



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

Division of State Government Accountability

Improper Payments to a Physical Therapist

Medicaid Program Department of Health



Executive Summary

Purpose

To determine whether Mark Amir, a physical therapist participating in New York's Medicaid program, billed Medicaid in accordance with its policies and guidelines and whether Medicaid made improper payments. The audit covers the period April 1, 2010 through September 30, 2013.

Background

Mark Amir is a physical therapist who owns and operates Madison Physical Therapy located in Brooklyn, New York. Mr. Amir's patients are primarily "dual-eligible" beneficiaries who are enrolled in both Medicare and Medicaid. Under this arrangement, Medicare is the primary payer and Medicaid pays beneficiaries' Medicare deductibles and coinsurance. Medicaid claims for Medicare deductibles or coinsurance are called "crossover" claims. In December 2009, the Department of Health (Department) implemented an automated crossover process whereby Medicare sends crossover claim data electronically to eMedNY, the Department's Medicaid claims processing system. The crossover system improved the accuracy of Medicaid payments for dual-eligible recipients. Prior to the implementation, providers reported Medicare payment information on separate claims to Medicaid. This often resulted in significant Medicaid overpayments when providers misreported pertinent Medicare claim payment data. Nevertheless, providers can still report Medicare payment information directly to Medicaid instead of using the crossover system. During our audit period, Medicaid paid Mark Amir \$305,215.

Key Findings

- Medicaid overpaid Mark Amir \$146,225 because he reported incorrect Medicare payment information to Medicaid. He avoided Medicaid's automated claims processing controls by submitting Medicare claims using the National Provider Identifier (NPI) for his group practice and the related Medicaid claims using his NPI as an individual provider.
- Mark Amir did not comply with certain Department regulations and administrative procedures for Medicaid program participation. As such, the propriety of the remaining Medicaid payments (totaling \$158,990) to Mr. Amir is questionable.

Key Recommendations

- Recover Medicaid overpayments totaling \$146,225 for Mark Amir's improper crossover claims.
- Review the remaining claim payments totaling \$158,990 and determine if recoveries and/or sanctions are warranted.

Other Related Audits/Reports of Interest

[Department of Health: Overpayments of Certain Medicare Crossover Claims \(Report 2011-S-28\)](#)

[Department of Health: Overpayments of Claims for Selected Professional Services \(Report 2010-S-73\)](#)

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

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 15, 2014

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
Corning Office Building
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 *Improper Payments to a Physical Therapist*. 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

Background

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. About 6 million people are enrolled in New York's Medicaid program. The federal government funds about 48.5 percent of New York's Medicaid claim costs; the State funds about 34 percent; and the localities (City of New York and counties) fund the remaining 17.5 percent. For the fiscal year ended March 31, 2013, Medicaid claim costs totaled about \$51 billion.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health insurance program for the elderly and disabled. Individuals enrolled in both programs are commonly referred to as "dual eligible." When this occurs, Medicare is generally the primary payer for medical services provided to dual-eligible people. As the secondary payer, Medicaid generally pays balances, including deductibles and coinsurance, not paid by Medicare.

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid claims are processed and paid by the Department's eMedNY system. In December 2009, the Department implemented an automated crossover system to process claims for dual-eligible individuals. Crossover claims are Medicare-approved claims for Medicaid recipients' Medicare deductibles or coinsurance. Under the system, Medicare automatically transfers claims it approves to Medicaid for processing and payment of Medicare deductibles or coinsurance. The intent of the automated crossover system was to minimize the need for providers to self-report Medicare payment information to New York's Medicaid program and thereby improve the accuracy of Medicaid payments for dual-eligible recipients' Medicare deductibles and coinsurance.

The Health Insurance Portability and Accountability Act of 1996 mandated the use of National Provider Identifiers (NPIs) by May 2008 for all health care providers participating in Medicare and Medicaid. NPIs uniquely identify providers in standardized transactions, such as health care claims and the coordination of benefits between health plans. For claims to cross over from Medicare to Medicaid properly, providers must enroll in both programs under the same NPI.

