Memorandum

Date APR 1 1 1994

From June Gibbs Brown
Inspector General

Subject Review of the Island Peer Review Organization's Denials of Full Medical Assistance Claims That New York State Identified As Successfully Recovered Through the Automated Void Process (A-02-93-01023)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on April 13, 1994 of our final audit report. A copy is attached.

The purpose of our review was to determine if full claim denials of inpatient hospital stays submitted by the Island Peer Review Organization (IPRO) for voiding were successfully processed and the affected Medicaid funds recouped; and whether the Federal Government and New York State (NYS) received their share of the recoupments. Our review was made of IPRO's denial determinations for admissions on or after January 1, 1988 and included denials voided by IPRO through March 27, 1993.

Based on our review, we obtained reasonable assurance that the automated void process was successfully processing voided transactions which resulted in recoupments from providers. Both NYS and the Federal Government received appropriate credits for the voided transactions through reduced expenditure levels. However, our review also disclosed a significant system weakness in that certain hospitals improperly rebilled previously voided claims. In effect, the provider's actions compromised the effectiveness of the automated void process because IPRO's denial determinations were not actually recouped. Therefore, neither NYS nor the Federal Government received their share of the denial determinations.

In our opinion, the improper claims were paid because there are no edits or controls in the Medicaid Management Information System (MMIS) that would preclude previously voided claims from being resubmitted by providers and having them reimbursed. Our tests identified 741 previously voided claims totalling $3,774,112 (Federal share $1,437,337) that were resubmitted and paid. As part of our audit, we contacted certain hospitals to obtain an understanding as

to why these hospitals were resubmitting previously voided claims. In summary, officials at certain hospitals indicated that the rebilling had been made in error. Other hospital officials indicated that they were trying to correct billing errors noted by IPRO's original denial determinations and finally, some indicated that IPRO had authorized them to rebill although we saw no evidence of this on IPRO's data files. Officials at many of the hospitals contacted expressed the need for better communications between IPRO and the hospital community.

Approximately 5 months after our audit began, it came to our attention that IPRO had been instructed by NYS to revoid any hospital claims that had been previously voided by them and appeared to have been resubmitted by the affected providers. We determined that through their revoiding process, IPRO identified a total of 564 claims, or $3,019,364 in overpayments, that appeared to have been incorrectly resubmitted, whereas, our review identified 741 claims, or $3,774,112. Our review was more complete and comprehensive than that conducted by IPRO.

Because of the NYS project and information from hospitals that IPRO may have reauthorized certain rebillings, we are recommending that NYS work with IPRO and the affected providers to determine the appropriate overpayment amounts and recover these claims which would result in credits for both NYS and the Federal Government. Additionally, we are recommending that NYS develop appropriate procedures and controls within their MMIS to ensure that previously denied and voided claims are not again reimbursed by Medicaid if they are resubmitted for payment by providers. We are also recommending that NYS assess IPRO's communication with hospitals to seek improvement.

In their comments, State officials generally concur with the recommendations discussed in our report. In addition, regional officials of the Health Care Financing Administration also concurred with the findings and recommendations contained in our report.

For further information, contact:
John Tournour
Regional Inspector General
for Audit Services, Region II
(212) 264-4620

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ISLAND PEER REVIEW ORGANIZATION'S DENIALS OF FULL MEDICAL ASSISTANCE CLAIMS THAT NEW YORK STATE IDENTIFIED AS SUCCESSFULLY RECOVERED THROUGH THE AUTOMATED VOID PROCESS

JUNE GIBBS BROWN
Inspector General

APRIL 1994
A-02-93-01023

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

Our Reference: Common Identification Number A-02-93-01023

Mr. Michael J. Dowling
Commissioner
New York State Department
of Social Services
40 North Pearl Street
Albany, New York 12243

Dear Mr. Dowling:

This is to advise you of the results of our REVIEW OF THE ISLAND PEER REVIEW ORGANIZATION'S DENIALS OF FULL MEDICAL ASSISTANCE CLAIMS THAT NEW YORK STATE IDENTIFIED AS SUCCESSFULLY RECOVERED THROUGH THE AUTOMATED VOID PROCESS. The purpose of our review was to determine if full claim denials submitted by the Island Peer Review Organization (IPRO) for voiding were successfully processed and the affected Medicaid funds recouped and to determine if both the Federal Government and New York State (NYS) received their share of the recoupments. Our review was made of IPRO's denial determinations for admissions on or after January 1, 1988 and included denials voided by IPRO through March 27, 1993.

