Department of Health

Medicaid Program – Overpayments for Therapy Services and Prescription Drugs Covered by Medicare

Report 2016-S-73 | October 2019

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine if the Department of Health overpaid health care providers' Medicaid claims for therapy services and prescription drugs that are covered by Medicare. The audit covered the period January 1, 2012 to December 31, 2016 for prescription drugs and January 1, 2012 to December 31, 2017 for therapy services.

About the Program

Many of the State's Medicaid recipients are also enrolled in Medicare. Such individuals are referred to as "dual-eligibles." The Medicare program covers physical, occupational, and speech therapy services, as well as prescription drugs. When these services are rendered to dual-eligible recipients, health care providers are required to bill Medicare, which is generally the primary payer, before billing Medicaid.

Key Findings

The audit identified $20.1 million in Medicaid payments for services provided to dual-eligible recipients that, according to the automated claim information, should have been paid by Medicare, as follows:

- $18.6 million was paid for physical, occupational, and speech therapy services provided by licensed therapists. Payments were made on behalf of 6,712 dual-eligible recipients, and 20 providers accounted for more than $13 million of the payments. Providers we spoke to indicated they were unaware the services were covered by Medicare and, therefore, did not bill Medicare.
- $1.5 million was paid for prescription drugs. While the Medicaid recipients had Medicare coverage for the services, over half of the claims were for individuals who had their Medicare coverage added retroactively, after the claims were paid by Medicaid.

Key Recommendations

- Review the $20.1 million in Medicaid payments for therapy services and prescription drugs and recover overpayments, as warranted. Ensure prompt attention is paid to the providers who received the largest amounts of the payments.
- Formally remind providers of the appropriate use of billing codes that indicate a service is not covered by Medicare, and their obligation to bill Medicare before Medicaid for services rendered to dual-eligible recipients.
- Implement claims processing controls that prevent Medicaid overpayments for therapy services and prescription drugs for dual-eligible recipients.

Office of the New York State Comptroller
Division of State Government Accountability

October 30, 2019

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
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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 *Overpayments for Therapy Services and Prescription Drugs Covered by Medicare*. 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.

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,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
CMS	Centers for Medicare & Medicaid Services	*Agency*
Department	Department of Health	*Auditee*
Dual-eligibles	Individuals enrolled in both Medicaid and Medicare	*Key Term*
eMedNY	Department's Medicaid claims processing system	*System*
HMS	Health Management Systems, Inc.	*Key Term*
NGS	National Government Services	*Key Term*
NPI	National Provider Identifier	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*
OPWDD	Office for People With Developmental Disabilities	*Agency*

Background

The New York State Medicaid program is a federal, State, and locally funded program that provides a wide range of medical services to individuals who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.5 percent.

The State's Medicaid program is administered by the Department of Health (Department). Medicaid claims from health care providers 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 and the amounts claimed for reimbursement are appropriate. Some of these edits verify whether Medicaid recipients have additional third-party health insurance that should be billed before Medicaid.

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. The Centers for Medicare & Medicaid Services (CMS) administer the Medicare program. Medicare is composed of multiple parts: in general, Part A provides coverage for inpatient hospital services and skilled nursing facility care; Part B provides coverage for a range of outpatient medical services (including therapy services), physicians' fees, and medical supplies; Medicare Part C is Medicare Advantage (i.e., Medicare managed care); and Part D provides prescription drug coverage.

Individuals enrolled in both Medicaid and Medicare are commonly referred to as "dual-eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligible recipients. Accordingly, after Medicare adjudicates a claim, it is transferred to the Department's eMedNY system via the automated Medicare crossover system. Medicaid then pays the balance that is not covered by Medicare (typically a coinsurance or deductible) that would otherwise be the financial obligation of the recipient.

Claims for services that are not covered by Medicare can also be submitted to Medicaid for payment. Typically, when Medicare denies a claim, Medicaid will pay the standard Medicaid fee. CMS instructs providers to use a modifier code of "GY" when billing for a service that is not covered by Medicare. By submitting a claim to Medicare with this modifier code, the provider is determining, in advance, that the procedure is not covered.

The Medicaid and Medicare programs have various policies pertaining to therapy services. For instance, certain physical, occupational, and speech therapy service providers, such as clinics certified by the Office for People With Developmental Disabilities (OPWDD), are required to report the National Provider Identifier (NPI) of the clinician who rendered services as the attending provider on their Medicaid claims. This includes licensed, registered, or certified "dependent" clinicians who work under supervision, such as physical therapy assistants and occupational therapy assistants.

