

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
FOR SERVICES PROVIDED TO
INCARCERATED BENEFICIARIES IN
THE STATE OF MARYLAND**



**JANET
INSPECTOR GENERAL**

**DECEMBER 2002
A-03-02-0004**

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Memorandum

Date DEC 2 2002

From Regional Inspector General For Audit Services

Subject Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Maryland (A-03-02-00004)

To Sonia A. Madison
Regional Administrator
Centers for Medicare & Medicaid Services

At the request of Senator Charles Grassley, Senate Finance Committee, we undertook a review of Medicare payments for services provided to incarcerated beneficiaries. The objective of our review was to determine whether Medicare fee-for-service claims paid in 10 states during the 3-year period of January 1, 1997 through December 31, 1999 were in compliance with Federal regulations and Centers for Medicare & Medicaid Services (CMS) guidelines. The State of Maryland was one of the 10 states selected for review.

Senator Grassley's request was made at the April 25, 2001 Senate Finance Committee hearing held to address improper payments in Federal programs. At this hearing, we released our report entitled, *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries*, wherein we noted that the Medicare program had paid \$32 million in fee-for-service benefits on behalf of 7,438 incarcerated beneficiaries during the 3-year period mentioned above. Generally, no Medicare payments should be made when a beneficiary is in state or local custody under a penal authority since the state or other government component is responsible for their medical and other needs. This is a rebuttable presumption that may be overcome only if certain strict conditions are met. These conditions are that there must be a state or local law requiring all such individuals, or groups of individuals, repay the cost of medical services *and* the incarcerating entity must enforce this requirement by diligently pursuing collection.

In order to determine the extent of improper Medicare payments made on behalf of incarcerated beneficiaries, we reviewed a randomly selected statistical sample of 100 claims from each of 10 states. The states selected represented about 70 percent of the \$32 million mentioned in our April 25, 2001 report and the claims reviewed were for services in the 3-year period covered in that report.

During our reviews in the 10 states, we found that Medicare payments are allowable for some categories of beneficiaries who are in custody under penal statute while unallowable for other categories of beneficiaries in custody under penal statute. This has occurred because regulations and CMS guidelines require that the state or local law requiring repayment of the costs of medical services and the enforcement requirements may apply to categories of individuals, rather than to all individuals. A category of beneficiaries is comprised of beneficiaries with the same legal status (e.g. not guilty by

reason of insanity (NGRI)). Therefore, the allowability of a Medicare payment depends on a beneficiary's specific category of legal status even though he or she is in custody under a penal statute. During our review we found this was an important distinction.

The State of Maryland pays the health care costs for prisoners who are under the custody of the Department of Public Safety and Corrections jurisdiction (i.e. state prisoners). However, Maryland law requires that patients admitted to any state hospital pay their own expenses for medical and psychiatric care and treatment. Payments for 35 of the 100 claims sampled in Maryland were made on behalf of 14 beneficiaries placed in state-operated psychiatric hospitals after they were found to be NGRI. We determined these payments were proper.

An additional 35 claims were proper because the beneficiaries were not in custody at the time services were rendered. Twenty-seven of these claims were for five beneficiaries who had been found to be NGRI but were conditionally released to half-way homes on the dates of service. An additional eight claims were for five beneficiaries who were not in custody at the times of services. Medicare payments for these beneficiaries were proper.

We identified two claims totaling \$2,328 that we considered to be unallowable according to Medicare reimbursement requirements. The claims were submitted on behalf of beneficiaries who were inmates in local detention centers at the time of service. We have determined these claims to be unallowable because, in the absence of third party coverage, neither the county detention centers nor their health care contractors make any attempt to collect health care costs from inmates.

We could not determine the allowability for 28 claims for 13 beneficiaries. We were unable to determine the exact whereabouts of 12 beneficiaries (27 claims), at the time the services were rendered. Therefore, we could not determine Medicare allowability. Passage of time, aliases, and the sometimes use of different Social Security Numbers contributed and made the process of determining the custody status of the beneficiary at the time of service a cumbersome and difficult task. Also, there was no centralized statewide database of incarcerations in the 24 county correctional facilities, and our search was confined to the county correctional facilities where the providers were located. We were unable to test the due diligence requirement for the remaining claim because the health care contractor for Baltimore County, where the beneficiary was incarcerated at the time of service, has been purchased by another company and records were not available.

As a result of our April 25, 2001 report, CMS plans to establish an edit in its Common Working File (CWF) that will deny claims for incarcerated beneficiaries. Claims meeting the conditions for payment will not be subject to this edit if the supplier or provider submitting the claim certifies, by using a modifier or a condition code on the claim, that he or she has been instructed by the state or local government component that the conditions for Medicare payment have been met. We believe when fully implemented this enhancement will prevent many improper payments for claims of

incarcerated beneficiaries. However, we believe CMS and its contractors will need to educate suppliers and providers on the proper use of the modifier or condition code. Also, claims with the modifier or condition code must be monitored to assure that the conditions for Medicare reimbursement are met.

In a written response to a draft of this report, CMS officials reported that CMS has taken steps to address the concerns raised in the draft report. The CMS reported that it was in the process of instructing its contractors to educate suppliers on the use of code modifiers to identify incarcerated beneficiaries. In addition, CMS stated that Change Request 2022 requires contractors to advise suppliers and providers of the involved policy and procedures on an annual basis.

