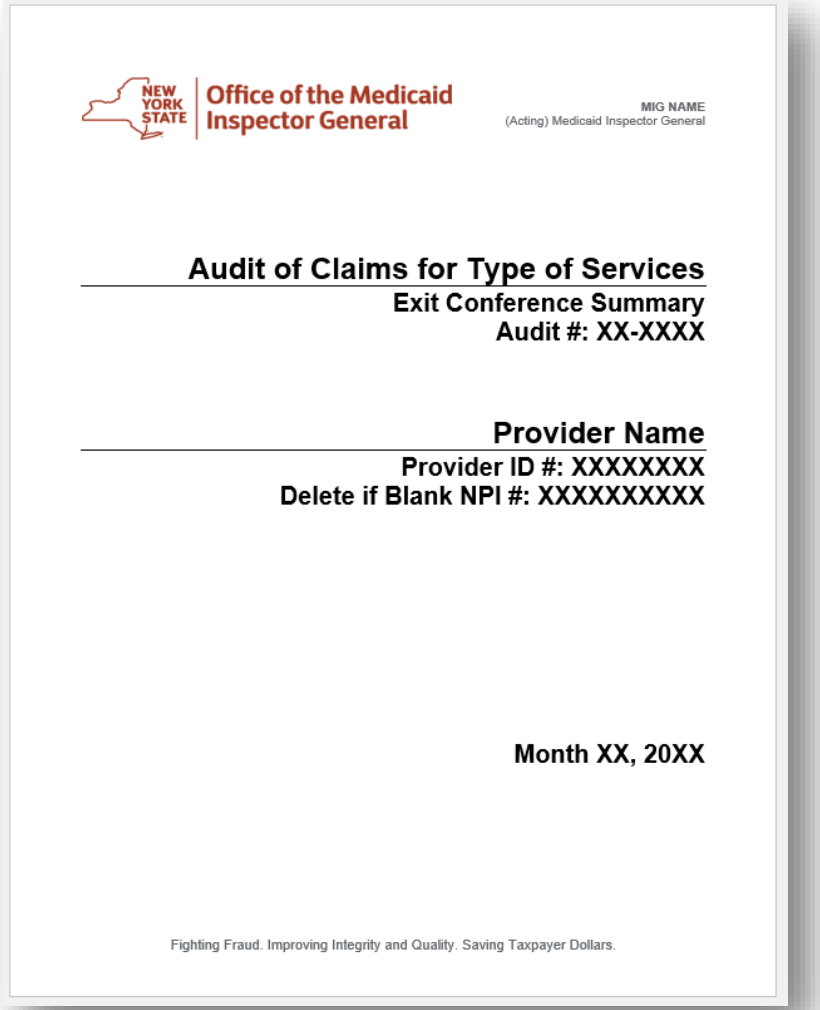
25	XX######X	X.X.	01/00/00	0	0	-	-	-	-				

EXIT CONFERENCE SUMMARY: EXPLAINED

- Audit data is shared with the provider via encrypted CD or File Transfer.
- The date of service is shared and the amount of money in proposed adjustments is calculated.
- The provider may ask questions and present documentation to the preliminary findings. Additional time will be granted to respond before issuance of the Draft Audit Report.