During our review period, IPRO was under contract with NYS to perform peer reviews of inpatient hospital stays to determine whether the services were appropriate and met professionally recognized standards. In performing these reviews, IPRO had the authority to deny claims when their examination of medical records determined that the claimed services were inappropriate or failed to meet professional standards. In this regard, IPRO developed the capacity to submit voided claims information via computer tapes directly to Computer Sciences Corporation (CSC) which is the fiscal agent for the NYS Medicaid program. The CSC operates the State's computerized Medicaid Management Information System (MMIS) and processes IPRO's voids which should result in the recovery of the affected Medicaid funds.

Under the automated void process, IPRO develops computer tapes on a periodic basis which contain pertinent information about hospital claims that IPRO has denied. The IPRO denial tapes are sent to CSC for processing. At CSC, the denial information is converted into void transactions which are reflected in three MMIS computer files. On the weekly paid claim file, the void transactions appear as credits which have the effect of reducing the total claims paid for the week as well as the payments to the affected hospitals. On the paid history file, the void transactions eliminate the recordation of the original claim which was denied by IPRO. On the credit history file, a record of the void transaction is posted as a credit. By reducing Medicaid expenditures via the posting of credits and the recovery of denied claims via reduced payments to hospitals, the automated void process benefits both NYS and the Federal Government.

Based on our audit tests of the automated void process, we obtained reasonable assurance that, during our review period, the system was successful in voiding claims denied by IPRO. We also obtained reasonable assurances that the system reduced payments to providers and resulted in reduced program expenditures which benefitted both NYS and the Federal Government.

However, our review also identified a significant system weakness which permitted hospitals to resubmit previously voided claims through the MMIS and have the claims paid despite the fact that IPRO had made a denial determination and the original claim had been voided. Because the automated void process deleted all reference to the original claims on the paid history files, there was no control or edit which would detect that the providers were resubmitting improper, previously voided claims. Rather, the MMIS treated the providers' resubmitted claims as entirely new claims. The absence of controls to detect or reject the improperly resubmitted claims constitutes a significant weakness which compromises the effectiveness of the automated void process in that denied claims have in effect not been recovered or properly credited.

Our review identified $3,774,112 (Federal share $1,437,337) in previously voided Medicaid claims which appear to have been inappropriately resubmitted for payment by the affected hospitals and paid by NYS. Specifically, we found that 741 denied claims previously voided by IPRO and recouped by NYS were resubmitted for payment by 104 hospitals and were paid by the MMIS. As a result, IPRO denials for these previously voided claims were unrecovered and thus neither the State nor Federal Government had been properly credited with their share of these overpayments.

During the latter phases of our audit field work, we learned that NYS, without formally advising us, had initiated a project with IPRO to conduct similar tests to determine and quantify the extent of the problem of providers resubmitting previously denied claims. The tests performed by IPRO confirmed our determination that previously voided claims have been resubmitted by providers. However, as NYS did not coordinate their project with us, there are differences in the amount of improper claims identified by the two reviews. The amount of improper payments identified by our audit was higher than that computed by IPRO. Through inquiries and analysis, we were able to identify certain of the reasons for the differences and these are discussed later in this report. We believe our review was more comprehensive than that performed by IPRO.

As part of our audit, we also contacted certain hospitals to obtain an understanding as to why these hospitals were resubmitting previously voided claims. In summary, officials at certain hospitals indicated that the rebillings had been made in error. Others indicated that they were trying to correct billing errors noted by IPRO's original denial determinations and finally, some indicated that IPRO had authorized them to rebill although we saw no evidence of this on IPRO's data files. Officials at many of the hospitals contacted expressed the need for better communications between IPRO and the hospital community.

