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

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Division of State Government Accountability

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# **Medicaid Overpayments for Medicare Part B Services Billed Directly to eMedNY**

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## **Medicaid Program Department of Health**

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## Executive Summary

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### Purpose

To determine whether Medicaid made improper payments to providers who submitted Part B cost-sharing claims directly to eMedNY. The audit covered the period from June 1, 2012 through May 31, 2017.

### Background

Many of the State's Medicaid recipients are also eligible for Medicare, the federal health insurance program for people age 65 or older and people under 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligible." The Medicare program has multiple parts. Medicare Part B provides supplementary medical insurance coverage for a range of outpatient medical services, physician services, and medical supplies. Medicare enrollees are responsible for paying all costs of Part B services until their annual deductible is met. After the deductible is met, Medicare begins to pay its share and the enrollee is responsible for any coinsurance. Typically, Medicare will pay 80 percent of its approved amount for a service and the enrollee is responsible for the remaining 20 percent. Generally, Medicaid will pay these Part B cost-sharing amounts (e.g., deductibles and coinsurance) on behalf of dual-eligibles.

In December 2009, the Department of Health (Department) implemented its automated Medicare/Medicaid crossover system. Under this system, providers submit medical claims for dual-eligibles to Medicare. After Medicare processes the claims, they are automatically transferred to the Department's eMedNY system for payment of deductibles and coinsurance. The intent of the automated crossover system was to minimize the need for providers to self-report Medicare claim data to eMedNY and thereby improve the accuracy of Medicaid payments for dual-eligibles. In certain instances, providers may still submit these claims directly to eMedNY for payment (i.e., self-report Medicare data). In these situations, the claims bypass the payment controls enforced by the crossover system.

### Key Findings

Auditors identified up to \$8.7 million in improper payments for costs related to Medicare Part B deductibles and coinsurance between June 1, 2012 and May 31, 2017. Specifically, the audit found that Medicaid made:

- Questionable payments totaling \$5.3 million to providers who claimed excessive Part B coinsurance amounts.
- Overpayments totaling \$2.3 million to providers for the Part B coinsurance on services Medicaid did not cover.
- Overpayments totaling \$1.1 million to providers for Part B deductibles that exceeded dual-eligibles' yearly limits.

### Key Recommendations

- Review the payments identified by the audit and recover overpayments, as appropriate.
- Formally advise providers to report accurate claim information when billing Medicaid for Part B

- deductibles and coinsurance on direct-bill claims to help ensure claims are paid appropriately.
- Enhance system controls to detect and prevent overpayments for Part B deductibles and coinsurance on direct-bill claims.

### **Other Related Audits/Reports of Interest**

[Department of Health: Reducing Medicaid Costs for Recipients With End Stage Renal Disease \(2015-S-14\)](#)

[Department of Health: Medicaid Claims Processing Activity April 1, 2017 Through September 30, 2017 \(2017-S-23\)](#)

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**State of New York**  
**Office of the State Comptroller**

**Division of State Government Accountability**

December 11, 2018

Howard A. Zucker, M.D., J.D.  
Commissioner  
Department of Health  
Corning Tower  
Empire State Plaza  
Albany, NY 12237

Dear Dr. Zucker:

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 *Medicaid Overpayments for Medicare Part B Services Billed Directly to eMedNY*. This 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.

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](http://www.osc.state.ny.us)

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## Background

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The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about \$62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3 percent.

The Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs. CMS issues regulations that set general parameters for the Medicaid program. Each state administers its Medicaid program in accordance with a CMS-approved Medicaid State Plan (Plan). The Plan dictates the policies and procedures that a state must follow in administering the Medicaid program, including those related to covered services and reimbursement methodologies. Any changes or amendments to the Plan require CMS approval.

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid claims are processed and paid by an automated system called eMedNY. When eMedNY processes claims, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement. Specifically, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service.

Many of the State's Medicaid recipients are also eligible for Medicare, the federal health insurance program for people age 65 or older and people under 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligible." The Medicare program has multiple parts. Medicare Part B provides supplementary medical insurance coverage for a range of outpatient medical services, physician services, and medical supplies. Medicare enrollees are responsible for paying all costs of Part B services until their annual deductible is met. After the deductible is met, Medicare begins to pay its share and the enrollee is responsible for any coinsurance. Typically, Medicare will pay 80 percent of its approved amount for a service and the enrollee is responsible for the remaining 20 percent. Generally, Medicaid will pay these Part B cost-sharing amounts (e.g., deductibles and coinsurance) on behalf of dual-eligibles.

