Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NONINSTITUTIONAL PROVIDERS IN NORTH CAROLINA DID NOT RECONCILE INVOICE RECORDS WITH CREDIT BALANCES AND REPORT THE ASSOCIATED MEDICAID OVERPAYMENTS TO THE STATE AGENCY

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

Gloria L. Jarmon
Deputy Inspector General

November 2012
A-04-11-04016

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In North Carolina, the Department of Health and Human Services (State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance administers the Medicaid program.

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

Credit balances may occur when a provider's reimbursement for services that it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

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

Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, the State must make the adjustment no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

In North Carolina, the State's regulations do not require providers to refund Medicaid overpayments within a specific period. However, section 7 of North Carolina's *Basic Medicaid Billing Guide* requires providers to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In North Carolina, the audit focused on two general types of noninstitutional providers: multispecialty physician groups and multispecialty physician and medical diagnostic clinics.

OBJECTIVES

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

SUMMARY OF FINDINGS

Generally, the eight noninstitutional providers that we sampled did not reconcile invoice records with credit balances and report the associated Medicaid overpayments to the State agency. Of the 185 invoice records with both Medicaid payments and credit balances in our sample, 112 contained Medicaid overpayments, but 73 did not. The Medicaid overpayments associated with these 112 invoice records totaled $10,097 ($7,098 Federal share). Based on these results, we estimated that the State agency could realize an additional Statewide recovery of $1,258,900 ($902,461 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

The providers did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. The reconciliation process was at the discretion of the providers, and some providers did not reconcile invoice records for more than 6 years. Some noninstitutional providers stated that they were unaware of the State agency's requirement for the quarterly reporting of all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

RECOMMENDATIONS

We recommend that the State agency:

- refund $10,097 ($7,098 Federal share) to the Federal Government for overpayments paid to the selected noninstitutional providers and

- enhance its efforts to recover additional overpayments estimated at $1,258,900 ($902,461 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations and summarized the corrective actions that it is planning. The State agency's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In North Carolina, the Department of Health and Human Services (State agency) supervises the administration of the Medicaid program. Within the State agency, the Division of Medical Assistance administers the Medicaid program.

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

North Carolina's Medicaid program defines a credit balance as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors.[1] Credit balances may occur when a provider's reimbursement for services it provides exceeds the allowable amount or when the reimbursement is for unallowable costs, resulting in an overpayment. Credit balances also may occur when a provider receives payments from Medicaid and another third-party payer for the same services.

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

Federal and State Requirements Related to Medicaid Overpayments

Under 42 CFR § 433.312, States are responsible for recovering from providers any amounts paid in excess of allowable Medicaid amounts and for refunding the Federal share to CMS. Effective March 23, 2010, States have up to 1 year from the date of discovery of an overpayment for Medicaid services to recover, or attempt to recover, the overpayment before making an adjustment to refund the Federal share. Except for overpayments resulting from fraud, States must make the adjustment

[1] North Carolina Department of Health and Human Services, *Basic Medicaid Billing Guide*, April 2010, pp. 7-9 (Billing Guide).

no later than the deadline for filing the quarterly expenditure report (Form CMS-64) for the quarter in which the 1-year period ends, regardless of whether the State recovers the overpayment.

In general, an overpayment is discovered when a State either (1) notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery or (2) initiates a formal recoupment action. Discovery may also occur when the provider initially acknowledges a specific overpaid amount in writing to the State. If a Federal review (such as an audit) indicates that a State has failed to identify an overpayment, the overpayment is considered as discovered on the date the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.[2]

In North Carolina, the State agency's regulations do not require providers to refund Medicaid overpayments within a specific period. However, North Carolina's Billing Guide requires providers to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems as of the last day of each calendar quarter.[3]

Selected Noninstitutional Providers

This audit is part of a multistate review of credit balances at acute care hospitals, nursing facilities, and certain noninstitutional providers. In North Carolina, our audit focused on two general types of noninstitutional providers: multispecialty physician groups and multispecialty physician and medical diagnostic clinics. Table 1 identifies the primary classification for each of the eight multispecialty providers that we randomly selected for review.

