



Office of Audit Services
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JUL 08 2008

Report Number: A-01-07-00008

Ms. Virginia Mui
Director, Patient Financial Services
Boston Medical Center
One Boston Medical Center Place
Boston, Massachusetts 02118-2393

Dear Ms. Mui:


Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Credit Balances at Boston Medical Center for the Period Ending March 31, 2007." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact George Nedder, Audit Manager, at (617) 565-3463 or through e-mail at George.Nedder@oig.hhs.gov. Please refer to report number A-01-07-00008 in all correspondence.

Sincerely,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Center for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICAID CREDIT BALANCES AT
BOSTON MEDICAL CENTER
FOR THE PERIOD ENDING
MARCH 31, 2007**



Daniel R. Levinson
Inspector General

July 2008
A-01-07-00008

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Title XIX of the Social Security Act authorizes Federal funds to States for Medicaid programs that provide medical assistance to low-income and disabled individuals. Each State Medicaid program reimburses providers for these services. Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed, such as when a provider receives payments for the same service from the Medicaid program and another third party payer. In these cases, the provider should return the existing overpayment to the Medicaid program, which is the payer of last resort.

MassHealth, the Massachusetts Medicaid program, requires providers to return overpayments classified as credit balances to MassHealth within 60 days of their receipt. MassHealth reinforced this regulation in November 2004, when it issued a Bulletin to providers stating that MassHealth may impose administrative fines against providers who do not return overpayments classified as credit balances within 60 days of their receipt.

Boston Medical Center (the Hospital) is a private, not-for-profit, 581-bed academic teaching hospital in Boston, Massachusetts. Hospital officials reported that the Hospital returned \$431,512 in Medicaid overpayments for the period September 30, 2003, through September 30, 2006.

OBJECTIVE

Our objective was to determine whether the credit balances recorded in the Hospital's accounting records for inpatient and outpatient services for Medicaid beneficiaries represented overpayments more than 60 days old that the Hospital should have returned to the Medicaid program in a timely manner.

SUMMARY OF FINDING

As of March 31, 2007, the Hospital's accounting records for Medicaid beneficiaries contained 645 overpayments more than 60 days old. Thus the Hospital did not promptly return Medicaid overpayments of \$198,287 (\$99,144 Federal share) to the Medicaid program, in accordance with State Medicaid requirements. These errors occurred because the Hospital did not follow its internal procedures for processing and returning Medicaid overpayments in a timely manner.

RECOMMENDATIONS

We recommend that the Hospital:

- return overpayments totaling \$198,287 (\$99,144 Federal share) to MassHealth and
- continue efforts to identify and return all overpayments to Medicaid in accordance with State requirements.

BOSTON MEDICAL CENTER COMMENTS

In its written comments on our draft report, the Hospital agreed with our finding and recommendations. The Hospital's comments are included in their entirety in the Appendix.

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INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act authorizes Federal funds to States for Medicaid programs that provide medical assistance to low-income and disabled individuals. Each State Medicaid program reimburses providers for these services. Credit balances generally occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the charges billed, such as when a provider receives payments for the same service from the Medicaid program and another third party payer. In these cases, the provider should return the existing overpayment to the Medicaid program, which is the payer of last resort.

MassHealth, the Massachusetts Medicaid program, requires providers to return overpayments classified as credit balances to MassHealth within 60 days of their receipt. MassHealth reinforced this regulation in November 2004, when it issued a Bulletin to providers stating that MassHealth may impose administrative fines against providers who do not return overpayments classified as credit balances within 60 days of their receipt.

Boston Medical Center (the Hospital) is a private, not-for-profit, 581-bed academic teaching hospital in Boston, Massachusetts. Hospital officials reported that the Hospital returned \$431,513 in Medicaid overpayments for the period September 30, 2003, through September 30, 2006.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the credit balances recorded in the Hospital's accounting records for inpatient and outpatient services for Medicaid beneficiaries represented overpayments more than 60 days old that the Hospital should have returned to the Medicaid program in a timely manner.

Scope

As of March 31, 2007, the Hospital's accounts related to Medicaid beneficiaries contained 8,045 credit balances totaling \$2,067,686. We reviewed 801 outpatient accounts totaling \$522,045. Specifically, we limited our review to the outpatient accounts of 214 beneficiaries who were involved in motor vehicle accidents and thus were likely to have other payment sources, 187 beneficiaries who had private insurance in addition to Medicaid, and 400 beneficiaries who were dually eligible for Medicare and Medicaid and had accounts with credit balances greater than \$207.

We limited our review of internal controls to obtaining an understanding of the Hospital's controls related to reviewing credit balances and reporting overpayments to the Medicaid program.

We performed fieldwork from September 2007 through April 2008 at Boston Medical Center in Boston, Massachusetts.

