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

May 8, 2003

Our Reference: Report Number A-02-02-01004

Dr. Antonia C. Novello, Commissioner
New York State Department of Health
Empire State Plaza, 14th Floor, Room 1408
Corning Tower
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Compliance with New York State Medicaid Inpatient Prospective Payment System Transfer Regulations." A copy of this audit report will be forwarded to the action official noted below for her review and any action deemed necessary.

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 have a bearing on the final determination.

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To facilitate identification, please refer to Report Number A-02-02-01004 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Regional Administrator
Centers for Medicare and Medicaid Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, New York 10278

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

COMPLIANCE WITH NEW YORK STATE MEDICAID INPATIENT PROSPECTIVE PAYMENT SYSTEM TRANSFER REGULATIONS

JANET REHNQUIST
Inspector General

MAY 2003
A-02-02-01004

Notices

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OAS FINDINGS AND OPINIONS

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

Office of Inspector General

http://oig.hhs.gov/

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVES

The objectives of our audit were to determine whether (1) Prospective Payment System (PPS) hospitals were paid in accordance with New York State (NYS) Medicaid policy when beneficiaries were transferred to other PPS hospitals, and (2) Medicaid overpayments resulted from the incorrect coding of the patient (discharge) status on claims for the transferred beneficiaries.

FINDINGS

For the most part, PPS hospitals in NYS were paid in accordance with Medicaid policy when beneficiaries were transferred to other PPS hospitals. However, we noted a relatively small number of exceptions that resulted from the incorrect coding of the patient (discharge) status on claims for transferred beneficiaries.

Under the NYS Medicaid PPS, hospitals were supposed to be paid an amount per discharge for inpatient hospital services rendered to beneficiaries that have been assigned to the appropriate diagnosis related group (DRG) based on such factors as each beneficiary's medical diagnosis, sex, age, birth weight, and procedures performed. Discharges of beneficiaries to their homes and those instances where they left against medical advice (LAMA) were eligible for the full DRG payment. Conversely, NYS Medicaid PPS regulations indicated that generally, reimbursement for claims involving the transfer of a beneficiary to another PPS hospital would be paid less than the full DRG amount. Also, according to NYS Department of Health (DOH) instructions, providers were to enter a patient status code indicating "Transferred to DRG hospital" on the claim form to properly identify when a patient was transferred to another acute care hospital. A transfer incorrectly reported by the transferring hospital as a discharge would usually result in an overpayment because both hospitals would receive the full DRG amount.

We have concluded based on substantive testing that, in general, the NYS DOH had sufficient controls in place to ensure proper patient (discharge) status codes were utilized by PPS hospitals in claiming Medicaid reimbursement for transferred beneficiaries. Our conclusion was based primarily on the fact that there were a very small number of potential improperly coded LAMA and "discharged to home" claims identified by our computer analyses.

For the 1-year period ended March 31, 2001, we identified a total maximum sample universe of 895 potential improperly coded Medicaid LAMA and "discharged to home" claims for which the DRG Medicaid paid amount would, based on a preliminary "pricing" analysis, have been greater than the per diem transfer payment amount. From this universe, we judgmentally selected claims submitted by the top seven hospitals, each with potential overpayments exceeding $100,000, for detailed review. In addition, we augmented this judgmental sample with a detailed review of claims submitted by four providers in the Albany, New York area. In total, we selected 185 claims from 11 hospitals having a total potential Medicaid overpayment amount of $1,428,171.

The NYS DOH had overpaid hospitals a total of $986,316 ($493,158 Federal share) for 74 of the 185 claims reviewed. Specifically, overpayments for which hospitals incorrectly coded the patient (discharge) status included:

- $904,525 ($452,263 Federal share) for 62 claims coded to indicate the beneficiaries were discharged to home, but the medical records indicated they were transferred to other PPS hospitals;

- $62,772 ($31,386 Federal share) for nine claims coded to indicate the beneficiaries left against medical advice, but the medical records indicated they were transferred to other PPS hospitals, and;

- $6,151 ($3,075 Federal share) for one claim where the beneficiary was actually "transferred" between units within the same PPS hospital.