Table 1: Primary Classification

Provider	Description
Provider 1	Clinic/center
Provider 2	Clinic/center
Provider 3	Internal medicine
Provider 4	Ophthalmology
Provider 5	Emergency medicine
Provider 6	Internal medicine
Provider 7	Federally qualified health center
Provider 8	Radiology

[2] 42 CFR § 433.316.

[3] Billing Guide, pp. 7-9. In its Medicaid Bulletins to providers, the State has clarified that hospitals and nursing facilities are required to submit a quarterly report even if no Medicaid credit balance exists. However, noninstitutional providers are required to submit a quarterly report only when they identify outstanding Medicaid credit balances. See, e.g., *North Carolina Medicaid Bulletin*, September 2010, p. 11.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

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

Scope

Our audit period covered 13,244 invoice records with unresolved credit balances[4] as of the most recent quarter ended for each of the 8 noninstitutional providers in our sample. The most recent quarter ended for three providers was June 30, 2011, and the most recent quarter ended for the remaining five providers was September 30, 2011. The unresolved credit balances totaled $1,261,942. The 8 sampling frames included 7,931 invoice records with unresolved credit balances[5] totaling $920,623.

We did not review the overall internal control structure of the State agency or the noninstitutional providers that we sampled. We limited our review of the State agency's internal controls to determining the capabilities of the Medicaid claims processing system in preventing overpayments and determining whether there were backlogs in processing provider adjustments and refunds. We limited our internal control review at the eight sampled providers to obtaining an understanding of the policies and procedures that the noninstitutional providers used to review credit balances and report overpayments to the State agency.

From September 2011 through April 2012, we conducted fieldwork at the State agency's offices in Raleigh, North Carolina, and the eight noninstitutional providers at various locations throughout North Carolina.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations and State agency policy guidelines pertaining to Medicaid overpayments;

- interviewed State agency personnel responsible for monitoring Medicaid overpayments;

- created a sampling frame for the first stage of our sample design consisting of 282 noninstitutional providers, from which we randomly selected 8 providers using the probability-proportional-to-size methodology (Appendix A);

- reviewed the providers' policies and procedures for reviewing credit balances and reporting overpayments to the State agency;

[4] The invoice records with these credit balances also contained Medicaid payments.

[5] Each credit balance in our sampling frame was unresolved for at least 60 days and greater than $3.

- determined the providers' total number and associated dollar amount of all invoices with credit balances and reconciled to the providers' accounting records to identify total credit balances with Medicaid payments;

- created a sampling frame for each of the eight selected providers for the second stage of our sample design;

- selected a random sample of 30 invoice records for each of the 5 providers that had more than 30 invoice records and reviewed all invoice records from each of the 3 providers that did not have more than 30 invoice records (Appendix A);

- reviewed patient payment data, remittance advices, details of patient accounts receivable, and additional supporting documentation for each of the selected invoice records to determine overpayments that should be reported to the State agency;

- estimated Statewide unrecovered Medicaid overpayments associated with unresolved credit balances that should be reported to the State agency;

- determined whether the provider had taken action, subsequent to our audit period, to report to the State agency the Medicaid overpayments identified in our sample; and

- discussed our audit results with the eight providers in our sample.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

Generally, the eight noninstitutional providers that we sampled did not reconcile invoice records with credit balances and report the associated Medicaid overpayments to the State agency. Of the 185 invoice records with both Medicaid payments and credit balances in our sample, 112 contained Medicaid overpayments, but 73 did not. The Medicaid overpayments associated with these 112 invoice records totaled $10,097 ($7,098 Federal share). Based on these results, we estimated that the State agency could realize an additional Statewide recovery of $1,258,900 ($902,461 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