In December 2009, the Department implemented its automated Medicare/Medicaid crossover system. The intent of the automated crossover system was to minimize the need for providers to self-report Medicare claim data to eMedNY and thereby improve the accuracy of Medicaid payments for dual-eligibles. Under this system, providers submit medical claims for dual-eligibles to Medicare. After Medicare processes the claims, they are automatically transferred to eMedNY for payment of any deductibles, coinsurance, and copayments. In certain instances, providers may still submit their claims directly to eMedNY. In these situations, the claims bypass the payment controls enforced by the crossover system.

In 2011, the Department amended New York State's Plan to no longer reimburse practitioners for the Medicare Part B coinsurance for services that are not covered for Medicaid-only enrollees (with some exceptions, such as physician-administered drugs). In 2015, the Department further amended the State's Plan to limit Medicaid's reimbursement of Medicare Part B coinsurance so that the combined Medicare payment and Medicaid coinsurance payment to a provider for a service would not exceed the amount Medicaid would have paid for a Medicaid-only enrollee. This change was effective July 1, 2015.

For the five-year period ended May 31, 2017, Medicaid paid about \$237 million for Part B cost-sharing on practitioner claims that were submitted directly to eMedNY.

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## Audit Findings and Recommendations

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For the five-year period ended May 31, 2017, we identified \$5.3 million in potential overpayments for Part B coinsurance billed to Medicaid. The payments were deemed potentially overpaid because providers submitted coinsurance amounts that were higher than the amounts typically billed to Medicaid for the services rendered. Coinsurance amounts are generally 20 percent of Medicare's approved amount for a service. We found several providers who billed Part B coinsurance amounts that exceeded 40 percent or more of the Medicare-approved amount.

In addition, we identified \$3.4 million in actual overpayments for Part B coinsurance and deductibles. The overpayments occurred because eMedNY controls were not in place to prevent the payment of coinsurance for non-covered services as well as excessive annual deductibles. Medicaid also made coinsurance overpayments for a certain durable medical equipment (DME) service because eMedNY did not pay the coinsurance in accordance with the State Plan.

### Potential Coinsurance Overpayments

We identified \$5.3 million in potential overpayments on 91,901 claims that providers billed directly to Medicaid for the Part B coinsurance. We identified the claims because the coinsurance amounts Medicaid paid were higher than the amounts typically billed to Medicaid for the services rendered. Medicaid relies on providers to report accurate Medicare payment information on direct-billed claims. When providers report inaccurate information on their claims, it causes eMedNY to make incorrect payments. We found some providers were billing coinsurance amounts that were 40 percent or more of the Medicare-approved amount. The majority of the potential overpayments (\$5.2 million) occurred from June 1, 2012 to June 30, 2015. The potential overpayments significantly decreased after July 1, 2015 (\$77,000), when the Department amended the State Plan and further limited Medicaid's reimbursement of Part B coinsurance.

We found that 15 providers were responsible for more than \$600,000 of the overpayments. We requested documentation for 240 claims from five of the top providers whose coinsurance charges appeared to be excessive. We reviewed the documentation to determine the accuracy of the reported Medicare amounts and determine the causes of overpayments. We found that all 240 claims were improperly billed to Medicaid. Specifically, we found that the providers did not have supporting documentation for 163 of the claims. We also found that Medicare denied 50 of the claims. As a result, there was no coinsurance to reimburse.

For the remaining 27 claims, the providers reported incorrect Medicare payment information to eMedNY, which resulted in overpayments. For example, one provider claimed that the Medicare-approved amount for a radiology service was \$300, and billed Medicaid for \$280 in coinsurance (i.e., 93 percent of the reported Medicare-approved amount). However, according to the supporting documentation, the Medicare-approved amount was \$249 and the coinsurance was \$50. At the time of the claim, according to Medicaid policy, when Medicare's payment exceeded Medicaid's fee for a service, Medicaid would pay 20 percent of the coinsurance. Since Medicare's \$199 payment ( $\$249 \times 80$  percent) exceeded Medicaid's standard \$127 fee for this service,



Medicaid should have only paid the provider \$10 ( $\$50 \times 20$  percent). The incorrectly reported payment information caused Medicaid to make a \$270 overpayment ( $\$280 - \$10$ ).

