



Office Of Inspector General
Office of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

February 25, 2004

Report Number: A-02-02-01037

Mr. Martin Cammer
Vice President, Faculty Practice
Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, New York 11219

Dear Mr. Cammer:

Enclosed are two copies of our final report entitled "Review of Medicare Secondary Payer Processes at Maimonides Medical Center for Claims Paid between July 1, 2001 and March 31, 2002". A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

The objectives of the audit were to assess the effects on the Medicare program of Maimonides Medical Center's (Maimonides) processes and controls with respect to the Medicare Secondary Payer (MSP) provision. Specifically, the audit evaluated the processes, procedures and controls for identifying your patients' insurers and filing health insurance claims. We also examined the related MSP accounting functions for recording accounts receivable and cash receipts and for tracking and recording credit balances.

Medicare laws, regulations and guidelines specify the conditions under which parties other than the Medicare program have the primary responsibility to pay for health care services rendered to Medicare beneficiaries. These laws, regulations and guidelines specify the responsibilities of the beneficiary, the Centers for Medicare & Medicaid Services (CMS), the Medicare providers and the Medicare contractor with respect to the MSP provisions.

The results of our review indicate that Maimonides's MSP processes, procedures and controls were generally adequate and resulted in proper determinations, but that Maimonides did not always identify the appropriate primary payer. As a result, the Medicare program was overcharged on behalf of three of the 40 beneficiaries in our review in the amount of \$2,154, a private insurer was overcharged for one beneficiary in the amount of \$10,000 and Maimonides had not collected \$161 from other insurers for services rendered to two beneficiaries. We also determined that Maimonides underreported its credit balances (i.e., excess payments resulting from billing or claims processing errors) to CMS in the amount of \$2,154.

We are recommending that Maimonides:

Review its written policies on MSP questionnaires to ensure that the policy is current and consistent.

Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,

- Ensure that the Medicare program is reimbursed \$2,154 for the improper payments identified in this audit,

Resubmit claims to collect \$161 due from a private insurer and Medicaid, and

- Ensure that pending adjustments, such as the credit balance of \$2,154 identified through this audit, are included in its CMS-838.

In written comments, Maimonides concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Maimonides also noted that it has implemented tighter internal controls and improved MSP processes to assure compliance with MSP requirements.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-02-02-01014 in all correspondence. Any questions or further comments on any aspect of the report are welcome. Please address them to me at (212) 264-4620 or through e-mail at thorgan@oig.hhs.gov.

Sincerely,



Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Mr. James T. Kerr, Regional Administrator
Centers for Medicare & Medicaid Services
26 Federal Plaza, Room 3811
New York, New York 10278

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE SECONDARY
PAYER PROCESSES**

AT

**MAIMONIDES MEDICAL CENTER
FOR CLAIMS PAID BETWEEN
JULY 1, 2001 AND MARCH 31, 2002**



Inspector General

FEBRUARY 2004

A-02-02-01037

Office of Inspector General

<http://oig.hhs.gov>

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Office of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900A
New York, NY 10278

February 25, 2004

Our Reference: Report No. A-02-02-01037

Mr. Martin Cammer
Vice President, Faculty Practice
Maimonides Medical Center
4802 Tenth Avenue
Brooklyn, New York 11219

Dear Mr. Cammer:

This report provides the results of our "REVIEW OF MEDICARE SECONDARY PAYER PROCESSES AT MAIMONIDES MEDICAL CENTER FOR CLAIMS PAID BETWEEN JULY 1, 2001 AND MARCH 31, 2002".

The objectives of the review were to assess the effects on the Medicare program of Maimonides Medical Center's (Maimonides) processes and controls with respect to the Medicare Secondary Payer (MSP) provision. Specifically, the audit evaluated Maimonides's processes, procedures and controls for identifying its patients' insurers and filing health insurance claims. We also examined the related MSP accounting functions for recording accounts receivable and cash receipts and for tracking and recording credit balances.