In addition, one hospital lacked supporting medical documentation for two claims with a total Medicaid paid of $12,868 ($6,434 Federal share).

According to hospital officials, the incorrect coding of the patient (discharge) status occurred, for the most part, because of internal control and system problems, including data entry errors. In addition, some hospital officials and personnel were not fully aware of or had misinterpreted NYS Medicaid regulations.

RECOMMENDATIONS

We recommend that NYS DOH:

- Refund $493,158 to the Federal Government for its share of the identified overpayments;

- Research the economic feasibility of analyzing the remaining claims in our universe to determine if they resulted in overpayments to PPS hospitals, and;

- Instruct hospitals to review all internal procedures and processes related to claims submission to assure that PPS transfers are properly reported.

AUDITEE'S COMMENTS

The auditee did not provide written or verbal comments on our draft report dated February 25, 2003. In our draft report, we requested the auditee to provide us written comments within 30 calendar days and offered to meet with them to discuss the draft report. On April 15, 2003, the auditee submitted a written request, based on the complexity of the issues, for an extension to April 29, 2003 to provide comments on the draft report. We granted that extension.

After a telephone call to the auditee on April 28, 2003, an auditee official stated that they did not expect to issue a written response within the next two weeks. In addition, the NYS DOH official indicated that we should issue our report without their comments because he was not sure when we would receive their comments.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) authorizes Federal grants to states for Medicaid programs that provide medical assistance to low-income families, elderly individuals, and persons with disabilities. The Medicaid program is administered by each state in accordance with an approved state plan. While the state has considerable flexibility in designing its plan and operating its Medicaid program, it must comply with Federal requirements specified in the Medicaid statute, regulations, and program guidance. Additionally, the Secretary, who has delegated this authority to the Centers for Medicare and Medicaid Services (CMS) [1], must approve the plan.

The Department of Health (DOH) was the single state agency responsible for administering the Medicaid program in New York State (NYS). The NYS DOH contracted with a fiscal agent, Computer Sciences Corporation (CSC), to process Medicaid claims and make payments to providers through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

Hospital Reimbursement Methodology

Section 1886 (d) of the Act, enacted as part of the Socials Security Amendments of 1983 (Public Law 98-21), established the Medicare Prospective Payment System (PPS) for inpatient hospital services. Under this system, hospital admissions were grouped by applicable diagnoses into diagnosis related groups (DRGs). Payment amounts for the DRGs were prospectively determined. The NYS DOH also utilized a case-based or DRG system as its reimbursement methodology for inpatient hospital services.

Under the NYS Medicaid PPS, hospitals were paid an amount per discharge for inpatient hospital services rendered to beneficiaries that have been assigned to the appropriate DRG based on such factors as each beneficiary's medical diagnosis, sex, age, birthweight, and procedures performed. The NYS Medicaid regulations related to payments for PPS hospital claims indicated that generally, reimbursement for claims involving the transfer of a beneficiary would be at less than the full DRG amount. A transfer incorrectly reported by the transferring hospital as a discharge would usually result in an overpayment because both hospitals would receive the full DRG amount.

Specifically, with respect to transfers, the New York Code of Rules and Regulations (NYCRR) Title 10 Section 86-1.54(l) - Transfers, stated that generally rates of payment to acute care non-exempt facilities for patients that are transferred to another acute care non-exempt facility shall be determined on the basis of a per diem rate for each day of the patient's stay in the transferring facility.

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[1] CMS was formerly known as the Health Care Financing Administration (HCFA).

Further, NYCRR Title 10 Section 86-1.50(j) - Transfers, stated that a transfer patient is defined for purposes of transfer per diem payments as a patient who is not discharged, who is not transferred among two or more divisions of merged or consolidated facilities, who is not assigned to a DRG specifically identified as a DRG for transferred patients only, and who meets one of the following conditions: (1) is transferred from an acute care facility reimbursed under the DRG cased-based payment system to another acute care facility reimbursed under this system, (2) transferred to an out-of-state acute care facility, or (3) is a neonate who is being transferred to an exempt hospital for neonatal services.

