

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NONINSTITUTIONAL PROVIDERS IN
CALIFORNIA DID NOT ALWAYS
RECONCILE INVOICE RECORDS WITH
CREDIT BALANCES AND REFUND TO
THE STATE AGENCY THE ASSOCIATED
MEDICAID OVERPAYMENTS**

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



**Lori A. Ahlstrand
Regional Inspector General**

**July 2013
A-09-12-02047**

Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

BACKGROUND

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. 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 California, the Department of Health Care Services (State agency) administers the program.

Providers of Medicaid services submit claims to States to receive compensation. The States process and pay the claims. The Federal Government pays its share (Federal share) of State medical assistance expenditures according to a defined formula (42 CFR § 433.10).

Credit balances may occur when a provider's reimbursement for services exceeds the allowable amount or when the reimbursement is for unallowable costs. Credit balances may also occur when a provider receives payments from Medicaid and another third-party payer for the same services. Additionally, credit balances may occur when reimbursements for services are recorded incorrectly. Credit balances do not always contain overpayments due back to the Medicaid program.

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

California regulations require providers eligible for electronic claims submission to review payment records and refund Medicaid overpayments within a specific period.

This audit is part of a multistate review of credit balances at acute-care hospitals, nursing facilities, and certain noninstitutional providers. In California, the audit focused on two types of noninstitutional providers: physicians and physician groups. We randomly sampled 8 noninstitutional providers from 1,515 providers that had paid claims, totaling about \$219 million, as of the quarter ended September 30, 2011, and reviewed their invoice records as of the quarter ended March 31, 2012.

OBJECTIVES

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

SUMMARY OF FINDINGS

Of the eight noninstitutional providers in our sample, two providers always reconciled invoice records, one provider never reconciled invoice records, and five providers did not always reconcile invoice records with credit balances and refund to the State agency the associated Medicaid overpayments:

- One provider did not record Medicaid payments received, including \$882,602 for the quarter ended September 30, 2011; as a result, we could not determine whether there were Medicaid credit balances that might have contained Medicaid overpayments.
- For 5 providers, we sampled a total of 129 invoice records with Medicaid credit balances that were unresolved for at least 60 days and found that 63 contained Medicaid overpayments and 66 did not. The Medicaid overpayments associated with the 63 invoice records totaled \$6,961 (\$4,040 Federal share).

Using these results, we estimated that the State agency could realize an additional statewide recovery of \$1,081,493 (\$618,749 Federal share) from noninstitutional providers and obtain future savings if it enhanced its efforts to recover Medicaid overpayments in provider accounts.

The providers did not identify and refund Medicaid overpayments because the State agency did not provide adequate oversight to ensure that providers exercised reasonable diligence in reconciling invoice records with credit balances to identify and refund Medicaid overpayments that were due to the State agency. In addition, the State agency's requirement to review payment records and refund Medicaid overpayments applied only to providers eligible for electronic claims submission. Finally, the State agency did not require providers to submit reports that showed all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$6,961 (\$4,040 Federal share) to the Federal Government for Medicaid overpayments to the providers,
- ensure that the one provider that never reconciled invoice records reviews payment records and refunds to the State agency any identified Medicaid overpayments, and
- enhance its efforts to recover additional Medicaid overpayments estimated at \$1,081,493 (\$618,749 Federal share) from noninstitutional providers and realize future savings by requiring and ensuring that all providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and described actions that it planned to take to address our recommendations.

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INTRODUCTION

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. 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 California, the Department of Health Care Services (State agency) administers the program.

Providers of Medicaid services submit claims to States to receive compensation. The States process and pay the claims. The Federal Government pays its share (Federal share) of State medical assistance expenditures according to a defined formula (42 CFR § 433.10).

Credit balances may occur when a provider's reimbursement for services exceeds the allowable amount or when the reimbursement is for unallowable costs. Credit balances may also occur when a provider receives payments from Medicaid and another third-party payer for the same services. Additionally, credit balances may occur when reimbursements for services are recorded incorrectly. Credit balances do not always contain overpayments due back to the Medicaid program.

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

Federal and State Requirements Related to Medicaid Overpayments

States are responsible for recovering from providers any amounts paid in excess of allowable Medicaid amounts and for refunding to CMS the Federal share (42 CFR § 433.312). 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 (42 CFR § 433.316).