The results of our audit indicate that Maimonides's MSP processes, procedures and controls were generally adequate and resulted in proper determinations. We found, however, that Maimonides had not updated some of its written MSP procedures and did not always identify the appropriate primary payer. As a result, the Medicare program was overcharged on behalf of three of the 40 beneficiaries in our review in the amount of \$2,154, a private insurer was overcharged for one of the beneficiaries in the amount of \$10,000 and Maimonides had not collected \$161 from other insurers for services rendered to two of the beneficiaries. We also determined that Maimonides underreported its credit balances (*i.e.*, excess payments resulting from billing or claims processing errors) to the Centers for Medicare & Medicaid Services (CMS) in the amount of \$2,154 on Form CMS-838.

We recommend that Maimonides:

- ❑ Review its written policies on MSP questionnaires to ensure that the policy is current and consistent,
- ❑ Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,

- ❑ Ensure that the Medicare program is reimbursed \$2,154 for the improper payments identified in this audit,
- ❑ Resubmit claims to collect \$161 due from a private insurer and Medicaid, and
- ❑ Ensure that pending adjustments, such as the credit balance of \$2,154 identified through this audit, are included in its CMS-838.

Maimonides, in its response dated February 6, 2004, concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Maimonides also noted that it has implemented tighter internal controls and improved MSP processes to assure compliance with our recommendations. The full text of Maimonides's response is attached as Appendix B to this report.

INTRODUCTION

BACKGROUND

The Social Security Amendments of 1965 established the Medicare program under Title XVIII of the Social Security Act (Act). Section 1862(b) [42 U.S.C. 1395y] of the Act established the Medicare Secondary Payer (MSP) provisions and the conditions under which the Medicare program does not have the primary financial responsibility for health care services rendered to Medicare beneficiaries.

Specifically, Medicare is the secondary payer for:

- ❑ The Working Aged - beneficiaries age 65 or over, or their spouses, who are covered under employer group health plans (EGHP);
- ❑ The Disabled – beneficiaries under age 65 who are covered by a Large Employer Group Health Plan (LGHP), and
- ❑ Individuals with End-Stage Renal Disease – beneficiaries covered by an EGHP during the first 30 months of Medicare entitlement based on end-stage renal disease (ESRD).

In addition, Medicare may be the secondary payer for any beneficiary for:

- ❑ Claims involving No-Fault or Liability Insurance, or
- ❑ Claims involving other Government Programs, such as a State or Federal workers' compensation program or the Department of Veterans Affairs.

A secondary payment is coordinated with the primary payment such that Medicare will generally pay the difference between the amount charged and the amount of a primary payment, subject to certain limits. Under certain circumstances, however, the provider is obligated to accept a primary payment as payment in full, in which case no residual payment is due from Medicare. Finally, any improper primary Medicare payments must be repaid within 60 days of a notice or other information indicating that the MSP provisions apply.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The audit objectives were to assess the effects on the Medicare program of hospital processes and controls with respect to the MSP provision. Specifically, the audit evaluated processes used to identify the patients' insurers, file claims, record accounts receivable and cash receipts, and track and record credit balances.

Scope

The audit population included claims paid between July 1, 2001 and March 31, 2002 with the following characteristics:

- Cost Avoidances - these claims were included because the population included paid claims for a beneficiary for whom other claims were denied because of prepayment MSP edits;
- MSP Adjustment Claims – these claims were included in the population because the provider re-filed the claim to indicate a change in the beneficiary's MSP status;
- Other MSP Claims – these claims were processed for primary payment by Medicare but were included in the population to determine if other claim indicators suggested that only secondary benefits were due;
- Non-Group Health Plan Claims – these claims were processed for secondary Medicare payments, but the primary payer was not an EGHP or LGHP; they were selected because of the possibility that the secondary Medicare payment was improper, and
- No Pay Claims – the provider filed these claims to indicate that another payer was responsible for payment. These items were included in the population to determine whether Medicare should have paid any other claims for the same beneficiary.

