Report of the

Bureau of Medicaid Fraud and Abuse

for the Period

January 16, 1978 - October 31, 1978

STATE OF NEW YORK

Hugh L. Carey, Governor

DEPARTMENT OF SOCIAL SERVICES

Barbara B. Blum, Commissioner

The Bureau of Medicaid Fraud and Abuse is mandated to seek restitution for erroneous Medicaid payments, to obtain legal and administrative action against Medicaid providers engaged in unacceptable practices, and to serve as a deterrent against future attempts to defraud or abuse the Medicaid Program. The Bureau works closely with the Department of Health in its efforts to achieve these goals. This report is prepared for the purpose of providing information to the Legislature on the progress and achievements of the DSS Bureau of Medicaid Fraud and Abuse. It covers activities undertaken through October 31, 1978.

Fiscal Recoveries

The Bureau of Medicaid Fraud and Abuse to date has received cash repayment, taken adjustment for, or reached final settlement (stipulated) on restitution amounting to $41,552,000. Of this total, $16,000,000 was collected in fiscal 1977-78, with the remaining $25,552,000 having been collected or settled upon during the first six months of fiscal 1978-79.

The staggering increase in state expenditures for medical care services in the clinic areas has made it imperative for the Bureau to undertake an indepth investigation of clinic practices, with the goal of recovering any improper payments which are identified. Accordingly, a major segment of the Bureau's operation has been devoted to monitoring the activities of hospital-based and free-standing clinics. To date, these activities have resulted in recoveries totaling $31,175,857.

Among the abuses observed among clinics are: "family ganging" (one member of a family is treated for an illnes, and all accompanying family members are treated, whether or not they are ill); "ping-ponging" (patients who come to the clinic with one complaint are referred to a number of different specialists); and the practice of requiring a patient to return for follow-up visits several times when one or two visits would have sufficed.

As previously reported, we have identified $5.9 million in duplicate payments to some 5,200 physician providers. These non-hospital and non-clinic activities have resulted in recoveries totaling $1,611,895.63 to date.

Administrative Action

Another focal point of the Bureau's activities has been to undertake administrative actions against providers found engaging in unacceptable practices. Administrative Actions under Part 515 of the Department's Regulations provide for a wide range of penalties which can be assessed against providers, up to and including disqualification from the Medicaid Program.

Since the inception of the Bureau, there have been 134 disqualifications of providers from the Medical Assistance Program for unacceptable practices. In addition, 27 other providers have either been suspended from the Program or ordered to make restitution.

All providers who have been subject to administrative action were afforded the opportunity to appeal these determinations through a formal hearing procedure. The Department has promptly scheduled and executed these hearings, thereby establishing the credibility of its efforts.

The Bureau has established a system to ensure that information on the results of administrative hearings is circulated statewide. The Bureau informs the Division of Medical Assistance (DMA) of all administrative actions. DMA is then responsible for informing the local Commissioners of Social Services and Administrators of the Medicaid Management Information System (MMIS) of these

actions so that no improper payments will be made to these providers.

Lists of disqualified providers are also sent to the Department of Education so that they may initiate inquiry into the provider's professional conduct. Conversely, the names of all providers whose licenses have been revoked or suspended by the Board of Regents are compiled and transmitted to the Bureau for necessary action regarding the providers' right to participate in the Medicaid Program.

The Bureau is presently working towards the refinement of the Administrative sanctioning process. Final revisions of a draft of Part 515 of the Department's Regulations has been prepared in conjunction with the Department's Bureau of Administrative Adjudication. The revision provides for a clearer delineation of provider activities which are considered unacceptable. Department staff are also in the process of establishing procedures that will assure the uniform and consistent application of sanctions.

Prosecutorial Action

Recently, Governor Carey designated the Office of the Special Prosecutor for Nursing Homes, Health and Social Services (OSP) to act as the State's Medicaid Fraud Control Unit under provisions of new Federal Legislation which provides 90% Federal funding for costs of such activities. The Department of Social Services has reached a Memorandum of Understanding with the OSP delineating the two agencies' functions and responsibilities regarding Medicaid fraud. Meetings between the respective staffs were held to define and implement the needed lines of communication for referral of cases in both directions and for the interagency cooperation which is vital to the successful accomplishment of the mutual goals.

