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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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# Overpayments of Certain Medicare Crossover Claims

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**Medicaid Program  
Department of Health**

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# Executive Summary

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## Purpose

To determine if Medicaid overpaid Medicare crossover claims for physician and other outpatient services and to identify the claims processing control weaknesses that allowed the overpayments to occur. The audit covers the period December 3, 2009 through March 31, 2012.

## Background

Many Medicaid recipients are also eligible for Medicare, the federal health insurance program available to people 65 or more years-old, as well as people under 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as “dual eligible.” In general, for dual eligible individuals, Medicare is the primary claims payer - and Medicaid, as a secondary payer, pays the individual’s Medicare deductibles and coinsurance for the medical services rendered. On December 3, 2009, the Department of Health (Department) implemented the Medicare/Medicaid claim crossover system. Under the system, providers submit medical claims for dual eligible individuals to Medicare. After Medicare processes the claims, they are electronically transferred to the Medicaid claims processing system (eMedNY) for payment of deductibles and coinsurance. Prior to the automated crossover system, the Department relied on providers to self-report accurate information to eMedNY regarding how much Medicare paid and how much Medicaid owed; this often led to incorrect Medicaid payments of Medicare deductibles and coinsurance.

## Key Findings

- Medicaid made actual and potential overpayments (totaling about \$26.4 million) on 865,987 crossover claims that were processed during our audit period.
- The actual overpayments totaled about \$10 million (from 414,081 crossover claims). The overpayments occurred because eMedNY incorrectly interpreted certain crossover claim adjustment codes; and did not properly apply Medicaid reimbursement limits.
- The potential overpayments totaled \$16.4 million (from 451,906 crossover claims) where providers submitted their claims directly to Medicaid and bypassed the controls afforded by the crossover system.

## Key Recommendations

- Correct the flawed eMedNY computer controls that caused the Medicaid overpayments we identified during the audit.
- Recover the Medicaid overpayments totaling \$10 million caused by flawed eMedNY computer programs that incorrectly processed Medicare crossover claims.
- Review the \$16.4 million in potential Medicaid overpayments and recover where appropriate.

## Other Related Audits/Reports of Interest

[Department of Health: Overpayments for Services Also Covered by Medicare Part B \(2010-S-50\)](#)  
[Department of Health: Overpayments of Claims for Selected Professional Services \(2010-S-73\)](#)

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

**Division of State Government Accountability**

January 10, 2013

Nirav R. Shah, M.D., M.P.H.  
Commissioner  
Department of Health  
Corning Office 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 of Certain Medicare Crossover Claims*. This audit was performed pursuant 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](http://www.osc.state.ny.us)

## Background

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Medicaid is a federal, state and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The federal government funds about 49 percent of New York's Medicaid costs; the State funds about 34.4 percent; and the localities (the City of New York and counties) fund the remaining 16.6 percent. For the fiscal year ended March 31, 2012, New York's Medicaid program had more than 5.5 million enrollees and costs totaled approximately \$50 billion.

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 claims are processed by eMedNY, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate. For example, 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 enrolled in Medicare, the federal health insurance program for people 65 years of age and older and people under 65 years old with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual eligible." Generally, Medicare is the primary payer for medical services provided to dual eligible recipients. Medicaid may pay for any remaining balance not covered by Medicare. This may include Medicare deductibles and coinsurance on the medical services these individuals receive.

A Medicare "crossover claim" entails the transfer of processed claim information from Medicare to Medicaid or other health insurance payers that provide supplemental insurance benefits to Medicare beneficiaries. Many states have automated this process. On December 3, 2009, the Department implemented its automated Medicare/Medicaid crossover system. Under the system, providers submit medical claims to Medicare. After Medicare processes the claims, they are automatically transferred to Medicaid. When Medicare crossover claims are processed by eMedNY, they are subject to similar edits that standard Medicaid claims are subjected to.