Methodology

To accomplish the objectives, we:

- Reviewed applicable laws, regulations and guidelines;
- Reviewed the hospital's MSP procedures, processes and controls;
- Selected, through non-statistical means, all claims meeting the parameters described in the Scope section of this report for 40 beneficiaries;
- Obtained and reviewed, for each claim for each of the 40 beneficiaries:
 - Medicare claims,
 - Common Working File (CWF) data,
 - MSP Questionnaires,
 - Information in the Hospital Admission and Discharge Records,
 - Explanations of Benefits from other insurers, and
 - Information in the Hospital Financial System, Accounts Receivable and Cash Receipts Records, and

- Obtained and reviewed the Credit Balance Reports for each quarter in the audit period.

Fieldwork was performed at Empire Medicare Services (Empire), the Medicare contractor that processes Maimonides's claims, in Syracuse, New York and at Maimonides Medical Center in Brooklyn, New York between August 2002 and August 2003. The audit was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

CRITERIA

Medicare laws, regulations and guidelines specify the conditions under which parties other than the Medicare program have the primary responsibility to pay for health care services rendered to Medicare beneficiaries. As noted above, Medicare is generally the secondary payer for three categories of beneficiaries (the working aged, the disabled and beneficiaries with ESRD). In addition, parties other than Medicare (e.g., automobile no fault insurance, liability insurance or workers compensation programs) may have the primary obligation to pay claims resulting from accidents involving any Medicare beneficiary.

These laws, regulations and guidelines also specify the responsibilities of the beneficiary, the Centers for Medicare & Medicaid Services (CMS), the Medicare providers and the Medicare contractor with respect to the MSP provisions.

Further details about the MSP laws, regulations and guidelines are included in Appendix A.

Review of MSP Processes, Procedures and Controls

To evaluate the adequacy of Maimonides's MSP processes, procedures and controls, we conducted interviews with Maimonides officials and reviewed items such as:

- written policies and procedures addressing patient registration and admission, and
- the billing, accounts receivable, and cash receipts processes for MSP claims.

We found that Maimonides's MSP processes, procedures and controls were generally adequate. However, we also noted that the written procedures on the MSP questionnaires were not always current or consistent, e.g., an internal memorandum issued by Maimonides in February 1999 stated that MSP questionnaires are not required for certain outpatient visits. The MSP questionnaire policy dated March 1999 and August 1999, however, required an MSP questionnaire for every encounter and was outdated at the time of our audit. Specifically, CMS program memoranda issued in September 2001 and March 2002 indicated that questionnaires are only required once every 90 days for certain outpatient services.

Identifying MSP Coverage

The identification of MSP coverage under Medicare laws, regulations and guidelines involves the beneficiary, CMS, Medicare providers such as Maimonides and Medicare contractors such as Empire. For example, when beneficiaries enroll for Medicare, CMS requests information about other primary coverage. Using this and other information, CMS updates the Common Working File to record the beneficiaries' MSP information.

Hospitals are required to consider the CWF data before billing Medicare and are generally also required to obtain specific information about all other insurance coverage before filing Medicare claims. Under most circumstances, hospitals must record the patient's responses to the requested information on an MSP questionnaire. For "hospital reference lab" services (i.e., laboratory services on behalf of beneficiaries who are not hospital patients) and "recurring outpatient services" (i.e., identical services rendered on an outpatient basis more than once within a billing cycle), however, information obtained within the last 90 days may be accepted without further development. CMS requires that providers retain copies of the MSP questionnaires for 10 years.

Medicare contractors, such as Empire, are generally advised to accept assertions of Medicare primary payer responsibility as shown on the Medicare claim and are expected to update the CWF file as new information is received from a hospital or a beneficiary.

To evaluate the adequacy of Maimonides's MSP questionnaires for the 40 beneficiaries in our sample we considered whether Maimonides had maintained the questionnaires and whether the questionnaires provided complete answers about other insurance coverage, as required by Chapter III of CMS's Hospital Manual. We received 65 (83 percent) of the 78 questionnaires requested. We determined that 54 (83 percent) of the 65 questionnaires were incomplete and sometimes lacked critical MSP information. For example, one questionnaire did not provide answers regarding the beneficiary's or the spouse's other insurance coverage, or information about the beneficiary's employer; it was, therefore, impossible to determine the beneficiary's MSP status from the questionnaire alone. Finally, we determined that five (7.7 percent) of the 65 questionnaires had inconsistencies (e.g., a questionnaire stated that the beneficiary was not employed, yet questionnaire also stated that the beneficiary was still working. This inconsistency made it impossible to determine whether the employer's health insurance was primary to Medicare).

