DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

MAY 2 3 2005

Report Number A-07-05-03071

Steve Renne
Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, Missouri 65102

Dear Mr. Renne:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Missouri's Accounts Receivable System for Medicaid Provider Overpayments" for the period October 1, 2002, through September 30, 2003. A copy of this report will be forwarded to the action official noted below for his/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 may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to report number A-07-05-03071 in all correspondence. Any questions regarding this report are welcome. Please contact Greg Tambke, Audit Manager, of our Jefferson City Office at (573) 893-8338, extension 30.

Sincerely yours,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Tom Lenz
Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
601 E. 12th Street, Room 235
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MISSOURI'S ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS

MAY 2005
A-07-05-03071

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:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

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 compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov/

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a nationwide review focusing on States' accounts receivable systems for Medicaid provider overpayments that were reportable during the period October 1, 2002, through September 30, 2003. The Department of Social Services (State agency) is responsible for administering the Medicaid program in Missouri.

Provisions of the Social Security Act (the Act) provide the Centers for Medicare & Medicaid Services (CMS) with the authority to approve States' plans for administering the Medicaid program. If the State plan meets specific Federal requirements, CMS matches the State's Medicaid spending through Federal financial participation. The Act provides CMS with the authority to disallow the Federal share for any Medicaid provider overpayments. States are required to return the Federal share of overpayments within 60 days of the date of discovery. States must credit the Federal share of those overpayments on the CMS 64 report for the quarter in which the 60-day period ends. Pursuant to Federal Regulations, any appeal rights extended to a provider do not extend the date of discovery.

The State may reclaim the Federal share of certain unrecovered overpayments previously returned to CMS if a provider files for bankruptcy or goes out of business. The State may reclaim the Federal share of an overpayment after providing evidence to CMS that it has vigorously pursued collection.

OBJECTIVE

Our objective was to determine if the State agency reported Medicaid provider overpayments pursuant to Federal regulations.

FINDINGS

The State agency did not report 34 Medicaid provider overpayments on the quarterly CMS 64 reports pursuant to Federal regulations. As of December 7, 2004, all or some portion of 29 of the 34 overpayments remained unreported. The State agency did not have sufficient policies and procedures in place to ensure all overpayments were reported pursuant to Federal regulations. As a result, the State agency delayed returning the Federal share of overpayments totaling $1,090,421. Of that amount, the State agency had not yet reported or returned to the Federal Government overpayments totaling $1,068,751 as of December 7, 2004.

Additionally, the State agency reclaimed $25,049, which was the Federal share of 30 overpayments previously refunded to CMS for providers the State agency determined to be bankrupt or out of business. The State agency did not reclaim the Federal share pursuant to Federal regulations.

RECOMMENDATIONS

The State agency should:

- return to the Federal Government $1,093,800 of overpayments as soon as possible and

- strengthen policies and procedures to ensure all overpayments are reported pursuant to Federal regulations.

Specifically, it should:

- return the Federal share of all identified Medicaid provider overpayments within established timeframes;

- develop policies and procedures to report Medicaid Fraud Control Unit overpayments as required; and

- ensure that reclamations of the Federal share for bankrupt or out of business providers are performed pursuant to Federal regulations.

Auditee's Comments

Although the State agency agreed with some of our findings and recommendations, it disagreed with certain aspects of our findings and recommendations. The State agency's complete response is included in its entirety as Appendix A.

Office of Inspector General's Response

We adjusted the report to reflect changes discovered after further review of the support provided for two cases. However, we maintain that the State agency should return $1,093,800 of overpayments to the Federal Government as soon as possible.

OTHER MATTER

By not reporting overpayments in a timely manner and inappropriately reclaiming Federal share amounts, the State agency effectively denied CMS the use of funds that would have otherwise been available for the Medicaid program. The Cash Management Improvement Act of 1990 provides a means to calculate the value of opportunity costs such as this. Applying that methodology, CMS could have realized potential interest income totaling $24,972.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

State Responsibility for Medicaid Provider Overpayments

The Medicaid program, established by Title XIX of the Social Security Act (Act), provides grants to States for medical and health-related services to eligible low-income persons. The program is a jointly funded cooperative venture between the Federal and State Governments.

The Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program at the Federal level and is responsible for ensuring that State Medicaid programs meet all Federal requirements. States are required to submit to CMS a comprehensive State plan that describes the nature and scope of its program. If the State plan meets specific Federal requirements, CMS matches the State's Medicaid spending through Federal financial participation (FFP). The FFP amount is determined by a formula based on the State's per capita income.

Each State establishes or designates an agency to manage the Medicaid program. The Department of Social Services (State agency) is responsible for administering the Medicaid program in Missouri.

Criteria for Medicaid Provider Overpayments

CMS cites section 1903(d)(2) of the Act as the principal authority in disallowing the Federal share for provider overpayments. The Consolidated Omnibus Budget Reconciliation Act of 1985 amended section 1903(d)(2) and stated that CMS will adjust reimbursement to a State for any overpayment.

States are required to return the Federal share of overpayments within 60 days of the date of discovery, whether or not the recovery was made. This legislation is codified in 42 CFR § 433 subpart F, "Refunding of Federal Share of Medicaid Overpayments to Providers," which requires States to credit the Federal share of overpayments on the CMS 64 report for the quarter in which the 60-day period following discovery ends. Pursuant to Federal regulations, any appeal rights extended to a provider do not extend the date of discovery.

Pursuant to 42 CFR § 433.316, an overpayment resulting from a situation other than fraud or abuse is "discovered" on the earliest date that:

1. any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

2. a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or

3. any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

Additionally, the regulation specifies that overpayments resulting from fraud or abuse are discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider.

Finally, 42 CFR § 433.320 specifies that if a provider is determined to be bankrupt or out of business, the State may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. These amounts may be reclaimed only if the State agency vigorously pursues recovery. Additionally, the State agency must submit to CMS a statement of its efforts to locate the provider and its assets, and to recover the overpayment.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

Our objective was to determine if the State agency reported Medicaid provider overpayments pursuant to Federal regulations.

Scope

We examined Medicaid provider overpayments subject to the requirements of 42 CFR § 433, subpart F, for the period October 1, 2002, through September 30, 2003. We also reviewed MFCU overpayments that were reportable during Federal fiscal years (FY) 1998 through 2002 but had not yet been reported on the CMS 64 report as of December 7, 2004. Therefore, we reviewed 216 provider overpayments totaling $18,395,201 with Federal share amounts that were due to be refunded to the Federal Government during FY 2003.

Additionally, we reviewed 42 overpayments for which the Federal share totaling $464,194 was reclaimed by the State agency during FY 2003 after it determined the provider was bankrupt or out of business.

We did not review the overall internal control structure of the State agency's operations or financial management. However, we gained an understanding of controls with respect to provider overpayments.

We performed fieldwork at the State agency offices in Jefferson City, MO, between December 2004 and February 2005.

Methodology

We reviewed applicable Federal criteria, including section 1903 of the Act and 42 CFR § 433. We also reviewed applicable sections of the State Medicaid manual and the State agency's policies and procedures.

During fieldwork, we interviewed State agency officials responsible for identifying and monitoring collections of overpayments, as well as staff responsible for reporting the Federal share of overpayments. We reviewed overpayment case files to determine the date of discovery, status of the overpayment, and if any adjustments or write-offs occurred during the audit period. In addition, we reviewed information provided by the Medicaid Fraud Control Unit (MFCU) to determine if there were any outstanding balances for MFCU overpayments.

We also reviewed supporting documentation for Federal amounts written-off and reclaimed by the State agency during FY 2003 after it determined the provider was bankrupt or out of business.

In addition, we compared the CMS 64 reports submitted to CMS by the State agency to supporting documentation. Furthermore, we verified the collection of some overpayments with information provided from the Medicaid Management Information System.

We calculated the number of days between the actual and required reporting dates. We analyzed this information to determine if the State agency reported overpayments accurately and in compliance with time requirements. We applied a cutoff date, December 7, 2004, for overpayments that remained unreported during our audit.

Finally, we calculated potential lost interest using the Cash Management Improvement Act of 1990 (CMIA) rate[1] applied to the Federal share of late overpayments and amounts inappropriately reclaimed by the State agency.

We performed the audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency did not report 34 Medicaid provider overpayments on the quarterly CMS 64 reports pursuant to Federal regulations. As of December 7, 2004, all or some portion of 29 of the 34 overpayments remained unreported. The State agency did not have sufficient policies and procedures in place to ensure all overpayments were reported pursuant to Federal regulations. As a result, the State agency delayed returning the Federal share of overpayments totaling $1,090,421. Of that amount, the State agency had not yet reported or returned to the Federal Government overpayments totaling $1,068,751 as of December 7, 2004.