NEW YORK STATE | Office of the Medicaid Inspector General

MIG NAME
(Acting) Medicaid Inspector General

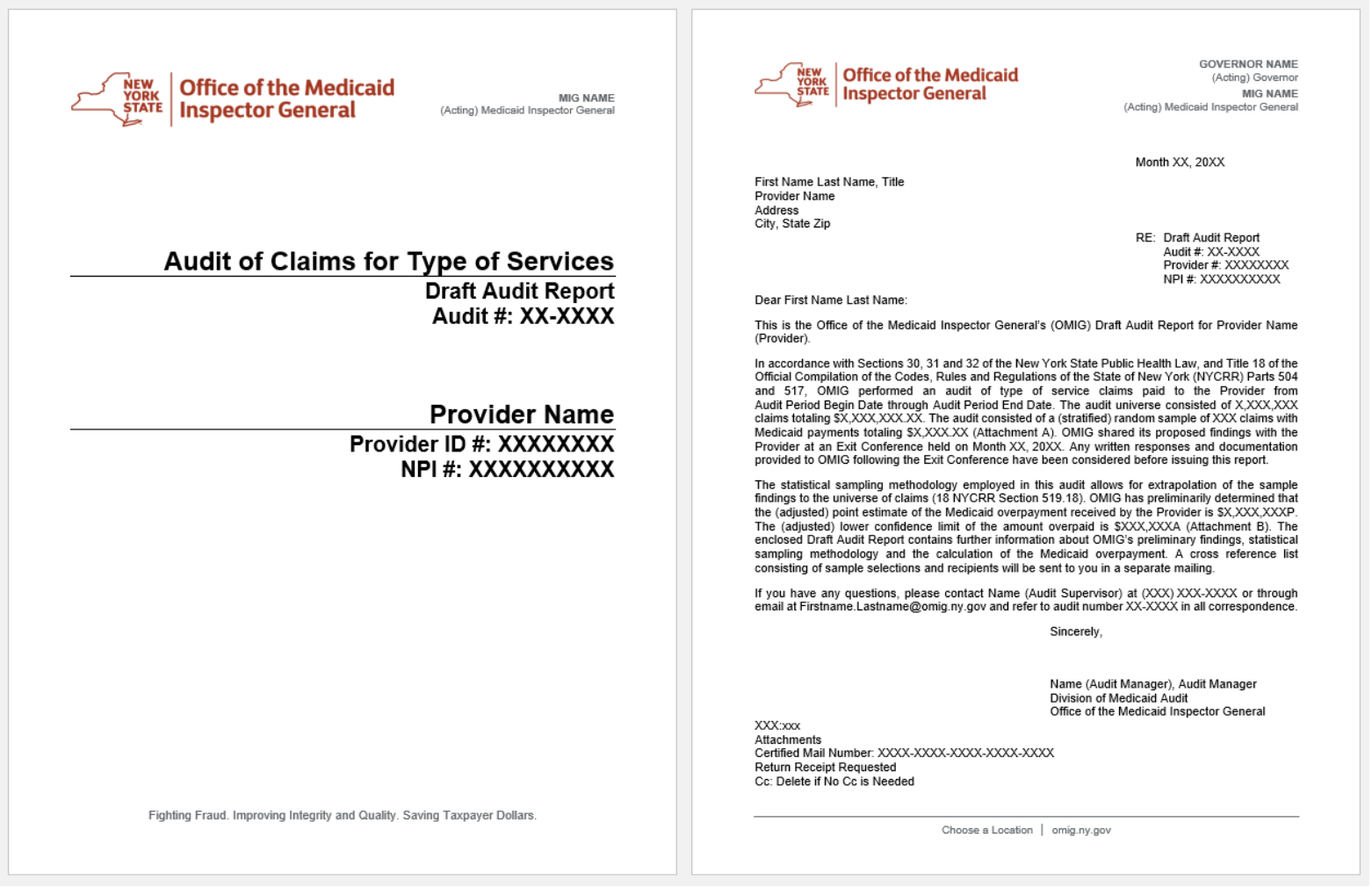
Audit of Claims for Type of Services
Exit Conference Summary
Audit #: XX-XXXX

Provider Name
Provider ID #: XXXXXXXX
Delete if Blank NPI #: XXXXXXXXXX

Month XX, 20XX

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars.

DRAFT AUDIT REPORT



NEW YORK STATE | Office of the Medicaid Inspector General

MIG NAME
(Acting) Medicaid Inspector General

Audit of Claims for Type of Services

Draft Audit Report
Audit #: XX-XXXX

Provider Name

Provider ID #: XXXXXXXX
NPI #: XXXXXXXXXX

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars.

NEW YORK STATE | Office of the Medicaid Inspector General

GOVERNOR NAME
(Acting) Governor
MIG NAME
(Acting) Medicaid Inspector General

Month XX, 20XX

First Name Last Name, Title
Provider Name
Address
City, State Zip

RE: Draft Audit Report
Audit #: XX-XXXX
Provider #: XXXXXXXX
NPI #: XXXXXXXXXX

Dear First Name Last Name:

This is the Office of the Medicaid Inspector General's (OMIG) Draft Audit Report for Provider Name (Provider).