Our review of the 93 Medicare claims (paid at \$342,200.40 during the audit period) for the 40 beneficiaries indicated that Maimonides generally processed MSP claims correctly despite the incomplete or inconsistent answers to the MSP questionnaires. We, therefore, believe that Maimonides's reliance on other sources of MSP information (e.g., Explanations of Benefits from other insurers and notes and records in Maimonides's financial system) generally resulted in proper MSP determinations. We note, however, that better MSP questionnaires might have reduced payment delays resulting from instances when Maimonides had to re-file or re-develop claims (for example, by contacting the beneficiary or the beneficiary's other insurers) before Medicare or other insurers would authorize payment. While these efforts resulted, on the whole,

in proper payments from Medicare, the audit identified six claims for which Maimonides had been improperly paid \$12,315:

- Medicare issued secondary payments for three claims for which Medicare had no responsibility for payment. In all three instances, either the Medicare claim or the “Explanation of Benefits” from the primary health insurers indicated that Maimonides was obligated to accept the primary benefits as payment in full. However, Maimonides claimed and received Medicare secondary payments in the amount of \$2,154. Based on our audit, Maimonides officials agreed that the primary payments should have been accepted as payment in full and prepared adjustment claims to refund the Medicare payments.
- A private insurer issued a primary payment in the amount of \$10,000 before Maimonides determined that Medicare had primary responsibility for this beneficiary. Maimonides became aware that Medicare was primary in December 2001 and received the Medicare payment in March 2002. As a result of our audit, a refund to the private insurer was processed in August 2003.
- Payments that were due from other insurers, amounting to \$161, were not claimed in two instances. In the first instance, Medicare properly paid primary benefits but Maimonides never filed a claim for secondary payments with the beneficiary’s private insurer. For the other claim, a private insurer issued the primary payment and Medicare paid secondary benefits. There was, however, a residual benefit due from Medicaid. As a result of our audit, Maimonides filed claims for the benefits due from the other insurers.

CAUSE

These improper payments resulted from weaknesses in the gathering of MSP information in the admission and registration processes as well as the failure to resolve contradictory MSP information on a timely basis.

Review of the Medicare Credit Balance Report

A credit balance is the result of an improper or excess payment (e.g., duplicate payments from Medicare and another insurer) because of billing or claims processing errors. When such situations occur, the Paperwork Burden Reduction Act of 1980 and §§1815(a), 1833(e) and 1866(a)(1)(C) of the Social Security Act require providers to refund incorrect payments and to submit a Medicare Credit Balance Report (Form CMS-838) to the Medicare contractor within 30 days after the close of each calendar quarter.

- We determined that Maimonides did not report credit balances totaling \$2,154 for three of the 40 beneficiaries in our sample, on the CMS-838. Medicare had issued secondary payments in all three instances, despite the fact that Maimonides had evidence that the payment from the private insurer represented payment in full under the terms of a contractual arrangement. Chapter IV of the Hospital Manual instructs providers to report

this type of activity on the Credit Balance Report (Form CMS-838) and to reimburse Medicare within 60 days of receiving payment from the other insurer. We found, however, that improper Medicare payments issued in August 2001, January 2002 and March 2002 were not properly adjusted until August 2003.

CAUSE

The unreported credit balances are primarily a consequence of the claims processing errors reported above.

RECOMMENDATIONS

We recommend that Maimonides:

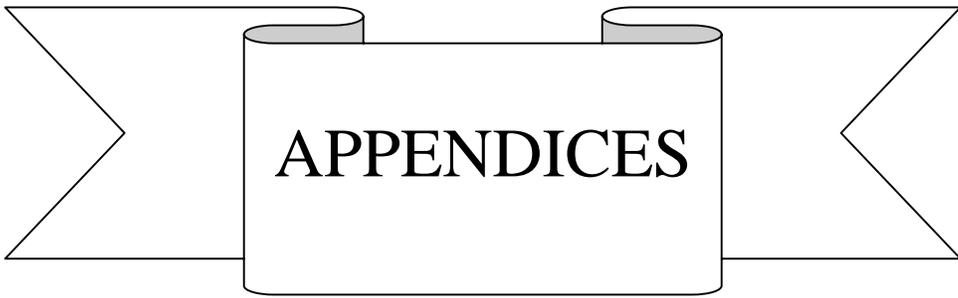
- ❑ Review its written policies on MSP questionnaires to ensure that the policy is current and consistent,
- ❑ Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,
- ❑ Ensure that the Medicare program is reimbursed \$2,154 for the improper payments identified in this audit,
- ❑ Resubmit claims to seek \$161 payments due from a private insurer and Medicaid, and
- ❑ Ensure that pending adjustments, such as the credit balances of \$2,154 identified through this audit, are included in its CMS-838.

Maimonides Medical Center's Response

Maimonides, in its response dated February 6, 2004, concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Maimonides also noted that it has implemented tighter internal controls and improved MSP processes to assure compliance with our recommendations. The full text of Maimonides's response is attached as Appendix B to this report.

Office of Audit Services' Comments

We are pleased to note that Maimonides has initiated corrective actions and review of its procedures to address the recommendations.



APPENDICES

Summary of Key Guidelines related to the MSP Program

The Social Security Act § 1862(b) sets forth the laws for the Medicare as Secondary Payer program. The basic provisions of the MSP laws were established and amended over time through the following legislation:

- The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) provides that Medicare is a secondary payer when an employee (or employee's spouse) age 65 through 69 is covered by an employer group health plan (EGHP) effective January 1, 1983. These provisions apply only to those employers with at least 20 employees.
- The Deficit Reduction Act of 1984 (P.L. 98-369) broadened the definition of a "working spouse" effective January 1, 1985 to include all spouses (regardless of age) covered by an EGHP.
- The Consolidated Omnibus Reconciliation Act of 1985 (P.L. 98-272) expanded the definition of "working aged" effective January 1, 1986 to include employees over the age of 69.
- The Omnibus Reconciliation Act of 1986 (OBRA) (P.L. 99-509) expanded the MSP provisions effective January 1, 1987 to include disabled employees and their working spouses who are covered by a "large" EGHP, which is defined as a plan offered by an employer with at least 100 employees.
- The OBRA of 1987 (P.L. 100-203) clarified the OBRA of 1986 provisions to indicate that government entities are primary payers for disabled employees covered by Medicare.
- The OBRA of 1989 (P.L. 101-239) established penalties for primary payers who fail to honor their obligations to provide for primary payments. It also clarified that secondary Medicare payments are limited to an amount not to exceed amounts payable if Medicare were primary; the limit applies to both the Medicare payment itself and the total payments from both the primary payer and Medicare.
- The OBRA of 1990 (P.L. 101-508) modified MSP provisions for Medicare beneficiaries with end-stage renal disease (ESRD) by instituting an 18-month period after the start of dialysis during which Medicare is secondary. The provision applied solely to services rendered between 1991 and 1995.
- The OBRA of 1993 (P.L.103-66) extended the provisions of OBRA of 1990 such that Medicare is secondary for the first 18 months of ESRD entitlement for services rendered through September 30, 1998.

- The Balanced Budget Act of 1997 (BBA) (P.L. 105-33) instituted a 30-month period after the start of dialysis during which Medicare is secondary. It also extended the time period

during which the United States may seek recovery of conditional Medicare payments from liable primary payers to three years from the date when the service was rendered. Finally, the BBA clarified that beneficiaries are generally not liable for MSP overpayments unless Medicare issued payment directly to the beneficiary.

