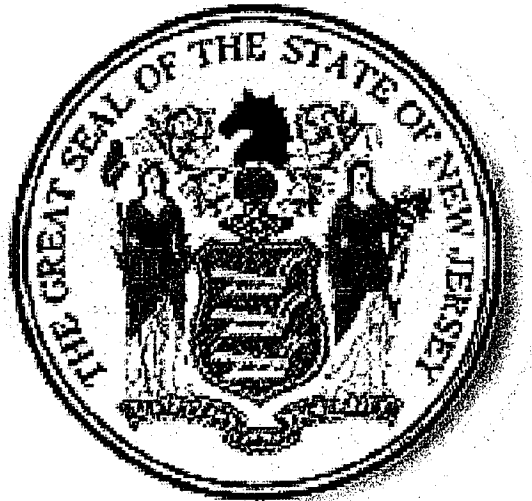


STATE OF NEW JERSEY

OFFICE OF THE MEDICAID INSPECTOR GENERAL

Mark Anderson, Medicaid Inspector General



2009 Annual Report



State of New Jersey

OFFICE OF THE MEDICAID INSPECTOR GENERAL

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JON S. CORZINE
Governor

MARK ANDERSON
Medicaid Inspector General

October 30, 2009

The Honorable Jon S. Corzine
Governor, State of New Jersey
State House
Trenton, NJ 08625

Dear Governor Corzine:

Enclosed is the first Annual Report for the Office of the Medicaid Inspector General summarizing the highlights of our agency since we began operations in March 2009. The Office of the Medicaid Inspector General appreciates the opportunity to address New Jersey's Medicaid fraud, waste, and abuse problems. Our staff has identified numerous new strategies to control and prevent fraud, waste, and abuse in the Medicaid program. We have also recovered funds and provided costs savings for this period in the amount of \$193,317,604, a 14.87% increase over this same period last year.

This report includes information about investigations, audits, administrative actions, referrals, and civil actions initiated and completed by the Office of the Medicaid Inspector General.

It is an honor and privilege to serve as the Medicaid Inspector General for the State of New Jersey and I am proud of our office's accomplishments and look forward to continuing the valuable services our office provides.

Respectfully,

A handwritten signature in black ink that reads "Mark Anderson".

Mark Anderson

Medicaid Inspector General

cc: Edward McBride, Chief Counsel, Office of the Governor
The Honorable Richard J. Codey, Senate President, New Jersey State Senate
The Honorable Joseph J. Roberts, Jr., Speaker, New Jersey General Assembly

Statement from the Medicaid Inspector General

It is an honor to present the first Annual Report for the Office of the Medicaid Inspector General (OMIG) introducing our Office and highlighting the major accomplishments and investigations conducted by our staff since we opened our doors on March 16, 2009, including a 14.87% increase of recoveries and cost savings over the same period last year.

In order to achieve our objectives of detecting, preventing, and investigating fraud and abuse in the Medicaid, FamilyCare, and Charity Care programs, we have begun to implement a number of initiatives. One of those initiatives is to reach out to all 21 counties in the State of New Jersey to coordinate with them on recipient fraud issues and to discuss the problems they face. We have met with over half of the 21 counties to date and continue to receive fraud and abuse referrals from the counties as a result of our efforts.

We are also focused on marketing our office through various tools, including the recent launch of our website which includes additional ways to report fraud, waste, and abuse to our office, a Medicaid fraud poster for providers to download and display in their offices, and a listserv so that the public can track our accomplishments.

We also meet regularly with the Departments of Human Services, Health and Senior Services, and Children and Families to discuss case referrals and proposed regulations affecting both recipients and providers and recent fraud and abuse trends in Medicaid, FamilyCare and Charity Care, among other things. It is OMIG's goal to work

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We are meeting with provider groups across the state in order to educate them about our office. We hope these meetings will facilitate effective communication about Medicaid fraud and abuse and give providers an opportunity to refer potential fraud and abuse cases in their industry to our office.

As part of our investigative role, we are conducting surveillance work on both providers and recipients based on, among other things, tips we receive. This type of work has and *will* continue to yield fruit, resulting in increased recoveries and criminal referrals. Additionally, we are in the process of establishing our Audit and Regulatory Units. Our Audit Unit will be reviewing cost reports and claims submitted by providers in order to determine whether there is overbilling and possible indicia of fraud. Our Regulatory Unit will work very closely with the Attorney General's office on cases that go to litigation as well as the various departments that administrate the Medicaid programs to recommend proposed regulatory changes to the programs.