In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of type of service claims paid to the Provider from Audit Period Begin Date through Audit Period End Date. The audit universe consisted of X,XXX,XXX claims totaling $X,XXX,XXX.XX. The audit consisted of a (stratified) random sample of XXX claims with Medicaid payments totaling $X,XXX.XX (Attachment A). OMIG shared its proposed findings with the Provider at an Exit Conference held on Month XX, 20XX. Any written responses and documentation provided to OMIG following the Exit Conference have been considered before issuing this report.

The statistical sampling methodology employed in this audit allows for extrapolation of the sample findings to the universe of claims (18 NYCRR Section 519.18). OMIG has preliminarily determined that the (adjusted) point estimate of the Medicaid overpayment received by the Provider is $X,XXX,XXXP. The (adjusted) lower confidence limit of the amount overpaid is $XXX,XXXA (Attachment B). The enclosed Draft Audit Report contains further information about OMIG's preliminary findings, statistical sampling methodology and the calculation of the Medicaid overpayment. A cross reference list consisting of sample selections and recipients will be sent to you in a separate mailing.

If you have any questions, please contact Name (Audit Supervisor) at (XXX) XXX-XXXX or through email at Firstname.Lastname@omig.ny.gov and refer to audit number XX-XXXX in all correspondence.

Sincerely,

Name (Audit Manager), Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

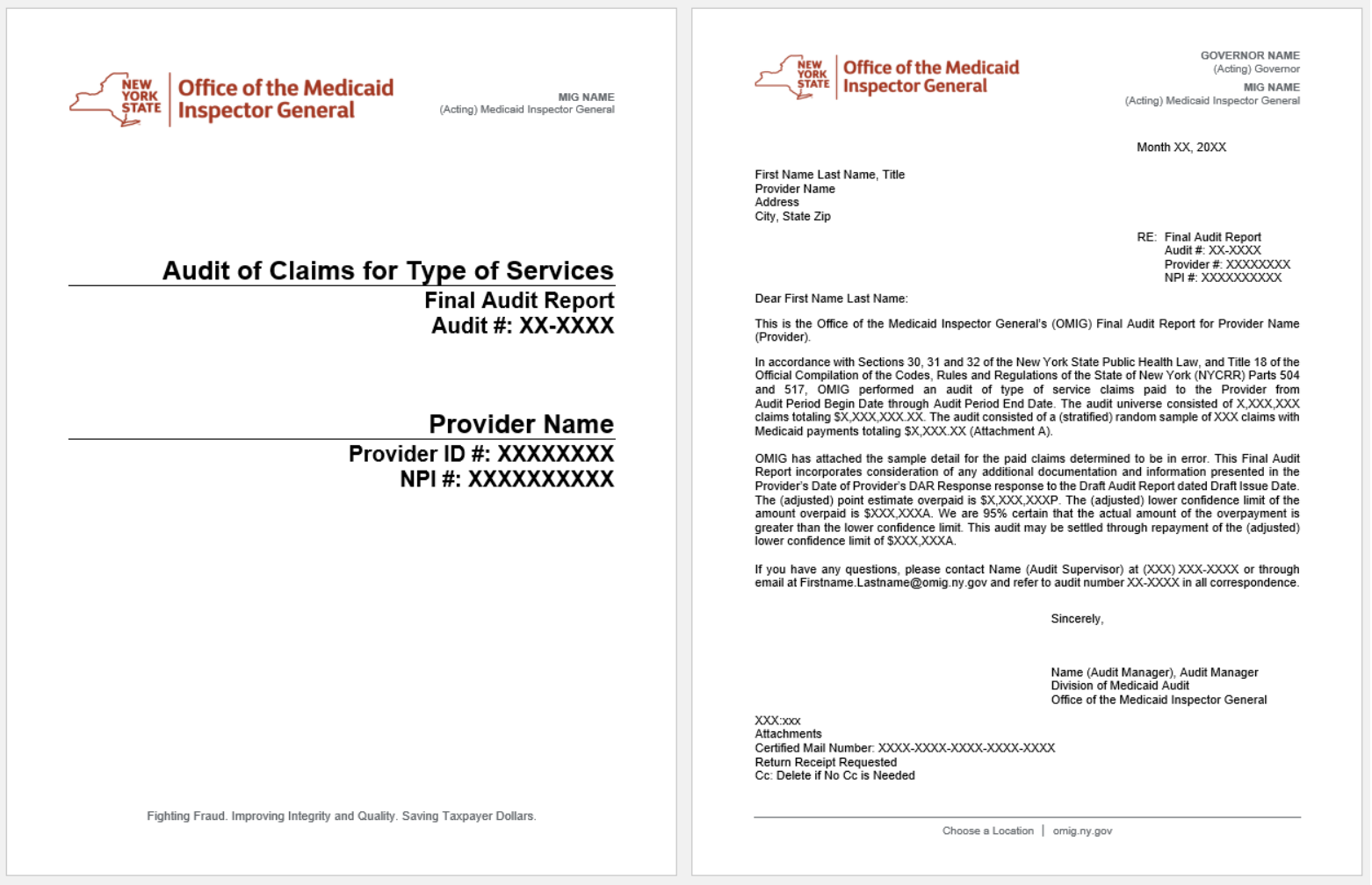
XXX:xxx
Attachments
Certified Mail Number: XXXX-XXXX-XXXX-XXXX-XXXX
Return Receipt Requested
Cc: Delete if No Cc is Needed

