**New York State Office of the State Comptroller**
Thomas P. DiNapoli

Division of State Government Accountability

# Overpayments for Services Also Covered by Medicare Part B

## Medicaid Program
## Department of Health

Report 2010-S-50 June 2012

# Executive Summary

## Purpose

To determine if the Department of Health overpaid health care providers' Medicaid claims for Medicare Part B deductibles and coinsurance. The audit covers the year 2008.

## Background

Medicaid and Medicare are public programs that provide medical services to specific groups of people. Medicaid is a social health program for certain individuals and families with low incomes and few resources. Each state establishes its own Medicaid eligibility standards and determines the type, amount, and rate of payment for medical services. Medicare is a federal health insurance program that helps pay for hospital (Part A) and medical (Part B) care for elderly and certain disabled Americans. For most Part B services, Medicare requires a deductible and/or coinsurance. Some people qualify for both Medicaid and Medicare and have their Medicare Part B deductibles and coinsurance paid by Medicaid. A Medicaid claim for Medicare deductibles or coinsurance is called a "crossover claim." Generally, the amount Medicaid will pay for a crossover claim is the Medicare-approved amount less the amount Medicare paid for the service. It is critical that health care providers report accurate Medicare information on their crossover claims – otherwise, overpayments can occur. Some providers hire service bureaus to prepare and submit their Medicaid claims for them. Medicaid rules require service bureaus to have systems in place that allow providers to review their claims for accuracy prior to billing Medicaid.

## Key Findings

- The Department's eMedNY computer system did not have controls to detect improper crossover claims submitted by certain providers. Nearly 259,000 Medicaid claims for Medicare Part B coinsurance were processed and paid incorrectly during 2008. In each case, the health care providers reported inflated Medicare Part B coinsurance amounts to Medicaid, enriching their Medicaid reimbursements. As a result, the Department overpaid these providers $8.5 million.
- Not all service bureaus had a system in place that would allow providers to review their Medicaid claims prior to billing them. One service bureau who prepared claims on behalf of several providers submitted 30,000 claims to Medicaid with improper Medicare Part B information. This resulted in overpayments totaling $1.2 million.

## Key Recommendations

- Review and recover the Medicaid claim payments for the providers we identified who reported improper Medicare Part B payment information.
- Make sure all service bureaus have adequate systems in place for providers to review their claims prior to submitting them to Medicaid.

## Other Related Audits/Reports of Interest

Medicaid – Overpayments for Medicare Part B Beneficiaries (2008-S-63)
Medicaid - Overpayments of Coinsurance Fees for Medicare Beneficiaries (2008-S-128)

# State of New York
# Office of the State Comptroller

## Division of State Government Accountability

June 20, 2012

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Overpayments for Services Also Covered by Medicare Part B*. This audit was done according to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Office of the State Comptroller*
*Division of State Government Accountability*

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This report is also available on our website at: www.osc.state.ny.us

# Background

The Department of Health (Department) administers the Medicaid program in New York State. Many of the State's Medicaid recipients are also eligible for Medicare, and as such, they are referred to as "dual eligible." Generally, Medicare is the primary payer of claims for services provided to dual eligible recipients. After Medicare adjudicates a claim, Medicaid pays the balance that is not covered by Medicare and would otherwise be the financial obligation of the recipient. As a result, for dual eligibles, Medicaid generally would pay deductibles and coinsurance not covered by Medicare.

The Centers for Medicare and Medicaid Services (CMS) administer the Medicare program. Medicare health insurance consists of several parts. Medicare Part A pays for inpatient hospital, skilled nursing, and other inpatient care. Medicare Part B provides supplementary medical insurance covering a broad range of outpatient medical services, physicians' fees, and medical supplies. To be covered under Part B, services must be either medically necessary or one of several prescribed preventive benefits. In 2008, about 585,000 Medicaid recipients received services (which cost about $665 million) that were covered by Medicare Part B.

When services are provided under Medicare Part B, recipients are generally required to pay coinsurance. The coinsurance amount for a Part B service is usually 20 percent of the allowable charge, with certain exceptions. Providers who accept dual eligible persons cannot bill them for Medicare coinsurance. Instead, the coinsurance must be billed to Medicaid. A Medicaid claim for Medicare coinsurance is called a "crossover claim." Generally, the amount Medicaid pays for a crossover claim is the Medicare-approved amount less the Medicare paid amount, as reported by health care providers. Also, whenever the Medicare payment exceeds the amount Medicaid would normally pay for a service, the Medicaid payment is usually limited to 20 percent of the Medicare coinsurance amount. Thus, it is critical that Medicare data on Medicaid claims be accurate - otherwise overpayments can occur.