Additionally, the Medicare program covers physical, occupational, and speech therapy services provided by therapists, nurse practitioners, clinical nurse specialists, and physician assistants. However, maintenance therapy services (physical, occupational, and speech therapy services provided to maintain the patient's condition or to prevent or slow further deterioration) are payable by Medicare when rendered by a licensed therapist; Medicare does not cover maintenance therapy services provided by therapy assistants. In such cases involving dual-eligibles, Medicaid would be the primary payer.

Also, during the audit period, Medicare law limited payments for therapy services on behalf of individual recipients by calendar year. Medicare had two limits: one for physical therapy and speech-language pathology services combined, and a second limit for occupational therapy services. During the audit period, the payment limits increased annually from $1,880 per person in 2012 to $1,980 per person in 2017. Once Medicare pays these annual amounts for dual-eligibles, Medicaid is then generally the primary payer for these services.

Currently, the Office of the Medicaid Inspector General (OMIG) contracts with Health Management Systems, Inc. (HMS) to perform, among other duties, third-party liability match and recovery services. Under this contract, HMS identifies, verifies, and recovers Medicaid overpayments from liable third-party payers, including Medicare.

Audit Findings and Recommendations

Based on a review of paid Medicaid claims for the audit period, we found the State's Medicaid program made payments of about $20.1 million for services that, according to the claims data, were Medicare-covered services that should have been paid by Medicare. The payments included $18.6 million for physical, occupational, and speech therapy services and $1.5 million for prescription drugs. Based on our tests of supporting claim documentation, we found providers – mainly clinics – were generally unaware that Medicare covers therapy services, particularly maintenance therapy provided by licensed therapists. As a result, the providers often did not bill Medicare for the services or incorrectly reported the "GY" modifier, which caused Medicare to automatically deny the claims. Also, most of the prescription drug claims were paid for recipients whose Medicare Part D coverage was retroactively updated; therefore, the recipients' Medicare coverage information was not available to providers on the service dates.

We recommend the Department review the findings identified in this report and recover overpayments, as appropriate. The Department should also remind providers to follow all established billing procedures, including the requirement to bill Medicare before Medicaid for services on behalf of dual-eligible recipients and the appropriate use of the "GY" modifier. Payment controls should also be implemented to prevent the Medicaid overpayments we identified.

Medicaid Payments for Therapy Services

For the period from January 1, 2012 through December 31, 2017, we analyzed 1.1 million claims (totaling $95.9 million) that indicated Medicare-covered therapy services were provided. Of this amount, we found that Medicaid:

- Paid for services for 6,142 dual-eligible recipients where Medicare did not pay up to the required yearly Medicare payment limit; and
- Paid for services for another 570 dual-eligible recipients where Medicare did not make any payments toward the required yearly Medicare payment limit.

Medicaid made $43.3 million in payments for therapy services on behalf of these 6,712 recipients (6,142 + 570). By calculating the difference between the required annual Medicare payment limit and what Medicare paid for these services on a per-recipient basis, we identified Medicaid payments of $18.6 million that, based on the claims data, should have been covered by Medicare. We further determined 20 providers accounted for more than $13 million of these payments.

To test the claims and identify causes of improper payments, we judgmentally selected a sample of 54 claims, totaling $5,371, from six of the highest-paid providers. Our review confirmed $3,584 in overpayments to five providers for 40 (74 percent) improperly billed claims. Our sample results are summarized in the following table.

Overpayments Among 54 Sampled Claims From Six Providers

	Number of Sampled Claims	Provider Did Not Bill Medicare*	Provider Incorrectly Reported "GY" Modifier*	Physical Therapy Assistant**	Overpayment
Provider 1***	7		7		$727
Provider 2***	10	5	1	4	413
Provider 3***	10		10		648
Provider 4	10			10	
Provider 5***	7		7		526
Provider 6***	10	10			1,270
Totals	**54**	**15**	**25**	**14**	**$3,584**

* Claims resulted in Medicaid overpayments.

** Providers incorrectly reported a licensed therapist instead of a physical therapy assistant as the attending provider on the claims we reviewed.