The providers did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. The reconciliation process was at the discretion of the providers, and some providers did not reconcile invoice records for more than

6 years.[6] Some noninstitutional providers stated that they were unaware of the State agency's requirement for the quarterly reporting of all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

INVOICE RECORDS WITH UNRESOLVED CREDIT BALANCES

As of the end of the most recent quarter, the accounting records for the 8 noninstitutional providers contained 13,244 invoice records with unresolved credit balances totaling $1,261,942. Although Medicaid had reimbursed the providers for some portion of these invoice records, the providers had not reconciled, or otherwise evaluated, the invoice records to determine whether the unresolved credit balances contained Medicaid overpayments that should have been returned to the State agency.

Of the 13,244 invoice records with unresolved credit balances, 10,111 invoice records totaling $924,578, or 76 percent, had credit balances that were at least 60 days old, and some were unresolved for more than 6 years, as shown in Table 2.

Table 2: Invoice Records With Unresolved Credit Balances

Time Unresolved	Number of Invoice Records	Unresolved Credit Balances
60–365 days	5,479	$685,049
1–2 years	2,524	171,679
2–3 years	1,050	43,628
3–4 years	555	17,220
4–5 years	343	5,311
5–6 years	154	1,665
More than 6 years	6	26
Total	**10,111**	**$924,578**

The providers did not reconcile these invoice records with unresolved credit balances because there was no requirement for them to do so.

MEDICAID OVERPAYMENTS NOT REPORTED

The State agency's Billing Guide states that providers are required to submit a quarterly report showing all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems as of the last day of each calendar quarter. The report requires specific information for each credit balance on a claim-by-claim basis, and the State agency uses the report to monitor and recover credit balances due to Medicaid.

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

Under Federal regulations, a State must refund the Federal share of an overpayment to CMS within a specified period after it is discovered. The overpayment would be discovered when the provider acknowledges the overpayment amount on the quarterly report that it submits to the State. The State would refund the Federal share on the quarterly CMS-64 report to CMS.

The State agency's quarterly report is similar to the report that Medicare providers are required to submit under §§ 1815(a), 1833(e), 1866(a)(1)(C), and related provisions of the Act.[7] Both the State agency's quarterly report and Medicare's report notify the appropriate officials that the provider has determined that a credit is due to the applicable Federal program for an overpayment.

Among the noninstitutional providers in our sample, the practices for reconciling credit balances and identifying and reporting overpayments varied widely, and some of the providers did not report Medicaid overpayments to the State agency. Seven of the eight providers did not routinely submit the required quarterly report, although some providers had submitted a report subsequent to our audit period.

Of the 185 invoice records with both Medicaid payments and credit balances in our sample, 112 contained overpayments totaling $10,097 ($7,098 Federal share). The eight noninstitutional providers acknowledged that the overpayments occurred, and we verified that the providers had refunded $4,975 ($3,477 Federal share) of the overpayments to the State agency subsequent to our audit period.

The overpayments occurred because the noninstitutional providers received duplicate payments and third-party payments, as well as making various billing and accounting errors. Duplicate payments were typically caused by the noninstitutional providers erroneously generating multiple billings or by Medicaid paying more than once for the same services. Third-party payments resulted from noninstitutional providers receiving payment from a third-party insurer, such as a commercial insurer or Medicare, for a service paid for by Medicaid. Billing and accounting errors included overstated billings, the use of incorrect identifiers for the type of services provided, and posting errors.

INEFFECTIVE POLICIES AND PROCEDURES

The providers did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to identify and return overpayments that were due the State agency. The reconciliation process was at the discretion of the providers, and some providers did not reconcile their invoice records for more than 6 years. In addition, some provider officials stated that they were unaware of the State agency's requirement for the quarterly reporting of all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

[7] See Form CMS-838, Medicare Credit Balance Report.

