
**Thomas P. DiNapoli
COMPTROLLER**



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**OFFICE OF THE
NEW YORK STATE COMPTROLLER**

**DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY**

DEPARTMENT OF HEALTH

**MEDICAID
OVERPAYMENTS FOR
MEDICARE PART B
BENEFICIARIES**

Report 2008-S-63

AUDIT OBJECTIVE

Our objective was to identify Medicaid overpayments made to providers who did not properly report Medicare Part B payments on their Medicaid claims for dual eligible patients.

AUDIT RESULTS - SUMMARY

During the year ended December 31, 2006, our audit identified an estimated \$1.8 million in Medicaid overpayments to medical providers who received payment from Medicaid for services already paid for by Medicare's Part B coverage. We identified 50,090 claims submitted by physicians, durable medical equipment dealers, and laboratories who did not report payments received from Medicare when billing Medicaid. In each case, the provider billed Medicaid for the entire cost of each Medicare-approved service, without reducing the amount billed to Medicaid by the amount Medicare already paid toward the claim.

This report, dated December 10, 2008, is available on our website at: <http://www.osc.state.ny.us>.

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Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

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, referred to as "dual eligibles". Medicaid is the payor of last resort for medical claims, paying for any balance unpaid after all other insurance such as Medicare settles.

Therefore, a medical provider should bill Medicare first for these dual eligible patients and bill Medicaid only after the amount to be paid by Medicare is known. On the Medicaid billing, the provider must report the amount received from Medicare and Medicaid will typically pay an amount based upon the portion of the bill not covered by Medicare. Thus, it is critical that Medicare information be entered accurately on the Medicaid billing. Otherwise, a Medicaid overpayment will occur.

AUDIT FINDINGS AND RECOMMENDATION

Medicaid Overpayments for Medicare Part B Beneficiaries

We obtained from the federal Department of Health and Human Service's Center for Medicare and Medicaid Services (CMS) the 2006 Part B Medicare payment information for dual eligible patients in New York State. We then compared the amounts paid by Medicare with the amounts reported on New York's Medicaid system. Our test was designed to identify instances where medical providers billed Medicaid and either failed to report or misreported the amounts paid by Medicare, thus setting up a potential overpayment situation. Our audit identified a number of physicians, durable medical equipment dealers, and laboratories that received amounts from Medicare for services but did not report any of the amounts received from Medicare on their Medicaid claims. This caused Medicaid to overpay these medical providers by \$1.8 million.

Nearly all of these overpayments (\$1.6 million) were made to physicians and appear to be caused by two basic problems. In some cases, medical providers will bill Medicare and Medicaid simultaneously, an inappropriate practice. For example, one

physician billed Medicaid \$3,084 for administering chemotherapy to a dual eligible beneficiary and reported that Medicare did not pay anything toward this service. From the information provided by CMS, we determined Medicare reimbursed the physician \$2,518 for this service, leaving a balance of \$566 for Medicaid to pay. Because the Medicare payment information was not reported on the Medicaid claim, Medicaid paid the entire amount \$3,084 instead of the \$566. We identified two other providers who received overpayments of \$200,643 and \$55,829, billed Medicare and Medicaid at the same time and never reported the Medicare payments on their Medicaid claims. During our visits to these providers, each indicated they were unsure about the proper way to bill for dual eligible beneficiaries. However, we doubt these explanations because the Department has issued specific guidance on the proper billing of Medicaid for dual eligible patients and the Department reminds medical providers of such requirements on a regular basis. Further, it is clear that the medical provider collected twice for the same service.

In other instances, a medical service provider may fail to adjust Medicaid claims for late payments received from Medicare. Medicare may reject a bill, necessitating a rebilling of Medicare or an appeal. Based upon the initial rejection by Medicare, the medical provider may bill Medicaid for the entire amount and Medicaid will pay. If Medicare subsequently reverses its decision and pays the claim, the medical provider must adjust its Medicaid billings to account for the payment from Medicare. Some overpayments occurred because late Medicare payments were never used to adjust the Medicaid billings. Our audit focused on the 2006 claims and thus allowed sufficient time for medical providers to adjust their Medicaid claims.

We informed the Department's Medicaid Inspector General of our findings and shared all information we obtained from CMS necessary to investigate these physicians and all remaining providers we identified during our audit. The Medicaid Inspector General's staff indicated that they would look further into our findings.

Recommendation

Fully investigate the \$1.8 million in overpayments we identified and recover inappropriate payments.

AUDIT SCOPE AND METHODOLOGY

We conducted our audit according to generally accepted government auditing standards. We audited Medicaid claims submitted by medical care providers for recipients that are eligible for Medicaid and Medicare. Our audit was limited to the claims covered by Medicare Part B submitted by physicians, durable medical equipment dealers, and laboratories for the year 2006. To accomplish our objective we obtained Medicare claim information from the federal Centers for Medicare and Medicaid Services and compared it with Medicaid claim information maintained by the Department. We interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant Medicaid payment policies and procedures. We also visited selected Medicaid providers with larger overpayments.

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 who 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 their review and comment. Department officials generally agreed with our recommendation and indicated actions planned or taken to implement the recommendation. We considered their comments in preparing this report. A complete copy of the Department's response is included as Appendix A.

Within 90 days of 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 recommendation contained herein, and where the recommendation was not implemented, the reasons therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include Sheila Emminger, Warren Fitzgerald, Dan Towle, Jacqueline Keays-Holston, Christopher Morris, Wendy Matson, Lisa Rooney and Judith McEleney.

APPENDIX A - AUDITEE RESPONSE



STATE OF NEW YORK DEPARTMENT OF HEALTH

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Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

October 3, 2008

Sheila Emminger, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
State Audit Bureau
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Emminger:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2008-S-63 on "Medicaid Out-of-Pocket Payments for Medicare Part B Beneficiaries."

Thank you for the opportunity to comment.

Sincerely,

Wendy E. Saunders
Chief of Staff

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Homer Charbonneau
Ron Farrell
Randall Griffin
Gail Kerker
Sandra Pettinato
Robert W. Reed
James Sheehan

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2008-S-63 on
"Medicaid Overpayments for Medicare Part B Beneficiaries"**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2008-S-63 on "Medicaid Overpayments for Medicare Part B Beneficiaries."

Recommendation #1:

Fully investigate the \$1.8 million in overpayments we identified and recover inappropriate payments.

Response #1:

The Medicare claims information must be validated before the Office of the Medicaid Inspector General (OMIG) can assess the validity of the audit findings. Its sole access to Medicare adjudicated claim data is through the Medicare-Medicaid Data Match Program. The OMIG will additionally run the potential findings against its third party recovery database, to determine any overlap with its established third-party liability recovery efforts.

OMIG notes that the OSC obtained the Medicare payment information from the Research Data Assistance Center (ResDAC). OSC is requested to share its data request with the OMIG along with the protocol involved in obtaining the data. OMIG review of the ResDAC website did not indicate the availability of Medicare paid claims data.