Quarterly Report of the Bureau of Medicaid Fraud and Abuse Covering the Period October 16, 1977 -- January 15, 1978

STATE OF NEW YORK

Hugh L. Carey, Governor

DEPARTMENT OF SOCIAL SERVICES

Barbara B. Blum, Acting Commissioner

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SUMMARY

The Department of Social Services' Bureau of Medicaid Fraud and Abuse has four major objectives during its first year of operation (State Fiscal Year 1977-78, April 1, 1977 to March 31, 1978):

1. Recover $20 million in improper Medicaid provider claims

   As of January 31, 1978, with three quarters of the Fiscal Year 1977-78 completed, the Bureau has recouped a total of $15,338,022.41. The four quarter goal of $20 million is expected to be achieved on target. Emphasis to date has been in identifying, via sophisticated computer analysis of 197 - 1977 Medicaid payments, duplicate payments to all Medicaid providers.

2. Detect, investigate, and cause to be prosecuted, fraudulent Medicaid providers

   The Bureau has obtained 82 convictions, with an additional 41 indictments still pending, in cases uncovered, investigated, and referred by the Bureau for prosecution.

3. Disqualify, suspend, or censure providers detected abusing the Medicaid program

   Since its inception in April 1977, the Bureau has disqualified or suspended a total of 124 Medicaid providers from the program.

4. Improper management of the Medicaid program

   As a direct feedback from the Bureau of Medicaid Fraud and Abuse to the administration of the Medicaid program within DSS, a number of amendments to the Social Services Law, and to DSS regulations, have been proposed to improve quality of care and to remedy fiscal abuses in the program. In addition, staff of the Bureau are directly involved in MMIS development to assure that fraud and abuse detection techniques are properly integrated in the MMIS payment process.

I. Recoveries of Improper Medicaid Claims

A. Clinics and Hospital Outpatient Departments

The Bureau of Medicaid Fraud and Abuse initiated recoupment efforts in clinics through "test" audits of twenty voluntary and proprietary hospital OPD's based on computer detection of duplicate payments. These "test" audits were used to:

1. substantiate the validity of the computer information on duplicates produced by Social Services Program Operations (data processing). This was accomplished by examining a valid statistical sample of the total billings.

2. detect other "abusive" practices in clinic billing procedures which may inflate the costs of the Medicaid Program.

Bureau investigations are revealing that clinic Medicaid billing abuses may constitute an even greater amount of improper payments from that detected in billings by individual practioners. The most frequently used means of unnecessarily increasing clinic revenues appear to be:

- submission of duplicate billings in high volume,
- unnecessary referrals between clinics (whether financially related or unrelated),
- variations between the "rate setting" visit count and the numbers of visits actually billed,
- poor or no documentation of services rendered, and
- duplicate billings to Medicare without a corresponding offset to Medicaid costs.

Initial computer analysis of Medicaid billings from outpatient clinics in New York City indicates duplicate payments totaling 15 million dollars were made to 163 clinics. Bureau investigations and audits have commenced in the first 20 of these claims.

Once the findings are completed and validated, restitution will be assessed against private facilities and adjustments made against future payments to the City of New York for the Health and Hospitals Corporation.

B. Other Providers

Continued computer generated scrutiny of Medicaid payment tapes indicates widespread abusive or fraudulent billing practices. Recent refinement of our computer edits are being used to isolate:

- excessive provision or utilization of services,
- "ping ponging" of patients,
- family ganging,
- billing at incorrect rates or fees,
- billing twice for the same services, and
- other unacceptable practices depending on provider type.

As a result of these computer runs, the Bureau is in the process of seeking restitution of improper payments by either direct billing to the provider for the improper amount (lower dollar offenders) or by calling the provider in for discussions. Over 3,500 providers are involved in an estimated over-payment of $22 million for duplicate billings and incorrect fees alone. To date, about 300 providers have been interviewed and restitution of almost $600,000 obtained.

Duplicate payments to non MD's coupled with other infractions that require more discriminating investigatory techniques are expected to far exceed these initial results.