Additionally, the State agency reclaimed $25,049, which was the Federal share of 30 overpayments previously refunded to CMS for providers the State agency determined to be bankrupt or out of business. The State agency did not reclaim the Federal share pursuant to Federal regulations.

[1]The annualized interest rate per the CMIA was 1.14 percent. The CMIA was passed to improve the transfer of Federal funds between the Federal Government and the States, Territories, and the District of Columbia and provides a means to assess an interest liability to the Federal Government and/or the States to compensate for the lost value of funds.

OVERPAYMENTS NOT REPORTED TIMELY

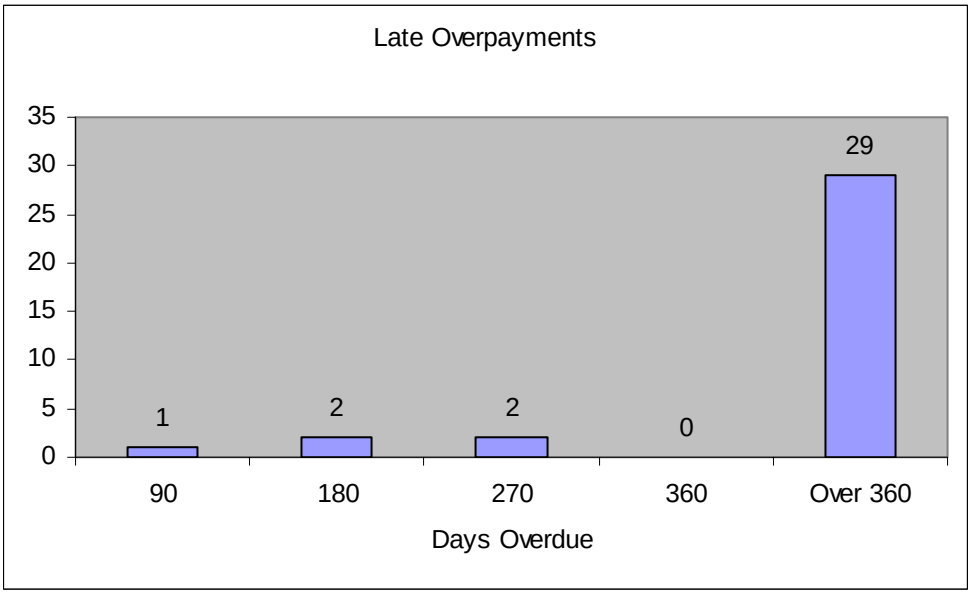
Criteria-The State Agency Must Return the Federal Share Within 60 Days of Discovery

Pursuant to 42 CFR § 433, subpart F, the State agency has 60 days, from the date of discovery, to recover a provider overpayment. The State agency must refund the Federal share of overpayments at the end of the 60-day period, whether or not the State has recovered the overpayment from the provider. The State agency must credit the Federal share on the CMS 64 report for the quarter in which the 60-day period following discovery ends. Any appeal rights extended to a provider do not extend the date of discovery.

Condition-The State Agency Reported Overpayments Late

The State agency did not report 34 overpayments on the proper quarterly CMS 64 report as required. Specifically, the State agency did not report all or some portion of 29 overpayments, and it reported 5 others late. MFCU identified 27 of the 29 unreported overpayments.

The following chart provides a breakdown of the 34 past due overpayments:



Cause- The State Agency's Policies and Procedures Were Insufficient

The State agency's policies and procedures were insufficient to ensure timely reporting of all overpayments. Specifically, it did not have policies and procedures in place to ensure that it reported the 27 overpayments identified by MFCU in a timely manner.

The State agency did not report the remaining seven overpayments pursuant to Federal regulations due to human error or misinterpretation of Federal regulations. For example, it did not report two overpayments, because it considered circuit court appeals to be a justifiable reason for delaying the return of the Federal share.

Effect-The State Agency Did Not Return the Federal Share When Due

The State agency did not return to the Federal Government the Federal share of 34 overpayments totaling $1,090,421 when due. Of that amount, the State agency had not reported or returned $1,068,751 FFP as of December 7, 2004.