*** One of the 20 providers that accounted for more than $13 million of the $18.6 million identified.

We determined four providers (#1, #2, #3, and #5) incorrectly billed 30 claims, totaling $2,314 in overpayments, to Medicaid for maintenance therapy services provided by a licensed therapist, which are payable by Medicare. Supporting documentation for these claims showed Medicare denied 25 (of the 30) claims because the provider reported a "GY" modifier. Providers stated they used the "GY" modifier because they did not think Medicare covered the services. CMS instructs providers to use the "GY" modifier to indicate the service is statutorily non-covered or is not a Medicare benefit. According to officials from National Government Services (or NGS, which is CMS' contractor for the processing of New York State Medicare Part A and Part B fee-for-service claims), providers should not use the "GY" modifier with procedure codes that are in the Medicare fee schedule – as was the case with the procedure codes in our sample – because the Medicare billing system will automatically deny any services, even if they should be paid. Instead, claims with covered codes should be billed to Medicare to assess the medical necessity of the services. The Department should remind providers of the proper use of this modifier code to prevent future Medicaid overpayments. The remaining 5 (of the 30) claims were not billed to Medicare prior to Medicaid by one of the providers (#2), as required by regulation.

Two clinic providers (#2 and #4) incorrectly reported that a licensed therapist – instead of a therapy assistant – rendered maintenance therapy services on 14 sampled claims totaling $1,787. In the December 2013 Medicaid Update, the Department issued guidance reminding clinics that they should bill for therapy services using the NPI of the clinician who rendered services. The NPI on the claims in our sample indicated that a licensed therapist provided the maintenance services, even though supporting documentation showed it was a therapy assistant. Because Medicare does not pay for maintenance therapy services provided by a therapy assistant, these claims would not have been included in our review had the providers reported the correct NPI and, consequently, we are not reporting them as overpayments.

We also found one provider (#6) did not bill Medicare for any of the ten speech therapy services, totaling $1,270, included in our sample. All ten claims were for speech therapy services provided by a licensed therapist, which are payable by Medicare. The provider cited a lack of proper supporting documentation as the reason for not billing Medicare and informed auditors that it will reevaluate its documentation practices to become Medicare compliant and will bill Medicare prior to Medicaid on future claims.

Medicaid Payments for Prescription Drugs

We identified overpayments of about $1.5 million for prescription drugs covered by Medicare for recipients who also had Medicare Part D coverage. Approximately 51 percent of these claims, totaling $823,522, were paid for recipients whose Medicare coverage was retroactively updated (when an individual signs up for Medicare, coverage can be retroactively applied, in which case the actual Medicare coverage start date is earlier than the actual enrollment date). As a result, the recipients' coverage information was not available to providers (was not in eMedNY) on the service dates and, as such, Medicare was not billed for the services. Approximately 13 percent of the claims, totaling $147,894, were paid for recipients whose Medicare Part D coverage was known at the time the claims were billed to Medicaid. Lastly, we were unable to determine if the recipients' Medicare coverage was known at the time that 36 percent of the claims, totaling $481,911, were billed to Medicaid. Department officials reviewed a sample of this population and determined the recipients' Medicare Part D coverages were retroactively updated after the Medicaid claims were paid.

Recommendations

1. Using a risk-based approach, assess the $20.1 million in claims paid to providers for Medicare-covered services to dual-eligibles and recover

overpayments, as appropriate. Ensure prompt attention is paid to those providers who received the largest dollar amounts of payments, and recover the $3,584 in overpayments we identified from our sample of therapy services.

2. Formally remind providers to comply with all Medicaid and Medicare billing rules, including:

   - Recording the NPI of the clinician who rendered services as the attending provider on Medicaid claims;
   - Properly using the “GY” modifier code; and
   - Billing Medicare prior to Medicaid for services on behalf of dual-eligibles.

3. Develop and implement controls to identify and prevent Medicaid overpayments on behalf of dual-eligibles for the types of therapy services and prescription drug claims included in the audit.

Audit Scope, Objective, and Methodology

The objective of the audit was to determine if the Department overpaid health care providers' Medicaid claims for therapy services and prescription drugs that are covered by Medicare. Our audit focused on fee-for-service claims for pharmacy and physical, occupational, and speech therapy services billed from January 1, 2012 through December 31, 2016. During the audit fieldwork, we extended the period for therapy services to include claims through December 31, 2017.