MEDICAID OVERPAYMENTS AND ESTIMATED PROGRAM RECOVERIES

Of the 185 invoice records with both Medicaid payments and credit balances in our sample, 112 contained overpayments totaling $10,097 ($7,098 Federal share) paid to 8 noninstitutional providers. The State agency should refund the Federal share of those overpayments to CMS. (See Appendix B for details of our sample results.)

We estimated that the State agency could realize an additional Statewide recovery of $1,258,900 ($902,461 Federal share) from our audit period and obtain future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments. (See Appendix B for details of our Statewide estimate.)

RECOMMENDATIONS

We recommend that the State agency:

- refund $10,097 ($7,098 Federal share) to the Federal Government for overpayments paid to the selected noninstitutional providers and

- enhance its efforts to recover additional overpayments estimated at $1,258,900 ($902,461 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

STATE AGENCY COMMENTS

The State agency concurred with our findings and recommendations and summarized the corrective actions that it is planning. The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of certain noninstitutional providers in North Carolina that received a Medicaid payment during the quarter ended March 31, 2011, with the exception of one provider that we had previously reviewed (report number A-04-10-04007). These noninstitutional providers were either multispecialty physician groups or multispecialty physician and medical diagnostic clinics. A multispecialty group is identified in North Carolina's Medicaid Management Information System (MMIS) as provider type 022 and specialty code 070. Multispecialty physician and medical diagnostic clinics are identified as provider type 052 and specialty code 070.

SAMPLING FRAME

From North Carolina's MMIS, we created a database of all payments made to noninstitutional providers during the quarter ended March 31, 2011. The database consisted of 988,875 claims with Medicaid payments totaling $74,553,816, representing 1,280 noninstitutional providers. We then eliminated all providers with less than 500 Medicaid claims, providers that received less than $10,000 in Medicaid payments, out-of-State providers, and providers affiliated with our previous audit mentioned above. The resulting sampling frame of 842,382 claims and Medicaid payments totaling $62,615,865 represented 282 noninstitutional providers.

SAMPLE UNIT

The primary sample unit was a noninstitutional provider. The secondary sample unit was an invoice record with a Medicaid payment and a credit balance greater than $3 in a provider's account that was at least 60 days old as of the date of the most recently ended quarter.

SAMPLE DESIGN

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

SAMPLE SIZE

We selected eight noninstitutional providers as the primary units. For the secondary units, we selected a random sample of 30 invoice records with Medicaid payments and credit balances from 5 providers and all invoice records with Medicaid payments and credit balances from the remaining 3 providers, for a total of 185 invoice records in the amount of $30,857.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS OF MEDICAID OVERPAYMENTS

Provider	Amount of Actual Overpayments	Federal Share of Overpayments
Provider 1	$1,176	$873
Provider 2	5,485	3,765
Provider 3	1,022	744
Provider 4	878	621
Provider 5	933	684
Provider 6	49	37
Provider 7	516	347
Provider 8	38	27
Total	**$10,097**	**$7,098**

STATEWIDE ESTIMATE OF POTENTIAL SAVINGS[1]

Frame Size for the Selected Providers	Value of Frame for the Selected Providers	Sample Size	Value of Sample	Number of Overpayments in Sample	Value of Overpayments in Sample	Value of Overpayments in Sample (Federal Share)
7,931	$920,623	185	$30,857	112	$10,097	$7,098

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$1,268,997
Lower limit	436,594
Upper limit	2,101,401

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

Point estimate	$909,559
Lower limit	312,810
Upper limit	1,506,309

[1] The estimated value of overpayments includes the value of overpayments in the sample.

APPENDIX C: STATE AGENCY COMMENTS

North Carolina Department of Health and Human Services
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Beverly Eaves Perdue, Governor

Albert A. Delia, Acting Secretary

October 10, 2012

Lori S. Pilcher, Regional Inspector
General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-11-04016

Dear Ms. Pilcher:

We have reviewed your draft report entitled *Noninstitutional Providers in North Carolina Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency*. The following represents our response and corrective action plan to the Audit Findings and Recommendations.