Prior to the crossover system, the Department relied on providers to accurately self-report the amount Medicare paid on a claim and how much Medicaid owed for deductibles and coinsurance. This often led to incorrect Medicaid payments of Medicare deductibles and coinsurance. To ensure eMedNY processes crossover claims correctly, the Department requires Medicaid providers to submit claims for dual eligible persons directly to Medicare (as opposed to self-reporting Medicare information to eMedNY).

Since December 3, 2009, Medicaid reimbursed about 41.4 million claims (totaling \$1.1 billion) that were electronically crossed over from Medicare.

## Audit Findings and Recommendations

Because of flaws in certain eMedNY computer programs designed to process electronic Medicare crossover claims, Medicaid incorrectly processed such claims (for physician and other outpatient services) causing actual overpayments totaling about \$10 million. Also, because providers bypassed the crossover system and the controls that it affords, an additional \$16.4 million was potentially overpaid on similar claims.

### Actual Overpayments

eMedNY made actual overpayments totaling about \$10 million on 414,081 crossover claims. These overpayments occurred because eMedNY incorrectly interpreted certain crossover claim adjustment codes; and did not properly apply Medicaid reimbursement limits to other crossover claims.

#### *Incorrect Interpretations of Claim Adjustment Reason Codes*

In some instances, Medicare rejects a claim because the services are not medically necessary. In other instances, Medicare denies payment because the services in question duplicate those from another claim. In general, Medicaid should not pay claims that Medicare has denied. However, eMedNY made overpayments totaling \$6.9 million for 137,025 crossover claims that Medicare denied. In these instances, Medicare processed the providers' claims, determined they were ineligible for reimbursement, and electronically forwarded information (including the claim adjustment reason code [or CARC]) which explained the claim denials to eMedNY. However, eMedNY incorrectly interpreted certain CARC data and, as a result, improperly paid for the denied services.

In one case, for example, Medicare denied a claim for a physician-administered drug (a drug injected at a health care facility). According to the CARC, Medicare denied the claim because the drug was not medically necessary. However, when the claim crossed over to Medicaid, eMedNY incorrectly interpreted the CARC and paid the provider \$2,872. Because Medicare denied the claim for the drug, Medicaid should not have paid for it. The denied claim was submitted along with three other claims for physician-administered drugs that Medicare did pay for. The three other claims crossed over to Medicaid, and eMedNY correctly processed and paid them (\$18) for coinsurance.

In another case, a physician submitted three claims to Medicare for the same service - an office visit for the evaluation of a new patient. Medicare paid the first claim and denied the second and third (or duplicate) claims. According to the CARCs for both the second and third claims, the claims were "duplicate claim/service." However, eMedNY incorrectly interpreted the CARCs for the two duplicate claims and improperly paid \$114 (\$57 x 2) for them.

We identified several CARC codes that eMedNY incorrectly interpreted. In response to the audit, the Department took immediate steps to correct the system design flaws that allowed the

incorrect processing of claims with certain CARC codes.

### *Reimbursement Limits Were Not Properly Applied*

Overpayments of \$3.1 million were made on 277,056 crossover claims because eMedNY did not apply New York State Medicaid reimbursement limits to electronic Medicare crossover claims. Since July 1, 2003, the State limits Medicaid reimbursement of Medicare coinsurance for certain services to 20 percent of the coinsurance charge. However, when the automated crossover system was implemented in December 2009, the 20 percent limit was not applied to physician services billed by group providers.

For example, on March 3, 2010, a group practice with 45 participating physicians billed a claim to Medicare for surgical procedures performed on a dual eligible recipient. When the claim crossed over to Medicaid, instead of paying \$123, or 20 percent of the Medicare coinsurance charge of \$615, eMedNY reimbursed the Medicaid group provider the full coinsurance amount. In this instance, eMedNY did not apply the 20 percent reimbursement limit and overpaid the group provider \$492 (\$615 - \$123).

In response to our preliminary observations, the Department is beginning a review of errors in eMedNY computer programs that inadvertently caused overpayments of crossover claims for services billed by group providers.