We confirmed that Medicaid made overpayments totaling \$46,030 for the 240 incorrectly direct-billed claims we tested. Based on these results, we believe the remaining 91,661 claims are at high risk of being overpaid.

## Recommendations

1. Review the \$46,030 for the 240 claims we tested and make recoveries, as appropriate.
2. Using a risk-based approach, assess the remaining \$5.27 million in potential overpayments made to providers for Part B coinsurance, and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers who received the largest dollar amounts of the payments.

## Actual Coinsurance and Deductible Overpayments

Medicaid made \$3.4 million in overpayments for costs related to Medicare Part B deductibles and coinsurance between June 1, 2012 and May 31, 2017. These overpayments occurred because the Department did not have adequate claims processing controls in place to prevent the overpayments. In addition, the providers reported inaccurate Medicare payment information on their claims.

### *Overpayments for Non-Covered Services*

Beginning in October 2011, with CMS approval, the Department made changes to eMedNY to reflect a State Plan amendment that affected practitioner services. The State Plan was amended to state that, "If a procedure is designated 'inactive' on the procedure code file, i.e., procedures that are not covered by Medicaid and have been assigned a \$0 amount, Medicaid will not reimburse any portion of the Medicare Part B coinsurance amount for these procedures." We found that the Department phased in the required changes from October 2011 to December 2015. As a result of the Department phasing in the changes, Medicaid paid Part B coinsurance for services not approved under the State Plan amendment. Using the amended State Plan payment methodology, we identified \$2.3 million in improper Part B coinsurance payments during this four-year period.

At the time our fieldwork ended, a Department official expressed a concern that some services we identified as non-covered may potentially have been covered by Medicaid. For example, the official stated that Medicaid instructs providers to use certain procedure codes (i.e., covered codes) to represent a broad range of therapy services, while Medicare instructs providers to use the procedure code that describes, with more specificity, the therapy service rendered (identified as non-covered by the Department). Since providers are required to report the exact information Medicare used to process their claim, they cannot submit a different procedure code for the therapy service on their claim to Medicaid. Therefore, the official believes some of

these claims may be for services that Medicaid covered and that the coinsurance payments may also be appropriate. However, the Department did not provide documentation, such as rules or regulations, to substantiate this concern or govern the payment of such scenarios. Further, we did not observe the establishment of a process in eMedNY to handle such a concern for the purposes of payment. We note that the CMS-approved State Plan amendment does not address the Department's specific concern regarding these services. Rather, according to the State Plan, the Medicaid program will not pay the Part B coinsurance for services identified as non-covered, and the Department listed each of the procedure codes we identified in the \$2.3 million in paid claims as non-covered. Accordingly, we believe the payments for the non-covered services we identified were inappropriately paid.

### *Overpayments for Annual Deductibles*

CMS establishes the annual Part B deductible amount for each calendar year. The Department programs eMedNY with this information to ensure that the deductible amount submitted on a claim does not exceed the annual Part B deductible. However, eMedNY is not programmed to examine deductible payments made on other claims in the dual-eligible's history. This can lead to overpayments when deductible amounts are submitted over multiple claims.

We compared the total deductible payments Medicaid made for dual-eligibles per year to the annual Part B deductible and identified \$1.1 million in overpayments for 2012 through 2017. For example, the Part B deductible in 2016 was \$166. However, Medicaid made deductible payments totaling \$1,301 to four providers for a dual-eligible that year. As a result, Medicaid made \$1,135 (\$1,301 - \$166) in deductible overpayments for this dual-eligible.

### *Incorrect Coinsurance Calculations on DME Claims*

From June 1, 2012 to November 30, 2015, we identified \$49,981 in Part B coinsurance overpayments for DME claims where Medicare's payment exceeded Medicaid's fee. Medicaid should have paid 20 percent of the coinsurance amount for claims prior to July 1, 2015, or no coinsurance for claims on or after July 1, 2015, since Medicare's payment exceeded Medicaid's fee. However, Medicaid paid the full coinsurance amount on these claims. For example, one provider reported that Medicare paid \$6,059 for a cochlear implant on April 5, 2014, and that the Part B coinsurance was \$1,546. Medicare's payment of \$6,059 exceeded Medicaid's fee of \$4,800 for this service. Therefore, Medicaid should have paid \$309 ( $\$1,546 \times 20$  percent), but instead overpaid the provider \$1,237 ( $\$1,546 - \$309$ ). The Department made changes to eMedNY in December 2015 that have since prevented the overpayments from occurring.