FEDERAL SHARE INAPPROPRIATELY RECLAIMED

Criteria-The State Agency Must Vigorously Pursue Recovery

Pursuant to 42 § CFR 433, subpart F, and the State Medicaid manual, section 2853.4, the State agency may reclaim from the Federal Government the amount of the Federal share of any unrecovered overpayment if the provider files for bankruptcy or goes out of business. These amounts may be reclaimed only if the State agency vigorously pursues recovery until the date of bankruptcy or closing of the business. Additionally, the agency must submit to CMS a statement of its efforts to locate the provider and its assets, and to recover the overpayment.

Condition- The State Agency Inappropriately Reclaimed the Federal Share

The State agency inappropriately reclaimed the Federal share of 30 overpayments previously refunded to CMS for providers the State agency determined to be bankrupt or out of business.

Cause- The State Agency's Policies and Procedures Were Insufficient

The State agency's policies and procedures were insufficient to ensure that the State agency vigorously pursued recovery of overpayments from bankrupt and out of business providers before requesting to reclaim the Federal share from CMS. First, it was unable to demonstrate that sufficient efforts were made to determine whether or not providers were actually out of business. Second, it did not submit to CMS a statement of its efforts to locate the provider and its assets, and to recover the overpayment.

Effect- The State Agency Incorrectly Reclaimed the Federal Share

As a result, the State agency reclaimed the Federal share for 30 overpayments totaling $25,049 that should not have been reclaimed.

RECOMMENDATIONS

The State agency should:

- return to the Federal Government $1,093,800 of overpayments as soon as possible and

- strengthen policies and procedures to ensure all overpayments are reported pursuant to Federal regulations.

Specifically, it should:

- return the Federal share of all identified Medicaid provider overpayments within established timeframes,

- develop policies and procedures to report MFCU overpayments as required, and

- ensure that it reclaims the Federal share for bankrupt or out of business providers pursuant to Federal regulations.

AUDITEE'S RESPONSE AND OFFICE OF INSPECTOR GENERAL'S COMMENTS

Although the State agency agreed with some of our findings and recommendations, it disagreed with certain aspects of our findings and recommendations. Its comments are summarized below and included in their entirety as Appendix A.

1. The State agency should return to the Federal Government $1,093,800 of overpayments as soon as possible

Auditee's Response

The State agency agreed with our findings for 13 cases and stated it will return $247,627 to the Federal Government. However, the State agency stated that for 13 cases, it received a partial reimbursement of the overpayments totaling $1,291,590 through court orders. However, $282,945 was not awarded through court orders, and the State agency did not agree to return the Federal share of the overpayments. For two cases, the State agency stated that "the amount of FFP calculated by OIG was incorrect or not current," but it agreed to "return the correct amount of FFP." For one case, the State agency claimed that it did not receive reimbursement through a court order for an overpayment of $5,000 and stated it will not return the amount to the Federal Government.

Finally, the State agency did not agree that it incorrectly reclaimed the Federal share for 30 overpayments made to bankrupt or out of business providers. The State agency asserted that it had documentation to support that the providers were bankrupt and to demonstrate its efforts to locate the providers that were out of business.

Office of Inspector General's Comments

Pursuant to 42 CFR § 433, subpart F, the State agency must refund the Federal share of overpayments at the end of the 60-day period following discovery, whether or not the State has recovered the overpayment from the provider. We determined that the court awarded the full amount for the 13 cases for which the State agency stated it only received partial

reimbursement. However, the State agency had not yet recovered the portion totaling $282,945. We maintain that the State agency is required to return the Federal share for the entire overpayment for the 13 cases regardless of how much has been collected.

The State agency stated that our calculations of the Federal share for two overpayments were incorrect or not current. After reviewing the supporting documentation for these two cases, we determined that one overpayment was overstated by $3,890. In a separate overpayment, we also determined that our calculations included a duplicate recovery of $4,650. We adjusted the report to reflect these changes. We contacted State officials regarding the contention that our Federal share calculation was not current. We learned that the State agency had recovered additional payments from a provider following our fieldwork. This recovery occurred subsequent to our audit period, and therefore no adjustment is necessary.