California regulations require providers eligible for electronic claims submission to review payment records and refund Medicaid overpayments within a specific period (California Administrative Code, Title 22, §§ 51502.1(f)(7) and 51008(d)).

Selected Noninstitutional Providers

This audit is part of a multistate review of credit balances at acute-care hospitals, nursing facilities, and certain noninstitutional providers. In California, the audit focused on two types of noninstitutional providers: physicians and physician groups. Table 1 identifies the primary classification for each of the eight providers we sampled. Seven of the eight providers were eligible for electronic claims submission.

Table 1: Primary Classifications for Providers

Provider	Description
1	Pediatric hospital medicine
2	Pathology
3	Clinic/center
4	Hospital medicine
5	Pathology
6	Pathology
7	Clinic/center
8	Medical imaging

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

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

Scope

Of 1,515 noninstitutional providers with payments as of the quarter ended September 30, 2011, totaling \$219,337,953, we randomly sampled 8 providers. We reviewed the providers' invoice records as of the quarter ended March 31, 2012. We determined that one provider never reconciled invoice records; consequently, we could not determine whether there were Medicaid credit balances. The remaining 7 providers had 268 invoice records with Medicaid credit balances, totaling \$23,849. Two of the seven providers had no invoice records with Medicaid credit balances that were unresolved for at least 60 days. The remaining 5 providers had 182 invoice records with Medicaid credit balances, totaling \$20,333, that were unresolved for at

least 60 days. Of the 182 invoice records, we randomly sampled 129 invoice records, totaling \$19,045.

We did not review the overall internal control structure of the State agency or the noninstitutional providers. We limited our internal control review to obtaining an understanding of the policies and procedures that the providers used to review and reconcile invoice records with credit balances and refund to the State agency any Medicaid overpayments.

We conducted our audit from May 2012 to March 2013 and performed fieldwork at the State agency's office in Sacramento, California, and at various locations throughout California and Missouri¹ for the eight providers.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidelines pertaining to Medicaid overpayments;
- discussed with State agency personnel the State agency's policies and procedures for identifying and recovering Medicaid overpayments from noninstitutional providers;
- created a sampling frame for the first stage of our sample design, consisting of 1,515 noninstitutional providers from which we randomly selected 8 providers using the probability-proportional-to-size methodology;
- reviewed the providers' policies and procedures for reviewing and reconciling invoice records with credit balances and refunding to the State agency Medicaid overpayments;
- determined the providers' total number and associated dollar amount of all invoice records with credit balances and identified total Medicaid credit balances;
- created a sampling frame for the second stage of our sample design, consisting of 5 of the 8 selected providers;
- selected a random sample of 50 invoice records with Medicaid credit balances that were unresolved for at least 60 days from 2 providers that had more than 50 such invoice records (a total of 100 invoice records);
- reviewed all the invoice records with Medicaid credit balances that were unresolved for at least 60 days from 3 providers that had fewer than 50 such invoice records (a total of 29 invoice records);

¹The eight providers were located in California. One provider contracted with a Missouri billing company for claims processing.

- reviewed payment records, patient account details, and additional support for each of the selected invoice records to determine whether there were Medicaid overpayments that should be refunded to the State agency;
- estimated the statewide unrecovered Medicaid overpayments associated with noninstitutional providers' Medicaid credit balances;
- discussed the results of our review with the eight providers in our sample; and
- provided the results of our review to the State agency.

See Appendix A for details on our sample design and methodology and Appendix B for our sample results and estimates.

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

Of the eight noninstitutional providers in our sample, two providers always reconciled invoice records, one provider never reconciled invoice records, and five providers did not always reconcile invoice records with credit balances and refund to the State agency the associated Medicaid overpayments:

- One provider did not record Medicaid payments received, including \$882,602 for the quarter ended September 30, 2011; as a result, we could not determine whether there were Medicaid credit balances that might have contained Medicaid overpayments.
- For 5 providers, we sampled a total of 129 invoice records with Medicaid credit balances that were unresolved for at least 60 days and found that 63 contained Medicaid overpayments and 66 did not. The Medicaid overpayments associated with the 63 invoice records totaled \$6,961 (\$4,040 Federal share).