Hospitals in NYS obtained Medicaid reimbursement by submitting claims to the MMIS. Among the information required on the claim was a code indicating patient status on the last day of service. The patient (discharge) status options listed in the MMIS Provider Manual included:

Discharged/transferred to home or self care (routine discharge);
Transferred to DRG hospital, and;
Left against medical advice.

The patient (discharge) status code recorded on the claim by the hospital was the determining factor whether NYS DOH paid the inpatient claim as a discharge or a transfer.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether (1) PPS hospitals were paid in accordance with NYS Medicaid policy when beneficiaries were transferred to other PPS hospitals, and (2) Medicaid overpayments resulted from the incorrect coding of the patient (discharge) status on claims for the transferred beneficiaries.

Scope

For discharges during the 1-year period ended March 31, 2001, we reviewed the propriety of Medicaid payments made and the accuracy of coding by PPS hospitals for claims indicating a "left against medical advice" (LAMA) or "discharged to home" patient (discharge) status.

We identified the major NYS DOH controls for ensuring that proper patient (discharge) status codes were utilized by PPS hospitals in claiming Medicaid reimbursement, but we did not evaluate them. Rather, we assessed the NYS DOH controls and performed our review using substantive testing.

Methodology

To accomplish our objectives, we:

- Reviewed applicable laws and regulations including:
    - NYS Medicaid State Plan;

- NYCRR;
- MMIS Inpatient Provider Manual, and;
- NYS DOH Data Dictionary Descriptions;

- Interviewed NYS DOH officials;

- Using various computer applications:

  - Obtained, from the NYS MMIS, Medicaid inpatient claims data for the period April 1, 2000 through March 31, 2001;

  - Matched acute care inpatient claims coded as LAMA and "discharged to home" against acute care inpatient claims by beneficiary and date of discharge/admission (i.e., identified beneficiaries being discharged from one PPS hospital and admitted to another on the same day), and thereby;

  - Identified 1,536 total potential improperly coded LAMA and "discharged to home" claims, with a total Medicaid paid of $12,318,721 that had been submitted by 156 hospitals (provider numbers);

- Performed a preliminary "pricing" analysis[2] of the 1,536 claims which resulted in a maximum total sample universe of 895 claims for which the DRG Medicaid paid amount would have been greater than the per diem transfer payment amount. From this maximum total universe, we judgmentally selected claims submitted by the top seven hospitals, each with potential overpayments exceeding $100,000, for detailed review. In addition, we augmented this judgmental sample with a detailed review of claims submitted by four providers in the Albany, New York area. In total, we selected 185 claims from 11 hospitals.

- Performed a final "pricing" of the 185 claims selected for review and determined the total potential Medicaid overpayment amount to be $1,428,171;

- Reviewed documentation for the 185 judgmentally selected claims, including:
  - Medical records, and;
  - Billing records, including remittance statements and claim forms;

- Obtained a limited understanding of each selected hospital's internal controls by interviewing hospital officials, and;

- Verified the accuracy of the MMIS claims data by:

  - Tracing the Medicaid paid amounts for the 185 sample claims to paid amounts shown on the hospitals' remittance statements;

[2] The "pricing" analysis was considered preliminary because a required component, the capital add-on factor, was not included in the calculation of the transfer payments and, therefore, was not reflected in the calculated overpayment amounts.

- Comparing medical and beneficiary data for the 185 sample claims with information contained in the supporting medical records, and;

- Conducting site visits to 9 hospitals to confirm the same-day admission for 28 of the 185 sample claims.

Fieldwork was performed at selected hospitals in New York City and the Albany, New York area from July through October 2002. Our audit was made in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

In general, the NYS DOH had sufficient controls in place to ensure proper patient (discharge) status codes were utilized by PPS hospitals in claiming Medicaid reimbursement for transferred beneficiaries. However, we found that the NYS DOH overpaid hospitals a total of $986,316 ($493,158 Federal share) for 74 improper inpatient claims. Of these, 72 claims represented instances where hospitals incorrectly coded the patient (discharge) status and 2 claims lacked supporting medical record documentation.

NYS DOH Controls

In general, the NYS DOH had sufficient controls in place to ensure the patient (discharge) status for patients transferred from one PPS hospital to another were correctly coded. We had identified the major controls as follows:

- Regulations cited in NYCRR Title 10;
- The MMIS, and;
- Review of inpatient claims by the Island Peer Review Organization (IPRO).

