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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 14, 2005

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Payments for
Durable Medical Equipment
Report 2004-S-18

Dear Dr. Novello:

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, we audited the Department of Health's practices for detecting and preventing inappropriate Medicaid payments for durable medical equipment provided to Medicaid recipients also covered by Medicare. Our audit covered the period January 1, 2001 through December 31, 2002.

A. Background

The Department of Health (Department) administers New York State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. The Department uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims from service providers and to pay the providers for medical services rendered to eligible Medicaid recipients. In New York, the Federal, State, and local governments jointly fund the Medicaid program.

Durable medical equipment (DME) is defined as devices and equipment that are ordered by a practitioner and prescribed for home use in the treatment of a specific medical condition, can withstand repeated use, and are primarily and customarily used for medical purposes. Hospital beds, oxygen equipment, and prosthetic devices are examples of DME. Eligible Medicaid recipients who enroll in the Medicare program are required to enroll in the Medicare Part B program which covers certain DME costs. Medicaid will pay the Medicare Part B enrollment costs for Medicaid recipients. By law, Medicaid is the always the payer of last resort. When a Medicaid recipient also has

Medicare Part B coverage (dual eligible), Medicaid pays for Medicare deductibles, coinsurance and remaining expenses after all of the recipient's Medicare benefits have been exhausted.

In New York, if a medical provider serves a dual eligible recipient, the provider is responsible for determining whether the service is fully or partly covered by Medicare. For example, the Medicaid identification card carried by a recipient indicates whether the recipient is also covered by Medicare. If the recipient's identification card shows that Medicare coverage is available, the provider must bill Medicare before billing Medicaid. After billing Medicare, the provider will receive an Explanation of Medical Benefits from Medicare. The Explanation of Medical Benefits will indicate the portion of the billed services (if any) that was covered by Medicare, less any deductible or coinsurance amount. Using this information, the provider may then bill Medicaid for the deductible or coinsurance amount plus any DME services not covered by Medicare.

If a provider serving a dual eligible recipient bills Medicaid before billing Medicare, Medicaid could overpay claims by the amount Medicare should have paid. In such instances, any Medicaid overpayments should be recovered from the provider and the provider should bill Medicare. However, it is preferable for a state's Medicaid claims processing system to prevent such overpayments before they are made (e.g., by determining whether the services claimed for dual eligible recipients were in fact billed to Medicare before they were billed to Medicaid).

In the two years ended December 31, 2002, New York's Medicaid program paid DME providers about $126 million for equipment and services provided to dual eligible recipients.

B. Audit Scope, Objective and Methodology

For the period January 1, 2001 through December 31, 2002, we audited the Department's practices for processing claims from DME providers serving dual eligible recipients. The objective of our performance audit was to determine whether the practices developed by the Department detected or prevented Medicaid overpayments to DME providers that had not billed Medicare.

To accomplish our audit objective, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined relevant Department payment policies and procedures. We also examined a judgmental sample of Medicaid claims submitted by DME providers serving dual eligible recipients. In our review of these claims, we visited the providers and examined copies of the Explanation of Medical Benefits obtained by the providers from Medicare to determine whether Medicare had been billed for the services claimed. To identify recipients who were dual eligible, we obtained Medicare eligibility information from the federal Centers for Medicare and Medicaid Services (CMS). Details of our sampling methodology are presented in the section of this report describing our audit findings.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess those operations of the Department that are within our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and

applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions, and recommendations.

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, several of which are performed by the Division of State Services. 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 Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

We found DME providers serving dual eligible recipients did not always bill Medicare for Medicare-eligible services. Instead, the providers bill the services to Medicaid and are reimbursed by Medicaid. The Department's claims processing system does not prevent these overpayments because it does not flag claims involving dual eligible recipients for a determination of their Medicare billing status.

According to Department officials, overpayments of this kind should be prevented when the new Medicaid claims processing system, eMedNY, is operational.

Claims Paid for Medicare Eligible Recipients Who Had No Medicare Billings

Medicaid claims submitted for payment by service providers are processed by the MMIS. The MMIS contains a number of automated processing controls (edits) for identifying claims that are incorrect or potentially incorrect. Such claims are either rejected or set aside for further review. However, the MMIS has no edits for identifying claims that relate to dual eligible recipients. As a result, such claims cannot be set aside to determine whether the services were billed to Medicare before they were billed to Medicaid. We note that we identified the need for such edits in our prior audit report 95-S-91, *Medicaid Payments for Medicare Beneficiaries*, which was issued in May 1997.

Department officials noted that the MMIS will soon be replaced by a new claims processing system called eMedNY, and eMedNY will have edits for identifying claims that relate to dual eligible recipients. Moreover, such claims will be set aside to determine whether the services were billed to Medicare.