## **Potential Overpayments**

eMedNY made potential overpayments of \$16.4 million (on 451,906 crossover claims) because 24,812 providers submitted their claims directly to Medicaid - instead of billing Medicare and allowing the claims to crossover to Medicaid. 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 eligible persons. However, providers were able to circumvent certain eMedNY controls for the crossover process and submit crossover claims directly to eMedNY.

When a claim for a dual eligible person is not subjected to the crossover process, Medicaid depends on the providers (or their billing service bureaus) to accurately report Medicare payment data. Often, however, this self-reported payment data was not accurate. Without accurate Medicare data, the Department cannot be adequately assured that Medicare paid a particular claim - and if paid, the amount of the payment. Further, without sufficient Medicare data, we could not determine definitively if all 451,906 claims in question were overpaid - and if so, by how much. Nonetheless, based on the available eMedNY data, we concluded that the 451,906 claims for dual eligible persons were highly questionable. For example, for most of these claims, the amounts paid for Medicare coinsurance were higher than the amounts customarily charged to Medicaid. However, to actually determine whether overpayments occurred requires detailed analysis of the related claims.



We performed such analysis on 219 potentially problematic claims a service bureau submitted on behalf of a particular high risk provider, whose charges for coinsurance consistently appeared to be excessive. We asked the provider and its service bureau to provide us with pertinent documentation (including Medicare payment data) for the 219 claims. According to the service bureau, all 219 claims were billed directly to Medicaid in error - and therefore, these claims were not subjected to the crossover process. Moreover, bureau officials also acknowledged that the claims included excessive charges for coinsurance. Based on our inquiry, we confirmed that Medicaid actually overpaid the 219 claims by \$20,266.

The overpayments included, for example, 136 incorrect claims for office visits. In each instance, the service bureau billed an excessive amount for coinsurance (\$158) when Medicare's base fee for such visits was only \$79. Further, the coinsurance amount that Medicaid should have paid was only about \$16 ( $\$79 \times 20$  percent), and therefore, Medicaid overpaid each of the 136 claims for office visits by \$142 ( $\$158 - \$16$ ). Because the service bureau should have been aware of and followed the proper procedures for submitting these claims, we recommend the Department follow-up with this particular bureau.

Based on our review, we concluded that each of the 451,906 claims in question were of high risk of overpayment - primarily because the amounts of coinsurance claimed (and paid) were higher than the amounts usually charged to Medicaid. Moreover, if Medicaid overpaid all 451,906 questionable claims similarly to those of the aforementioned provider, we estimate that the overpayments would have totaled about \$16.4 million.

## Recommendations

1. Review and recover the \$10 million in actual overpayments attributable to the eMedNY control deficiencies we identified.
2. Design and implement eMedNY controls to properly process and pay Medicare crossover claims submitted by group providers. In particular, these controls should ensure that eMedNY properly limits crossover claims for professional services to 20 percent of the coinsurance charge.
3. Review the \$16.4 million in potential Medicaid overpayments attributable to providers directly billing crossover claims to Medicaid and recover overpayments, where appropriate.
4. Implement the controls necessary to prevent providers from billing crossover claims directly to the Medicaid program. Consider denying crossover claims providers submit directly to Medicaid.
5. Follow-up with providers and billing service bureaus (including the bureau identified in this report) who routinely submit claims for Medicare coinsurance charges for services provided to dual eligible persons directly to Medicaid.



## Audit Scope and Methodology

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The objectives of our audit were to determine if Medicaid overpaid Medicare crossover claims and to identify the eMedNY claims processing control weaknesses that allowed the overpayments to occur. Our audit tests and analysis were based on Medicaid payments for dual eligibles' Medicare cost-sharing responsibilities related to physician and other outpatient services. The claims were reimbursed by Medicaid from December 3, 2009 through March 31, 2012.

To accomplish our objectives, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. We analyzed and examined crossover claims that were electronically submitted by Medicare to the Medicaid program and crossover claims billed directly to eMedNY by Medicaid providers. We also interviewed representatives from a particular Medicaid billing service bureau that submitted crossover claims to Medicaid on behalf of a physician included in our review.

We conducted our performance audit in accordance with generally accepted government auditing standards. These 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

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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.

