



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

January 21, 2003

Common Identification No. A-05-02-00080

Mr. Kevin Jones
Director of Finance
Administration
Aurora Sinai Medical Center
945 North 12th Street
Milwaukee, WI 53201

Dear Mr. Jones:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicaid and Medicare Credit Balances at Aurora Sinai Medical Center" as of May 31, 2002 and March 31, 2002, respectively. A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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, OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general 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 Common Identification Number A-05-02-00080 in all correspondence relating to this report.

Sincerely yours,

Paul Swanson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Cheryl Harris, Associate Regional Administrator
Centers for Medicare & Medicaid Services-
Division of Medicaid, Region V
233 North Michigan Avenue
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID AND
MEDICARE CREDIT BALANCES
AT
AURORA SINAI MEDICAL CENTER
MILWAUKEE, WISCONSIN**



JANET REHNQUIST
Inspector General

JANUARY 2003
A-05-02-00080

EXECUTIVE SUMMARY

OBJECTIVE

The audit objective was to determine whether the Medicaid and Medicare credit balances recorded on Aurora Sinai Medical Center's accounting records for inpatient and outpatient services represented overpayments reportable to the Medicaid and Medicare programs.

FINDINGS

The provider did not always identify and report overpayments in a timely manner to the Medicaid and Medicare programs in accordance with State and Federal regulations. In our opinion, this is due to:

- The provider not being aware of Medicaid regulations requiring overpayments be reported within 30 days of occurrence; and
- Provider policies and procedures, in effect as we started our review, not being in accordance with Medicaid and Medicare regulations.

As a result, estimated Medicaid overpayments of \$515,498 and Medicare overpayments of \$637 were not reported to the programs in a timely manner. During our field work, \$193 of the overpayment was recovered by the Medicare program.

RECOMMENDATIONS

We recommend that Aurora Sinai Medical Center:

- Ensure Medicaid recovers overpayments of \$515,498;
- Ensure Medicare recovers overpayments of \$444;
- Revise policies and procedures to ensure that existing and future overpayments are identified and reported;
- Identify and report future Medicaid overpayments within 30 days of occurrence or discovery, as specified in State regulations, Medicare overpayments within quarterly reporting requirements; and
- Submit adjustment request forms for unreported Medicaid overpayments.

PROVIDER RESPONSE AND OAS COMMENTS

Generally, Aurora Sinai concurred with the results of our review and has already initiated corrective actions with regards to the recommendations. We agree with the corrective actions taken, to date, to resolve the overpayments and in response to the procedural recommendations.

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Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
GAMP	General Assistance Medical Program
HCFA	Health Care Financing Administration
HFS	Department of Health and Family Services
MA	Medical Assistance (i.e., Medicaid)
Sinai	Aurora Sinai Medical Center (formerly Sinai Samaritan Medical Center)

INTRODUCTION

BACKGROUND

Credit balances generally occur when reimbursement for services provided to a Medicaid or Medicare beneficiary exceeds the charges billed. When a provider receives a duplicate payment from the Medicaid or Medicare program, or receives payment from another payer after Medicaid or Medicare reimbursement has been received, an overpayment exists and should be recovered by the respective program. Credit balances also occur from errors in calculating contractual allowances, errors in calculating coinsurance and other accounting errors. In these cases, an overpayment is not likely to exist.

Governing regulations for the handling of Medicaid credit balances are found in Wisconsin Administrative Code HFS 106, while applicable Medicare regulations are found in Title 42 of the Code of Federal Regulations (CFR). According to Wisconsin Administrative Code, providers are required to refund Medicaid overpayments within 30 days of receipt or discovery, depending on the nature of the overpayment. Effective April 1992, all providers of health care services participating in the Medicare program were required to submit a Medicare Credit Balance Report on a quarterly basis.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective. The objective of our audit was to determine whether the Medicaid and Medicare credit balances recorded in Aurora Sinai Medical Center's (Sinai) accounting records for inpatient and outpatient services represented overpayments that should have been reported to the Medicaid and Medicare programs.

Scope. As of May 31, 2002, Sinai identified 2,012 inpatient and outpatient Medicaid credit balances, totaling \$2,747,303, of which 1,061 credit balances, totaling \$2,629,846, were in excess of \$1,000 for inpatient and \$100 for outpatient services. For the quarter ended March 31, 2002, Sinai also reported 22 Medicare outpatient credit balances, totaling \$4,653. No Medicare inpatient credit balances were reported for the quarter ended March 31, 2002.