Mark Amir is a physical therapist who owns and operates Madison Physical Therapy located in Brooklyn, New York. For the period from April 1, 2010 through September 30, 2013, Medicaid paid Mr. Amir \$305,215 for 9,471 claims. Generally, Medicare pays 80 percent of the Medicare-approved fees for outpatient therapy services, and beneficiaries are responsible for the coinsurance (or remaining 20 percent of the approved fee). Medicare limits how much it pays for medically necessary outpatient therapy services in one calendar year. For 2013, the limit was \$1,900 for outpatient physical therapy and outpatient speech-language pathology services combined.

Audit Findings and Recommendations

For the period April 1, 2010 through September 30, 2013, Medicaid overpaid Mark Amir \$146,225 for 3,837 claims he submitted to the Medicaid program with incorrect Medicare payment information. In addition, Mark Amir did not fully comply with certain Department regulations and administrative procedures for Medicaid program participation. As such, the propriety of the remaining Medicaid payments (totaling \$158,990) made to Mr. Amir during our audit period is questionable.

Claims With Incorrect Medicare Payment Data

For the period April 1, 2010 through September 30, 2013, Medicaid reimbursed Mark Amir \$214,617 for 8,168 crossover claims for Medicare coinsurance. To determine if Mark Amir's claims were proper, we selected a judgmental sample of 124 claims and compared them to the related medical records and the actual Medicare payment information, per Medicare payment remittances. For each claim, Mr. Amir reported incorrect Medicare payment information to Medicaid. In nine instances, Mr. Amir never billed Medicare. Moreover, Medicare denied 87 of the remaining 115 services included in our sample because either the beneficiaries exceeded their physical therapy service limits or Mr. Amir did not provide Medicare with sufficient and proper claim documentation. For example, Mr. Amir billed Medicaid \$452 for coinsurance for five separate procedures performed during a single visit, although Medicare payment information showed that Medicare disapproved all of the procedures and denied the related claims. Nevertheless, for each claim, Mr. Amir reported incorrect Medicare payment data to Medicaid, causing overpayments of those claims.

For the other claims we sampled, Medicare approved payment. However, Mark Amir reported incorrect Medicare coinsurance amounts to Medicaid, which caused overpayments. The following table illustrates one of these improper claims:

Procedure Code	Medicare Approved	Medicare Paid	Medicare Coinsurance	Medicare Coinsurance Reported by Mr. Amir	Medicaid Overpayment
97110	\$65.79	\$52.63	\$13.16	\$164.00	\$150.84
97140	29.04	23.23	5.81	82.00	76.19
G0283	13.52	10.82	2.70	62.00	59.30
Totals	\$108.35	\$86.68	\$21.67	\$308.00	\$286.33

In this case, Mark Amir billed Medicare for three procedures performed on a dual-eligible recipient during a single visit in 2012. Medicare approved the services for \$108.35, paid Mr. Amir \$86.68, and charged the beneficiary \$21.67 for coinsurance. However, Mr. Amir reported Medicare coinsurance charges of \$308, resulting in a Medicaid overpayment of \$286.33.

Given the test results from our original sample, we compared the Medicare data Mark Amir reported on his remaining Medicaid crossover claims to the actual Medicare-approved fees and corresponding coinsurance charges. Including our original sample, we determined that Medicaid overpaid 3,837 crossover claims by \$146,225 because Mr. Amir billed Medicaid incorrect Medicare coinsurance amounts.

The Health Insurance Portability and Accountability Act of 1996 mandated the use of NPIs by May 2008 for all health care providers participating in Medicare and Medicaid. Prior to the implementation of the automated crossover system (in December 2009), the Department informed all Medicaid providers that their NPIs (including those applied to Medicare crossover claims) must be registered with New York's Medicaid program. Moreover, if a provider's NPI was not registered with Medicaid, eMedNY would reject crossover claims from that provider.

Mark Amir had separate NPIs as an individual practitioner and for his group practice, Madison Physical Therapy. He billed Medicare using the NPI for Madison Physical Therapy. However, although Mr. Amir registered his NPI as an individual practitioner with Medicaid, he did not register Madison Physical Therapy's NPI. Consequently, he avoided the crossover system's automated controls because Medicare could not cross over claims from Madison Physical Therapy to Medicaid. To ensure his claims were paid, Mr. Amir billed Medicaid directly using his individual NPI, and overstated the amounts owed by Medicaid for those claims.

