NEW YORK STATE OF OPPORTUNITY. | Office of the Medicaid Inspector General

HEALTHCARE PROVIDER ENGAGEMENT FORUM

NEW YORK STATE OF OPPORTUNITY. | Office of the Medicaid Inspector General

Overview of OMIG's Auditing Process

OMIG's Mission

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.

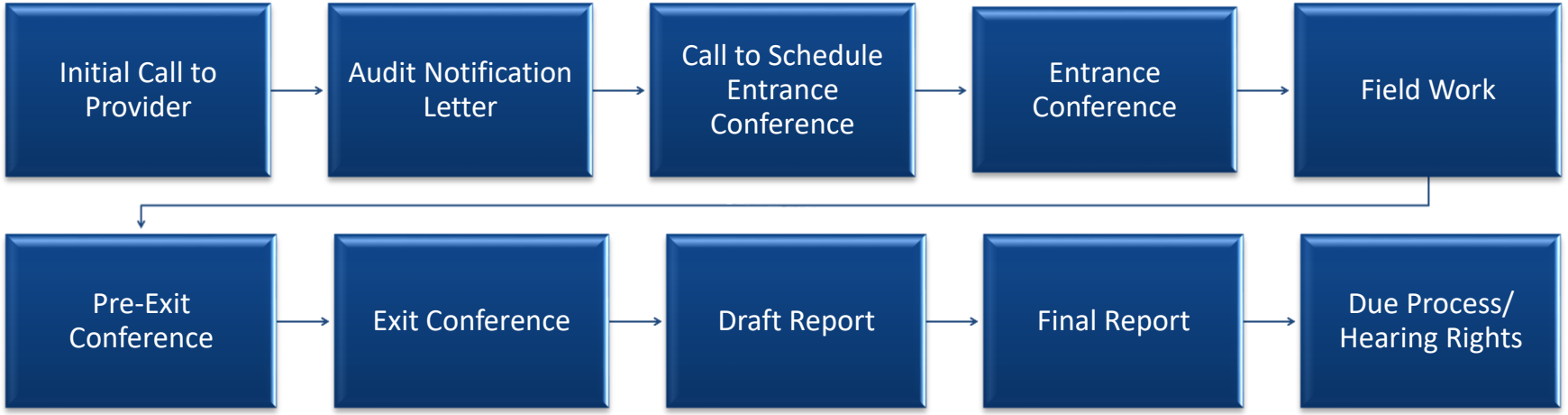
OMIG Authority

- 18 NYCRR 504.3 “Duties of the Provider” - by enrolling, the provider agrees to:
  - prepare & maintain contemporaneous records (18 NYCRR 504.3[a])
  - keep all necessary records for six (6) years (18 NYCRR 504.3[a])
  - permit audits (18 NYCRR 504.3[g])

Background Information

- Audits pursuant to 18 NYCRR Part 517 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:
  - censure;
  - exclusion;
  - conditional or limited participation in the program;
  - criminal referral; and/or
  - provider payment withhold

Audit Process



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 DOH Regulations and Provider Manuals

Claims for Medicaid Reimbursable Services

Phase 1: Planning

Division of Medicaid Audit: Staff Involved

- ❑ Subject Matter Expert
  - The programmatic expert in the area.
- ❑ Audit Manager
- ❑ Audit Supervisor
- ❑ Auditor
- ❑ Other senior managers, executives as needed

Audit Protocols

- Audit protocols are intended solely as guidance
- Audits focus on criteria listed in protocols, but additional findings may be uncovered during the course of the audit
- Protocols are not a substitute for a review of the statutory and regulatory law
- Audit Protocols can be found on OMIG's website at: https://omig.ny.gov/audit/audit-protocols

Audit Criteria

- NYS Department of Health (DOH) criteria
  - NYCRR Title 10
- Social Services criteria
  - NYCRR Title 18
- Mental Hygiene criteria
  - NYCRR Title 14
- Provider/eMedNY manuals
  - Billing Guidelines
  - Policy Guidelines
- Medicaid Updates
- Administrative Directive Memoranda (ADMs)

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
- After letter is sent, audit supervisor calls provider to set date for the entrance conference

Phase 2: Fieldwork & Analysis

Entrance Conference Outline

Select Audit Type Review
Entrance Conference Outline

Provider Name
Provider ID # XXXXXXXX
Audit # XX-XXXX

OMIG STAFF: Audit Supervisor
Auditors

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

DATE: MMMM d, yyyy

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 procedure/rate 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 $Amount Paid (Universe) for # of Services (Universe) claims during that time period. The OMIG review will involve a (stratified) random sample of XXX cases/paid claims for which $Amount Paid (Sample). 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.