We did not perform a detailed review of Sinai's internal controls. Our audit included extensive substantive testing, thereby reducing our need to perform an internal control review. We limited our review of internal controls to determining whether the provider had adequate policies and procedures for reporting overpayments to the Medicaid and Medicare programs and whether we could rely on the contents of the credit balance listings provided for audit purposes.

Other than the issues discussed in the Findings and Recommendations section of this report, we found no instances of noncompliance with applicable laws and regulations. With respect to those items not tested, nothing came to our attention to cause us to believe that the untested items were not in compliance with applicable laws and regulations.

Methodology. We reviewed 250 Medicaid credit balances, totaling \$1,914,184, which included a statistical sample of 243 credit balances identified as Medicaid accounts and an additional 7 Medicaid credit balances that were not identified with the program. We also reviewed all 11 of the Medicare outpatient credit balances that exceeded \$100 (totaling \$4,153).

For the period ending May 31, 2002, our sample of Medicaid credit balances included a review of all balances that exceeded \$10,000 and a random sample of inpatient services over \$1,000, but not in excess of \$10,000, and outpatient services over \$100, but not in excess of \$10,000. We reviewed all Medicare outpatient credit balances reported for the quarter ended March 31, 2002 in excess of \$100. No Medicare inpatient credit balances were reported.

To accomplish our objective, we:

- reconciled provider listings of all inpatient and outpatient credit balances to the Medicaid credit balance reports, as of May 31, 2002, and the Medicare credit balance report, as of March 31, 2002;
- reviewed Medicaid and Medicare remittance advices, patient accounts receivable detail, patient invoices, patient registration forms and adjustment forms to determine the reasons for the credit balances and whether Medicaid or Medicare overpayments had occurred; and
- identified overpayments from the inpatient and outpatient credit balances that should be reported to the Medicaid or Medicare program.

Fieldwork was performed at Sinai's patient financial services offices, located at Aurora Health Care, in Milwaukee, Wisconsin, during July and August 2002 and in the Madison field office through September 2002.

Our audit was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Based on our review, we determined that the provider did not always identify and report Medicaid and Medicare overpayments in a timely manner, as required by State and Federal regulations. Because the provider's policies and procedures were not in accordance with such regulations, Medicaid overpayments of \$515,498 and Medicare overpayments of \$637 were not reported to the respective programs in a timely manner.

We determined that the provider's policies and procedures, effective prior to May 31, 2002, did not state that Medicaid overpayments be refunded within 30 days of receipt or discovery, depending on the nature of the overpayment. Although provider staff were aware of

Medicare's quarterly reporting requirement, they were not aware of the Medicaid reporting requirements.

CRITERIA

Medicaid Criteria. Wisconsin Administrative Code HFS 106.03(7)(h) states:

“In the event a provider receives a payment first from MA and then from medicare, another health care plan or another third party payer for the same service, the provider shall, within 30 days after receipt of the second and any subsequent payment, refund to MA the MA payment or the payment from medicare, the health care plan or other third party, whichever is less.”

Wisconsin Administrative Code HFS 106.04(5)(a) states:

“... if a provider receives a payment under the MA program to which the provider is not entitled or in an amount greater than that to which the provider is entitled, the provider shall return to the department the amount of the overpayment, including but not limited to erroneous, excess, duplicative and improper payments, regardless of cause, within 30 days after the date of the overpayment in the case of a duplicative payment from MA, medicare or other health care payer and within 30 days after the date of discovery in the case of all other overpayments.”

Medicare Criteria. Title 42 of the Code of Federal Regulations Part 489.20 (h) states:

“If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.”

However, for the purpose of this review, we will use 90 days as the reporting criteria in accordance with the Centers for Medicare and Medicaid Services quarterly Medicare Credit Balance Report (i.e., Form HCFA-838) requirement.

UNTIMELY REPORTING OF OVERPAYMENTS

We found that the provider did not always identify and report overpayments in a timely manner to the Medicaid and Medicare programs in accordance with State and Federal regulations.

Medicaid overpayments were not always reported within 30 days as specified in the Medicaid regulations. We found that overpayments for inpatient credit balances sampled occurred 39 to 1,536 days prior to our review date. Similarly, overpayments for outpatient cases sampled occurred 34 to 1,416 days prior to our review date. The number of days between the overpayment and our review date of May 31, 2002, along with the corresponding refund amounts are summarized, as follows:

Medicaid Sample Results

Refund Amounts and Days from Overpayment to May 31, 2002

DAYS	Inpatient		Outpatient	
	Cases	Refund Amount	Cases	Refund Amount
31-360 Days	16	\$ 38,241	17	\$ 52,362
361-720 Days	13	50,027	20	14,311
Over 720 Days	7	283,479	14	10,067
Total	36	\$ 371,747	51	\$ 76,740

Medicare credit balances were not always reported within the 90-day quarterly reporting requirement specified in the Medicare regulations. We determined that 2 of the 11 Medicare outpatient overpayments were not reported within the 90-day quarterly reporting requirement. The overpayments occurred 188 and 633 days prior to being reported.

