Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NONINSTITUTIONAL PROVIDERS IN NEW YORK STATE DID NOT ALWAYS RECONCILE ACCOUNT RECORDS WITH CREDIT BALANCES AND REPORT THE ASSOCIATED MEDICAID OVERPAYMENTS TO THE STATE AGENCY

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

James P. Edert
Regional Inspector General
for Audit Services

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Office of Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New York State, the Department of Health (State agency) administers Medicaid.

Providers of Medicaid services submit claims to States to receive compensation. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims. Pursuant to 42 CFR section 433.10, the Federal Government pays its share (Federal share) of State medical assistance expenditures according to a defined formula.

A credit balance is an improper or excess payment made to a provider as a result of recipient billing or claims-processing errors. Credit balances may occur when a provider's reimbursement for services that it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

Providers record and accumulate charges and reimbursements for services in each patient's account record. Providers should review account records containing credit balances to include a reconciliation of all charges and payment records, and, if the reconciliation identifies a Medicaid overpayment, the provider should report the overpayment to the State. The State must refund the Federal share of the overpayment to CMS (the Act, § 1903(d)(2)(A) and 42 CFR pt. 433, subpart F).

Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, the State must make the adjustment no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In New York, the audit focused on noninstitutional providers.

OBJECTIVES

Our objectives were to determine whether noninstitutional providers reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency.

SUMMARY OF FINDINGS

Noninstitutional providers in New York did not always reconcile account records with credit balances and report the associated Medicaid overpayments to the State agency. Identification and reporting of Medicaid overpayments was at the discretion of the providers since the State agency did not require providers to exercise reasonable diligence in reconciling account records. Three of the eight providers that we randomly selected for review implemented and adhered to procedures for periodically reconciling account records and reporting identified Medicaid overpayments as required. However, the remaining five providers had no reconciliation procedures or did not adhere to established procedures.

Of the 54 account records with credit balances in our sample, 51 contained unresolved Medicaid overpayments totaling $2,009 ($1,113 Federal share). On the basis of these results, we estimated that the State agency could realize an additional statewide recovery of at least $899,745 ($498,269 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,009 ($1,113 Federal share) to the Federal Government for overpayments paid to the selected noninstitutional providers and

- enhance its efforts to recover additional overpayments estimated at $899,745 ($498,269 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling account records containing credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with either of our recommendations. After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer Medicaid. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers Medicaid. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New York State, the Department of Health (State agency) administers Medicaid.

Providers of Medicaid services submit claims to States to receive compensation. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims. Pursuant to 42 CFR section 433.10, the Federal Government pays its share (Federal share) of State medical assistance expenditures according to a defined formula.

A credit balance is an improper or excess payment made to a provider as a result of recipient billing or claims-processing errors. Credit balances may occur when a provider's reimbursement for services that it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

Providers record and accumulate charges and reimbursements for services in each patient's account record. Providers should review account records containing credit balances to include a reconciliation of all charges and payment records, and, if the reconciliation identifies a Medicaid overpayment, the provider should report the overpayment to the State. The State must refund the Federal share of the overpayment to CMS (the Act, § 1903(d)(2)(A) and 42 CFR pt. 433, subpart F).

Federal and State Requirements Related to Medicaid Overpayments

Under 42 CFR section 433.312, States are responsible for recovering from providers any amounts paid in excess of allowable Medicaid amounts and for refunding the Federal share to CMS.

Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, States must make the adjustment no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered as discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.[1]

Selected Noninstitutional Providers

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers.[2] In New York, our audit focused on noninstitutional providers. Table 1 identifies the primary classification for each of the eight noninstitutional providers that we randomly selected for review.

Table 1: Primary Classification

Provider	Description
Provider 1	Radiology
Provider 2	Ambulance services
Provider 3	Radiology
Provider 4	Oncology and hematology
Provider 5	Radiology
Provider 6	Optician
Provider 7	Ophthalmology
Provider 8	Internal medicine

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether noninstitutional providers reconciled account records with credit balances and reported the associated Medicaid overpayments to the State agency.

Scope

Our audit period covered 54 account records with unresolved credit balances as of the quarter ended September 30, 2011. The unresolved credit balances totaled $2,120.

We did not review the overall internal control structure of the State agency or the noninstitutional providers that we sampled. We limited our internal control review to obtaining

[1] 42 CFR § 433.316.

[2] Noninstitutional providers are any person or entity with a Medicaid provider agreement other than a hospital, long-term care nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

an understanding of the policies and procedures that the eight sampled providers used to reconcile credit balances and report overpayments to the State agency.