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.

Entrance Conference

- Purpose
  - Evaluate billing practices and documentation for compliance with laws, regulations and policies at the time of submission
- Scope
  - Program area
    - Specific Category of Service (COS) and Rate/Procedure Codes
  - Audit Period
    - Date of payment
  - Universe and Sample Information
    - Number of claims
    - Dollar amount

Scope & Methodology

- Audit Methodology
  - Varies between audit areas, focusing on procedures involving the category of service and sampled selection

18 NYCRR 519.18(g)

- “An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made or penalty to be imposed.”

Entrance Conference

- 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 claims during the audit period

Entrance Conference

- ❑ 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

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 claims and record the findings of any possible disallowed claims

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

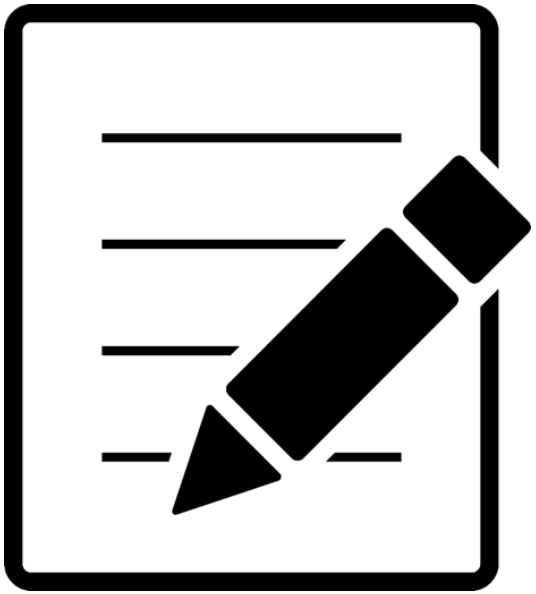
- Auditors may interview provider's clinical, billing, and compliance staff as needed during the fieldwork
- Copy of policy and procedures may be requested

Conclusion of Field Work

- 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
- 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

Phase 3: Reporting

Reports



- ❑ Exit Conference Summary
- ❑ Draft Audit Report
- ❑ Final Audit Report
- ❑ Summation Letter
- ❑ Termination Letter
- ❑ Stipulation Agreement-repayment agreement

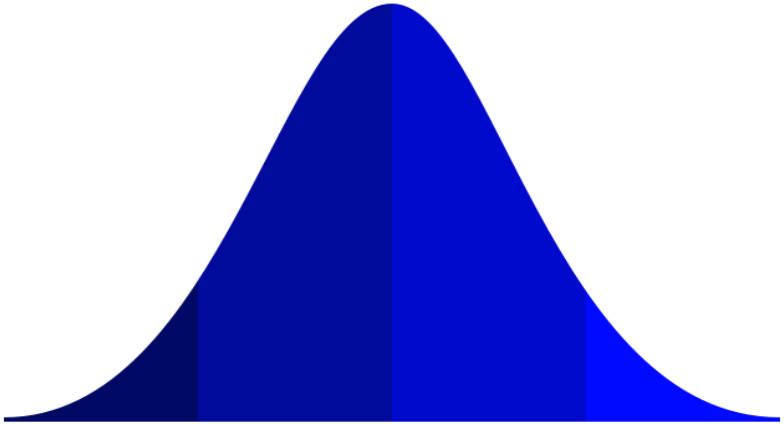
Exit Conference

- Provider receives Exit Conference Summary prior to meeting
- Provider also receives an encrypted CD containing:
  - 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