Based on our assessment via substantive testing, we have concluded that the identified major controls were generally effective in ensuring proper discharge status codes were utilized by PPS inpatient hospitals in claiming Medicaid reimbursement. Our conclusion was based primarily on the fact that there were a very small number of identified potential improperly coded LAMA and "discharged to home" claims resulting from the computer matches, i.e., only 1,536 same-day discharge and admissions out of nearly 500,000 claims. Our conclusion was also based on our determination that claim adjustments resulting in patient (discharge) status code corrections had been initiated by IPRO. Specifically, when we reviewed financial and medical records at the selected hospitals, we found two claims whose patient (discharge) status had been changed to "Transferred to DRG hospital" (and thereby corrected after our initial draw down of the data) as the result of IPRO review. As such, these two claims were not part of any recommended financial adjustment.

Improperly Coded Patient (Discharge) Status

We found that hospitals had improperly coded the patient (discharge) status on a total of 72 claims. As a result, NYS DOH overpaid hospitals $973,448 ($486,724 Federal share). Details are discussed below.

- ***Improperly Coded Transfers from One PPS Hospital to Another***

  There were 62 claims that hospitals had coded as "discharged to home" which should have been coded as transfers because medical records indicated hospital personnel had knowledge the beneficiaries were going to other PPS hospitals on the same day. An example of a claim found to be incorrectly coded as "discharged to home" follows:

  One hospital received Medicaid reimbursement totaling $93,022 for a claim that indicated the beneficiary was admitted on February 13, 2001 and "discharged to home" on March 15, 2001. However, a review of the medical records indicated this beneficiary was actually transferred to another hospital on March 15, 2001.

  Specifically, there was a Patient Transfer Summary contained in the patient's medical record that identified the receiving hospital and indicated a consent to transfer. In addition, the portion of the Patient Transfer Summary completed by the registered nurse (RN) indicated a copy of the medical records, nursing notes, and transfer summary were to accompany the beneficiary. It further noted the transporting ambulance had been notified, receiving site bed availability confirmed and the RN's report given to the receiving RN.

  Had the hospital correctly coded this claim as a transfer, it would have received Medicaid reimbursement totaling $69,088. Therefore, we calculated the overpayment to be $23,934.

  There were another nine claims hospitals coded as LAMA which should have been coded as transfers because the medical records indicated hospital personnel had knowledge the beneficiaries were going to other PPS hospitals on the same day. An example of a claim found to be incorrectly coded as LAMA follows:

One hospital received Medicaid reimbursement totaling $2,363 for a claim that indicated the beneficiary was admitted on October 10, 2000 and left against medical advice on October 11, 2000. However, a review of the medical records indicated this beneficiary was actually transferred to another hospital on October 11, 2000.

Specifically, progress notes dated October 11, 2000 indicated, "Family requested to transfer the pt (sic) to . . . Hospital" and "Pt (sic) transferred to . . . Hospital via ambulance".

We determined the hospital would have received $773 for this claim if it had been correctly coded as a transfer. Therefore, we calculated the overpayment to be $1,590.

As previously indicated, NYS DOH regulations at NYCRR Title 10 Section 86-1.50(j) and Section 86-1.54(l) defined a transfer patient and stipulated that generally rates of payment shall be based on a per diem rate for each day of the patient's stay in the transferring facility. Further, according to NYS DOH officials, a claim for the full inpatient DRG payment would be improper if it was determined the discharging hospital was aware the patient was going to another PPS hospital, yet coded the claim as LAMA or "discharged to home".

Hospital officials identified the following system and internal control problems as causes for the improperly coded claims:

- System interface failures;
- Data entry errors;
- Conflicting information in the medical records;
- Inadequate review of claim information prior to submission to the MMIS, and;
- Lack of knowledge of and misinterpretation of Medicaid regulations.

With respect to the last cause of improper coding, we had noted that six of the nine incorrectly coded LAMA claims had been submitted by Health and Hospital Corporation (HHC) hospitals. Officials at an HHC hospital which had submitted four of the improper claims informed us it was their policy to code claims as LAMA if the beneficiary indicated a desire to go to another facility even though the hospital could provide the needed services.