As a result of the State's project to independently calculate the amount of the improper rebilled claims and information from hospitals that IPRO may have reauthorized certain rebillings, we are recommending that NYS work with IPRO and the affected providers to review our findings and determine what portion of the $3,774,112 (Federal share $1,437,337) represents firm denial amounts that were not eligible for rebilling. Once determined, the improper claims should be recouped and the Federal share returned.

We also recommend that NYS develop appropriate edits and controls within their MMIS to detect and preclude the payment of previously denied claims which have not been reauthorized for rebilling by IPRO. Finally, we recommend that NYS assess IPRO's communications with hospitals and seek ways to improve them. In this regard, we are pleased to note that IPRO, as a result of their independent tests, has recently issued written guidance to providers cautioning them against resubmitting voided claims. This guidance will assist in reducing the problem. However, we encourage NYS to seek input from the hospital community on additional ways of improving guidance and communications to enhance the effectiveness of the automated void process.

INTRODUCTION

Background

The Medicaid program, authorized by Title XIX of the Social Security Act, as amended, provides grants to States for furnishing medical assistance to eligible low-income persons. The States arrange with medical service providers such as physicians, pharmacies, hospitals, nursing homes, and other organizations to provide the needed medical assistance.

On May 1, 1966, NYS initiated its Medicaid program. The NYS Department of Social Services (DSS) is the Single State Agency for Medicaid. The DSS delegates certain of its responsibilities to other State agencies. One such agency is the Department of Health (DOH). The DOH is responsible for developing medical standards, monitoring the quality of care provided to patients, and establishing Medicaid rates and fees. To ensure that the services provided to a patient are appropriate and to help control health care costs, DOH contracted with IPRO to perform utilization reviews. As part of their reviews, IPRO evaluates the appropriateness of inpatient hospital admissions and discharges and reviews the quality of care provided.

During our review period, IPRO's responsibilities included reviewing inpatient stays (except AIDS cases) at New York City and Long Island hospitals from January 1988 to April 1989, reviewing inpatient stays (except AIDS cases) at all NYS hospitals after April 1989, and reviewing selected AIDS cases after April 1991. When IPRO performed peer reviews of inpatient hospital stays reimbursed by Medicaid, it determined whether the services provided were appropriate and whether the care provided met professionally recognized standards. Based on their peer review, IPRO

either approved a hospital stay, disallowed the entire stay which should have resulted in full recovery of Medicaid funds, or disallowed a portion of the stay which should have resulted in partial recovery of Medicaid funds.

When IPRO denied an entire stay or a portion of a stay, the denial determination was sent to the affected hospital. Hospital officials then had the opportunity to appeal the determination. If, after appeal, IPRO determined that the denial was appropriate, it notified the hospital of its final determination. For admissions on or after January 1, 1988, IPRO had the capability of submitting claims to be voided via computer tapes to New York's MMIS fiscal agent. When processed, the voided claims resulted in recovery of IPRO's full denials.

Under the automated void process, IPRO develops computer tapes on a periodic basis which contain pertinent information about hospital claims that IPRO has denied. The IPRO denial tapes are sent to CSC for processing. At CSC, the denial information is converted into void transactions which are reflected in three MMIS computer files. On the weekly paid claim file, the void transactions appear as credits which have the effect of reducing the total claims paid for the week as well as the payments to the affected hospitals. On the paid history file, the void transactions eliminate the recordation of the original claim which was denied by IPRO. On the credit history file, a record of the void transaction is posted as a credit. By reducing Medicaid expenditures via the posting of credits and the recovery of denied claims via reduced payments to hospitals, the automated void process benefits both NYS and the Federal Government.

Scope of Review

The purpose of our review was to determine if full claim denials submitted by IPRO for voiding were successfully processed and the affected Medicaid funds recouped and whether the Federal Government and NYS received their share of the recoupments. Our review was made of IPRO's denial determinations for admissions on or after January 1, 1988 and included denials voided by IPRO through March 27, 1993. Our review was limited to full denial determinations and did not include partial claims' denials.