Pursuant to the memorandum of understanding, the Bureau will conduct a preliminary investigation, including legal analysis, to determine if evidence of potential fraud or abuse exists and, if warranted, promptly refer any fraud case to the Office of the Special Prosecutor. If the OSP decides not to prosecute a case, they have agreed to refer it back to the Bureau within 30 days for any action which we feel appropriate. To date, we have referred seven cases to the OSP and we are awaiting their decisions as to whether or not they will prosecute. In addition, Bureau staff have conducted numerous training sessions for OSP staff.

Previous to the designation of the Fraud Control Unit, in those cases where unacceptable practices revealed indications of potential fraud, the Bureau developed the case for referral to local prosecutors and/or U.S. Attorneys. In most of these cases the evidence had been gathered in such a way that an indictment was obtained by a prosecutor's office without the need for further investigation on their part. Since February, 1978, convictions have been obtained in 12 cases which were prepared by the Bureau and referred to prosecutorial agencies, bringing our Statewide conviction total to 94. Another 42 indictments remain to be adjudicated.

Local and U.S. Attorney's will complete any cases referred to them prior to the assumption of fraud responsibilities by the OSP. All of our technical and legal support will be at the disposal of the local and U.S. Attorneys for such cases, as well as for any cases which they may initiate on their own, as they will continue to maintain concurrent jurisdiction.

In addition, the Bureau supervises fourteen contract counties to handle their own fraud and abuse cases. The Bureau provides technical assistance in order to aid these counties in the development of legal cases within their juridiction.

The Bureau has also cooperated with the State Attorney General's Office in defending six Article 78 proceedings in State Supreme Court. The Department has been

upheld in three of these actions, and three others were adjourned for a later time.

Other Legal Activities

Arrangements have been made with the Attorney General's Office in New York City for the purpose of commencing civil action to recover monies from providers, including the recovery of treble damages based on Section 145-b of the Social Services Law. Agreement has been reached with the U.S. Attorney's Office in the Southern District of New York City for recent conviction of a corporation in Federal Court.

Recently promulgated federal regulations mandate suspensions from the Medicare and Medicaid Programs if a provider is convicted of fraudulent activities. New York State is taking a harsher stand by disqualifying from the Medicaid Program any provider convicted of fraudulent practices in the Medicaid Program, or any medicaid related fraud (offering a false instrument for filing, etc.).

New Developments

One of the keys to continued success in deterring providers from improperly and excessively billing the Medicaid Program is the refinement of the computer system employed by the Bureau and its implementation on a statewide basis. In conjunction with the Bureau, the Department's Social Services Program Operations staff (SSPO) have taken the following important steps to improve the system:

1) Consolidation of New York City's five payment files so that all payments made by New York City to a provider on behalf of any and all clients will be grouped and can be analyzed as a whole.

2) Expansion of the computer detection systems into upstate counties. Albany, Monroe, Suffolk Counties became operational in September, 1978. Within the next few months, Broome County will be functional. Analysis is anticipated to begin in another eight computerized counties in early 1979 with expectations that these will be operational by the end of that year. Included in this group of counties will be Nassau, Onondaga, Westchester, Erie, Rockland, Oneida, Orange and Ulster.

3) Conversion to Microfiche to reduce storage and security problems will consolidate available information and maintain the confidentiality of files. Not only will all Medicaid payment data be stored on Microfiche, but so will the management reports and the historical data of the Provider Tracking System. Microfiche is a computer output medium in which data contained on 270 computer pages are miniaturized on to one postcard-sized sheet of film.

Other Activities

During the first fifteen months of its operations, the Bureau of Medicaid Fraud and Abuse has concentrated a large portion of its efforts in the areas of clinics and physicians. Within these areas, much attention has been given to the specific disallowance areas of duplicate payments. This concentration has resulted primarily from the availability and high quality of the computer edits for duplicate payments. Within the past two months, the Bureau has expanded both the range of providers covered by its activities and the scope of the reviews being undertaken. The limited reviews of physician abuses have been replaced by comprehensive reviews of the entire practice of targeted physicians. Some of these audits have already been completed and it is anticipated that the system will be fully operational within a few weeks.