To determine the Medicaid overpayment amounts for the improperly coded claims, we calculated the difference between what the hospitals had actually been paid and what they would have received had the claims been coded as a transfer. Of the 62 improperly coded "discharged to home" claims, 59 resulted in overpayments totaling $904,525 ($452,263 Federal share). For the improperly coded LAMA claims, eight of the nine error claims resulted in overpayments totaling $62,772 ($31,386 Federal share).

- ***Improperly Coded Intra-facility "Transfer"***

  One hospital submitted claims using two separate Medicaid provider numbers. The first provider number was related to the main facility, whereas, the other was related to a specialized unit within the same hospital. The hospital improperly coded as "discharged to home" a claim submitted to and paid by Medicaid for a beneficiary who was actually "transferred" from the specialized unit to the main facility.

  Specifically, the hospital submitted a claim to Medicaid and received reimbursement totaling $6,151 for a beneficiary who was admitted to its specialized unit on September 29, 2000. After being stabilized, the same beneficiary was "transferred" to the main facility on October 3, 2000 for follow-up care and discharged from there on October 5, 2000. The hospital submitted another claim to Medicaid for this second discharge and received additional reimbursement totaling $6,151.

  According to NYS DOH officials, the hospital's two provider numbers did not represent a merged facility, but rather two units of the same facility. Further, it was their opinion that intra-facility "transfers" should be treated the same as transfers among merged facilities. That is, the facility that initially admitted the beneficiary would receive the full inpatient DRG payment and the second admitting facility would receive no reimbursement for the hospital stay. Thus, the overpayment for the improperly coded claim is, in this instance, the $6,151 ($3,075 Federal share) in reimbursement the hospital received under the main facility's provider number.

  Hospital officials indicated the cause for the improperly coded intra-facility "transfer" was coding problems between the main facility and the specialized unit.

Missing Medical Record Documentation

One hospital was unable to produce medical record documentation to support two claims in our review. The patient (discharge) status indicated on one claim was LAMA and on the other was "discharged to home". The total overpayment for the two[3] claims was $12,868 ($6,434 Federal share).

Several NYS DOH regulations specified record keeping requirements including:

- The NYCRR Title 18 Section 515.2(b)(6) - Unacceptable Practices under the Medical Assistance Program, stated that failing to maintain or to make available for purposes of audit or investigation records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with other requirements of the Title was considered unacceptable record keeping.

- The NYCRR Title 18 Section 517.3(b)(1) - Audit and Record Retention, stated that all providers... who are paid in accordance with rates, fees and schedules established by the

[3] One of the claims lacking supporting medical record documentation also represented an improperly coded intra-facility "transfer".

department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished... must be kept by the provider for a period of six years from the date of care, services or supplies were furnished or billed, whichever is later.

- The NYCRR Title 18 Section 517.3(b)(2) - Audit and Record Retention, stated that all information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date of care, services or supplies furnished or billed, whichever is later, and must be furnished, upon request, to... the Secretary of the United States Department of Health and Human Services... for audit and review.

Finally, the UB-92 HCFA-1450 (the claim form used by hospitals to submit claims to the MMIS) required hospitals to certify that, among other things, records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

Hospital officials indicated it was difficult for their record retention and retrieval system to produce medical records for claims as old as those included in our review.

Other Matters

As previously indicated, we performed a preliminary "pricing" analysis of the 1,536 identified potential improperly coded claims. This analysis resulted in a maximum total sample universe of 895 claims for which the DRG Medicaid paid amount would have been greater than the per diem transfer payment amount. Because we had already judgmentally selected 185 of these claims for review, there remained a universe of 710 potential improperly coded claims with preliminary estimates of Medicaid overpayments totaling $2,634,162. These 710 claims were submitted by 109 hospitals whose preliminary estimates of Medicaid overpayment amounts ranged from a high of $96,352 to a low of $22. However, 26 of the 109 providers had potential overpayments exceeding $50,000.