# Audit Findings and Recommendations

## Claims With Improper Medicare Payment Data

For the 2008 year, we identified 259,152 Medicaid claims that were overpaid by almost $8.5 million because providers did not properly report Medicare payment data on crossover claims. The largest overpayment to a provider was $511,000. Each of nine other providers received more than $100,000 in Medicaid overpayments. At the time of the overpayments, eMedNY did not have sufficient controls to detect inaccurate Medicare data on claims and prevent the related Medicaid overpayments from occurring.

Medicaid authorizes billing service bureaus to verify recipients' Medicaid eligibility, obtain service authorizations from the Department, and submit claims on behalf of approved providers. Service bureaus must be enrolled in Medicaid and comply with all applicable regulations and policies set forth by the Department. Thus, service bureaus must maintain a system, approved by the Department, to notify providers of claims which are ready for submission. The Department requires providers to review and verify the accuracy of their claims (and to correct or delete improper claims) before the service bureau submits them to Medicaid.

One particular billing service bureau prepared and submitted claims for six of the ten most overpaid providers we identified. This service bureau consistently overstated the Medicare-approved amounts for services on the Medicaid claims it prepared. Specifically, it reported the providers' billed amounts as the Medicare-approved amounts. Because the providers' billed amounts were higher than the Medicare-approved amounts, Medicaid overpaid the claims. For example, the service bureau billed Medicaid for a session of therapeutic exercise and, on the claim, reported that Medicare approved $120 for the session. However, Medicare actually approved only $62.70 for the service, and therefore, Medicaid overpaid the claim by $57.30 ($120 - $62.70). In total, this service bureau submitted more than 30,000 improper claims which led to more than $1.2 million in overpayments in 2008.

We visited the billing service bureau and explained our findings to bureau officials. We also advised bureau officials how to correct their improper claims. Further, we determined the bureau's owner was unaware that the Department required bureaus to have a process for client providers to review their claims for accuracy prior to submission to Medicaid - and therefore, this bureau had no such process. Consequently, the bureau's clients did not review and correct their claims before the bureau submitted them to eMedNY. We conclude that the Department should take steps to ensure that the service bureau we visited (and the others statewide as well) have an adequate system for providers to review their claims prior to submission to Medicaid.

At the time of our audit fieldwork, nine of the problem providers we identified were under investigation by the Office of the Medicaid Inspector General (OMIG). These providers accounted for nearly $1.6 million of the $8.5 million in overpayments that we identified. Nonetheless, the Department (and/or the OMIG) should take the necessary actions to assess and recover, as appropriate, the remaining $6.9 million in overpayments that were not yet

subject to investigation when our fieldwork ended. Further, such efforts should be focused on the overpayments to the providers who used the billing services bureau previously referenced.

In 1997, we issued audit report (95-S-91) entitled "Medicaid Payments for Medicare Beneficiaries," wherein we recommended the Department implement automated system controls to coordinate claims processing for services rendered to dual eligible persons. This is commonly referred to as a "crossover" system. At that time, several other states already had crossover systems. Usually, under this system, claims for services provided to dual eligible persons must be submitted to Medicare before they can be processed by Medicaid. Once adjudicated by Medicare, the claim crosses over to Medicaid for processing. Generally, under crossover systems, Medicaid denies claims for dual eligible persons if the claims have yet to be adjudicated by Medicare.

In December 2009, the Department implemented a crossover system for claims for dual eligible persons. At that time, the Department directed providers (with some limited exceptions) to submit such claims through the crossover system. Nevertheless, providers retained the capability to submit claims for dual eligible persons to Medicaid directly (and separately from Medicare) through eMedNY's standard adjudication process. The overpayments we identified occurred in 2008 (prior to the crossover). They were attributable to claims with improper Medicare data, and the crossover system would likely have prevented many of them. Moreover, because providers can still submit claims for dual eligible persons through eMedNY's standard processes, many continue to do so - thus circumventing the controls of the crossover system.

We focused our audit on claims for durable medical equipment and physician, laboratory, transportation and eye care services for dual eligible persons. In 2010, Medicaid paid 18.6 million claims (totaling $232.1 million) for these items and services. Providers, however, submitted nearly 5.2 million of these claims (totaling about $75 million) through the standard eMedNY process - instead of the crossover system. Thus, the standard eMedNY-processed claims accounted for 28 percent of the claims in question and nearly 32 percent of the Medicaid payments for them. Payments made through the crossover system averaged $11.70 per claim, while those processed through standard means averaged $14.40 per claim ($2.70 or 23 percent more than the average payment from the crossover system).