CAUSE

We attribute the untimely identification and reporting of overpayments to:

- The provider personnel not being aware that Medicaid regulations require overpayment reporting within 30 days of occurrence; and
- Provider policies and procedures, prior to May 31, 2002, which were not in accordance with Medicaid and Medicare regulations.

We noted that most inpatient overpayments were due to Medicaid paying even though another payer was responsible for the charges, while most of the outpatient overpayments were due to billing for cancelled charges or general payment errors.

EFFECT

As a result of the provider not promptly identifying and reporting overpayments, we estimate Medicaid overpayments of \$515,498 (Federal share \$305,639) and Medicare overpayments of \$637, were not reported within the specified time periods. At the time of our review, only \$193 in Medicare overpayments had been recovered. Therefore, \$515,498 in Medicaid overpayments and \$444 in Medicare overpayments remains outstanding.

The Medicaid estimate of \$515,498 (\$403,488 inpatient and \$112,010 outpatient) was based on a statistical sample of 243 Medicaid credit balance accounts and the results of our review of seven additional credit balances that the provider had not identified to the Medicaid program. Based on our statistical sample of 243 Medicaid credit balances, we estimate unreported Medicaid overpayments amounting to \$489,433. The estimate has a precision of plus or minus \$18,725 at the 90 percent confidence level. This projection was combined

with unreported Medicaid overpayments of \$26,065 for the seven additional cases. The combined estimate of unreported Medicaid overpayments was \$515,498 (Federal share \$305,639). Details of our estimation methodology are presented in Appendix A.

RECOMMENDATIONS

We recommend that Aurora Sinai Medical Center:

1. Ensure Medicaid recovers overpayments totaling \$515,498 (\$305,639 Federal share);
2. Ensure Medicare recovers overpayments totaling \$444;
3. Revise policies and procedures to ensure that overpayments are identified and reported in accordance with State and Federal regulations;
4. Identify and report future Medicaid overpayments within 30 days of occurrence or discovery, as specified in the regulation, and Medicare overpayments within quarterly reporting requirements; and
5. Submit the appropriate adjustment request forms for the unreported Medicaid overpayments.

PROVIDER RESPONSE

Generally, Aurora Sinai concurred with the results of our review and has initiated corrective action for specific errors resulting in Medicaid overpayments of \$448,487. For the overpayment estimate of \$67,011, Aurora Sinai is reviewing each of the remaining 818 cases to determine the actual amount due the Medicaid program. Upon completion of its review, Aurora Sinai will report or refund, as necessary, overpayments to the Medicaid program. Aurora Sinai has reported the Medicare overpayments and has directly contacted Medicare in order to resolve recovery of the \$444. Further, Aurora Sinai agreed with the three procedural recommendations and has already initiated corrective actions.

OAS COMMENTS

We agree with the corrective actions taken, to date, to resolve the overpayments that were not properly reported to the Medicaid and Medicare programs within the 30 and 60-day reporting requirements. Further, we agree with the provider's corrective actions in response to our three procedural recommendations.

OTHER MATTERS

During our review we identified unrecovered overpayments totaling \$219,209 due the General Assistance Medical Program (GAMP). The GAMP program is a community provider network that offers medical services to county residents that meet strict income

guidelines. At the time medical services are provided the patient is not eligible for Medicaid. The GAMP program works to establish retroactive Medicaid coverage for patients, then contacts the provider to return GAMP funds. However, the provider generally waits until they receive payment from Medicaid before refunding the amount GAMP paid. Although we determined refunds remained due GAMP, these credit balances represent valid Medicaid obligations and payments and are not refundable to the Federal government. Some of the GAMP overpayments have existed, as many as 1,304 days past the Medicaid payment date, well beyond the State's allowance window for processing and refunding overpayments.