For our review period, we obtained from IPRO final denial determination information which had been previously provided to NYS for recoupment. Using this information, we performed various computer programming applications at the MMIS fiscal agent to determine if the voids processed by IPRO were successful and resulted in a recoupment of the affected Medicaid funds. Our applications extracted all inpatient claims on file at the MMIS fiscal agent for each of the recipients that IPRO denied Medicaid stays during our review period. We compared the denial determination information to the extracted claims information to determine if recoupment action had occurred. We also made tests to verify that the voided transactions were posted to the credit history files and that the credits flowed into the weekly expenditure reports.

For those occurrences in which we determined that the original claims were successfully voided by IPRO and recouped by NYS but then subsequently resubmitted by the affected hospitals and paid by Medicaid, we calculated the overpayment amounts that remain unrecovered. Our computations were made as of August 31, 1993. As such, any recoupments made by NYS after this date would lower the unrecovered amounts discussed in this report.

Our review was conducted in accordance with governmental auditing standards. It included such tests and other auditing procedures that we considered necessary in the circumstances. During our review period, we interviewed IPRO and NYS officials and reviewed applicable policies and procedures relevant to the automated void process. We documented our understanding of the automated void process and conducted tests to determine that it had been placed in operation and was working. While acquiring an understanding of the internal control structure, it became apparent that no internal controls, edits, or other mechanisms existed within the MMIS which would preclude a hospital from resubmitting a claim for a previously voided stay and being reimbursed. As a result, we assessed control risk at the maximum level and decided to perform substantive testing of the total number of full Medicaid denials for the 213 hospitals included in our review. As part of our review, we did not perform a facility-wide review of the electronic data processing general and application controls within the MMIS.

Audit field work was performed at DSS, DOH, IPRO, and the MMIS fiscal agent during the period March 1993 to December 1993.

RESULTS OF REVIEW

Our review provided reasonable assurance that the automated void process was successfully processing voided transactions which resulted in recoupments from providers. This resulted in both NYS and the Federal Government receiving appropriate credits for the voided transactions through reduced expenditure levels. However, our review also disclosed that certain providers improperly rebilled the previously voided claims. In effect, the providers' actions compromised the effectiveness of the automated void process because IPRO's denial determinations were not actually recouped and therefore, neither NYS nor the Federal Government received their share of the denial determinations.

For our audit period, we determined that IPRO successfully voided and NYS recouped a total of 12,329 inpatient claims at 213 hospitals within NYS. We were able to locate 1,852 of the 12,329 claims on the MMIS paid claims history files and were not able to locate 10,477 because they remained successfully voided and recouped. For 1,111 of the 1,852 claims, we determined that IPRO reversed its original denial determinations which permitted the affected providers to properly resubmit these claims for payment. However, for the remaining 741 inpatient claims found at 104 of the 213 hospitals included in our review, IPRO's final denial determination information indicated that the denials were not reversed and as such the affected providers were not entitled to reimbursement.

In our opinion, the improper claims were paid because there are no edits or controls in the MMIS that would preclude previously voided claims from being resubmitted by providers and having them reimbursed. Under the automated void process, the original claim is eliminated from the paid history files when the void transaction is processed and therefore the resubmitted claim is treated as a new claim. Our tests identified $3,774,112 in previously voided claims, of which the Federal share was $1,437,337, that were resubmitted for payment and were paid. As a result, IPRO's void process was circumvented and providers received payment for claims that had been denied. In addition, neither NYS nor the Federal Government effectively received credit for the claims which IPRO had denied.