Exit Conference

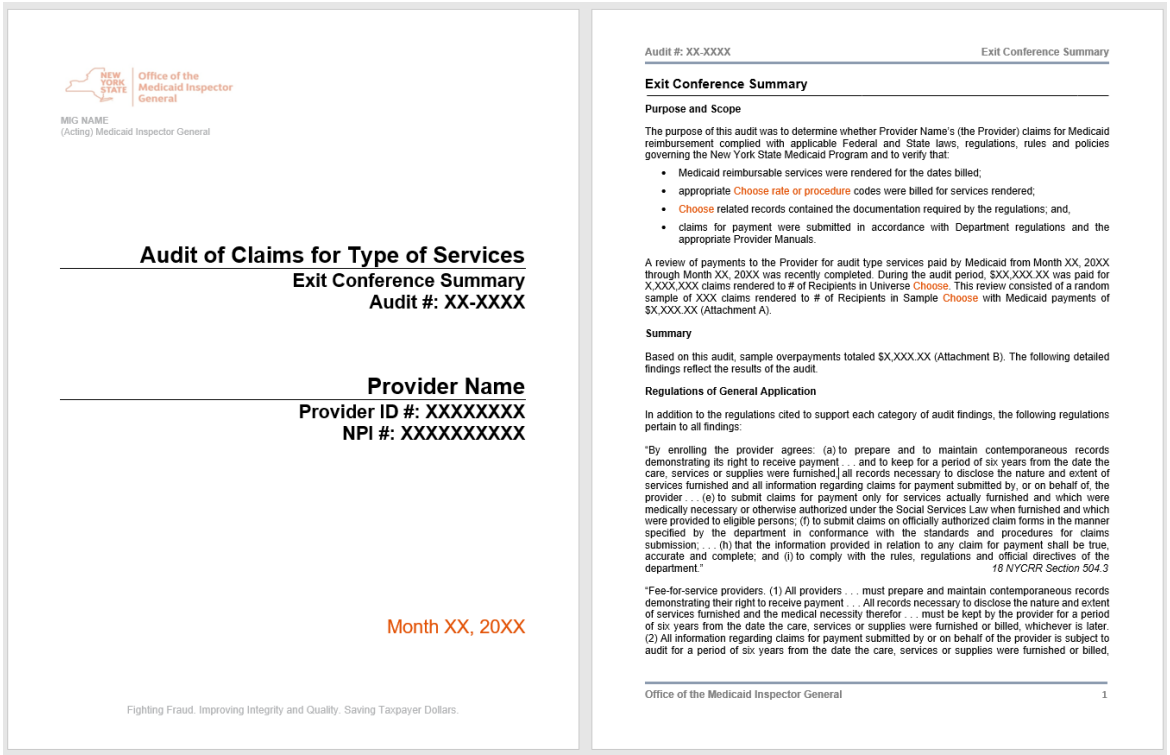
- ❑ Present audit finding details
- ❑ Additional documentation/information may be presented
- ❑ Explain process
  - Draft Audit Report
  - Final Audit Report
  - Rights to an Administrative Hearing
- ❑ Answer questions

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
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 or procedure codes were billed for services rendered;
- Choose 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 Month XX, 20XX through Month XX, 20XX was recently completed. During the audit period, $XX,XXX.XX was paid for X,XXX,XXX claims rendered to # of Recipients in Universe Choose. This review consisted of a random sample of XXX claims rendered to # of Recipients in Sample Choose with Medicaid payments of $X,XXX.XX (Attachment A).

Summary

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

Regulations of General Application

In addition to the regulations cited to support each category of audit findings, the following regulations pertain to all findings:

"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*

"Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment . . . All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed,

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Attachment C

OFFICE OF THE MEDICAID INSPECTOR GENERAL
PROVIDER NAME
REVIEW OF SAMPLE SELECTION
PROJECT NUMBER: XX-XXXX
REVIEW PERIOD: XX/XX/XX - XX/XX/XX