SUMMARY OF FINDINGS

Generally, the eight noninstitutional providers that we sampled did not reconcile invoice records with credit balances and report the associated Medicaid overpayments to the State agency. Of the 185 invoice records with both Medicaid payments and credit balances in our sample, 112 contained Medicaid overpayments, but 73 did not. The Medicaid overpayments associated with these 112 invoice records totaled $10,097 ($7,098 Federal share). Based on these results, we estimated that the State agency could realize an additional Statewide recovery of $1,258,900 ($902,461 Federal share) from our audit period and obtain future savings if it enhanced its efforts to recover overpayments in provider accounts.

The providers did not identify and report Medicaid overpayments because the State agency did not require providers to exercise reasonable diligence in reconciling invoice records with credit balances to determine whether overpayments existed. The reconciliation process was at the discretion of the providers, and some providers did not reconcile invoice records for more than 6 years. Some non-institutional providers stated that they were unaware of the State agency's requirement for the quarterly reporting of all identified Medicaid overpayments recorded as credit balances in the providers' accounting systems.

RECOMMENDATIONS

The recommendations were for the North Carolina Department of Health and Human Services to:

- refund $10,097 ($7,098 Federal share) to the Federal Government for overpayments paid to the selected non-institutional providers and
- enhance its efforts to recover additional overpayments estimated at $1,258,900 ($902,461 Federal share) from our audit period and realize future savings by requiring providers to exercise reasonable diligence in reconciling invoice records with credit balances and reporting the associated Medicaid overpayments.

DHHS Response: *The Department concurs with the findings and recommendations and will refund the Federal share of $7,098 by December 31, 2012. The Department also concurs with the summary of findings which addresses the need to enhance efforts to recover additional overpayments and realize future savings by imposing specific requirements on providers regarding the reconciliation of invoice records with credit balances and appropriately report associated overpayments. In this regard, the Department is planning the corrective actions below.*

NC DHHS Corrective Actions

To lessen the future likelihood of providers neglecting to properly report credit balance overpayments, the Program Integrity Section of the Division of Medical Assistance (DMA) is enhancing communication to all providers via the monthly DMA Medicaid Bulletin. The article, published quarterly, will reinforce the requirement that providers identify credit balance overpayments and submit quarterly reports that reflect the overpayment and the methodology as well as timeframes used to refund Medicaid. The Department will also develop enforceable rules making this requirement the responsibility of all Medicaid providers.

Earlier this year, DMA began discussions with its third party contractor regarding the feasibility of the contractor assuming responsibility for the Credit Balance Reporting Process; which is currently a manual process performed by Program Integrity Third Party Liability (TPL) staff. The benefit to this transition of responsibility would be the automation of the process, resulting in the ability to better track refunds and adjustments made by providers as well as tracking which providers neglect to submit Quarterly Credit Balance Reports over a period of time. DMA will continue with these discussions and will amend the existing contract if an agreement is reached. If no agreement is reached, consideration will be given to developing a Request For Proposal (RFP).

The Department is committed to improving the Department's Medicaid program and continues to take steps to make Medicaid more efficient and effective in meeting the needs of qualified individuals within the state. The Department will address the issues contained in this report and continue to move forward with changes to identify and correct problems in this program.

We also greatly appreciate the professionalism of the OIG audit staff, the objective manner in which they conducted the audit fieldwork and the fiscally sound recommendations in the report.

If you need any additional information, please contact Monica Hughes at (919) 855-3720.

Sincerely,

Albert A. Delia

AAD:mh

cc: Dan Stewart, Assistant Secretary for Finance and Business Operations
Michael Watson, Director, Division of Medical Assistance
Laketha Miller, Controller, Office of the Controller
Eddie Berryman, Director, Office of Internal Audit
Tara Larson, Chief Clinical Operations Officer
Debbie Pittard, Acting Assistant Director
Patricia D. Allen, Program Integrity Business Operations Manager