Among the abuses already observed among physicians: billing for services not rendered; billing for services performed by non-qualified personnel; billing for services which were inconsistent with the diagnosis; and overutilization (billing for services not medically necessary).

A comprehensive and revised audit plan for clinics has also been designed. Those clinics which have repaid the Department for identified duplicate payments will be reviewed again for the other items in the audit plan. Also incorporated into this plan will be provisions to utilize the Medicare-Medicaid payment data accumulated during our analysis of a sample of recipients determined to have dual coverage. This analysis identified evidence of duplicate payments, and claims for Medicare eligible clients which were entirely paid by Medicaid.

As the Bureau moves into preparation for full audits of the entire spectrum of providers (physicians, dentists, labs, pharmacies, medical supply stores, etc.) considerable emphasis is being devoted to defining quality of care issues that can be audited or defended in a court of law. In conjunction with program staff, the Bureau is in the process of compiling a consolidated listing of existing Department of Health and Department of Mental Hygiene regulations and the Medicaid policies stated in the State Medical Handbook. These manuals of standards and billing requirements are being prepared for all provider groups and will be utilized by the audit teams to review the services rendered and billed by providers. Thus far, the sections for physicians, chiropractors and podiatrists are in draft form.

In an effort to assist narcotics users (heroin) to overcome their addiction, New York State has encouraged these addicts to voluntarily participate in the Methadone Maintenance Treatment Program. Methadone is a synthetic narcotic whose controlled use allows the patient to stabilize his need for drugs and assists him to participate in rehabilitation activities such as vocational counseling and education. Providers of authorized services are eligible to receive payment under the Medical Assistance Program when care is provided to individuals enrolled in the Medicaid Program.

Various Methadone Maintenance Treatment Programs have been reviewed and the following abuses have been observed: billing for services not rendered (billing for treatment of individuals not actually enrolled in the program); continued billing of frequent visits by the same patient to the program (the number of visits should decrease over a period of time); continued billing for same dosage for all clients (dosage must depend on the individual case and should decline over a period of time); and billing for both inpatient and outpatient treatment services for the same client on the same day.

HEW - Related Projects

The Bureau has cooperated with the federal government by participating in projects sponsored by the Department of Health, Education and Welfare. These cooperative efforts have included the Croaker Project and Projects Integrity I and II. The Croaker Project centers on drug-related Medicaid matters. Project Integrity I required states to audit physicians and pharmacies.

We are presently working on Project Integrity II, a review of laboratories and clinics. Selecting the highest paid laboratories participating in the Medicaid Program during August 1975 or 1976, we reviewed a total of twenty labs. We expect, based on experience to date, that a number of labs will likely be referred to the Office of the Special Prosecutor. Six additional labs have already been disqualified from the Medicaid Program or are in some state of review by our Metropolitan Regional Office. The abuses uncovered during the review of labs include: billing for tests not requested by physicians; billing for panel tests,

such as SMA-6 and SMA-12, in addition to billing for components of these tests at the same time; and excessive billing for certain tests (tests which were not medically necessary).

MMIS

Consultation continues with MMIS in order to assist them in assuring that all registered providers are aware of appropriate standards to be followed. Recommendations are being made by Bureau staff regarding the draft provider manuals being prepared by MMIS for various provider groups. In addition, the Bureau is commenting on the claim forms to be used by different provider types to assure that all appropriate information is provided before payment is made. This will ensure that future audits of MMIS current payments will not encounter problems similar to those that the Bureau now finds when auditing New York City payment data (i.e. incomplete information, prescription filled without an order, etc.)

In order to meet federal requirements for MMIS certification, states are required to issue explanation of Medical Benefits forms (EOMB's) to Medical Assistance recipients so as to obtain verification of services rendered. Any discrepancies observed among EOMB's returned by recipients are immediately investigated by Bureau staff.

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