II. Investigations for Criminal Abuses

The search for criminal and civil fraud in the Medicaid Program is an important task of the Bureau of Medicaid Fraud and Abuse. This function is carried out by the Special Investigative Unit, a unit composed of investigators, auditors, medical professionals and lawyers. The Investigative Unit develops potential criminal investigations in a two stage process:

1. Potential fraud cases are targeted using EDP findings to pinpoint those providers who show unusual patterns of activity for which there is a high probability of fraud or abuse. From these, the unit is able to select for investigation those cases which will most likely lead to successful prosecution.

2. Against each case with a high probability of fraud or abuse, a multi-disciplinary, multi-faceted approach is used to build the case for referral to local prosecutors and U. S. Attorneys. To this end, information is gathered and analyzed from all possible sources, including Blue Cross/Blue Shield, the New York State Departments of Health and Education, Medicare and local district DSS payment files. Investigators interview potential witnesses, act as shoppers, undertake surveillance if necessary, and testify in court if required.

Of the cases referred to the various participating prosecutors to date, in most the evidence has been gathered in such a way that an indictment has been obtained by a prosecutor's office without the need for any further investigation on their part. Since October, eleven convictions and five indictments have

been obtained by prosecutors in cases investigated and referred by the Bureau of Medicaid Fraud and Abuse. This increases the total to 82 convictions, with 41 indictments still pending, since inception of the unit in late 1976. Significantly, the cases involved multi-count indictments in which convictions were obtained soon after indictment. Presently, the Bureau has over 100 active criminal investigations of fraud and other crimes for a variety of provider types, including psychiatrists, pharmacies, laboratories, surgeons and hospital clinics.

III. Administrative Actions

The Legal Staff of the Bureau of Medicaid Fraud and Abuse is currently involved in 20 administrative hearings requested by providers against whom sanctions are being sought for engaging in unacceptable practices in the Medicaid Program.

IV. Accounting/Collections and Provider Tracking

A new accounting system is being developed by the staff of the Bureau of Medicaid Fraud and Abuse which will correlate reported refunds of Medicaid monies on the individual County's State Claim E-2 Schedule with the information reported on the Fraud and Abuse Provider Tracking System. This system, along with the control of monies and adjustments being handled by the DSS Fiscal Affairs Unit, will provide the basis for a comprehensive report of all monies recovered by the Fraud and Abuse Unit statewide. Thus far, the Bureau has received or taken adjustments of $15,338,022.41 from clinics and other categories of providers.

The Provider Tracking System permits the Bureau to monitor the status of all actions against providers. In the past quarter, EDP designed the advance system and developed programs for four reports: a provider tracking profile giving synopsis of the Department's claim against a provider; a case status report showing the most recent action taken in a case; a hold report pinpointing provider claims being held; and a disposition report giving the final action taken on a case.

V. Other Activities

The Bureau is continuing to work extensively with staff of the Medicaid Management Information System on several projects. A joint effort is underway to prevent unwanted providers from enrolling in MMIS. In addition, staff from the Bureau is coordinating with the Division of Medical Assistance, Bradford National Corporation, the Department of Health, and Social Services Program Operations for development of a pharmacy claims system. This cooperative effort is intended to produce a system which will minimize the opportunity for fraud or abuse in this provider area.

During the implementation phase of MMIS, the Bureau's sophisticated fraud and abuse EDP detection system will be utilized to compare payments made through MMIS with those still being made by the New York City Department of Social Services. Once MMIS is operational, our EDP system will be maintained as an integral part of that system, either merging with the Surveillance and Utilization Review (S/UR subsystem) or serving as part of the system of prepayment edits.

We have established a very important working relationship with the S/UR Unit of the Division of Medical Assistance. This unit consists of medically-oriented technical personnel who are working with the legal, EDP and investigative auditing staff in preparation of potential fraud or abuse cases. Emphasis is placed on identifying overutilization, potential fraudulent practices and billing irregularities by analyzing selected data extracts. A report is prepared for each provider outlining questionable practices and requesting additional sort edit reports to extract specific patterns from a complete provider profile.