ATTACHMENT "C"
Page 1 of 4

Sample Number	CIN #		Patient Name	Date of Service	Rate Code Billed	Rate Code Derived	Amount Billed	Amount Derived	Over Payment	DETAILED AUDIT FINDINGS 1. FINDING DESCRIPTION	2. FINDING DESCRIPTION	3. FINDING DESCRIPTION	4. FINDING DESCRIPTION	5. FINDING DESCRIPTION	6. OTHER FINDINGS
1	0	0		01/00/00	0		$ -	$ -	$ -						
2	0	0		01/00/00	0		-	-	-						
3	0	0		01/00/00	0		-	-	-						
4	0	0		01/00/00	0		-	-	-						
5	0	0		01/00/00	0		-	-	-						
6	0	0		01/00/00	0		-	-	-						
7	0	0		01/00/00	0		-	-	-						
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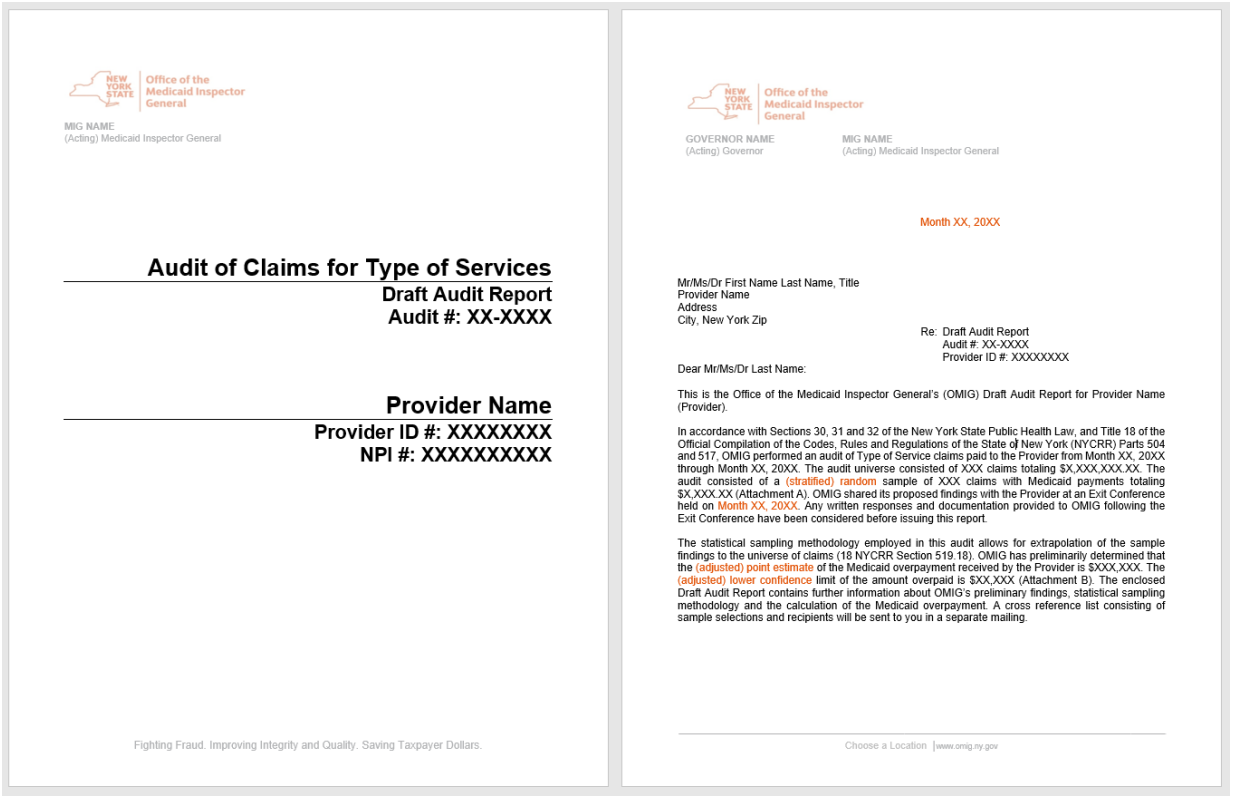
25	0	0		01/00/00	0		-	-	-						

NEW YORK STATE OF OPPORTUNITY. Office of the Medicaid Inspector General

Draft Audit Report

- Issued after review and consideration of new documentation or information presented at the exit conference
- Provider has 30 days to submit written objections to findings
  - 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

Draft Audit Report



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.

Office of the Medicaid Inspector General

GOVERNOR NAME
(Acting) Governor

MIG NAME
(Acting) Medicaid Inspector General

Month XX, 20XX

Mr/Ms/Dr First Name Last Name, Title
Provider Name
Address
City, New York Zip

Re: Draft Audit Report
Audit #: XX-XXXX
Provider ID #: XXXXXXXX

Dear Mr/Ms/Dr 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 Month XX, 20XX through Month XX, 20XX. The audit universe consisted of 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 $XXX,XXX. The (adjusted) lower confidence limit of the amount overpaid is $XX,XXX (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.