Moreover, if the average payment for the claims adjudicated through the standard process was the same as the average payment for crossover system claims, Medicaid could have saved about $14.1 million in 2010. Thus, there is material risk that significant overpayments, such as those identified in this report, continue to occur because large numbers of claims for persons with Medicare Part B coverage are not subjected to the crossover system.

## Recommendations

1. Review claim payments for the providers we identified who reported Medicare Part B payment data incorrectly. Investigate and recover the remaining $6.9 million in Medicaid overpayments that the OMIG had not reviewed at the time of our audit fieldwork.

2. Take steps to ensure that billing service bureaus have adequate systems in place for Medicaid providers to review their claims prior to the bureaus' submission of them to eMedNY.

3. Optimize the number of claims for dual eligible persons that are processed through the crossover process. As part of this process, formally assess the propriety of requiring most (if not all) providers to submit all claims for dual eligible persons through the crossover system.

# Audit Scope and Methodology

Our objective was to determine if Medicaid made overpayments to health care providers who did not properly report Medicare Part B information on their Medicaid crossover claims. Our audit period was from January 1, 2008 through December 31, 2008.

To accomplish our objective, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We reviewed applicable Federal and State laws and regulations. We examined the Department's Medicaid payment policies and procedures. From CMS, we obtained an electronic data file of claim payments for Medicare Part B in 2008. We then matched the Part B claim payments with the related Medicaid claims paid by the Department. We focused our review on about 11 million higher risk claims (including those with unusual Medicare payment data) submitted by physicians, laboratories, and transportation, eye care, and durable medical equipment providers. In 2008, Medicaid paid $145.4 million for these claims for services provided to about 391,000 recipients. Also, we visited a particular billing service bureau that submitted problematic claims to Medicaid on behalf of multiple health care providers.

We conducted our performance audit according to 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

# Authority

The audit was performed according to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

# Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions are planned to address them. Our rejoinder to the Department's response is included as a State Comptroller's Comment.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

# Contributors to This Report

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## Vision

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

March 15, 2012

Brian E. Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on Office of the State Comptroller Draft Audit Report 2010-S-50 on "Overpayments for Services Also Covered by Medicare Part B."

Thank you for the opportunity to comment.

Sincerely,

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: James C. Cox
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# Department of Health
# Comments on the Office of the State Comptroller's Draft Audit Report 2010-S-50 on Overpayments for Services Also Covered by Medicare Part B

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller (OSC) Draft Audit Report 2010-S-50 on "Overpayments for Services Also Covered by Medicare Part B."

**Recommendation #1:**

Review claim payments for the providers we identified who reported Medicare Part B payment data incorrectly. Investigate and recover the remaining $6.9 million in Medicaid overpayments that the Office of Medicaid Inspector General (OMIG) had not reviewed at the time of our audit fieldwork.

**Response #1:**

The OMIG will review the overpayments identified and pursue recoveries where appropriate.

**Recommendation #2:**

Take steps to ensure that billing service bureaus have adequate systems in place for Medicaid providers to review their claims prior to the bureaus' submission of them to eMedNY.

**Response #2:**

The Department is considering modifying the Regulation requiring it to approve service bureaus' systems as it believes the resources required to perform this activity would be better utilized in the continued review of questionable claims with high risk attributes. In addition, the Department will collaborate with the OMIG on evaluating whether additional OMIG review processes can be implemented.

* Comment

**Recommendation #3:**

Optimize the number of claims for dual eligible persons that are processed through the crossover process. As part of this process, formally assess the propriety of requiring most (if not all) providers to submit all claims for dual eligible persons through the crossover system.

**Responses #3:**

The Department believes that its current crossover process is optimized based on existing policies and practices. It will, however, formally assess relevant policies and practices and implement updates as warranted.

* See State Comptroller's Comment, page 12.

# State Comptroller's Comment

We question the propriety of modifying the Regulation - to ensure service bureaus provide Medicaid providers with the opportunity to review their claims prior to submission to Medicaid. As our report details, one service bureau alone submitted over 30,000 improper claims that Medicaid overpaid by more than $1.2 million. Consequently, it is critical that systems for pre-submission claim reviews exist and function properly to reduce the risk that service bureaus will submit excessive claims resulting in significant Medicaid overpayments.