RECOMMENDATIONS

We recommend that NYS DOH:

- Refund $493,158 to the Federal Government for its share of the identified overpayments;

- Research the economic feasibility of analyzing the remaining claims in our universe to determine if they resulted in overpayments to PPS hospitals, and;

- Instruct hospitals to review all internal procedures and processes related to claims submission to assure that PPS transfers are properly reported.

AUDITEE'S COMMENTS

The auditee did not provide written or verbal comments on our draft report dated February 25, 2003. In our draft report, we requested the auditee to provide us written comments within 30 calendar days and offered to meet with them to discuss the draft report. On April 15, 2003, the auditee submitted a written request, based on the complexity of the issues, for an extension to April 29, 2003 to provide comments on the draft report. We granted that extension.

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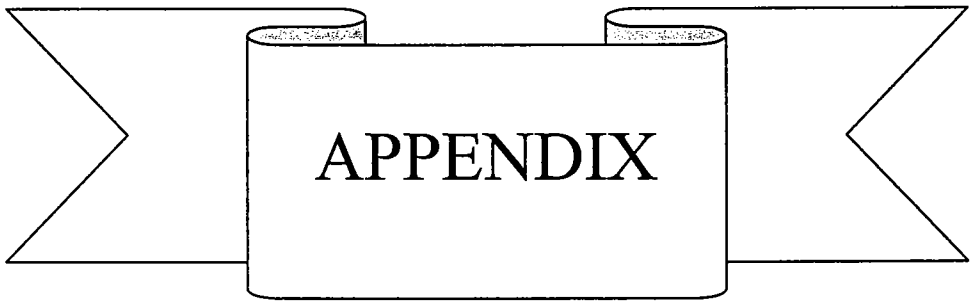
APPENDIX

Schedule of Medicaid Overpayments By Provider

PROVIDER	CLAIM	TYPE	MEDICAID PAID	RECOMMENDED AMOUNT	DIFFERENCE
00243105	82	L	$8,522.77	$2,466.86	$6,055.91
00243105	253	L	$5,867.41	$0.00	$5,867.41
00243105	653	T	$93,022.09	$69,088.52	$23,933.57
00243105	726	T	$6,771.86	$4,776.67	$1,995.19
00243105	799	T	$7,000.70	$0.00	$7,000.70
00243105	1195	T	$6,578.15	$3,599.34	$2,978.81
00243105	1280	T	$48,825.37	$11,084.96	$37,740.41
00243105	1309	T	$9,852.80	$5,643.06	$4,209.74
00243105	1348	T	$7,000.70	$3,770.28	$3,230.42
00243105	1355	T	$19,057.36	$16,588.97	$2,468.39
00243105	1487	T	$5,414.33	$3,288.37	$2,125.96
00243105	1518	T	$27,262.03	$6,242.40	$21,019.63
00710430	1250	T	$6,150.75	$0.00	$6,150.75
		13	**$251,326.32**	**$126,549.43**	**$124,776.89**
00243178	450	T	$12,892.26	$3,819.55	$9,072.71
00243178	480	T	$9,857.79	$5,033.53	$4,824.26
00243178	507	T	$55,671.71	$13,810.99	$41,860.72
00243178	536	T	$55,949.40	$32,208.03	$23,741.37
00243178	552	T	$88,188.77	$67,307.44	$20,881.33
00243178	568	T	$25,407.70	$6,371.95	$19,035.75
00243178	611	T	$70,991.49	$58,759.86	$12,231.63
00243178	984	T	$5,452.50	$3,618.12	$1,834.38
00243178	1144	T	$22,249.12	$5,317.12	$16,932.00
		9	**$346,660.74**	**$196,246.59**	**$150,414.15**
00243852	119	L	$2,363.23	$773.03	$1,590.20
00243852	165	L	$2,082.48	$3,342.72	$0.00
00243852	583	T	$840.81	$1,009.57	$0.00
00243852	608	T	$133,383.66	$63,563.86	$69,819.80
00243852	884	T	$23,923.89	$12,088.89	$11,835.00
00243852	962	T	$7,379.23	$2,249.41	$5,129.82
00243852	1043	T	$6,168.23	$3,719.01	$2,449.22
00243852	1248	T	$8,507.54	$6,469.75	$2,037.79
00243852	1293	T	$8,588.25	$3,150.46	$5,437.79
00243852	1473	T	$14,870.40	$3,258.68	$11,611.72
		10	**$208,107.72**	**$99,625.38**	**$109,911.34**
00246048	632	T	$333,136.89	$110,973.88	$222,163.01
00246048	724	T	$26,966.11	$26,929.92	$36.19
00246048	824	T	$14,015.18	$7,507.94	$6,507.24
00246048	874	T	$20,576.22	$12,438.76	$8,137.46
00246048	910	T	$54,235.29	$24,285.29	$29,950.00
00246048	948	T	$7,568.91	$4,522.96	$3,045.95
00246048	955	T	$23,145.75	$12,692.65	$10,453.10
00246048	1165	T	$10,978.14	$8,749.01	$2,229.13
00246048	1339	T	$7,318.06	$6,272.88	$1,045.18
00246048	1374	T	$16,831.89	$15,030.21	$1,801.68
00246048	1517	T	$56,833.30	$16,615.45	$40,217.85
		11	**$571,605.74**	**$246,018.95**	**$325,586.79**