To accomplish our audit objective and assess relevant internal controls, we interviewed officials from the Department, OPWDD, and OMIG; examined the Department's relevant Medicaid policies and procedures; and reviewed applicable federal and State laws, rules, and regulations. We used the Medicaid Data Warehouse and the eMedNY claims processing system to identify fee-for-service claims for therapy and pharmacy services covered by Medicare. To identify services covered by Medicare, we reviewed claims for services paid through the automated Medicaid/Medicare crossover system; researched the CMS website; and contacted NGS officials. We selected judgmental samples based on the most recent service dates and use of the "GY" modifier, from the highest-paid providers in our findings. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole.

We reviewed claims for dual-eligible recipients, but removed claims on behalf of recipients who also had other third-party insurance coverage on the service dates. We also obtained, and removed from our review, a list of claims that HMS identified for recovery for calendar years 2012 through 2016. Our review focused on therapy service and pharmacy claims, which totaled approximately $96 million and $38 million, respectively, during the audit scope. We removed all claims for therapy services when the claims indicated the services were provided by therapy assistants.

In calculating the audit findings related to therapy services, we determined, per recipient, the total amounts paid by Medicaid and Medicare annually by calendar year, as follows. When the annual Medicare payment limit was not met for a given member, we considered the improper payment as the lesser of the difference between the annual Medicare limit and Medicare payments, or the amount Medicaid paid. When Medicare made no payments for a given member, we considered the finding to be the lesser of the Medicaid paid amount or the Medicare annual limit.

Statutory Requirements

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.

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.

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 the report. In their response, Department officials concurred with most of the audit recommendations and indicated that certain actions would be taken to address them. Our response to Department comments pertaining to our recommendation for the need for additional payment controls is included in the report's State Comptroller's Comment.

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.

Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

September 27, 2019

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th 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 2016-S-73 entitled, "Medicaid Program – Overpayments for Therapy Services and Prescription Drugs Covered by Medicare."

Thank you for the opportunity to comment.

Sincerely,

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

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Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2016-S-73 entitled, "Medicaid Program – Overpayments for Therapy Services and Prescription Drugs Covered by Medicare"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-73 entitled, "Medicaid Program – Overpayments for Therapy Services and Prescription Drugs Covered by Medicare."

Recommendation #1:

Using a risk-based approach, assess the $20.1 million in claims paid to providers for Medicare-covered services to dual-eligibles and recover overpayments, as appropriate. Ensure prompt attention is paid to those providers who received the largest dollar amounts of payments, and recover the $3,584 in overpayments we identified from our sample of therapy services.

Response #1:

The Office of the Medicaid Inspector General's (OMIG's) contractor will review the identified overpayments and determine an appropriate course of action.

Recommendation #2:

Formally remind providers to comply with all Medicaid and Medicare billing rules, including:

- Recording the NPI of the clinician who rendered services as the attending provider on Medicaid claims;
- Properly using the "GY" modifier code; and
- Billing Medicare prior to Medicaid for services on behalf of dual-eligibles.

Response #2:

The Department will issue a Medicaid Update article to remind all providers to comply with all Medicaid and Medicare billing rules, including accurately reporting the NPI of the clinician who rendered services as the attending provider on Medicaid claims, to accurately use the "GY" modifier code, and when Medicare is present the provider must bill Medicare prior to Medicaid for services on behalf of dual-eligible.

Recommendation #3:

Develop and implement controls to identify and prevent Medicaid overpayments on behalf of dual-eligibles for the types of therapy services and prescription drug claims included in this audit.

Response #3:

The Department asserts that controls are already in place to prevent Medicaid overpayments on behalf of dual-eligibles for the types of therapy services and prescription drug claims included in this audit. The majority of overpayments ($1.3 million of the $1.5 million) were due to the inherent lag factor in updating coverage information in the point-of-sale claims processing system.

* Comment 1

State Comptroller's Comment

1. The audit identified $20.1 million in improper payments for therapy services and prescription drug claims, yet the Department's official response is that "controls are already in place" to prevent these types of overpayments. The $1.5 million that the Department references as "the majority of overpayments" relates only to the prescription drug claims included in the audit. Another $18.6 million for therapy services was also identified (over 92 percent of the total $20.1 million). We strongly urge the Department to put controls in place to stop Medicaid overpayments on behalf of dual-eligibles for the types of claims identified by this audit.

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