We conducted fieldwork at the State agency's offices in Albany, New York and the eight noninstitutional providers at various locations throughout New York.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations and State agency policy guidelines pertaining to Medicaid overpayments;

- interviewed State agency personnel responsible for monitoring Medicaid overpayments;

- created a sampling frame for the first stage of our sample design consisting of 3,591 noninstitutional Medicaid providers from which we randomly selected 8 providers (Appendix A);

- reviewed the providers' policies and procedures for reviewing credit balances and reporting overpayments to the State agency;

- determined the providers' total number and associated dollar amount of all account records with Medicaid credit balances;

- created a sampling frame for the second stage of our sample design that included credit balances that were greater than $3 and unresolved for at least 60 days;

- reviewed patient payment data, remittance advices, details of patient accounts receivable, and additional supporting documentation for each of the selected account records to determine Medicaid overpayments that should be reported to the State agency;

- estimated statewide unrecovered Medicaid overpayments associated with unresolved credit balances that should be reported to the State agency;

- determined whether the provider had taken action, subsequent to our audit period, to report to the State agency the Medicaid overpayments identified in our sample; and

- discussed our results with the providers in our sample.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

Noninstitutional providers in New York did not always reconcile account records with credit balances and report the associated Medicaid overpayments to the State agency. Identification and reporting of Medicaid overpayments was at the discretion of the providers since the State agency did not require providers to exercise reasonable diligence in reconciling account records. Three of the eight providers that we randomly selected for review implemented and adhered to procedures for periodically reconciling account records and reporting identified Medicaid overpayments as required. However, the remaining five providers had no reconciliation procedures or did not adhere to established procedures.

Of the 54 account records with credit balances in our sample, 51 contained unresolved Medicaid overpayments totaling $2,009 ($1,113 Federal share). On the basis of these results, we estimated that the State agency could realize an additional statewide recovery of at least $899,745 ($498,269 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

ACCOUNT RECORDS WITH UNRESOLVED MEDICAID OVERPAYMENTS

As of September 30, 2011, five of the eight noninstitutional providers had no account records with credit balances. The remaining 3 providers had 54 account records with unresolved credit balances totaling $2,120. Although Medicaid had reimbursed these providers, the providers had not reconciled, or otherwise evaluated, the account records to determine whether the unresolved credit balances contained Medicaid overpayments that should have been returned to the State agency.

Of the 54 account records with unresolved credit balances, 51 account records, totaling $2,009 ($1,113 Federal share), or 94 percent, had unresolved Medicaid overpayments that were at least 60 days old, and some were more than 6 years old, as shown in Table 2.

Table 2: Account Records With Unresolved Medicaid Overpayments

Time Unresolved	Number of Account Records	Medicaid Overpayment
60-365 days	2	$152
1-2 years	4	202
2-3 years	14	633
3-4 years	7	361
4-5 years	3	69
5-6 years	11	292
More than 6 years	10	300
Total	**51**	**$2,009**

The overpayments occurred because the providers submitted claims multiple times and improperly coordinated insurance benefits.[3]

[3] All three providers acknowledged that the overpayments occurred. We verified that the providers had reported $254 ($157 Federal share) of the overpayments to the State agency subsequent to our audit period.

POLICIES AND PROCEDURES NOT ALWAYS FOLLOWED

The three providers with unresolved credit balances did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling account records containing credit balances to identify and return overpayments that were due to the State agency. All three providers had policies and procedures in place for reconciling account records with credit balances; however, the providers did not always follow their procedures. Specifically, one provider made notes on patients' records if the provider discovered that credit balances were due but made no further efforts to return the overpayments to the State agency. A second provider did not always reconcile payments received from multiple insurers. Finally, a third provider performed preliminary reconciliations to identify Medicaid overpayments. However, the provider did not ensure that reported overpayments were successfully refunded and posted to account records.

MEDICAID OVERPAYMENTS AND ESTIMATED PROGRAM RECOVERIES

Of the 54 account records with credit balances in our sample, 51 contained Medicaid overpayments totaling $2,009 ($1,113 Federal share) paid to 3 noninstitutional providers. The State agency should refund the Federal share of those overpayments to CMS. (See Appendix B for details of our sample results.)

We estimated that the State agency could realize an additional statewide recovery of at least $899,745 ($498,269 Federal share) from our audit period and obtain future savings by requiring providers to exercise reasonable diligence in reconciling account records with credit balances and reporting the associated Medicaid overpayments. (See Appendix B for details of our statewide estimate.)

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,009 ($1,113 Federal share) to the Federal Government for overpayments paid to the selected noninstitutional providers and

- enhance its efforts to recover additional overpayments estimated at $899,745 ($498,269 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling account records containing credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with either of our recommendations. Regarding our first recommendation, the State agency stated that its Office of the Medicaid Inspector General will review our documentation and determine if a refund is appropriate. Regarding our second recommendation,

the State agency stated that it will consider conducting credit balance reviews of noninstitutional providers where feasible and as staffing resources allow.