APPENDICES

SAMPLING METHODOLOGY

POPULATION

The universe of Medicaid accounts with credit balances was defined as balances reported by Sinai as of May 31, 2002, which exceeded \$1,000 for inpatient and \$100 for outpatient accounts, as follows:

Stratum Number	Credit Balance Range	Number of Cases	Credit Balances
1	Inpatient > \$10,000	36	\$1,111,241
2	Inpatient > \$1,000 and ≤ \$10,000	228	888,451
3	Outpatient > \$10,000	7	232,716
4	Outpatient > \$100 and ≤ \$10,000	790	397,438
Total		1,061	\$2,629,846

In addition, we judgmentally selected an additional seven Medicaid credit balances as follows:

- Two additional Medicaid inpatient accounts with credit balances exceeding \$1,000, not included in the four strata described above.
- Two Medicare outpatient accounts with credit balances with refunds due the Medicaid program.
- Three additional inpatient accounts with credit balances, not included in the four strata described above.

The results of these additional cases will be added to the results of the four strata above.

SAMPLE DESIGN

For the period ending May 31, 2002, a stratified random sample of Medicaid credit balances was used for this review. Our sample was stratified by a 100 percent review of Medicaid inpatient and outpatient accounts with credit balances exceeding \$10,000 and random samples of 100 Medicaid inpatient accounts with credit balances greater than \$1,000, but not exceeding \$10,000, and 100 Medicaid outpatient accounts with credit balances exceeding \$100, but not in excess of \$10,000.

Additionally, our sample includes judgmentally selected accounts identified during validation and reconciliation procedures and their effect on the Medicaid program. The results of the

analysis of the seven additional Medicaid overpayments will be added to the results of the stratified selection previously described.

RESULTS OF SAMPLE:

The results of our review are as follows:

Stratum Number	Number of Cases	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	36	36	\$1,111,241	10	\$321,332
2	228	100	389,410	21	24,797
3	7	7	232,716	5	71,181
4	790	100	46,026	44	5,112
Total	1,061	243	\$1,779,393	80	\$422,422

The point estimate for the stratified sample was \$489,433, with a precision of plus or minus \$18,725 at the 90 percent confidence level. These results are combined with the cases selected judgmentally, as follows:

Description	Refund Due Medicaid	Precision (Plus/Minus)
Stratified Sample	\$489,433	\$18,725
Additional Medicaid Cases	26,065	-
Total	\$515,498	\$18,725

CAUSES OF MEDICAID CREDIT BALANCES

MEDICAID INPATIENT

Cause	Number	Refund Amount
➤ Medicaid made payment when another payer was responsible for the charges	11	\$ 255,131
➤ Medicaid and Medicaid HMO both paid as primary	3	44,720
➤ Medicaid made a duplicate payment	7	27,131
➤ Payment error	4	20,302
➤ Revised charges	4	17,216
➤ Billed services with different names	7	7,247
TOTAL	36	\$ 371,747

Medicaid Outpatient

Cause	Number	Refund Amount
➤ Provider billed for cancelled charges	5	\$ 39,948
➤ Payment error	16	32,464
➤ Medicaid made payment when another payer was responsible for the charges	12	1,908
➤ Medicaid made a duplicate payment	7	1,071
➤ Billed services with different names	4	556
➤ Payment was received after charges were revised in the account	2	504
➤ Billed services with Pro Fee and Pro Fee paid separately	2	166
➤ Same service with different dates	1	71
➤ Miscellaneous	2	52
TOTAL	51	\$ 76,740

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December 20, 2002

Department of Health and Human Services
Office of Audit Services
Attn: Paul Swanson, Regional Inspector General for Audit Services
233 North Michigan Avenue
Chicago, IL 60601

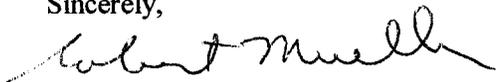
Re: A-05-02-00080

Dear Mr. Swanson:

Enclosed is Aurora Sinai Medical Center's written comments related to your draft report entitled "Review of Medicaid and Medicare Credit Balances at Aurora Sinai Medical Center" as of May 31, 2002 and March 31, 2002 respectively.

Please contact me directly at 414-647-3125 should you have any questions.

Sincerely,



Robert M. Mueller
Director, Patient Financial Services

tjl/RMM

Aurora Sinai Medical Center

Response to:

Department of Health and Human Services
Office of Inspector General

Review of Medicaid and Medicare Credit Balances
At Aurora Sinai Medical Center
As of May 31, 2002 and March 31, 2002, respectively

Common Identification Number A-05-02-00080

We have reviewed the above mentioned report; including its findings and recommendations and have the following responses:

Recommendation 1. *Ensure that Medicaid overpayments totaling \$515,498 (\$305,639 Federal share) are recovered by the Medicaid program.*

The \$515,498 amount contains both specific errors; (\$448,487) and a sampling estimate (\$67,011) on the remaining population. We have reviewed each of the specific errors and have corrected these as follows:

Refunded by check	\$39,737
Refunded by Medicaid recoupment	\$278,294
Reported to Medicaid and waiting for Medicaid recoupment	\$49,675
Settled with insurance carrier on a Medicaid HMO policy	\$82,592
Corrected a contractual adjustment previously recorded in error	\$1,814
Report discrepancy ##	<u>(\$3,625)</u>
	\$448,487

There is a discrepancy between the summary numbers reported (page 2 of Appendix A) and the detail list of errors provided by the audit team.