To identify the Medicaid payments that were made to DME providers on behalf of dual eligible recipients, we developed computer programs that extracted the payments from all the Medicaid payments that were made during the period. We determined during this period, 2.1 million claims totaling about $126 million in Medicaid payments were made to DME providers on behalf of dual eligible recipients.

We compared these 2.1 million Medicaid claims to Medicare claim information maintained by CMS to determine whether any of the Medicaid claims had also been billed to Medicare; we then analyzed the claims that had not been billed to Medicare to determine whether the DME services on the claims were in fact eligible for Medicare. We determined, according to the CMS claims information, about one million of the claims, totaling $58 million, had not been billed to Medicare, even though the services were eligible for Medicare. As a result, there is a potential Medicaid may have overpaid some of these providers.

We selected a sample of claims from the $58 million for further review. We identified the six DME providers with the largest number of claims in the population. Together, these six providers accounted for 85,702 of the more than one million claims in the population. These 85,702 claims accounted for about $5 million.

From these 85,702 claims, we judgmentally selected 119 claims totaling $74,739. To determine whether these 119 claims had been billed to Medicare, we visited the six providers and asked for documentation of such billing (i.e., the Explanation of Medical Benefits provided by Medicare in response to bills). We found Medicare had been billed for 87 of the claims, but had not been billed for 32 claims totaling $22,706 (30 percent of the total $74,739). Fourteen of the 32 unbilled claims came from one provider; this provider billed Medicare for only five of its 19 claims in the sample.

Medicare claims must be filed within one full calendar year following the year in which services were provided. Because of this one-year limit on Medicare billing, the Department cannot recover the overpayments identified by our audit. However, DME overpayments could be recovered if they were identified and pursued on an ongoing basis. In light of the amounts that are likely to be overpaid each year, the Department should assure the new claims processing system prevents these payments in the future. The Department should also contact DME providers and emphasize the need for the providers to bill Medicare, before billing Medicaid, when they serve dual eligible recipients.

Recommendation

Contact DME providers and emphasize the need for them to use all available resources to determine whether a recipient is covered by Medicare, and to bill Medicare, before billing Medicaid, when recipients are dual eligible. Also assure the new claims processing system is capable of preventing these payments in the future.

We provided a draft copy on the matters contained in this report to Department officials for their review and comment. We considered their comments in preparing this report. Department officials agreed with our recommendation and indicated they will again advise providers to bill all available third party health insurance carriers, including Medicare, before billing Medicaid. A complete copy of the Department's response is included 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 of Health shall report to the Governor, the State Comptroller and the leaders of the Legislature and its fiscal committees, advising what steps

were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Major contributors to this report were Ken Shulman, Donald Paupini, Sally Wojeski, Resa Swartz, Doug Abbott and Dana Newhouse.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Robert Barnes, Division of the Budget

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 8, 2005

David R. Hancox
Audit Director
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. Hancox:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2004-S-18) entitled " Medicaid Payments for Durable Medical Equipment."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

cc: Mr. Griffin
Mr. Howe
Ms. Kuhmerker
Mr. Reed
Mr. Seward
Mr. Van Slyke
Mr. Wing

Appendix A

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2004-S-18 Entitled
"Medicaid Payments for Durable Medical Equipment."

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2004-S-18) entitled "Medicaid Payments for Durable Medical Equipment."

Recommendation #1:

Contact Durable Medicaid Equipment (DME) providers and emphasize the need for them to use all available resources to determine whether a recipient is covered by Medicare, and to bill Medicare, before billing Medicaid, when recipients are dual eligible. Also assure the new claims processing system is capable of preventing these payments in the future.

Response #1:

The Medicaid Management Information System (MMIS) provider manual for Durable Medicaid Equipment on page 2-50, Section G, explicitly advises the provider to bill Medicare before billing Medicaid. "All charges must first be billed to Medicare. Only after an Explanation of Medical Benefits (EOB) is received from the Medicare intermediary and payment made, where appropriate, may a claim be submitted to Medicaid for reimbursement."

In addition, the Bureau of Medicaid Audit (BMA) routinely audits DME providers, and part of the DME audit plan is to determine that all available third party insurance is utilized whenever possible. Of the six providers looked at by OSC, two were also reviewed recently by BMA: Buffalo Wheelchair and Landauer Metropolitan, Inc. In both audits, the provider was cited for not utilizing Medicare for crossover recipients and disallowances were determined.

There are over 1,400 enrolled DME providers. To make the most effective use of audit resources, the Bureau selectively targets the providers based on a number of selection criteria. The Department plans to include, in a future issue of the ***Medicaid Update***, a reminder that DME providers more closely adhere to the requirements in the provider manual for utilizing all available third party health insurance.

Regarding the claims processing system's capabilities, there is nothing in eMedNY beyond what existed in Legacy MMIS at the moment. The issue is that, because Medicare coverage is not assured, follow-up audits as described above will continue to be necessary.