## **Recommendations**

3. Review the \$3.4 million in overpayments and make recoveries, as appropriate.
4. Formally remind providers who received overpayments to report accurate claim information when billing Medicaid for Part B deductibles and coinsurance on direct-bill claims to ensure

claims are paid appropriately.

5. Enhance system controls to identify and prevent overpayments of Part B deductible and coinsurance amounts.

## Audit Scope, Objective, and Methodology

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The objective of our audit was to determine whether Medicaid made improper payments to providers who submitted Part B cost-sharing claims directly to eMedNY. The audit covered the period from June 1, 2012 through May 31, 2017.

To accomplish our audit objective and assess related internal controls, we interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State laws, rules, and regulations. We used the Medicaid Data Warehouse to identify Medicare Part B cost-sharing claims that providers directly billed to Medicaid. We calculated overpayments applying Medicare's and Medicaid's payment rules to the claims. We shared our methodology with officials from the Department and the Office of the Medicaid Inspector General during the audit for their review.

We selected a judgmental sample of 240 Part B cost-sharing claims from providers who billed Medicaid for coinsurance amounts that exceeded 40 percent of Medicare's approved amount. We chose 5 providers among the top 15 who had the highest total potential overpayments. We requested and reviewed the Medicare Explanation of Benefits for these claims to determine the appropriate cost-sharing amounts.

We conducted our 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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.

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## Authority

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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.

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## Reporting Requirements

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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 the report. In their response, Department officials concurred with the audit recommendations and indicated the actions that will be taken to address them.

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

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## Contributors to This Report

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**Andrea Inman**, Audit Director  
**Warren Fitzgerald**, Audit Manager  
**Dan Towle**, Audit Supervisor  
**Rebecca Tuczynski**, Examiner-in-Charge  
**Kimberly Geary**, Examiner-in-Charge  
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## Division of State Government Accountability

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### Vision

A team of accountability experts respected for providing information that decision makers value.

### Mission

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

# Agency Comments



ANDREW M. CUOMO  
Governor

## Department of Health

HOWARD A. ZUCKER, M.D., J.D.  
Commissioner

SALLY DRESLIN, M.S., R.N.  
Executive Deputy Commissioner

November 14, 2018

Ms. Andrea Inman, Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street – 11<sup>th</sup> Floor  
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2017-S-36 entitled, "Medicaid Overpayments for Medicare Part B Services Billed Directly to eMedNY".

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.  
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner  
Donna Frescatore  
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Brian Kiernan  
Timothy Brown  
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Daniel Duffy  
Jeffrey Hammond  
Jill Montag  
Ryan Cox  
James Dematteo  
James Cataldo  
Diane Christensen  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2017-S-36 entitled,  
Medicaid Overpayments for Medicare Part B Services Billed  
Directly to eMedNY**

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The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2017-S-36 entitled, "Medicaid Overpayments for Medicare Part B Services Billed Directly to eMedNY."

**Recommendation #1**

Review the \$46,030 for the 240 claims we tested and make recoveries, as appropriate.

**Response #1**

The Office of the Medicaid Inspector General (OMIG) will review and determine an appropriate course of action.

**Recommendation #2**

Using a risk-based approach, assess the remaining \$5.27 million in potential overpayments made to providers for Part B coinsurance, and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers who received the largest dollar amounts of the payments.

**Response #2**

OMIG will review and determine an appropriate course of action.

**Recommendation #3**

Review the \$3.4 million in overpayments and make recoveries, as appropriate.

**Response #3**

OMIG will review and determine an appropriate course of action.

**Recommendation #4**

Formally remind providers who received overpayments to report accurate claim information when billing Medicaid for Part B deductibles and coinsurance on direct-bill claims to ensure claims are paid appropriately.

**Response #4**

The Department will remind providers in a Medicaid Update of their obligation to bill Medicaid for Part B deductibles and coinsurance on direct bill claims.

**Recommendation #5**

Enhance system controls to identify and prevent overpayments of Part B deductible and coinsurance amounts.

**Response #5**

The Department will review the reasonability edits currently in place for Medicare Part B claims, and assess if they can be strengthened, or whether new edits need to be designed to help mitigate provider billing errors that may result in Medicaid overpayments.