In the first two months of this cooperative effort, the S/UR team has analyzed 100 New York City providers, including 63 physicians, 10 laboratories, and 25 pharmacies. Analysis suggested possible abuse in 95 percent and billing irregularities in 30 percent.

The S/UR Unit will utilize this operational experience when MMIS and the S/UR subsystems commence providing the Bureau of Medicaid Fraud and Abuse with data. The Unit is assisting the Bureau in developing additional program edits for use now as well as for MMIS.

As a corollary to these review activities, the Division of Medical Assistance's S/UR staff is making recommendations for changes in Social Services regulations which seem vague, ill-defined, or lacking. This is essential because regulatory weaknesses have, in some cases, permitted, and even encouraged, provider abuse.

Efforts are being made to assist detection of fraud and abuse in upstate counties. Acceptance of the detection system by these counties has been most favorable. Agreements have been reached with four districts to furnish the Bureau of Medicaid Fraud and Abuse with data files which will be run against our computer programs. The information produced will be used by local agency staff in conjunction with Regional office personnel to conduct productive fraud and abuse investigations.

VI. Legislation

Final drafts of the 1978 Medicaid Fraud and Abuse Legislative proposals amending Social Services Law §§ 145 have been prepared. The bill will recodify the fraud and abuse provisions of the Social Services Law and will consolidate and expand upon existing law to strengthen the ability of the Department to deal effectively with individual provider fraud. This bill, together with shared health facilities registration provisions, will enable the Department of Social Services and the Department of Health to effectively monitor, investigate, and control "medicaid mills," through required registration, and with the ability to exercise more control over individual providers. The recodification will give a specific, rather than a general, legal basis for prohibiting and sanctioning persons engaged in unacceptable practices. It also would permit the Department of Social Services to assess a civil fine of up to $2,000 for each separate instance of unacceptable practice.

This legislation will increase the penalty for provider fraud from the misdemeanor level to a class E felony. It also provides felony penalties for clinic or laboratory fee-splitting arrangements. Finally, the recodification will authorize the Department of Social Services to refer the evidence obtained through its investigation to appropriate prosecutorial authorities.

VII. Regulations

The Department of Health, Education and Welfare has issued a program instruction calling upon the various states to establish administrative mechanisms to remedy abusive practices by providers in the Medical Assistance Program (HCFA-AT-77-105 (OPI), November 7, 1977). The Department has existing rules and regulations which it has employed in taking administrative action against providers (Part 515, 18 NYCRR). However, the Bureau of Medicaid Fraud and Abuse, in conjunction with the Bureau of Administrative Adjudication, is preparing a final draft of a revised Part 515 procedure which is in every way consistent with the Federal instruction. The new regulations will include:

1. A comprehensive definition of unacceptable practices.

2. An informal billing review procedure designed to encourage settlement and thereby obviate the need for a lengthy and expensive hearing.

3. A delineation of possible sanctions which the Commissioner may use against providers who engage in unacceptable practices.

4. Authority to suspend payment to providers engaging in unacceptable practices.

5. A formal hearing procedure.

The new regulations strike a balance between the interest in eliminating abusive practices from the Medical Assistance Program through stringent administrative procedures and sanctions, and the right of providers to have their practices judged fairly. In drafting the revised rules and regulations, the Department has incorporated the essential elements of due process as embodied in the State Administrative Procedures Act.

VIII. Civil Litigation

In conjunction with the Attorney General, Bureau Attorneys are currently involved in representing the Department in a number of civil proceedings. Such civil litigation has included Article 78 proceedings and motions to quash Department subpoenas issued during investigations. In recent months, the Legal staff has investigated and written memoranda on such legal points as:

1. Department exemption from the confidentiality regulations governing methadone clinics.

2. Payment of interest by and to the State on claims arising under the Medicaid Program.

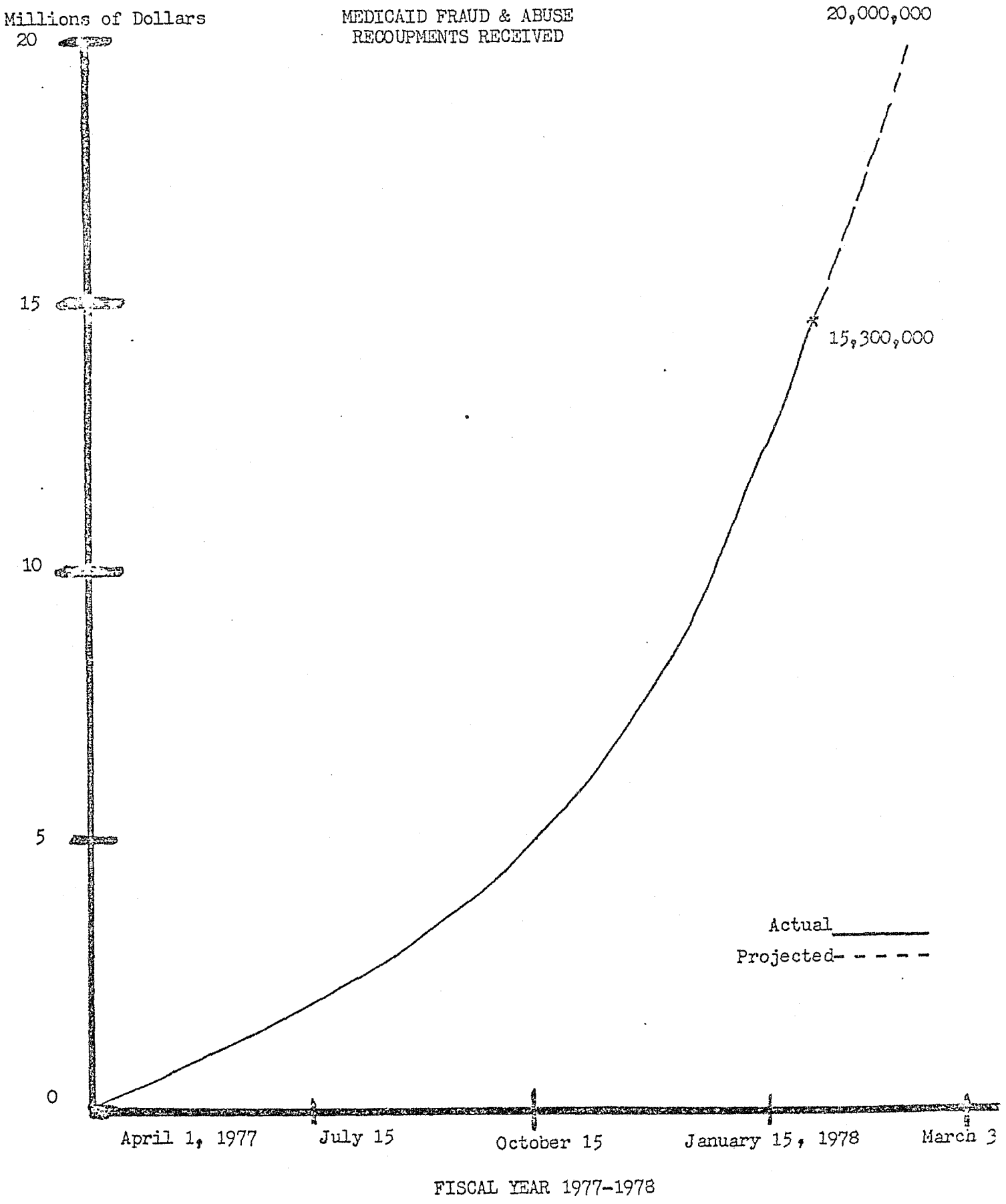
3. Imputing unacceptable practices of corporate principal to owner-agent.

