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COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER

DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY

DEPARTMENT OF HEALTH

MEDICAID OVERPAYMENTS OF MEDICARE PART B DEDUCTIBLES

Report 2006-S-122

AUDIT OBJECTIVE

Our audit objective was to identify Medicaid overpayments for Medicare Part B deductibles and the causes for such overpayments.

AUDIT RESULTS - SUMMARY

For the period January 1, 2003 to November 30, 2006, our audit identified an estimated $592,000 in Medicaid overpayments to over 2,000 medical providers who incorrectly billed Medicaid for Medicare Part B services. We found medical providers that billed Medicaid twice (and were paid twice) for clients' Medicare Part B deductible. We also identified numerous instances of providers submitting inaccurate Medicare Part B payment information on Medicaid claims to increase their payments from Medicaid. Because we did not have all of the Medicare Part B payment information needed at the time of our audit, we were not able to identify all of the overpayments that were occurring due to these conditions.

We found the Department lacked necessary controls on their eMedNY claims processing system to prevent these overpayments and needs to better clarify and communicate to providers its billing rules regarding Medicare Part B deductible claims.

Our report contains three recommendations.

This report, dated October 16, 2007, is available on our website at: http://www.osc.state.ny.us.
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Office of the State Comptroller
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BACKGROUND

The Department of Health (Department) administers the Medicaid program in New York State, which was established under Title XIX of the federal Social Security Act to provide medical assistance to needy individuals. Many of the State's Medicaid recipients are also eligible for Medicare which provides inpatient, outpatient, and prescription drug coverage for its eligible enrollees. Outpatient coverage, referred to as Medicare Part B, includes services such as doctor visits, clinical laboratory tests, blood work, outpatient hospital services, and, in some cases, home health care.

All patients enrolled in Medicare Part B are responsible for paying Medicare an annual deductible. In 2007, the deductible is $131 per individual, up from $124 in 2006 and $110 in 2005. Part B beneficiaries are also responsible for paying Medicare co-insurance, which is the difference between what Medicare allows and pays providers for a covered service. The amount Medicare pays to providers varies depending upon the service provided and whether a Medicare recipient has or has not met their annual deductible limit. For example, if a beneficiary has not met their annual deductible, Medicare deducts the balance of the beneficiary's deductible from the amount it pays the beneficiary's medical providers.

When a patient is eligible for Medicare and Medicaid (dual eligible), Medicaid will reimburse providers for the cost of the patients' annual Part B deductible and co-insurance. During the period January 1, 2003 to November 30, 2006, Medicaid paid over $19 million to approximately 11,000 providers to cover recipients' Medicare Part B deductibles.

To manage and process Medicaid claims, the Department uses the State's eMedNY system, which the Department implemented on March 24, 2005. Since its implementation, the Department has developed numerous computer checks (edits) in the eMedNY system to help prevent incorrect payments to providers. As new risks of incorrect payment processing are identified, including those identified by the Comptroller's audits, the Department adds edits to address those risks.

AUDIT FINDINGS AND RECOMMENDATIONS

Medicaid Overpayments of Medicare Part B Deductibles

All Medicare beneficiaries are responsible for paying an annual deductible amount and individual co-insurance for the Medicare Part B services they receive. Medicare does not bill beneficiaries directly for these costs. Rather, Medicare reduces the amount it pays the beneficiaries' medical providers for services. The medical provider is then responsible for billing the patient for this amount. However, when a patient is eligible for Medicare and Medicaid (dual eligible), Medicaid will reimburse providers for the full cost of their patients' annual Part B deductible and in most instances 20 percent of the co-insurance amount. Thus, the medical provider must bill Medicaid for the appropriate amount after it receives the Medicare payment.

According to Department regulations, medical providers are only entitled to Medicaid reimbursement for up to 100 percent of a recipient's annual Medicare Part B deductible and any required Medicare co-insurance. In 2007, the annual Part B deductible is $131 per beneficiary, up from $124 in 2006 and $110 in 2005.

We analyzed all Medicaid claims paid to providers for reimbursement of a client's Medicare Part B deductible during our audit period. Our analysis identified a number of providers who appeared to be incorrectly billing Medicaid for these deductibles. We identified the five medical service providers who we believed showed the highest potential overpayments and visited four of these providers. (We elected not to visit one of the top five providers because this provider was under investigation by the State Attorney General for, among other things, billing Medicaid improperly for Medicare deductibles.) We reviewed the Medicare billing records for all or a sample of their Medicaid claims involving a Part B deductible.