As part of our review, we contacted 24 of the 104 hospitals that had resubmitted previously voided claims to ascertain the reasons why claims previously denied and voided by IPRO were being resubmitted. Our correspondence to the 24 hospitals included 201 of the 741 claims in question. Officials at 21 of the 24 hospitals responded and provided explanations for 173 of the 201 claims. Based on the hospitals' responses, we determined that 81 of the 173 claims were rebilled in error by the providers. In addition, we found that for 70 of the 173 claims, hospital officials indicated that they incorrectly billed the original claim that IPRO initially reviewed and denied. As a result, these claims were resubmitted to reflect what the providers believed would correct the billing errors noted by IPRO's original denial determinations. For the remaining 22 claims, hospital officials contended that IPRO reversed their original denial determination, however, IPRO's data base did not reflect this reversal. Finally, many of the hospital officials contacted stated that there is a need for improved communication between themselves and IPRO which would help reduce confusion in the rebilling of previously voided claims.

Approximately 5 months after our audit began, it came to our attention that IPRO had been instructed by NYS to revoid any claims that had been previously voided by them and appeared to have been resubmitted by the affected providers. According to an IPRO official, it was our audit that prompted NYS to initiate this recoupment action. In a pro-forma memorandum sent to each of the affected hospitals on August 31, 1993, an IPRO official stated that:

> "IPRO has scanned its Medicaid claims data base and has identified those claims that were rebilled by your hospital after having been voided. The claims on the enclosed list were rebilled by your hospital yet they still appear on our system as a technical or admission denial. Therefore, we are submitting the rebilled claims to MMIS for voiding."

The IPRO memorandum goes on to state:

> "Please be aware that it is inappropriate for the provider to rebill Medicaid for claims that are denied by IPRO unless those denials are reversed and you are authorized to rebill. IPRO will be routinely screening for such inappropriate rebilling. Should a pattern appear we are required to report it to the Department of Health for appropriate action."

We determined that through their revoiding process, IPRO identified a total of 564 claims, or $3,019,364 in overpayments, that appeared to have been incorrectly resubmitted, whereas, our review identified 741 claims, or $3,774,112. We believe that one reason for this discrepancy is that IPRO's revoiding process did not include certain of IPRO's denials. Specifically, alternate level of care automatic denials and AIDS cases denials were not included in IPRO's revoiding process, but were included in our calculations. A second reason for the discrepancy is that IPRO's revoiding procedure was based on matching their original data base information with the current MMIS claims history files. However, we found that certain providers rebilled previously voided claims using different service dates than had originally been provided to IPRO and as such these claims would not have been revoided by IPRO. We believe our audit was more comprehensive then IPRO's review and accordingly, our results should be utilized in seeking recoveries.

Because of the NYS project and the responses received from the hospitals (as discussed above), we are recommending that NYS work with IPRO and the affected providers to determine the appropriate overpayment amounts and recover these claims thus resulting in credits for both NYS and the Federal Government.

APPENDIX A of our report includes a summary of the total and Federal share amounts identified by our audit as being improperly resubmitted for payment by the 104 hospitals in question. New York State will have to determine what portion of these resubmitted claims represent firm overpayments which need to be recovered.

Recommendations

We recommend that NYS:

1. Work with IPRO and the affected providers to determine what portion of the $3,774,112 (Federal share $1,437,337) identified by our audit represents firm denial amounts that were improperly resubmitted for payment and paid by New York's MMIS. Once determined, NYS should recoup the overpayment amounts and credit the Federal Government with its share.

2. Develop appropriate procedures and controls within their MMIS to ensure that previously denied and voided claims are not again reimbursed by Medicaid if they are resubmitted for payment by providers.

3. Assess IPRO's communications with hospitals to seek ways to improve them. As part of this process, we encourage NYS to seek input from the hospital community.

OTHER MATTERS

During our review, we found void transactions which IPRO had submitted and CSC had processed for admission dates prior to our audit period. Specifically, our review found that IPRO voided a total of 2,179 claims with admission dates prior to January 1, 1988. Our audit determined that 1,720 of the 2,179 voided claims were included in a prior review (CIN A-02-92-01009) by us and accordingly, we limited our testing to the remaining 459 voided claims.