We regularly communicate with the Attorney General's office regarding whistleblower cases involving Medicaid fraud filed under the Federal and New Jersey False Claims Acts. We also coordinate with the U.S. Attorney's office on cases that may have both federal and state implications. Lastly, we are meeting with other Offices of Medicaid Inspector Generals to share information on Medicaid fraud and abuse, in the hopes of being less reactive and more proactive.

In this Annual Report, you will find further information on the background of our office, our staff, and some of our investigations, as well as ways to contact our office. It is our honor to serve you and to ensure that, especially in these difficult financial times, that the State's Medicaid program dollars are being spent appropriately, not wastefully, and that the people who need the program most are benefitting.

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Very truly yours,



Mark Anderson

Medicaid Inspector General

Office of the Medicaid Inspector General Mission and Background

Signed into law on March 16, 2007, the Medicaid Program Integrity and Protection Act (The Act) established the Office of the Medicaid Inspector General. On December 15, 2008, Mark Anderson was confirmed as the first Medicaid Inspector General for the State of New Jersey. Administratively, OMIG's Chief of Staff, Niki A. Trunk, and First Assistant Medicaid Inspector General, Mark Moskovitz, provide assistance to the Medicaid Inspector General and our team of investigators, specialists, and analysts ensure the successful daily operation and long-term functioning of the office. Our mission: To improve and enhance the efficiency of the New Jersey Medicaid, FamilyCare, and Charity Care Programs by preventing, detecting and investigating fraud and abuse in these programs.

The Act provides that OMIG be independent so that it can function as a "watchdog" over the State's Medicaid programs. Efforts were undertaken, by creating our office, to separate the administrative functions and program integrity while still preserving the single state agency structure required by Federal law. Therefore, while the OMIG still makes recommendations to the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) regarding enrollment and regulations, OMIG is an independent agency.

The OMIG staff of 45 full-time employees, is comprised of investigators, physician specialists, nurses, and claims reviewers. Our staff, many of whom were transferred from DMAHS, are dedicated and committed to ferreting out fraud, waste, and abuse in the Medicaid system. The New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. §30:4D-53 et al., defines fraud as:

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An intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit to that person or another person, including any act that constitutes fraud under applicable federal or state law.

N.J.S.A. §30:4D-55. "Abuse" is defined:

Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to Medicaid or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. The term also includes recipient practices that result in unnecessary costs to Medicaid.

The federal Government Accountability Office defines waste as "a transgression that is less than fraud and abuse. Further, most waste does not involve a violation of law, but rather related primarily to mismanagement, in appropriate actions, or inadequate oversight." The National Health Care Anti-Fraud Association (NHCAA) illustrates examples of Medicaid fraud, waste and abuse:

- Billing for services never rendered, either by using genuine salient information, sometimes obtained through identity theft, to fabricate claims or by padding claims with charges for procedures or services that did not take place.
- Billing for more expensive services or procedures than were actually provided, or performed, commonly known as "upcoding" – i.e., falsely billing for a higher-priced treatment than was actually provided.
- Performing medically unnecessary services solely for the purpose of generating payments.

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- Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance.
- Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures that are not medically necessary.
- Unbundling, or billing each step of a procedure as if it were a separate procedure.

OMIG Units

Some of the functions, generally, of the OMIG are: pursuing civil and administrative enforcement actions against those who engage in fraud, waste, or abuse or other illegal or inappropriate acts perpetrated within the Medicaid program; and apprising the Governor and the heads of agencies with responsibility for the administration of the Medicaid, Family Care and Charity Care programs of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system. Consistent with the obligations of the office's enabling legislation, the Office of the Medicaid Inspector General is currently in the process of drafting regulations and creating compliance guidelines to assist providers in the development and implementation of their own compliance programs. OMIG is seeking input from key stakeholders to provide guidance that will be sufficiently comprehensive and useful.

OMIG has four units: Data Mining; Investigations; Recovery; and Third Party Liability.

Data Mining

The Data Mining Unit looks for unusual patterns in claim reimbursement from providers and refers findings to the Investigations Unit. This Unit also works with the

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Investigations Unit and meets with other states' Medicaid Inspector General data mining units staff to identify new schemes to generate data reports and potentially identify different fraud and abuse patterns to refer to our investigators.