4. Administrative recoupment based upon statistical sampling.

APPENDIX A

ACTUAL AND PROJECTED

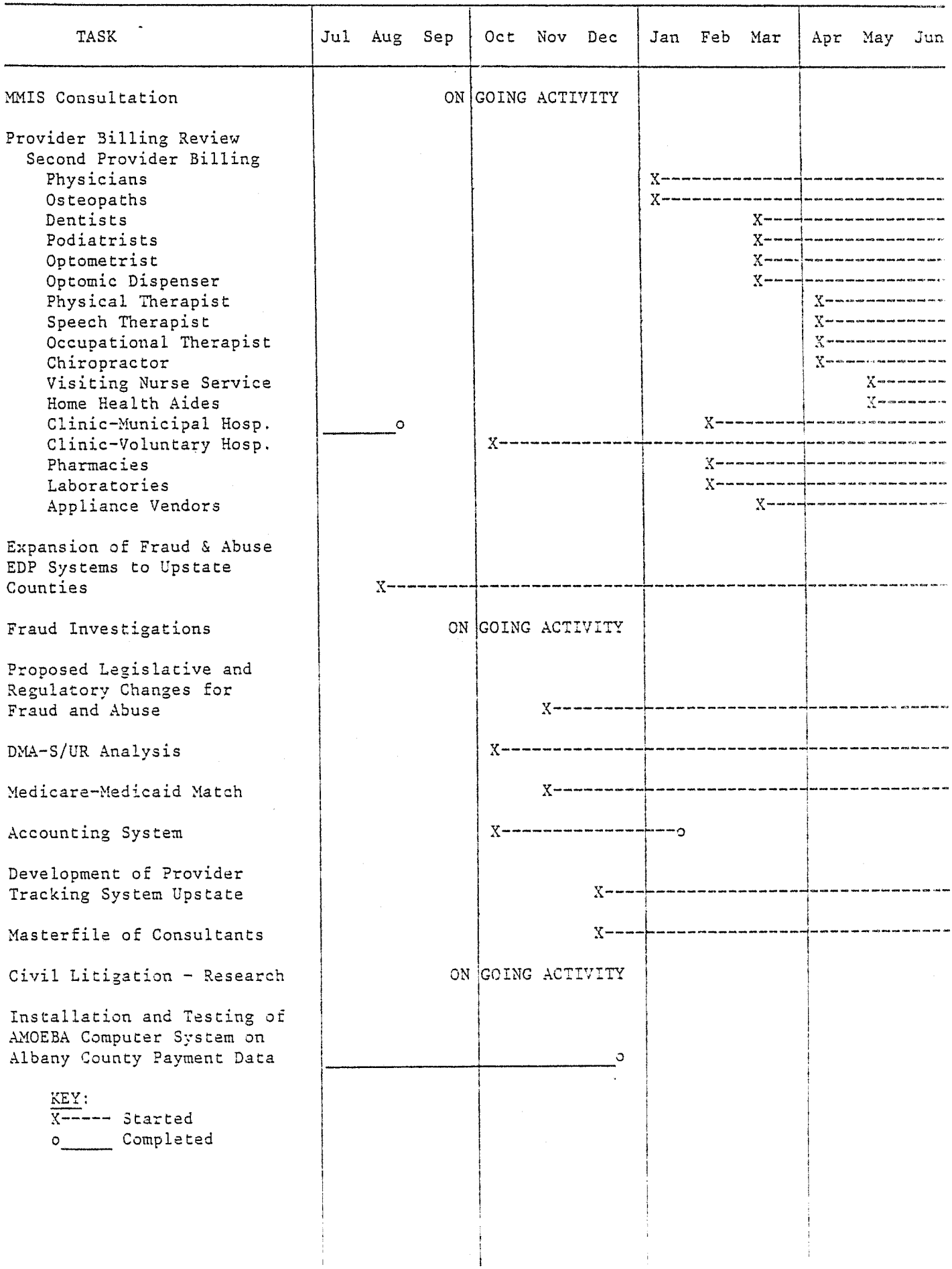
MEDICAID FRAUD & ABUSE
RECOUPMENTS RECEIVED



FISCAL YEAR 1977-1978

APPENDIX B

GANTT CHART OF ACTUAL AND PROJECTED TASKS



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