We determined that 14 of the 459 claims appeared on the MMIS claims history, but we were unable to locate the remaining 445 claims because they remained successfully voided and recouped. For the 14 claims, we found that IPRO reversed its original denial determinations for 13 of them and that one claim was improperly resubmitted by Bronx Municipal Hospital Center, MMIS No. 00246048. This one claim resulted in $23,854 being inappropriately reimbursed by Medicaid, of which the Federal share was $11,927.

Recommendation

We recommend that NYS:

1. Recover $23,854 for the one inappropriately resubmitted claim and credit the Federal Government with its share ($11,927) of the overpayment.

STATE AGENCY COMMENTS

In their comments, DSS officials stated that the findings discussed in our report fall under the jurisdiction of DOH, whose comments they have incorporated into their response.

In response to recommendation number one on page 9, DSS officials stated that DOH will take the appropriate action to recover any overpayments once we provide them with the claims history information. However, NYS officials believe that IPRO has already identified many of these claims as improperly rebilled and recoupment action has already occurred.

In response to recommendation number two regarding developing appropriate procedures and controls within the MMIS, DSS officials stated that DOH has submitted a proposal for a new edit that will prevent the repayment of a State-voided claim and that the implementation of this edit will be determined by DSS. Regarding recommendation number three, DOH's Bureau of Hospital Services agreed to reassess IPRO's communications with hospitals and make any necessary improvements.

As for the one inappropriately resubmitted claim with an admission date prior to January 1, 1988, DSS officials stated that DOH will review this claim and if warranted, make the necessary recovery.

The State's comments are provided in their entirety in APPENDIX B of this report.

OIG RESPONSE

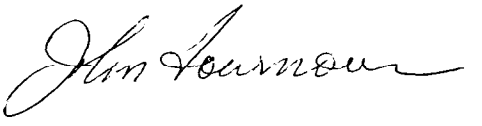
We are pleased to note that the State generally concurs with the findings contained within our report. In addition, we have provided the State with the claims history information, as requested, which should aid in the prompt recovery of any inappropriately resubmitted claims that remain unrecovered.

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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of the Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are available, if requested, 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 the referenced common identification number in all correspondence relating to this report.

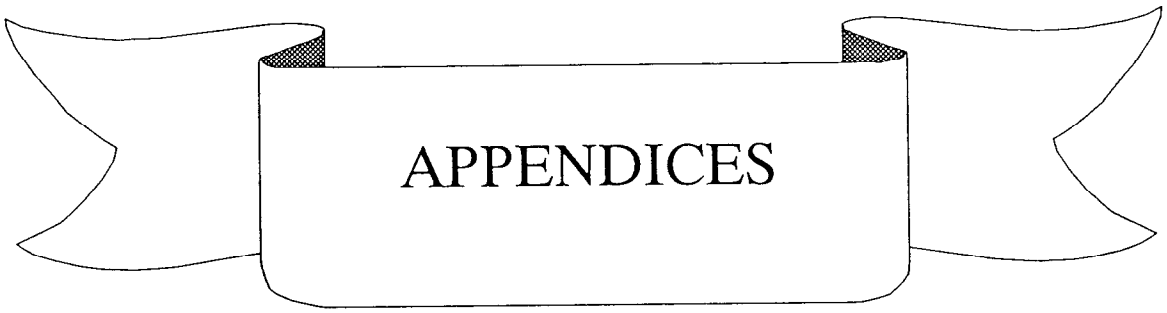
Sincerely yours,



John Tournour
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Arthur J. O'Leary
Associate Regional Administrator
Division of Medicaid, HCFA, Region II
U.S. Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278