We have changed our procedures (see response to recommendation 3.) and are now reviewing the remaining population of 818 cases identified in the report. This review and any related refunds, recoupments, or settlements will be completed by December 31, 2002. This will resolve the sampling estimate of \$67,011.

Recommendation 2. *Ensure that Medicare overpayments totaling \$444 are recovered by the Medicare contractor.*

The \$444 was reported on the 3-31-02 Medicare credit report (Form HCFA-838) according to sections 1815 (a) and 1833 (e) of the Social Security Act. Medicare has not yet recouped these monies. We have been contacting Medicare directly in an attempt to

resolve this issue. Our subsequent quarterly Medicare credit reports listed a total of 8 credits. All of these have been recouped by Medicare.

Recommendation 3. Revise policies and procedures to ensure that overpayments are identified and reported in accordance with State and Federal regulations.

We have revised our policies and procedures and instructed staff accordingly. New reports have been implemented which segregate Medicaid credit balances. Our new procedures now require staff to review Medicaid credits within 30 days of creation. This was implemented on November 1, 2002 (a copy of the new policies and procedures are attached)

Recommendation 4. Identify and report future Medicaid overpayments within 30 days of occurrence or discovery, as specified in the regulation, and Medicare overpayments within quarterly reporting requirements.

Our new procedures and staff restructuring have allowed us to report all new Medicaid overpayments within the 30 day requirement. We continue to review and report outstanding credits prior to the implementation of our new procedures. This review will be completed by the end of March 31, 2003.

Recommendation 5. Submit the appropriate adjustment request forms for the unreported Medicaid inpatient and outpatient overpayments.

Adjustment request forms are filed with Medicaid on a weekly basis. This report included all credits that have been reviewed by staff.

Other Matters: During our review we identified unrecovered overpayments totaling \$219,209 due to the General Assistance Medical Program (GAMP).

GAMP's procedures are to wait for the GAMP program to request the repayment after the patient has qualified for Medicaid benefits. This is done at GAMP's request to make their recording keeping and reconciliation's easier to manage. Since this report we have added to our procedures a review of all GAMP credits that have not been requested by GAMP within 90 days of the Medicaid payment and refund checks are sent. The overpayments (\$219,209) have been returned to the GAMP program.

Aurora Business Office Policies & Procedures

DRAFT AS OF 6/02

Area: Hospital Refunds	Policy No. 1012
Subject/Function: Medicaid Credit Balance Procedure	Page No. <u>1</u> of <u>1</u> pages
Effective Date: 6/27/02	Approved by:
Revision Date:	

Purpose:

To reduce amount of time between credit balance occurring and adjustment request sent to Medicaid.

Outcomes:

Timely refunds to Medicaid

Procedure:

1. Refund staff will review and determine that credit balance is appropriate.
2. Refund staff will be responsible to complete adjustment request within 30 days of credit occurring. Refund staff keeps copy of adjustment and checks account in 45 days.
3. If any Insurance Follow Up staff come across any Medicaid credits, these should be forwarded to appropriate Refund staff.

Aurora Business Office Policies & Procedures

DRAFT AS OF 6/02

Area: Hospital Refunds	Policy No. 1013
Subject/Function: Medicare Credit Balance Procedure	Page No. <u> 1 </u> of <u> 1 </u> pages
Effective Date: 6/27/02	Approved by:
Revision Date:	

Purpose:

To reduce amount of time between credit balance appearing and adjustment request sent to Medicare.

Outcomes:

Timely refunds to Medicare.

Procedure:

1. When an account goes into a credit status, it appears on the Credit Balance Report which the Refund analysts receive on a monthly basis.
2. Review accounts and pull the appropriate Medicare remit. The copies are given to the appropriate Billing Team to complete an adjustment to Medicare within 60 days of the credit balance appearing on the account.
3. If any Insurance Follow Up representatives come across a Medicare credit, they are to forward to the Medicare Billing Team.

ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson (RIGA). Other principal Office of Audit Services staff who contributed include:

Ross Anderson, *Audit Manager*

Donna Kern, *Senior Auditor*

Michael Carr, *Auditor*

Ken Joosse, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.