The State agency did not agree to return the Federal share of one provider overpayment totaling $5,000, which was ordered as reimbursement of investigation and prosecution costs for a MFCU overpayment. Documentation provided during the review indicated that MFCU received payment for this amount. Pursuant to section 1903(a)(6) of the Act, the State shall receive 90 percent of the sums expended with respect to costs incurred for the elimination of fraud. In addition, because MFCU is already 90-percent federally funded, Departmental Appeals Board Decision 480 stated that if a State did not return the Federal share of amounts such as the $5,000, MFCU would be funded twice. Therefore, we maintain that the State agency should return the $5,000 to the Federal Government.

The State agency did not agree that it incorrectly reclaimed the Federal share for 30 overpayments made to bankrupt or out of business providers. Pursuant to 42 § CFR 433, subpart F, and the State Medicaid manual, section 2853.4, the State agency may reclaim from the Federal Government the amount of the Federal share of any unrecovered overpayment if the provider files for bankruptcy or goes out of business. Unrecovered amounts may be reclaimed only if the State agency vigorously pursues recovery until the date of bankruptcy or closing of the business. Additionally, the agency must submit to CMS a statement of its efforts to locate the provider and its assets, and to recover the overpayment. During our review, the documentation provided by the State agency did not support vigorous pursuit of recovery. In some instances, no collection efforts were made. In another instance, the State agency collected overpayments from the provider after bankruptcy but did not return the Federal share. Furthermore, the State agency did not submit a statement of its collection efforts to CMS as required by the State Medicaid manual. Therefore, we maintain that the State agency did not provide reasonable due diligence as required and is not entitled to reclaim the $25,049 FFP for bankrupt or out of business providers.

2. The State agency should strengthen policies and procedures to ensure all overpayments are reported pursuant to Federal regulations.

Auditee's Response

The State agency indicated that it was taking steps to ensure timely and accurate reporting of all Medicaid provider overpayments on the CMS 64 report.

Office of Inspector General's Comments

We commend the State agency for taking action to ensure timely and accurate reporting of all Medicaid provider overpayments. During the exit conference held with State officials, the State agency indicated that it had already held discussions on changing policies and procedures. Specifically, the State agency was changing policies and procedures to ensure the return of FFP for all overpayments, regardless of provider appeal, as well as for overpayments identified by MFCU.

OTHER MATTER

Opportunity Cost

By not reporting overpayments in a timely manner and inappropriately reclaiming Federal share amounts, the State agency effectively denied CMS the use of funds that would have otherwise been available for the Medicaid program. The CMIA provides a means to calculate the value of opportunity costs such as this. Applying that methodology, CMS could have realized potential interest income totaling $24,972.

APPENDIX A

MISSOURI
DEPARTMENT OF SOCIAL SERVICES

MATT BLUNT
GOVERNOR

K. Gary Sherman
DIRECTOR

P. O. BOX 1527
BROADWAY STATE OFFICE BUILDING
JEFFERSON CITY
65102-1527
TELEPHONE: 573-751-4815, FAX: 573-751-3203

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

April 13, 2005

James P. Aasmundstad
Regional Inspector General
for Audit Services
Office of Inspector General
Federal Office Building
601 East 12th Street, Room 284A
Kansas City, Missouri 64106

Re: Report Number: A-07-05-03071

Dear Mr. Aasmundstad:

The Department of Social Services (DSS) has reviewed the draft report entitled "Review of Missouri's Account Receivable System for Medicaid Provider Overpayments" dated March 2, 2005. For ease of reference, the Office of Inspector General (OIG) recommendation has been repeated with the DSS comment.

1. The State agency should return to the Federal Government $1,093,579 of overpayments as soon as possible.

Response: The Department of Social Services/Division of Medical Services (DSS/DMS) has reviewed the proposed provider overpayments. Following is a breakout of the 29 cases reviewed by the OIG and the position of DSS/DMS on these cases.

- On 13 cases, DSS/DMS received through court orders full reimbursement of the provider overpayment, $247,627.65, and agrees with OIG on the return of the Federal Financial Participation (FFP).

- On 13 cases, DSS/DMS received through court orders a partial reimbursement of the provider overpayment, $1,291,590.85, and agrees to return the FFP on this amount. In these 13 cases, there was $282,944.99 in provider overpayments that was not awarded through the court orders and DSS/DMS does not agree to return the FFP on this amount.

- On 2 cases, DSS/DMS received through court orders full reimbursement of the provider overpayment, $192,080.50, but the amount of FFP calculated by OIG is incorrect or not current. DSS/DMS agrees to return the correct amount of FFP on these two provider overpayments.