We determined all four of the providers were incorrectly billing Medicaid for Medicare Part B deductibles. Three of these providers were billing twice the amount they were entitled to for the deductibles while the fourth consistently billed for a full deductible each time a service was provided, even though the recipient's annual Medicare Part B deductible was met and Medicare was paying the full amount. We confirmed the amount each provider was overpaid during our audit scope for the claims reviewed. We conservatively estimated overpayments to these providers for claims we did not review. The following chart summarizes our findings for the four providers we visited:

Provider	Confirmed Overpayments	Estimated Overpayments	Total
A	$51,889	$ 882	$ 52,771
B	$12,977	$30,532	$ 43,509
C	$ 3,210	$27,565	$ 30,775
D	$ 1,886	$26,183	$ 28,069
Total	**$69,962**	**$85,162**	**$155,124**

Our audit revealed a common incorrect billing pattern at three of the providers audited. These providers incorrectly billed Medicaid twice for Medicare Part B deductibles. We used this knowledge to reanalyze all Medicare Part B deductible claims paid by Medicaid during our audit period and identified many other providers with the same billing pattern. Based on this analysis, we estimate nearly $539,000 in overpayments were made to 2,045 providers that double billed Medicaid for a clients' Medicare Part B deductible. In total, we found over 10,000 instances of suspected double billing by these providers. This estimate is based on instances where the same provider was paid for duplicate claims (i.e., the provider was paid the same amount by Medicaid at least twice for the same client, date of service, and medical procedure and reported the same amount approved and paid by Medicare).

Our audit at one of the four providers also found nearly $53,000 in overpayments that occurred when the provider was paid for two claims involving a Part B deductible that were not exact duplicates. This provider (provider A) always submitted two claims for each client service. One claim, normally $100, was for reimbursement of the client's Medicare Part B deductible while the second claim, usually $12, was submitted to cover a fictitious coinsurance amount. This provider admitted to frequently billing Medicaid prior to receiving Medicare payment, which is not allowed, and always reported incorrect Medicare payment information on his Medicaid claim. In fact, this provider was paid about $7,700 by Medicaid for deductible reimbursements for the same client in the same year, when he was only entitled to $100.

In total, we identified an estimated $592,000 in overpayments ($539,000 due to double billings by over 2,000 providers and $53,000 due to excessive billings by the provider submitting two claims). The amount we identified would likely have been much greater; however, the Medicare payment data necessary to determine with greater accuracy the entire population of overpayments was not available to us at the time of our audit.

During our interviews of the providers we visited, each stated they were confused about properly billing Medicaid for Medicare deductibles and associated coinsurance. We found the Department issued a Medicaid update to providers in January 2005 describing the billing rules for these claims.

We presented our findings to the Department and learned the eMedNY claims processing system does not have edits in place to track Medicare deductible payments, and therefore did not prevent these overpayments. Department officials stated they will work to develop edits to prevent future overpayments. Additionally, we provided specific information on the four providers we visited to staff from the Office of the Medicaid Inspector General (OMIG). The OMIG staff indicated that they were looking further into these providers to assess whether there was fraud committed.

Recommendations

1. Develop and implement edits in the Department's eMedNY claims processing system to track Medicare deductible claims and prevent excessive/double billing.

2. Clarify and communicate to all providers the billing rules associated with Medicare deductibles and coinsurance.

3. Investigate and recover all overpayments made to providers for excessive/double billing of Medicare deductibles.

AUDIT SCOPE AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. Our performance audit focused on identifying Medicaid overpayments for Medicare deductibles during the period January 1, 2003 to November 30, 2006.

To meet our audit objective, we reviewed applicable statutes and Department policies and met with officials from the Department to clarify our audit criteria. We also completed numerous analyses of Medicaid claims in our scope, from which we identified providers with the greatest likelihood of over-billing Medicaid for Medicare deductibles. Based on our analyses, we visited a sample of four providers to review selected medical and billing records to assess whether the provider was overpaid. When possible, we used the results from our sampled providers to estimate total overpayments for all similar claims for that provider or for all providers.

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 to certain boards, commissions and public authorities, some of whom have minority voting rights. 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 pursuant 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 review and comment. We considered the Department's response in preparing this report. Department officials agreed with our recommendations and indicated specific actions they will take to implement them. A complete copy of the Department's response is included in this report as Appendix A.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department 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 why.

CONTRIBUTORS TO THE REPORT

Major contributors to this report were Robert Wolf, Dennis Graves, Christopher Morris and Daniel Towle.

APPENDIX A - AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

August 13, 2007

Kenneth Shulman, Audit Manager
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Mr. Shulman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report on "Medicaid Overpayments of Medicare Part B Deductibles" (2006-S-122).

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Chief of Staff

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Homer Charbonneau
Randall Griffin
Gail Kerker
Katherine Napoli
Robert W. Reed
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2006-S-122 on
"Medicaid Overpayments of
Medicare Part B Deductibles"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2006-S-122 on "Medicaid Overpayments of Medicare Part B Deductibles."

Recommendation #1:

Develop and implement edits in the Department's eMedNY claims processing system to track Medicare deductible claims and prevent excessive/double billing.

Response #1:

The Department will pursue development and implementation of an eMedNY system enhancement to track Medicare deductible claims and prevent excessive/double billing. Two alternatives, automated crossover billing and changing the crossover deductible editing to edit by recipient, are currently being researched.

Recommendation #2:

Clarify and communicate to all providers the billing rules associated with Medicare deductibles and coinsurance.

Response #2:

The Department will re-issue the applicable billing rules associated with Medicare deductibles and coinsurance.

Recommendation #3:

Investigate and recover all overpayments made to providers for excessive/double billing of Medicare deductibles.

Response #3:

A Systems Match and Recovery project to target and recover duplicate/excessive billings of Medicare Part B deductibles is under development.