Choose a Location | www.omig.ny.gov

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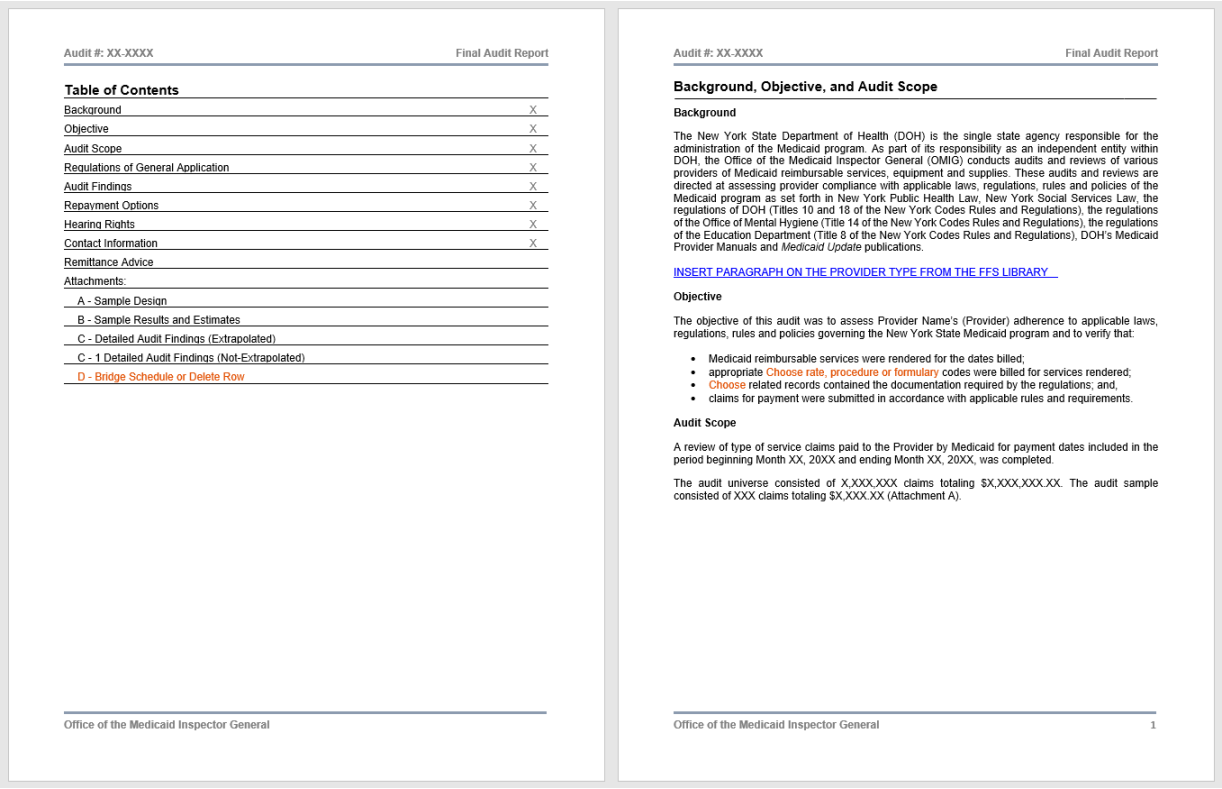
Final Audit Report

- The final audit report contains
  - Audit Objective
  - Audit Scope
  - Repayment Options
  - Hearing Rights

Final Audit Report



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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 PARAGRAPH ON THE PROVIDER TYPE FROM THE FFS 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 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 Month XX, 20XX and ending Month XX, 20XX, 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).

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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

Final Audit Report

- Hearing Rights
  - Hearing request must be made, in writing, within 60 days from date of Final Audit Report
  - 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

Other Reports

- Audit reports or agreements may also include:
  - Summation Letters
  - Termination Letters
  - Stipulation Agreement – repayment agreement

Provider Recommendations

- ❑ 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

OMIG Contact Information

- OMIG: 518-473-3782
- Website: www.omig.ny.gov
- Medicaid Fraud Hotline: 877-873-7283
- Join our listserv
- Follow us on Twitter: @NYSOMIG
- Like us on Facebook
- Dedicated e-mail: information@omig.ny.gov
- Bureau of Medicaid Fraud Allegations: bmfa@omig.ny.gov

HEALTHCARE PROVIDER ENGAGEMENT FORUM

Send comments, recommendations and/or feedback to:
information@omig.ny.gov

or

https://forms.office.com/g/2i3XPHYAYy