STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Commissioner

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 03 OMM/ADM-6

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: September 25, 2003

SUBJECT: Medicaid Provider Audit Activities

SUGGESTED DISTRIBUTION:
Medicaid Staff
Audit Staff
Legal Staff
Fiscal Staff

CONTACT PERSON:
Provider Audit: John M. Jordan, Director
Bureau of Medicaid Audit (518) 474-9723

Provider Fraud: Robert Tengeler, Director of
Bureau of Investigations & Enforcement (518) 473-1984

ATTACHMENTS:

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs. Law & Other Legal Ref.	Soc. Serv.	Manual Ref.	Misc. Ref.
		18 NYCRR 505 18 NYCRR 515 18 NYCRR 516 18 NYCRR 517 18 NYCRR 518 18 NYCRR 519	42 CFR 431.10 42 CFR Part 455 42 CFR 1007.11		State Penal Law

I. PURPOSE

The purpose of this Administrative Directive (ADM) is to advise local social services departments (hereafter referred to as local districts) of the New York State Department of Health's (hereafter referred to as the Department) responsibility, as the single state agency for Medicaid, for:

1. Medicaid provider audit recoveries,
2. Medicaid provider sanctions, and
3. Criminal referrals of Medicaid providers to the Attorney General.

In addition, this Directive identifies the latitude and limits of local districts with respect to provider audits, sanctions and criminal referrals of Medicaid providers. This Directive describes actions that local districts can take independently or through cooperation with the Department.

II. BACKGROUND

Local districts participate in the cost of Medicaid services. The percentage of cost sharing is dependent on the type of service. With a few exceptions, the local share of the total expenditure for a Medicaid covered and approved claim is 25%. The current economic climate has focused attention on increased Medicaid costs and has heightened the desire of localities to monitor claims payments.

In the past, each local district has been provided the Adjudicated Claims File that identified all Medicaid claims paid on behalf of recipients for whom it was fiscally responsible. However, the ability to use that file to effectively determine payment issues unique to a single provider or group of providers was limited and varied greatly from one district to the next.

The Department is continually attempting to improve and strengthen auditing and program integrity functions statewide. The initiation of the Medicaid Fraud Hotline, and participation in the development of the Medicaid data warehouse, as a part of eMedNY, are two examples of this overall effort.

Local districts have become more interested in the manipulation and analysis of payment information that is available for recipients for whom they share in the cost of Medicaid services. This function will be more easily facilitated as the data warehouse is made available to local districts. Local districts have also been interested in utilization and county comparative data. Local districts' interest in data has recently been extended to provider audit activities.

The Department, as the single state agency, must be assured that there is no duplication of effort between local districts (or their agents) and the State. In addition, the Department needs to ensure that proper audit procedures are followed when audits are conducted. In any audit activity, it is necessary to ensure the consistent application of program requirements when reviewing like providers of service. This is necessary to preserve the consistent application of Medicaid program monitoring and control functions.

Pursuant to federal regulations, the responsibility for Medicaid provider audit and provider sanctions cannot be delegated by the New York State Department of Health to any other political subdivision. While local districts may wish to review Medicaid expenditure information, they do not have the authority to conduct provider audits. Similarly, local districts do not have authority for administrative recovery of overpayments through provider withholds or the use of provider sanctions such as exclusions. Some additional program integrity functions such as pre-payment edit controls are also not available to local districts.

Audits, fraud control efforts and cost avoidance activities undertaken by the Department result in over $1 billion in total Medicaid savings each year. Approximately 300 providers are excluded from the Medicaid program and numerous criminal referrals are made to the Attorney General's (AG) office each year.

III. PROGRAM IMPLICATIONS

The responsibility for Medicaid provider audits resides with the single state agency for administration of the Medicaid program, the New York State Department of Health. This responsibility is contained in federal regulations and includes investigations, recovery of overpayments and sanctions of providers who commit Medicaid fraud while responsibility for program activities rests with the State, recoveries are shared with the federal government and local districts based on their respective share of program expenditures.

A. Provider Audit

State regulations at 18 NYCRR Part 517 contain the Department's authority to conduct audits of Medicaid providers, the period of review that is subject to audit and the audit process steps to be followed.

The Department uses numerous techniques to target Medicaid providers for audit. These include computer targeting, surge and intersect reports, the Department's surveillance utilization review system (SURS) and data warehouse special report applications. Additional case leads come from complaints, referrals and surveillance of aberrant provider behavior.

Audits of providers must be conducted in accordance with the standards set forth in Part 517, including the use of valid statistical sampling as provided for in 18 NYCRR Part 519. The programmatic requirements associated with billing for a particular service are generally set forth in 18 NYCRR Part 505 of the Department regulations and are also included in the Medicaid provider manuals. These programmatic requirements are used in determining a provider's compliance with Medicaid program laws, rules, regulations and policies.

When a determination is made that a provider has received overpayments, the Department, pursuant to federal and State regulations, must send the provider a draft audit report that contains the proposed audit findings.