APPENDICES

SCHEDULE OF AMOUNTS IMPROPERLY RESUBMITTED FOR PAYMENT

PROVIDER NUMBER	PROVIDER NAME	TOTAL AMOUNT NOT RECOUPED	FEDERAL SHARE
00243105	Beth Israel Medical Center	$174,851	$64,505
00243132	Cabrini Medical Center	10,952	0
00243178	Presbyterian Hospital-NYC	354,830	129,526
00243229	St. Vincent's Hospital	45,850	19,469
00243389	Hospital for Joint Diseases	16,025	8,012
00243421	Lenox Hill Hospital	54,956	3,327
00243476	NY Eye & Ear Infirmary	6,426	3,213
00243509	Mount Sinai Hospital	8,691	958
00243518	NY Hospital	124,358	60,226
00243554	Montefiore Medical Center	309,942	126,928
00243563	Our Lady of Mercy Medical Center	20,617	8,779
00243572	Brookdale Hospital	10,512	4,767
00243590	University Hospital of Brooklyn	16,124	8,062
00243614	Brooklyn Hospital	702,608	251,128
00243641	Maimonides Medical Center	35,696	9,237
00243678	Long Island College Hospital	26,053	8,200
00243701	Methodist Hospital of Brooklyn	7,891	1,832
00243825	Wyckoff Heights Hospital	60,795	26,277
00243843	Flushing Hospital	867	433
00243852	Jamaica Hospital	13,032	6,516
00243861	Mary Immaculate Hospital	31,995	9,376
00243898	Peninsula Hospital Center	4,669	2,334
00243903	L I J Medical Center	13,252	5,393
00243967	Nyack Hospital	3,301	1,650
00244091	Nassau County Medical Center	13,070	6,535
00244124	St. John's Queens Hospital	755	377
00244133	Booth Memorial Medical Center	44,844	22,422
00244202	Community Health System of Staten Island	3,550	825
00244211	Winthrop University Hospital	777	388
00244784	Astoria General Hospital	35	17
00245083	Union Hospital of the Bronx	17,248	7,953
00245432	Yonkers General Hospital	14,817	0
00245501	St. John's Riverside Hospital	3,326	1,663
00245529	Brookhaven Memorial Hospital	6,439	3,219
00245863	Erie County Medical Center	7,782	1,390
00246039	Bellevue Hospital Center	340,210	151,682
00246048	Bronx Municipal Hospital	31,013	11,238
00246075	City Hospital Center @ Elmhurst	66,250	25,927
00246108	Harlem Hospital Center	17,594	4,707
00246117	Kings County Hospital Center	947	473
00246135	Metropolitan Hospital Center	45,135	22,567
00246171	North Central Bronx	449	224
00248820	St. Vincent's Medical Center Richmond	7,355	3,677
00258360	Putnam Hospital Center	2,086	1,043
00268295	Brunswick Hospital	5,717	2,858
00268319	Southside Hospital	2,653	1,326
00268328	Franklin Hospital	17,127	2,572
00273092	Westchester Square Hospital	7,175	3,587
00273116	NY University Medical Center	3,895	1,947
00273854	Vassar Brothers Hospital	5,411	1,205
00273914	St. Luke's Hospital of Newburgh	3,175	644
00273932	Julia Butterfield Hospital	2,295	311
00274093	Lawrence Hospital	1,283	0
00274117	Mount Vernon Hospital	1,110	555
00274126	New Rochelle Hospital	1,265	632
00274153	Peekskill Hospital	4,512	2,256
00274162	Phelps Memorial Hospital	893	0
00274204	United Hospital	13,524	2,772
00274213	Westchester County Medical Center	171,399	83,482
00274231	Central General Hospital	3,965	0
00274295	Mercy Medical Center	3,976	415
00274328	Central Suffolk Hospital	4,642	2,321
00274337	Eastern Long Island Hospital	4,645	0
00274346	Good Samaritan Hospital	4,868	2,434
00274364	John T. Mather Memorial Hospital	1,578	493
00274382	Community Hospital of Western Suffern	12,401	6,200
00274406	South Hampton Hospital	3,750	0
00279034	Strong Memorial Hospital	14,251	1,395
00279098	Aurelia Osborn Fox Memorial Hospital	3,585	0
00279387	Margaretville Memorial Hospital	588	0
00279396	Crouse Irving Memorial Hospital	67,573	31,579
00301097	Genesee Hospital Rochester	3,875	1,937
00303315	Rochester General Hospital	865	432
00305000	Mary Imogene Bassett Hospital	728	364
00310843	Mercy Hospital of Watertown	2,458	1,229
00314998	Glens Falls Hospital	2,635	1,317
00315013	St. Joseph's Hospital Health Center	9,923	4,961
00318805	Samaritan Hospital Troy	1,156	298
00318823	St. Peter's Hospital	1,821	910
00335915	Columbia Green Medical Center	9,347	4,673
00351639	St. Mary's Hospital	3,277	1,638
00354201	Clifton Fine Hospital	2,873	1,436
00354229	Community Memorial Hospital	1,082	541
00354316	House of the Good Samaritan	987	493
00354412	Mercy Hospital of Buffalo	9,395	4,697
00354467	Niagara Falls Medical Center	17,306	3,922
00354590	Upstate Medical Center	16,886	8,284
00354623	Woman's Christian Association	384	192
00354967	St. Luke's Roosevelt Hospital	433,236	147,978
00355142	North General Hospital	11,101	5,550
00357795	University Hospital	44,965	22,482
00360614	Children's Hospital of Buffalo	2,086	1,043
00360650	St. Mary's Hospital Rochester	13,865	6,932
00360930	Moses Ludington Hospital	617	308
00363162	St. James Mercy Hospital	2,594	204
00384643	Millard Fillmore Hospital	11,454	5,727
00476022	Bronx Lebanon Hospital	62,689	16,304
00614755	United Health Service Hospital	60	30
00647269	Beekman Downtown Hospital	17,926	3,178
00652328	Bayley Seton Hospital	2,254	0
00710430	Beth Israel Medical Center	33,108	9,927
00729382	Episcopal Health Services	3,510	0
00734336	Interfaith Medical Center	6,234	4,299
00863869	Syosset Community Hospital	1,184	592
	GRAND TOTAL FOR 104 HOSPITALS	$3,774,112	$1,437,337