Recommendation

1. Recover Medicaid overpayments totaling \$146,225 for the 3,837 improper claims.

Claims With the Incorrect National Provider Identifier Code

All medical care providers must be enrolled in the Medicaid program to submit claims and receive payments for the services they render. Providers can enroll as individual providers or as group practices. Also, group practices must register their physicians and clinicians, who provide billable services, with Medicaid. When submitting Medicaid claims, group practices must identify the physician or clinician who actually rendered the services. Further, individual providers are prohibited from billing Medicaid for services rendered by other physicians or clinicians.

We concluded that Mark Amir did not perform the services he billed to Medicaid as an individual provider. Mr. Amir told us that other physical therapists employed by Madison Physical Therapy performed the services he billed to Medicaid. To confirm this, we examined medical records supporting 33 of Mr. Amir's Medicaid claims and found that other physical therapists performed the services for each claim. Yet Mr. Amir submitted claims for these services to Medicaid as an individual Medicaid provider - attesting that he rendered the services himself. Further, for 26 of the claims tested, the therapist who provided the service was not enrolled with Medicaid.

As previously noted, Mark Amir never enrolled Madison Physical Therapy (and its related NPI) with Medicaid. Consequently, Mr. Amir could not bill Medicaid for services rendered by staff of

Madison Physical Therapy, and he therefore submitted claims for those services using his NPI as an individual provider. Because Medicaid does not allow individual providers to submit claims for services rendered by other providers, we question the propriety of the remaining 5,634 (9,471 - 3,837) claim payments to Mr. Amir totaling \$158,990 (\$305,215 - \$146,225).

Medicaid regulations allow Department officials to impose administrative sanctions (including program restrictions or termination) and recover Medicaid payments to providers who fail to comply with prescribed Medicaid reimbursement policies. Based on our review, we conclude that the Department should review the \$158,990 in payments for services provided by clinicians other than Mark Amir and determine if recoveries and/or sanctions are warranted.

Recommendation

2. Review the remaining 5,634 claim payments totaling \$158,990 and determine if recoveries and/or sanctions are warranted.

Audit Scope and Methodology

The objectives of our audit were to determine whether Mark Amir billed Medicaid in accordance with its policies and guidelines and whether Medicaid made improper payments. Our audit period was from April 1, 2010 through September 30, 2013.

To accomplish our objectives and assess related internal controls, we interviewed officials from the Department and the Office of the Medicaid Inspector General (OMIG). We reviewed applicable sections of federal and State laws and regulations, and examined relevant Medicaid policies and procedures. To identify overpayments, we compared Medicare fee information for Medicare-approved physical therapy services to Mark Amir's Medicaid claims paid by eMedNY. We also interviewed Mr. Amir and reviewed supporting documentation for certain claims. We shared the detailed results of our findings with Department and OMIG officials.

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 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

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 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 informed us that OMIG referred the physical therapist to the New York State Attorney General's Medicaid Fraud Control Unit for further review. Based on the outcome of the referral, OMIG will review and recover overpayments as appropriate.

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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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

February 27, 2014

Mr. Brian Mason, Acting Assistant Comptroller
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-15 entitled, "Improper Payments to a Physical Therapist."

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 J. Nazarko
Jason A. Helgersen
James C. Cox
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Robert Loftus
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**Department Of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2013-S-15 Entitled
Improper Payments to a Physical Therapist**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-15 entitled, "Improper Payments to a Physical Therapist."

Recommendation #1:

Recover Medicaid overpayments totaling \$146,225 for the 3,837 improper claims.

Recommendation 2:

Review the remaining 5,634 claim payments totaling \$158,990 and determine if recoveries and/or sanctions are warranted.

Response #1 and #2:

The Office of the Medicaid Inspector General (OMIG) has referred the physical therapist to the New York State Attorney General Medicaid Fraud Control unit for criminal prosecution.

Depending on the outcome of the review by the New York State Attorney General Medicaid Fraud Control Unit, the OMIG will review and recover overpayments as appropriate.