After receiving comment from the provider, the Department must send a final audit report including: the nature and amount of audit findings; the basis and legal authority for the action to be taken; the intended date of the action; and the provider's right to appeal the audit finding and restrictions. If a hearing is requested, it is held and the Department's action is either upheld or reversed.

If the provider does not request a hearing, settles the audit, or the Department's findings are upheld after a hearing, the provider must repay the Department the identified overpayments. The provider can do this by making payment or by having its future Medicaid payments withheld at a set rate/percentage of payments.

Providers also have the opportunity to self-disclose payments they have received that may be inconsistent with acceptable Medicaid reimbursement requirements. In the instance of self-disclosures, the Department reserves the right to verify any amount of overpayment and/or to conduct audits of the provider. The Department has no requirements for notice when a provider self-discloses. It either accepts the claim and the payment or performs an audit and follows all processes related to an audit.

B. Provider Fraud

Provider fraud is investigated at many levels: local, State and federal. The ability to enforce administrative and criminal actions against a Medicaid provider,however, remains with State and federal officials.

The Department uses computer technology, surveillance and investigations (either independently or jointly with the Attorney General's office and/or appropriate federal agencies) to identify fraudulent activity.

In instances where there may have been a violation of State Penal Law (criminal fraud), the case is referred to the AG's office as required by federal regulations. The Medicaid Fraud Control Unit (MFCU) within the AG's office is responsible for investigation of criminal fraud. Investigation by the AG can result in prosecution.

Where the activity is determined to be an unacceptable practice but not criminal, the Department has the ability to sanction (exclude) the provider from participating in the Medicaid program. Exclusion is a severe penalty which means that a provider cannot bill or participate in the Medicaid and Medicare programs. Other less severe sanctions include censure and a limitation on the provider's Medicaid participation. Pursuant to federal and State regulation, notice of the proposed action must be given to the provider. As with audits, the provider has a right to request a hearing.

If the Department's action is upheld or if the provider does not request a hearing, action is taken to exclude the provider, based on 18 NYCRR Part 515. This results in no Medicaid reimbursement for medical care, services or supplies provided by the provider, or ordered or prescribed by the provider. The Department maintains a list of all excluded providers to ensure that they are not able to bill or order services for a recipient in the Medicaid program. This listing, the Excluded Provider Listing (PVR-292), is public information and available on the Department of Health website:
http://www.health.state.ny.us/nysdoh/medicaid/dqprvpg.htm

If the Department sanctions a provider, it can also recover any Medicaid overpayment or impose a monetary penalty under the authority of 18 NYCRR Part 516.

IV. REQUIRED ACTION

The Department is seeking to establish working relationships with interested local districts to assist in audits and fraud referrals consistent with State and federal regulations

A. Provider Audit (recovery of Medicaid overpayments)

Local districts may target providers which they believe may have received Medicaid overpayments. If such a provider is identified the district should:

a. Refer the case to the New York State Department of Health by contacting:

John M. Jordan, Director, Bureau of Medicaid Audit
Division of Medicaid Fraud Control and Program Integrity
Office of Medicaid Management
150 Broadway Riverview Center
Menands, New York
(518) 474-9723
jmj04@health.state.ny.us

b. Offer the provider the opportunity to self-disclose the overpayment to the New York State Department of Health. The contact for self-disclosures is also John M. Jordan (address above).

Local districts can review the local share of Medicaid payments made to providers by requesting information from the provider but the local district cannot conduct traditional audits that result in recovery of payments.

If a district wishes to review the local share of Medicaid payments, the local district must enter into a Memorandum of Understanding (MOU) with the Department. To ensure that any resultant recoveries taken by the State as a result of local review can withstand challenge at a minimum, the MOU must contain the following:

a. The scope of the review and the process governing the review. 18 NYCRR Part 517 should be used as a reference.
b. A statement that all recoveries from the review will be processed through the New York State Department of Health.
c. A description of the prescribed format of any review, including sampling protocols, work papers, etc.
d. A designated local district contact person.
e. A description of procedures for maintaining the confidentiality of any recipient specific information.
f. A statement of the local district's obligation to support its review, including during hearings and litigation.

The Department reserves the right to consider the activities and processes of the proposed local district review in determining whether any action can be

taken as a result of the review or whether additional audit by the State is warranted.

The Department contact regarding the MOU is John M. Jordan (address above).

B. Provider Fraud

Local districts can report potential fraud or abuse of the Medicaid program to the New York State Department of Health using the Fraud Hotline (1-877-873-7283).

The Department will investigate the case and take appropriate action. If there is evidence of criminal activity the matter will be referred to the AG's office.

Local districts can also contact the Department regarding issues of potential Medicaid provider fraud by contacting Robert Tengeler, Director, Bureau of Investigations within the Division of Medicaid Fraud Control and Program Integrity at (518) 473-1984, rgt02@health.state.ny.us

V. SYSTEM IMPLICATIONS

There are no system implications. Details of the use of the data warehouse will be provided in a separate Administrative Directive.

VI. EFFECTIVE DATE

This Administrative Directive is effective immediately.

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Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management