Using these results, we estimated that the State agency could realize an additional statewide recovery of \$1,081,493 (\$618,749 Federal share) from noninstitutional providers and obtain future savings if it enhanced its efforts to recover Medicaid overpayments in provider accounts.

The providers did not identify and refund Medicaid overpayments because the State agency did not provide adequate oversight to ensure that providers exercised reasonable diligence in reconciling invoice records with credit balances to identify and refund Medicaid overpayments that were due to the State agency. In addition, the State agency's requirement to review payment records and refund Medicaid overpayments applied only to providers eligible for electronic claims submission. Finally, the State agency did not require providers to submit reports that

showed all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.²

INVOICE RECORDS NOT RECONCILED

One provider never reconciled invoice records. Although the State agency reimbursed the provider for services, including \$882,602 for the quarter ended September 30, 2011, the provider did not record Medicaid payments received. As a result, we could not determine whether there were Medicaid credit balances that might have contained Medicaid overpayments due to the State agency.

INVOICE RECORDS WITH MEDICAID CREDIT BALANCES

For 5 providers, including 1 provider that was not eligible for electronic claims submission, we determined that 182 invoice records, totaling \$20,333, had Medicaid credit balances that were unresolved for at least 60 days, as shown in Table 2. Although the State agency reimbursed the providers for services, the providers had not reconciled, or otherwise evaluated, the invoice records to determine whether the Medicaid credit balances contained Medicaid overpayments that should have been refunded to the State agency.

Table 2: Invoice Records With Medicaid Credit Balances

Length of Time Unresolved	Number of Invoice Records	Amount of Medicaid Credit Balances
60–365 days	133	\$8,350
1–2 years	45	11,430
2–3 years	3	499
More than 3 years	1	54
Total	182	\$20,333

MEDICAID OVERPAYMENTS NOT REFUNDED

The California Administrative Code, Title 22, § 51502.1(f)(7), states that providers eligible for electronic claims submission must review payment records and promptly pursue corrections for any overpayments within the applicable limits of § 51008(d). Section 51008(d) requires that a request for adjustment or reconsideration of a processed claim be received not later than 6 months following the date of payment or denial of the claim. For overpayments identified later than 6 months, California's *Medi-Cal Provider Manual*, Part I, states that requests for overpayment adjustments may be submitted at any time.

Of the 129 invoice records in our sample, 63 contained Medicaid overpayments totaling \$6,961 (\$4,040 Federal share) that had not been refunded to the State agency. The overpayments were caused by duplicate payments, which typically occurred when providers erroneously generated

² A Federal requirement that providers must report and repay overpayments within a certain time period was added to section 1128J of the Act by section 6402(a) of the Patient Protection and Affordable Care Act, P.L. No. 111-148. CMS will issue Medicaid regulations in the future to establish Federal policies and procedures to implement the law.

multiple billings or when Medicaid paid more than once for the same service. The overpayments also were caused by billing errors, which included overstated amounts billed or paid, Medicaid and third-party claims billed in error, and payment received from Medicaid for services not billed.

INADEQUATE OVERSIGHT AND LACK OF REVIEW AND REPORTING REQUIREMENTS

The providers did not identify and refund Medicaid overpayments because the State agency did not provide adequate oversight to ensure that providers exercised reasonable diligence in reconciling invoice records with credit balances to identify and refund Medicaid overpayments that were due to the State agency. For example, State officials told us that the State agency does not periodically audit all noninstitutional providers. In addition, the State agency's requirement to review payment records and refund Medicaid overpayments applied only to providers eligible for electronic claims submission. Finally, the State agency did not require providers to submit reports that showed all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