Choose a Location | omig.ny.gov

DRAFT AUDIT REPORT: EXPLAINED

- Issued after review and consideration of new documentation or information presented at or subsequent to the exit conference.
  - Provider has 30 days to submit written objections to findings within the Draft Audit Report.
- Regulations require that any issues raised at an administrative hearing be limited to those contained in written objections to the Draft Audit Report.
- Response will be reviewed and considered prior to issuing the Final Audit Report.

FINAL AUDIT REPORT



NEW YORK STATE | Office of the Medicaid Inspector General

MIG NAME
(Acting) Medicaid Inspector General

Audit of Claims for Type of Services

Final Audit Report
Audit #: XX-XXXX

Provider Name

Provider ID #: XXXXXXXX
NPI #: XXXXXXXXXX

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars.

NEW YORK STATE | Office of the Medicaid Inspector General

GOVERNOR NAME
(Acting) Governor
MIG NAME
(Acting) Medicaid Inspector General

Month XX, 20XX

First Name Last Name, Title
Provider Name
Address
City, State Zip

RE: Final Audit Report
Audit #: XX-XXXX
Provider #: XXXXXXXX
NPI #: XXXXXXXXXX

Dear First Name Last Name:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Provider Name (Provider).

In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of type of service claims paid to the Provider from Audit Period Begin Date through Audit Period End Date. The audit universe consisted of X,XXX,XXX claims totaling $X,XXX,XXX.XX. The audit consisted of a (stratified) random sample of XXX claims with Medicaid payments totaling $X,XXX.XX (Attachment A).

OMIG has attached the sample detail for the paid claims determined to be in error. This Final Audit Report incorporates consideration of any additional documentation and information presented in the Provider's Date of Provider's DAR Response response to the Draft Audit Report dated Draft Issue Date. The (adjusted) point estimate overpaid is $X,XXX,XXXP. The (adjusted) lower confidence limit of the amount overpaid is $XXX,XXXA. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the (adjusted) lower confidence limit of $XXX,XXXA.

If you have any questions, please contact Name (Audit Supervisor) at (XXX) XXX-XXXX or through email at Firstname.Lastname@omig.ny.gov and refer to audit number XX-XXXX in all correspondence.