The State agency's comments are included in their entirety as Appendix C.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of New York noninstitutional Medicaid provider identification numbers (provider IDs) in 15 categories of service that had at least 500 Medicaid paid claim lines (claims) in the quarter ended September 30, 2011.

SAMPLING FRAME

The sampling frame consisted of an Excel file containing 5,536,515 claims associated with 3,591 noninstitutional Medicaid provider IDs in 15 categories of service with at least 500 Medicaid paid claims for the quarter ended September 30, 2011. The Medicaid reimbursement for the 5,536,515 claims totaled $121,723,906 of which the Federal share totaled $61,148,296. The Medicaid claims were extracted from the claims' file maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The primary sample unit was a noninstitutional Medicaid provider ID. The secondary sample unit was a Medicaid credit balance in a provider's account that was greater than $3 and outstanding for at least 60 days as of September 30, 2011.

SAMPLE DESIGN

We used a multistage sample design with the primary sample units (noninstitutional Medicaid provider IDs) selected from a population of 15 categories of service that had at least 500 Medicaid paid claims for the quarter ended September 30, 2011. The secondary sample units (Medicaid credit balance(s) in a provider's account that were greater than $3 and outstanding for at least 60 days as of September 30, 2011) were selected from the primary sample units.

SAMPLE SIZE

We selected eight noninstitutional Medicaid provider IDs as the primary units. We identified Medicaid credit balances at three providers as the secondary units. We reviewed 100 percent of each provider's secondary units, consisting of 2, 4, and 48 credit balances, respectively, for a total of 54 secondary units.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the primary sample. After generating eight random numbers for the primary sample, we selected the corresponding frame items. We obtained a sampling frame of all Medicaid credit balance(s) greater than $3 and outstanding for at least 60 days as of September 30, 2011, from each of the eight providers' accounts. Three providers met these selection criteria. We selected for review all credit balances for the three providers.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the 90-percent confidence interval.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS OF MEDICAID OVERPAYMENTS

Provider	Frame Size	Total Number Reviewed	Number of Sample Items in Error	Total Value of Sample	Amount of Actual Overpayments	Federal Share of Overpayments
Provider 1	2	2	1	$54	$3	$2
Provider 2	4	4	4	251	251	155
Provider 3	0	0	0	0	0	0
Provider 4	0	0	0	0	0	0
Provider 5	0	0	0	0	0	0
Provider 6	0	0	0	0	0	0
Provider 7	48	48	46	1,815	1,755	956
Provider 8	0	0	0	0	0	0
Total	**54**	**54**	**51**	**$2,120**	**$2,009**	**$1,113**

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS[1]

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$901,754
Lower limit	$(378,764)
Upper limit	$2,182,272

Estimated Value of Medicaid Overpayments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$499,382
Lower limit	$(198,342)
Upper limit	$1,197,107

[1] The estimated value of overpayments includes the value of overpayments in the sample.

APPENDIX C: STATE AGENCY COMMENTS

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

June 5, 2014

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Ref. No. A-02-11-01036

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the U.S. Department of Health and Human Services, Office of Inspector General Draft Audit Report #A-02-11-01036 entitled, "Noninstitutional Providers in New York Did Not Always Reconcile Account Records with Credit Balances and Report the Associated Medicaid Overpayments to the State Agency."

Thank you for the opportunity to comment.

Sincerely,

Michael J. Nazarko

Michael J. Nazarko
Deputy Commissioner
for Administration

Enclosure

cc: Jason A. Helgerson
James C. Cox
Diane Christensen
Lori Conway
Robert Loftus
Joan Kewley
James Russo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
OHIP Audit BML

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-11-01036 Entitled
Noninstitutional Providers in New York Did Not Always Reconcile Account Records with Credit Balances and Report the Associated Medicaid Overpayments to the State Agency

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The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) Draft Audit Report A-02-11-01036 entitled, "Noninstitutional Providers in New York Did Not Always Reconcile Account Records with Credit Balances and Report the Associated Medicaid Overpayments to the State Agency."

Recommendation #1

Refund $2,009 ($1,113 Federal share) to the Federal Government for overpayments paid to the selected non-institutional providers.

Response #1

The Office of the Medicaid Inspector General (OMIG) requested the documentation for review from the OIG. After review of that documentation, the OMIG will determine if a refund is appropriate.

Recommendation #2:

Enhance its efforts to recover additional overpayments estimated at $899,745 ($498,269 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling account records containing credit balances and reporting the associated Medicaid overpayments.

Response #2:

The OMIG's Recovery Audit Contractor (RAC) conducts credit balance reviews for large institutional providers such as hospitals. During calendar years 2011-2013, the contractor recovered over $19 million based on credit balance reviews. Conducting credit balance reviews of non-institutional providers will be considered, where feasible, and as staffing resources allow.