MEDICAID OVERPAYMENTS AND ESTIMATED STATEWIDE RECOVERY

Of the 129 invoice records in our sample, 63 contained Medicaid overpayments totaling \$6,961 (\$4,040 Federal share) paid to 5 providers. (See Appendix B for details of our sample results.) Also, we estimated that the State agency could realize an additional statewide recovery of \$1,081,493 (\$618,749 Federal share) from noninstitutional providers and obtain future savings by requiring and ensuring that all providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments. (See Appendix B for details of our statewide estimate.) Our estimated statewide recovery may be understated because one provider never reconciled invoice records with credit balances.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$6,961 (\$4,040 Federal share) to the Federal Government for Medicaid overpayments to the providers,
- ensure that the one provider that never reconciled invoice records reviews payment records and refunds to the State agency any identified Medicaid overpayments, and
- enhance its efforts to recover additional Medicaid overpayments estimated at \$1,081,493 (\$618,749 Federal share) from noninstitutional providers and realize future savings by requiring and ensuring that all providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and described actions that it planned to take to address our recommendations. The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of certain noninstitutional providers for California that received a Medicaid payment during the quarter ended September 30, 2011. These noninstitutional providers were either physicians or physician groups. Physicians are identified in California's Medicaid Management Information System (MMIS) as provider type 026. Physician groups are identified as provider type 022.

SAMPLING FRAME

From California's MMIS, we created a database of all payments made to certain noninstitutional providers during the quarter ended September 30, 2011. We combined providers by employer identification numbers or Social Security numbers to create a unique listing of providers. The database consisted of 5,197,769 claims with Medicaid payments totaling \$281,117,111, representing 11,871 providers. We then removed all providers with fewer than 500 Medicaid claims and excluded 1 provider that did not have an employer identification number or a Social Security number. The resulting sampling frame of 4,388,403 claims and Medicaid payments totaling \$219,337,953 represented 1,515 providers.

SAMPLE UNIT

The primary sample unit was a noninstitutional provider. The secondary sample unit was an invoice record with a Medicaid credit balance in a provider's account that was unresolved for at least 60 days as of March 31, 2012.

SAMPLE DESIGN

We used a multistage sample design based on probability-proportional-to-size weighted by the total number of Medicaid claims paid for the quarter ended September 30, 2011. The first stage consisted of a random selection of providers with probability of selection proportional to the total number of paid Medicaid claims. The second stage consisted of a simple random sample at each of the selected providers where the provider had 50 or more invoice records with Medicaid credit balances as of the quarter ended March 31, 2012. If the provider did not have at least 50 invoice records with Medicaid credit balances as of the quarter ended March 31, 2012, we selected for review all of that provider's invoice records with Medicaid credit balances.

SAMPLE SIZE

We selected eight noninstitutional providers as the primary units. For the secondary units, we selected a random sample of 50 invoice records with Medicaid credit balances from 2 providers (100 invoice records) and all invoice records with Medicaid credit balances from 3 providers (29 invoice records), for a total of 129 invoice records in the amount of \$19,045. We did not select invoice records with Medicaid credit balances from two providers because the Medicaid credit balances had not been unresolved for at least 60 days. We did not select invoice records

from the remaining provider because the provider never reconciled invoice records with credit balances.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

The sample selection used probability-proportional-to-size through which we considered the relative sizes of the noninstitutional providers when selecting the primary sampling units. For the secondary units, we consecutively numbered the invoice records with Medicaid credit balances in the sampling frame for each provider. After generating the random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the amount of Medicaid overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES**SAMPLE RESULTS OF MEDICAID OVERPAYMENTS**

Provider	Invoice Records	Sample Frame	Sample Size	No. of Overpayments	Amount of Overpayments	Amount of Overpayments (Federal Share)
1	4	4	4	2	\$81	\$50
2	14	0	0	0	0	0
3	0	0	0	0	0	0
4	29	23	23	10	542	284
5	20	0	0	0	0	0
6	145	100	50	9	315	158
7	2	2	2	2	337	208
8	54	53	50	40	5,686	3,340
Total	268	182	129	63	\$6,961	\$4,040

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS¹**First Stage**

Population (No. of Providers)	Frame Size (No. of Claims)	Value of Frame	Sample Size (No. of Providers)
1,515	4,388,403	\$219,337,953	8

Second Stage

Frame Size (No. of Invoice Records)	Value of Frame	Sample Size (No. of Invoice Records)	Value of Sample	No. of Overpayments in Sample	Amount of Overpayments in Sample	Amount of Overpayments in Sample (Federal Share)
182	\$20,333	129	\$19,045	63	\$6,961	\$4,040

¹To calculate the statewide estimate of potential savings, we included the payments for the eight providers, including the three providers with no overpayments.

Estimated Amount of Overpayments²
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$1,088,454
Lower limit	(127,775)
Upper limit	2,304,684

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

Point estimate	\$622,789
Lower limit	(83,814)
Upper limit	1,329,391

²The estimated amount of overpayments includes the amount of overpayments in the sample.