Schedule of Medicaid Overpayments By Provider

PROVIDER	CLAIM	TYPE	MEDICAID PAID	RECOMMENDED AMOUNT	DIFFERENCE
00246117	66	L	$27,074.29	$8,786.22	$18,288.07
00246117	205	L	$8,709.99	$2,826.12	$5,883.87
00246117	589	T	$188,185.20	$65,876.55	$122,308.65
00246117	659	T	$7,104.85	$3,367.52	$3,737.33
00246117	671	T	$18,894.90	$13,185.82	$5,709.08
00246117	675	T	$4,396.55	$1,685.29	$2,711.26
00246117	885	T	$12,948.44	$10,517.31	$2,431.13
00246117	888	T	$14,112.72	$5,148.83	$8,963.89
00246117	917	T	$5,871.42	$3,340.41	$2,531.01
00246117	1074	T	$8,952.30	$3,068.43	$5,883.87
00246117	1225	T	$21,177.87	$8,567.26	$12,610.61
00246117	1290	T	$5,822.62	$2,752.05	$3,070.57
		12	**$323,251.15**	**$129,121.81**	**$194,129.34**
00476022	622	T	$4,798.78	$4,056.01	$742.77
00476022	969	T	$1,150.14	$1,352.90	$0.00
00476022	1471	T	$13,636.33	$9,274.90	$4,361.43
		3	**$19,585.25**	**$14,683.81**	**$5,104.20**
00698866	142	L	$16,372.34	$4,445.39	$11,926.95
00698866	144	L	$9,453.62	$7,227.93	$2,225.69
00698866	221	L	$13,007.62	$7,096.26	$5,911.36
00698866	322	L	$17,024.39	$6,134.12	$10,890.27
00698866	662	T	$8,573.87	$8,528.99	$44.88
00698866	1387	T	$23,809.73	$9,780.14	$14,029.59
00698866	1461	T	$12,187.70	$5,542.50	$6,645.20
00698866	1500	T	$6,503.02	$4,567.72	$1,935.30
		8	**$106,932.29**	**$53,323.06**	**$53,609.23**
00277716	342	T	$711.16	$829.33	$0.00
00277716	443	T	$3,446.53	$1,573.27	$1,873.26
00277716	489	T	$37,582.25	$35,667.40	$1,914.85
00277716	525	T	$12,956.52	$11,754.03	$1,202.49
00277716	546	T	$42,804.25	$31,027.24	$11,777.01
00277716	557	T	$10,361.16	$6,740.45	$3,620.71
		6	**$107,861.87**	**$87,591.72**	**$20,388.32**
00314998	548	T	$3,901.23	$2,337.17	$1,564.06
		1	**$3,901.23**	**$2,337.17**	**$1,564.06**
00318823	364	T	$4,248.49	$3,416.38	$832.11
		1	**$4,248.49**	**$3,416.38**	**$832.11**
GRAND TOTALS		**74**	**$1,943,480.80**	**$958,914.29**	**$986,316.44**

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This report was prepared under the direction of Timothy J. Horgan (RIGAS). Other principal Office of Audit Services staff who contributed include:

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