Sincerely,

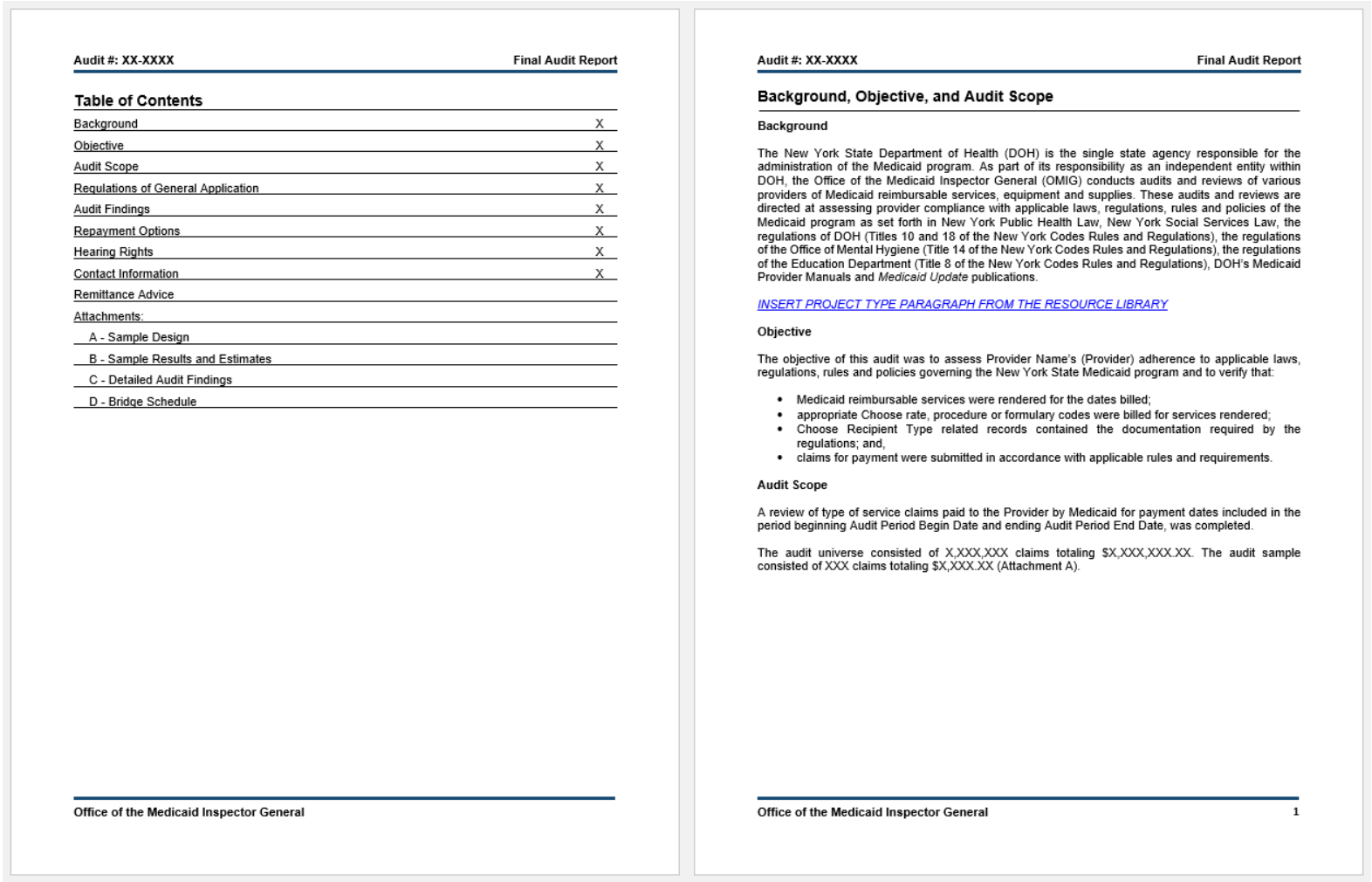
Name (Audit Manager), Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

XXX:xxx
Attachments
Certified Mail Number: XXXX-XXXX-XXXX-XXXX-XXXX
Return Receipt Requested
Cc: Delete if No Cc is Needed

Choose a Location | omig.ny.gov

FINAL AUDIT REPORT

- The final audit report contains:
  - Repayment Options
  - Hearing Rights



Audit #: XX-XXXX Final Audit Report

Table of Contents

Background X
Objective X
Audit Scope X
Regulations of General Application X
Audit Findings X
Repayment Options X
Hearing Rights X
Contact Information X
Remittance Advice
Attachments:
A - Sample Design
B - Sample Results and Estimates
C - Detailed Audit Findings
D - Bridge Schedule

Office of the Medicaid Inspector General

Audit #: XX-XXXX Final Audit Report

Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

INSERT PROJECT TYPE PARAGRAPH FROM THE RESOURCE LIBRARY

Objective

The objective of this audit was to assess Provider Name's (Provider) adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate Choose rate, procedure or formulary codes were billed for services rendered;
- Choose Recipient Type related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with applicable rules and requirements.