## 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 it. In their response, Department officials generally concurred with our recommendations and indicated that certain actions have been and 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.

## Contributors to This Report

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**Brian Mason**, Audit Director  
**Andrea Inman**, Audit Manager  
**Warren Fitzgerald**, Audit Supervisor  
**Earl Vincent**, 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

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



Sue Kelly  
Executive Deputy Commissioner

November 20, 2012

Ms. Andrea Inman, Audit Manager  
Office of the State Comptroller  
Division of State Government Accountability  
Medical Claims Unit  
Riverview Center  
150 Broadway  
Menands, New York 12204

Dear Ms. Inman:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2011-S-28 on "Overpayments of Certain Medicare Crossover Claims."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Sue Kelly".

Sue Kelly  
Executive Deputy Commissioner

Enclosure

cc: Michael Nazarko  
James C. Cox  
Jason A. Helgersen  
Diane Christensen  
Stephen Abbott  
Dennis Wendell  
Stephen LaCasse  
Ronald Farrell  
Michelle Contreras  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2011-S-28 on  
Overpayments of Certain Medicare Crossover Claims**

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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 2011-S-28 on "Overpayments of Certain Medicare Crossover Claims."

**Recommendation #1:**

Review and recover the \$10 million in actual overpayments attributable to the eMedNY control deficiencies we identified.

**Response #1:**

The Office of the Medicaid Inspector General (OMIG) will review the claims in question and recover where appropriate.

**Recommendation #2:**

Design and implement eMedNY controls to properly process and pay Medicare crossover claims submitted by group providers. In particular, these controls should ensure that eMedNY properly limits crossover claims for professional services to 20 percent of the coinsurance charge.

**Response #2:**

The Department will obtain and review a copy of the exception claims data which OSC furnished to OMIG, and then research the payment errors that occurred and determine the edits that need to be revised to ensure that claims prospectively pay appropriately. After completing this analysis, the Department will initiate eMedNY system edit changes as appropriate.

**Recommendation #3:**

Review the \$16.4 million in potential Medicaid overpayments attributable to providers directly billing crossover claims to Medicaid and recover overpayments, where appropriate.

**Response #3:**

The OMIG will review the potential overpayments and make recoveries where appropriate.

**Recommendation #4:**

Implement the controls necessary to prevent providers from billing crossover claims directly to the Medicaid program. Consider denying crossover claims providers submit directly to Medicaid.

**Response #4:**

While there are multiple valid reasons for providers to submit claims directly to Medicaid for Medicare/Medicaid dually eligible recipients, the Department will identify those situations where the claim processing edits could be strengthened and take action as warranted.

**Recommendation #5:**

Follow-up with providers and billing service bureaus (including the bureau identified in this report) who routinely submit claims for Medicare coinsurance charges for services provided to dual eligible persons directly to Medicaid.

**Response #5:**

The Department will issue billing guidance in its monthly Medicaid Update provider publication reminding providers and billing service bureaus that, when appropriate, Medicare must be billed prior to billing Medicaid for services provided to dual eligibles. The Department will additionally contact the billing service bureau identified by OSC in this audit, Claim Torrent, Inc., and direct it to correct the billing procedures identified by OSC as being inappropriate, and to also furnish documentation to the Department confirming the corrective actions taken. The Department will also contact OMIG regarding the feasibility of OMIG monitoring providers and their billing service bureaus in the future as a means of ensuring providers' adherence to Medicaid billing policies for dual eligibles.

It is additionally relevant to note that in response to OSC's preliminary audit report which recommended an investigation of Claim Torrent, OMIG did open an investigation but the initial assessment determined that investigators could not prove intent to defraud the Medicaid program based on the fact that eMedNY cannot require billing service bureaus to include their unique provider identification number (ID) on claims submitted for payment since the HIPAA-compliant claim layout does not include sufficient space for both the provider's ID and its billing service bureau's ID. Since Claim Torrent is a billing agent that utilizes information submitted by providers for billing, it would be difficult to distinguish fraud from errors.