- On 1 case, DSS/DMS did not receive any reimbursement through the court order for the provider overpayment of $5,000. DSS/DMS does not agree to return the FFP on this amount.

The enclosed worksheet provides additional details for these 29 cases.

- In addition, DSS/DMS has reviewed the 30 provider cases identified by OIG as "FFP reclaimed in error." The FFP for these 30 provider cases was reclaimed because the amounts due as an overpayment were not able to be collected. DSS/DMS has documentation to support the providers declaring bankruptcy and documentation supporting the efforts to locate the providers that are out of business. DSS/DMS does not agree to return the FFP of this amount.

2. The State agency should strengthen policies and procedures to ensure all overpayments are reported pursuant to Federal regulations.

Response: DSS/DMS is taking steps to ensure timely and accurate reporting of all Medicaid provider overpayments on the CMS 64.

The FFP amount DSS/DMS agrees to return will be reported on the CMS 64 quarter ending March 31, 2005. Please feel free to contact Q. Michael Ditmore, M.D., Interim Director, Division of Medical Services at 573/751-6922 if you have additional questions.

Sincerely,

K. Gary Sherman
Director

KGS/jw

Enclosure

Reviewed by OIG	PROVIDER NAME	Overpayment Amount	Overpayment Court Awarded to MFCU	Overpayment Court Awarded to DMS	Prosecution Cost Awarded by Court	Penalties & Fines Awarded by Court	
1	John Mellas MD	$16,672.50		$16,672.50			The overpayment amount determined by OIG is correct but the FFP amount changed after the March 11 cycle.
2	E Thomas Copeland Jr	$175,408.00		$175,408.00			The overpayment amount determined by OIG is correct but the FFP amount calculated by OIG is incorrect.
3	Edwards, Zenobia R., LCSW	$4,434.00	$3,934.00		$500.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
4	Ferro, Louie A., Jr.	$1,074,373.69		$944,977.00	$19,396.69	$110,000.00	The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
5	Phillips Prof. Home Health Services	$2,032.58	$1,832.55		$200.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
6	Pierce, Shirley, DDS	$9,164.00	$9,164.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
7	Angels Care Home Health	$5,500.00	$5,000.00		$500.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
8	Artman, Carl Jr., D.O.	$7,371.75	$900.00				The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
9	Carter, Melody J., LCSW	$130,682.60		$95,769.60	$25,002.00	$14,562.00	The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
10	Casebolt, Buford K., DDS	$2,000.00	$2,000.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
11	Fields, Felisha D.	$30,000.00	$30,000.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
12	Hartline, Tom L., PhD	$14,190.00	$13,190.00		$1,000.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
13	Holden Community Ambulance	$822.61	$822.61				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
14	Hughes, Larry	$218,000.00	$5,321.10		$2,568.81	$32,110.09	The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
15	Huq, Zahra A., DMD	$51,788.00	$51,788.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
16	Kamakas, Nicholas, DDS	$3,062.90	$3,062.90				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
17	Lancaster, Patsy A., R.N.	$214.50	$214.50				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
18	Lawrence, Thomas, LCSW	$51,727.00	$48,746.00		$2,981.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
19	Mann, Millard, Ph.D	$45,139.81	$2,187.17				The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
20	Nolan, Christine	$156.64	$156.64				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
21	Parks, Lyle F., M.D.	$1,000.00	$1,000.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
22	Roberts, Julie, SLP	$205,695.00	$152,154.38				The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
23	Roberts, Julie, SLP	$5,000.00			$5,000.00		The court did not award the Medicaid program with any reimbursement of the provider overpayment.
24	Saha, Debabrata, M.D.	$15,000.00	$15,000.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
25	Schaper, John, LCSW	$3,444.00	$3,444.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
26	Simpson, Floyd D., D.O.	$30,975.00	$30,975.00				The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
27	Snooks, Richard H., LCSW	$3,162.00	$2,662.00		$500.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
28	Tate, Edward, DDS	$22,798.00	$14,917.05		$1,250.00		The court has awarded the Medicaid program with a partial reimbursement of the provider overpayment.
29	Wilbanks, Donnie J., LCSW	$100,000.00		$100,000.00			The Medicaid program received full reimbursement of the provider overpayment and agrees with OIG's position.
		$2,213,142.08	$398,471.90	$1,332,827.10	$58,898.50	$156,672.09	
				$1,731,299.00			