Additional guidelines about the MSP provisions were included in the following CMS publications:

- CMS Hospital Manual, Chapter II §§ 262-264.17 and 289-289.24; Chapter III, §§ 300-301.3 and 308 to 309 and Chapter IV, § 468-484.7
- CMS Medicare Intermediary Manual, Part III, Chapter VI, § 3506-3521.4 and Chapter VII, § 3682-3697.3
- CMS Program Memoranda:
 - A-92-5 – June 8, 1992 “Reinstatement of Mandatory Credit Balance Reporting Requirements”
 - AB-01-18 – February 1, 2001 “New Automatic Notice of Change to Medicare Secondary Payer (MSP) Auxiliary File”
 - A-01-116 - September 25, 2001 - “Medicare Secondary Payer (MSP) Policies Relaxed for Hospitals”
 - AB-02-011 – February 1, 2002 “Notice of Interest Rate for Medicare Overpayments and Underpayments” and
 - A-02-021 - March 22, 2002 - “Medicare Secondary Payer (MSP) Information Collection Policies Changed for Hospitals”

The following “Intermediary Bulletins” from Empire Medicare Services, the Medicare contractor for Maimonides, also contained guidance related to the MSP provisions:

- Empire Medicare Services News Bulletin – March 1998 “Medicare as Secondary Payer”
- Empire Medicare Services News Update – September 2000 “Credit Balance Reporting Instructions – Changes Effective October 1, 2000”

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Finance



Maimonides

February 6, 2004

Mr. Timothy J. Horgan
Regional Inspector General
for Audit Services, Region II
Department of Health and Human Services
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Report No. A-02-0201037

Dear Mr. Horgan:

We received the U.S. Department of Health & Human Services, Office of Inspector General, Office of Audit Services' draft report entitled Review of Medicare Secondary Payor Processes at Maimonides Hospital for claims paid between July 1, 2001 and March 31, 2002. The Hospital has reviewed the report and the following comments are in response to the recommendations in the report.

Maimonides Medical Center conducts and continues to conduct periodic reviews of the Medicare Secondary Payor processes which are reported regularly to our Compliance Committee. As a result of these reviews, we have continually improved our processes and have conducted numerous in service educational programs for our admitting and registration staff.

The Medical Center was pleased to note that the Office of Inspector General Audit has found the Hospital's "MSP processes, procedures and controls were generally adequate and resulted in proper determinations".

With respect to the specific recommendations mentioned in the report, Maimonides has reviewed the recommendations and is implementing tighter controls to insure compliance with them. Please see the attached schedule detailing our specific responses to the Office of Inspector General recommendations.

Medicare Secondary Payor Processes
Page 2 of 3

We want to thank you and your staff for their assistance and guidance during the audit. If you have any questions or require any additional information, please feel free to contact me at 718-283-3900.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Cammer', with a long horizontal flourish extending to the right.

Martin A. Cammer
Vice President, Finance
Corporate Compliance Officer

cc: Elliot Hirshon, Audit Manager
Robert Naldi, Executive Vice President, CFO

Attachment

Recommendations	Actions
<ul style="list-style-type: none"> Review its written policies on MSP questionnaires to ensure that the policy is current and consistent. 	<ul style="list-style-type: none"> MMC is in the process of updating our MSP policy to insure it is correct and consistently applied across the institution.
<ul style="list-style-type: none"> Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information. 	<ul style="list-style-type: none"> Upon revision of the MSP policy, a focused training program will be held for all front end registrars, managers and supervisors. The training will focus on the completion of the MSP forms and to facilitate a better understanding of the purpose of the MSP policy.
<ul style="list-style-type: none"> Ensure that the Medicare program is reimbursed \$2,154 for the improper payments identified in this audit. 	<ul style="list-style-type: none"> CMS has been reimbursed for \$2,154 for the improper payments identified in this audit. We have also reimbursed the private insurer the \$10,000 identified during the audit.
<ul style="list-style-type: none"> Resubmit claims to collect \$161 due from a private insurer and Medicaid. 	<ul style="list-style-type: none"> Claims totaling \$161 have been submitted to the appropriate insurers.
<ul style="list-style-type: none"> Ensure that pending adjustments, such as the credit balance of \$2,154 identified through this audit, are included in its CMS-838. 	<ul style="list-style-type: none"> We are reviewing our existing Credit Balance policy and will modify it, if necessary, to meet CMS regulations. Managers will be trained regarding the time adjudication of incorrectly paid claims.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other principal OAS staff included:

NEW YORK

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Arlene Carey, *Auditor*

Gwendolyn Booker, *Auditor*

Camille O'Brady, *Auditor*

HEADQUARTERS

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