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MICHAEL J. DOWLING
Commissioner

February 18, 1994

Mr. John Tournour
Regional Inspector General
for Audit Services
Office of Inspector General
Office of Audit Services
Region II, 26 Federal Plaza
Federal Building
New York, NY 10278

Re: HHS/OIG Draft Report: Review of Island Peer Review Organization's Denials of Full MA Claims NYS Identified as Recovered through the Automated Void Process (A-02-93-01023) 94-002

Dear Mr. Tournour:

The issues raised in the referenced report come under the jurisdiction of the New York State Department of Health (DOH). We shared the report with DOH and have included their comments in our response.

Recommendation: Work with IPRO and the affected providers to determine what portion of the $3,774,112 (Federal share $1,437,337) identified by our audit represents firm denial amounts that were improperly resubmitted for payment and paid by New York's MMIS. Once determined, NYS should recoup the overpayment amounts and credit the Federal Government with its share.

Response: Once your Office provides us with the claims history information in tape format, DOH will take the necessary steps to recoup overpayment amounts on any claim that may have been resubmitted inappropriately. As indicated in the report, many of these cases were identified by the Island Peer Review Organization (IPRO) as improperly rebilled and action had already been taken to reprocess the voids.

Recommendation: Develop appropriate procedures and controls within their MMIS to ensure that previously denied and voided claims are not again reimbursed by Medicaid if they are resubmitted for payment by providers.

Response: The Department of Health has submitted a proposal for the development of a new edit which will prevent repayment of a State-voided claim. Implementation of the edit will be determined by the Department of Social Services.

Recommendation: Assess IPRO's communications with hospitals to seek ways to improve them. As part of this process, we encourage NYS to seek input from the hospital community.

Response; The DOH's Bureau of Hospital Services agrees to reevaluate how IPRO communicates with hospitals regarding denied claims and make improvements as appropriate.

Recommendation: Recover $23,854 for the one inappropriately resubmitted claim and credit the Federal Government with its share ($11,927) of the overpayment.

Response: Once DOH reviews the claims detail, it will take the necessary steps to make the recoupment, if warranted.

Thank you for sharing this report with us.

Sincerely,

John M. Daniels
Director
External Audit Unit
Office of Quality Assurance
and Audit