APPENDIX C: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

JUN - 3 2013

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
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Dear Ms. Ahlstrand:

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Noninstitutional Providers in California Did Not Always Reconcile Invoice Records with Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments*.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Melanie Pascua, Audit Coordinator, at (916) 445-2410 if you have any questions.

Sincerely,

Toby Douglas
Director

Enclosure

Ms. Lori A. Ahlstrand
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**Department of Health Care Services Response to the
Office of Inspector General's Draft Report Entitled:
*Noninstitutional Providers in California Did Not Always Reconcile Invoice Records with
Credit Balances and Refund to the State Agency the
Associated Medicaid Overpayments*
Report A-09-12-02047, May 2013**

Finding #1: One provider did not record Medicaid payments received, including \$882,602 for the quarter ended September 30, 2011. As a result, OIG could not determine whether there were Medicaid credit balances that might have contained Medicaid overpayments.

Recommendation: The Department of Health Care Services (DHCS) ensures that the one provider that never reconciled invoice records reviews payment records and refunds DHCS any identified Medicaid overpayments.

Response: DHCS agrees with the recommendation and will take corrective action by conducting an onsite audit of the one provider. Audits and Investigations (A&I), Medical Review Branch (MRB) will contact the provider, schedule an audit and do an onsite review by reconciling invoice records with credit balances that are unresolved for at least 60 days. MRB will determine if there are any credit balances that may result in overpayments by reviewing duplicate payments, billing errors, and payments received for services not billed. MRB will also look at aged accounts receivables and revenue journals for credit balances. If there are Medicaid overpayments identified, MRB will issue a demand letter and collect the overpayments.

Timeline for corrective action: Medical Review Branch will conduct the onsite audit as soon as the department receives the provider's information from OIG.

Finding #2: OIG sampled 129 invoice records of five providers with Medicaid credit balances that were unresolved for at least 60 days and found that 63 contained Medicaid overpayments and 66 did not. The Medicaid overpayments associated with the 63 invoice records totaled \$6,961 (\$4,040 Federal share).

Recommendation: DHCS refund \$6,961 (\$4,040 Federal share) to the Federal Government for Medicaid overpayments to the providers.

Response: DHCS agrees with the recommendation to refund \$6,961 (\$4,040 Federal share) to the Federal Government for Medicaid overpayments.

Timeline for corrective action: DHCS expects to review the invoice records of the five providers within the third quarter of 2013 and thereby issuing demand letters to recoup the credit balances. The process initiates the repayment of the Federal share.

Finding #3: OIG estimated that DHCS could realize an additional statewide recovery of

\$1,081,493 (\$618,749 Federal share) from noninstitutional providers and obtain future saving if it enhanced its efforts to recover Medicaid overpayments in provider accounts.

Recommendation: DHCS to enhance its efforts to recover additional Medicaid overpayments estimated at \$1,081,493 (\$618,749 Federal share) from noninstitutional providers. DHCS is to realize future savings by requiring and ensuring that all providers exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

Response: DHCS agrees with the recommendation that the department needs to enhance its efforts to recover additional Medicaid overpayments from noninstitutional providers. DHCS – A&I-MRB will require and ensure noninstitutional providers (physicians and physician groups) exercise reasonable diligence in reconciling invoice records with credit balances and report the associated Medicaid overpayments. Medical Review Branch will inform the noninstitutional providers in writing to conduct self-audits on credit balances that are unresolved for at least 60 days. In the self-audit letters, MRB will instruct noninstitutional providers to review duplicate payments, billing errors, and payments received for services not billed. MRB will also include directions on how the provider is to report and refund all identified Medicaid overpayments to the department in the self-audit letter.

In addition to the providers conducting self-audits, MRB will include an additional audit step in the audit program to review credit balances for noninstitutional providers. MRB will review duplicate payments, billing errors, and payments received for services not billed in addition to looking at aged accounts receivables and revenue journals for credit balances. If there are Medicaid overpayments identified, MRB will issue a demand letter and collect the overpayment.

Timeline for corrective action: The corrective action plan is on the agenda for discussion during the A&I-MRB Production meeting held in June 2013.