Methodology

To accomplish our objective, we:

- reviewed State and Federal regulations pertaining to credit balances;
- extracted from the credit balance list all Medicaid inpatient and outpatient credit balances and reconciled these credit balances to the Hospital's accounting records as of March 31, 2007;
- reviewed Medicaid remittance advices, patient accounts receivable detail, and adjustment forms for all accounts to determine whether Medicaid overpayments had occurred; and
- coordinated our audit with officials from the Commonwealth of Massachusetts Office of Medicaid.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

As of March 31, 2007, the Hospital's accounting records for Medicaid beneficiaries contained 645 overpayments more than 60 days old. Thus the Hospital did not promptly return Medicaid overpayments of \$198,287 (\$99,144 Federal share) to the Medicaid program, in accordance with State Medicaid requirements. These errors occurred because the Hospital did not follow its internal procedures for processing and returning Medicaid overpayments in a timely manner.

STATE MEDICAID REQUIREMENTS

MassHealth regulations require that all providers make diligent efforts to obtain payment first from other resources, so that MassHealth will be the payer of last resort and providers will not receive overpayments from the Medicaid program. 130 Code of Massachusetts Regulations (CMR) 450.235 provides examples of provider overpayments. These include, but are not limited to, payments to a provider for services not actually provided or duplicate payments for the same service from other health insurers, worker's compensation insurers, or other third party payers. Pursuant to 130 CMR 450.238 (B)(7), providers who do not return overpayments within 60 days of receipt may be subject to sanctions, including administrative fines and suspension or termination from participating in MassHealth.

MassHealth reinforced this requirement in November 2004, when it issued a Bulletin to providers stating that it may impose administrative fines against providers who do not return overpayments classified as credit balances within 60 days of their receipt.

OUTSTANDING CREDIT BALANCES CONTAINING OVERPAYMENTS

The Hospital did not always return Medicaid overpayments within 60 days, as specified by State Medicaid requirements. Of the 801 outpatient claims with credit balances, 645 contained Medicaid overpayments more than 60 days old that the Hospital should have returned to MassHealth. These overpayments resulted when the Hospital received payments for the same service from the Medicaid program and another third party payer. The ages of the credit balances ranged from 182 to 1,523 days, as the following table summarizes.

Ages of Credit Balances and Amounts of Unreported Overpayments

Days	Claims	Refund Amount
121 – 365	67	\$ 14,028
366 – 730	409	141,648
731 – 1,000	65	18,243
Over 1,001	104	24,368
TOTAL	645	\$ 198,287

AMOUNT OF UNREFUNDED OVERPAYMENTS

As a result of not promptly resolving its credit balances and reporting overpayments, the Hospital did not return overpayments of \$198,287 (\$99,144 Federal share) to MassHealth within 60 days of their receipt.

CAUSE OF UNREFUNDED OVERPAYMENTS

These errors occurred because the Hospital did not follow its internal procedures for processing and returning Medicaid credit balances in a timely manner.

RECOMMENDATIONS

We recommend that the Hospital:

- return overpayments totaling \$198,287 (\$99,144 Federal share) to MassHealth and
- continue efforts to identify and return all overpayments to Medicaid in accordance with State Medicaid requirements.

BOSTON MEDICAL CENTER COMMENTS

In its written comments on our draft report, the Hospital agreed with our finding and recommendations. The Hospital's comments are included in their entirety in the Appendix.

APPENDIX



APPENDIX

One Boston Medical Center Place
Boston, MA 02118-2393
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Tel: 617 414 5000
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June 25, 2008

Mr. Michael J. Armstrong
Regional Inspector General
Office for Audit Services
Region 1
John F. Kennedy Federal Building
Boston, Ma. 02203

Report Number: A-01-07-00008

Dear Mr. Armstrong:

Thank you for your letter and draft report dated June 4, 2008. We appreciate the opportunity to comment on the results of this audit report. We agree to return overpayments totaling \$198,287 to MassHealth. Also, we substantially agree with the observations and findings in this audit report.

In general, the policies and procedures of Boston Medical Center are effective in resolving Medicaid credit balances in accordance with Medicaid regulations. Over the years, Boston Medical Center has demonstrated significant decreases in credits owed to MassHealth due to our efforts in following the standard policies and procedures. We will continue our efforts to identify and return all overpayments to Medicaid in accordance with State Medicaid requirements.

Because of past experience with the MassHealth retraction process, we prefer to return the overpayment, totaling \$198,287, by an Accounts Payable check and not by retracting the payment from the Medicaid 835 remittance advices. Please send an invoice in the amount of \$198,287 to my attention. We will process the payment as soon as possible.

If you have any questions or require additional information from us, please do not hesitate to contact me at 617-414-1609.

Sincerely,



Virginia Mull
Director, Patient Financial Services

CC: Ronald Bartlett, Vice President for Finance and CFO
William Ibbotson, Associate Director Patient Financial Services