Audit Scope

A review of type of service claims paid to the Provider by Medicaid for payment dates included in the period beginning Audit Period Begin Date and ending Audit Period End Date, was completed.

The audit universe consisted of X,XXX,XXX claims totaling $X,XXX,XXX.XX. The audit sample consisted of XXX claims totaling $X,XXX.XX (Attachment A).

Office of the Medicaid Inspector General 1

FINAL AUDIT REPORT

REPAYMENT OPTIONS

- Make full payment by check or money order within 20 days of Final Audit Report; or,
- Enter into a repayment agreement
- Interest applied if repayment terms exceed 90 days from date of Final Audit Report
- Failure to select a payment option above, OMIG, in its discretion, may use any remedy allowed by law to collect the amount due
- Financial Hardship
    - Affords providers the opportunity to apply for relief in the event an OMIG audit may pose a financial hardship to the organization

HEARING RIGHTS

- Hearing request must be made, in writing, within 60 days from date of Final Audit Report
    - The 60 days is set forth in statute and regulation, and cannot be extended by the agency
- The issues and documentation considered at the hearing are limited to issues directly relating to the final determination
- Full listing of hearing rights:
  18 NYCRR Part 519

NEW YORK STATE

Office of the Medicaid Inspector General

BEST PRACTICES

BEST PRACTICES

- Assemble and inform your team
- Ensure key staff involved in the audit process are available and accessible
- Understand your process for storage and retrieval of medical/billing records. Things to consider:
  - Paper and/or electronic records
  - Multiple systems or upgraded systems
  - Onsite and/or off-site storage
  - Multiple locations
  - Open vs closed cases
- Advise the audit team of bankruptcy or self-disclosure
- Communicate with the auditor(s) throughout the process

BEST PRACTICES (POST AUDIT)

- Consider adjustments to compliance program to address issues identified in OMIG audit
- Assess any self-disclosure obligations
  - Pursuant to 18 NYCRR SubPart 521-3, any person who has received an overpayment under the NYS Medicaid program is required to report, return and explain the overpayment through OMIG's Self-Disclosure Program.
  - Providers should, following an audit, exercise reasonable diligence to determine whether the practice(s) that resulted in the overpayment identified in OMIG's audit also occurred outside of the timeframe covered by this audit, and submit a self-disclosure, if appropriate.
  - Additional information and resources concerning OMIG's self-disclosure program can be found at https://omig.ny.gov/provider-resources/self-disclosure.

LOST, DESTROYED OR DAMAGED RECORDS

- By enrolling in Medicaid, providers agree to have records demonstrating the right to receive payment under the Medicaid program, and to maintain those records for a period of six years from the date the care, services or supplies were furnished. Records must be produced upon request.
- This requirement encompasses all types of records including electronic records, and all types of loss, destruction, corruption or inaccessibility including, but not limited to data corruption, theft, and other issues.
- OMIG has developed a process for providers to self-disclose lost, damaged or destroyed records. Reports must be submitted to OMIG no later than 30 days after discovery.

QUESTIONS ON POSTED PROTOCOLS

- Questions related to the audit process should be directed to: Audit@omig.ny.gov
- Questions related Medicaid policy cited within the protocols should be directed to the relevant oversight agency (e.g., DOH, OMH, OASAS, OPWDD, etc.)
- If a provider suspects an error or discrepancy in a protocol document, please contact: Protocols@omig.ny.gov
- Ensuring accurate protocol information is essential for both compliance and audit accuracy. OMIG encourages and welcomes provider feedback.

OMIG CONTACT INFORMATION

- OMIG main office phone: 518-473-3782
- Website: www.omig.ny.gov
- Bureau of Medicaid Fraud Allegations: Medicaid Fraud Hotline: 877-873-7283; email: bmfa@omig.ny.gov
- Bureau of Compliance email: compliance@omig.ny.gov; phone: (518) 408-0401
- Division of Medicaid Audit: Audit@omig.ny.gov
- Self-Disclosure Unit email: selfdisclosures@omig.ny.gov; phone: (518) 402-7030
- Join our listserv
- Follow us on X: @NYSOMIG
- Dedicated e-mail: information@omig.ny.gov

NEW YORK STATE

Office of the Medicaid Inspector General