OMIG also works with state, local, and federal entities to acquire non-Medicaid data, such as vital statistics, and Medicare data from additional sources to maximize the utility of these tools and improve our ability to expose anomalous behavior.

Investigations

The Investigations Unit is charged with looking into various medical providers including, but not limited to, adult medical daycare centers (AMDCs), pharmacies, laboratories, and durable medical equipment providers. It conducts investigations of Medicaid, FamilyCare, and Charity Care providers and recipients. When fraud and abuse is discovered, we initiate administrative action or refer it to the state Attorney General for criminal prosecution.

Administrative actions include the exclusion or termination of providers from the Medicaid Program, monetary penalties, suspension of Medicaid privileges for a specified period of time, and the restriction of a Medicaid recipient to a single provider of a particular service.

Provider issues that could result in criminal prosecution are referred to the New Jersey Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for possible criminal prosecution. In order for the OMIG to be truly effective, it is vital that a high level of cooperation and coordination exists between the MFCU and the OMIG. Established by State law and federal regulations, MFCU is the first referral destination for all cases of suspected provider fraud, where there is potential criminal liability.

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Our Investigators receive allegations of fraud, waste, and abuse from many sources including, but not limited to: the New Jersey Medicaid fraud hotline (1.888.937.2835); other state and federal agencies; the New Jersey Departments of Human Services and Health and Senior Services; state agency websites; in-house referrals; Explanation of Medical Benefits (EOMB) responses; written correspondence; information brought to the attention of an investigator during the course of unrelated investigations; media; county welfare agencies; and Medicaid recipients.

Hotline contact information is disseminated to the public through a number of avenues including the distribution of posters and the OMIG website. Calls to the hotline are reviewed by OMIG staff for assignment and investigation.

Recovery

Our Recovery Unit sends out Notices of Claims and Notices of Demands, works with federal authorities to ensure that the federal government receives its monetary share of a recovery once a recovery is identified and/or received, works with DMAHS to ensure fraudulent providers are terminated, and recovers the money from providers and recipients on behalf of the State of New Jersey.

Third Party Liability (TPL)

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer. A significant amount of the State's Medicaid recoveries are the result of the OMIG's efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds. Since Medicaid is the payor of last resort, the Third Party Liability Unit (TPL), working with an outside

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vendor, seeks to determine whether Medicaid recipients have other insurance. If the beneficiary has other insurance, TPL recovers money from the private insurer.

There are two main methods for determining if a recipient has third party insurance coverage: identification of insurance during the Medicaid eligibility intake process at the local county welfare agency (CWA); and a state contractor identifies the client's third party's insurance not reported during intake.

Third party insurance coverage, Medicare and/or commercial, should be identified during the intake process at the CWA. Applicants for Medicaid services complete paperwork at these agencies and identify any third party health insurance coverage they have, including policy information. In addition, the state contractor routinely processes matches with the Centers for Medicare and Medicaid Services (CMS) and commercial insurance carriers to identify third party insurance coverage. Additional third party information identified by the contractor is used to update the client eligibility file. As a result of our contract with our current state vendor, we have recovered and provided cost savings to the State in the amount of \$176,662,042, through October 2009.

Highlights

Overview

The Office ends its first seven months having identified numerous new strategies to control and prevent fraud, waste, and abuse in the Medicaid program. The Office obtained recoveries and cost savings of \$193,317,604 through October 2009.

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Our first days and weeks in operation consisted of establishing Memorandums of Understanding with other State Agencies, meeting with the counties to educate them on our office and offer our services, and implementing new marketing tools such as the launch of our website.

Additionally, the Center for Medicare and Medicaid Services (CMS) conducted a previously scheduled audit of our Investigations Unit. We are proud to report that CMS was so impressed with the practices of our Special Projects Unit (SPU) within the Investigations Unit that CMS is going to recommend these practices be utilized in other Investigation units across the country. The SPU conducts background checks to ensure the integrity of the enrollment process into the Medicaid Program. Since March, our SPU staff has prevented 14 pharmacies from enrolling in the Medicaid program because of various concerns including: pending licensing actions by the Board of Pharmacy, failing to disclose required information on applications, pending criminal investigations or actions, and filing applications on behalf of non-operational pharmacies. By preventing these pharmacies from becoming Medicaid providers, we have avoided potential fraud, waste and abuse. Below are some of the investigations we have conducted, and the recoveries we have made in our short time of operation.

Investigations and Recoveries

In both coordination with and independent of the Departments of Human Services and Health and Senior Services, our Investigations Unit has conducted extensive investigations of numerous providers and recipients.

For example, one recipient became a subject of investigation by our office when she drastically under-reported her income. She stated she had a household income of \$15,000 but neglected to put on her Family Care application that she was living with her

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children's father in a house valued at \$900,000. When contacted by one of our investigators, she refused to provide copies of prior years' tax returns and disenrolled from Family Care. She received the benefit coverage for herself and her child in the amount of \$9,034.62. We recovered a compromised amount of \$6,500 on June 17, 2009.

Our investigations of providers include pharmacists and pharmacies that employ them. For example, our Special Projects Unit performed a background check of a pharmacy in Colts Neck, NJ. During the course of this investigation, our SPU investigators discovered that the owner's husband was working at another New Jersey pharmacy as a pharmacist even though he has been federally excluded for 13 years because of a conviction in New York in 2005. In order to obtain employment with this pharmacy, the excluded pharmacist failed to answer an employment application seeking to know whether the applicant had ever been federally excluded from participating in any federal health care programs. Our SPU unit is currently seeking revocation of this pharmacist's pharmacy license from the Board of Pharmacy. This case has additionally been referred to our Recovery Unit and we are seeking recovery of approximately \$3,000,000.00.

Our investigators also ensure all providers are properly credentialed. For example, Comm-Unity, a Partial Care Provider, operated with a Clinical Director who did not meet credentialing standards as required by regulations. As a result of an investigation conducted by our staff, we recovered \$71,140.87 through settlement on May 15, 2009 because this Director was not properly credentialed.

Similarly, our investigators revealed that Medi Taxi, a medical transportation provider, billed Medicaid for trips where recipients were driven to their destinations by unlicensed drivers in violation of state law. Investigators referred this case to our

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Recovery Unit which filed a Notice of Claim on July 20, 2009 for \$60,202.50 including principal and interest. This claim is still pending.

Likewise, our Recovery Unit recently filed a Notice of Claim against Delta Invalid Coach, Inc., another transportation provider, for \$289,483 in principal and \$29,390.26 in interest for a total claim of \$318,893.26 because our Investigations Unit uncovered that Delta operated from April 3, 2007, through January 30, 2008, without possessing valid liability insurance as required by regulation. To date, our Recovery Unit has withheld \$25,891.25 in Medicaid payments to this provider and will continue to withhold payments on a weekly basis.

Finally, our investigators identified \$204,313.44 in false claims from Drug Fair Group who provided services for Medicaid, PAAD and FamilyCare recipients at its Bridgewater Pharmacy, not an approved Medicaid provider, but billed using the provider number of other Drug Fair pharmacies which were approved providers. Our Recovery Unit has filed a Notice of Claim and this case is also currently pending.

Our office also receives referrals from other federal, state and local entities. For example, based on a phone call from the Department of Agriculture advising our staff that one or more owners of Horizon Adult Medical Day Care in Patterson would be pleading guilty for fraud and settling a case with the U.S. Attorney's Office, we found that Horizon routinely overbilled for beneficiaries who were either out on specific days, attended intermittently, or never attended at all, thus inflating the payments this center received. We recovered \$401,054.88.

As a result of these and other efforts as well as through the success of our TPL unit, we have recovered and provided cost savings amounting to a total of \$193,317,604

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from March 16, 2009 through October 20, 2009, an increase of 14.87% over last year for the same period.

Because of his role as Medicaid Inspector General, Mark Anderson was also appointed by Governor Jon S. Corzine to serve on the Governor's ARRA Task Force which oversees the receipt of federal ARRA stimulus dollars by the State of New Jersey. Mr. Anderson also serves on the Task Force's Internal Control's subcommittee where he, along with the Inspector General Mary Jane Cooper, educates state agencies on their internal controls and shows them how to prevent fraud, waste and abuse in their receipt of these funds. For more information on the Task Force or these internal controls training, please visit www.nj.gov/recovery.

How to Contact the Office of the Medicaid Inspector General

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If you suspect fraud, waste or abuse in the Medicaid, Family Care and/or Charity Care programs, please call our hotline at 1.888.937.2835, email us at njmedicaidfraud@omig.state.nj.us or submit a form electronically on our website: www.nj.gov/njomig