The CMS indicated that its contractors are required to use a variety of techniques to monitor claims to identify potentially non-covered services, including services to incarcerated beneficiaries. The Medicare Program Integrity Manual (PIM) sets forth a number of techniques to monitor and identify aberrant billing situations. For example, Chapter 2.1 of the PIM requires contractors to use data analysis to “Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk.” The CMS believes that these techniques and procedures provide adequate safeguards to minimize the risk of inappropriately paying for services to incarcerated beneficiaries. We have summarized the CMS’ response along with our comments after the conclusions and recommendations section of the report. The full text of CMS’ response is included as an APPENDIX to this report.

INTRODUCTION

BACKGROUND

Under current federal law and regulations, payments for Medicare payments made on behalf of beneficiaries in the custody of law enforcement agencies are generally unallowable except when certain requirements are met.

Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services or if the services are paid directly or indirectly by a government entity. Furthermore, regulations at 42 CFR 411.4 states that:

- (a) General rule. Except as provided in 411.8(b)(for services paid by a governmental entity), Medicare does not pay for service if: (1) The beneficiary has no legal obligation to pay for the service; and (2) No other person or organization (such as a prepayment plan of which the beneficiary is a member) has a legal obligation to provide or pay for that service.*

- (b) Special conditions for services furnished to individuals in custody of penal authorities. Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in*

the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.*
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.*

Under these criteria, Medicare payments on behalf of prisoners in custody of federal authorities are not allowable since these prisoners by definition are not subject to state or local laws regarding the terms of their care. For prisoners in custody of state or local government entities, the component operating the prison is presumed to be responsible for the medical needs of its prisoners. This is a rebuttable presumption that must be affirmatively overcome by the initiative of the state or local government entity. There must be a law requiring all individuals or groups of individuals in their custody to repay the cost of medical service. In addition, the entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals or groups of individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. Guidelines in CMS contractor manuals state the government entity must enforce the requirement to pay and seek collection from all individuals in custody with the same legal status (e.g., NGRI).

Section 202(x)(1)(A) of the Social Security Act requires the Social Security Administration (SSA) to suspend Old Age and Survivors and Disability Insurance (i.e., Social Security benefits) to persons who are incarcerated. To implement this requirement, SSA, with the assistance of the Federal Bureau of Prisons (FBOP) and various state and local entities, developed and maintains a database of incarcerated individuals.

The Office of Inspector General matched a file of incarcerated Medicare beneficiaries provided by SSA to CMS's National Claims History file for claims paid between January 1, 1997 and December 31, 1999. Based on the matching, we compiled a database of claims paid on behalf of beneficiaries whose SSA payments had been suspended due to incarceration on the dates of service. We created a listing for Maryland that included 1,500 claims totaling \$604,649. Using the Maryland listing, we selected a random statistical sample of 100 fee-for-services claims totaling \$60,281 paid between January 1, 1997 through December 31, 1999.

OBJECTIVE, SCOPE AND METHODOLOGY

Our objective was to determine whether Medicare payments for services provided to beneficiaries reported to be incarcerated during the period January 1, 1997 through

December 31, 1999 were in compliance with regulations and CMS guidelines. To achieve our objective, we:

- Reviewed applicable Federal laws and regulations, Medicare reimbursement policies and procedures and pertinent provisions of the Social Security Act pertaining to incarcerated beneficiaries.
- Met with CMS officials in Region III to discuss Medicare criteria involving incarcerated beneficiaries and to ascertain if any supplier or provider had contacted them to inquire about Medicare guidelines for health care services furnished to incarcerated beneficiaries.
- Reviewed applicable Maryland laws and regulations pertaining to health care cost liabilities for incarcerated beneficiaries and other individuals in the penal system.
- Conducted inquiries and researched local laws to determine if counties, where the individuals in our sample were incarcerated, have laws requiring inmates to pay for the cost of their health care.
- Met with various state officials including individuals from the Maryland Department of Public Safety and Corrections, and Department of Health and Mental Hygiene (DHMH).
- Reviewed a sample of Medicare and non-Medicare claims to determine if collection procedures were reasonable and applied uniformly for all claims.
- Held discussions with officials of the Medicare fiscal intermediary and carrier in Maryland to ascertain if they have controls in place to detect claims submitted on behalf of incarcerated beneficiaries.
- Checked the FBOP database to determine if any beneficiaries, whose incarceration status on the date of service could not be determined, were confined in a Federal prison.

We conducted our review in accordance with generally accepted government auditing standards. Our review was limited in scope. The internal control review was limited to performing inquiries at the contractor level to determine if they have controls in place to detect claims submitted on behalf of incarcerated beneficiaries. Our review was not intended to be a full scale internal control assessment of the suppliers/providers and was more limited than that which would be necessary to express an opinion on the adequacy of the suppliers' or providers' operations taken as a whole. The objectives of our audit did not require an understanding or assessment of the overall internal control structure of the suppliers and providers. We performed our review during the period October 2001 through May 2002.

FINDINGS AND RECOMMENDATIONS

Since prisoner data from SSA was not contained in CMS’s records, the Medicare fiscal intermediary and carrier in Maryland did not have controls in place to detect claims submitted on behalf of incarcerated beneficiaries.

We found 70 percent of the sampled claims in Maryland were appropriate. Thirty-five of the 100 sample claims were for beneficiaries who were found to be NGRI and were in state-operated psychiatric hospitals. Another 35 claims were for beneficiaries who were not in custody at the time the services were rendered. These 70 claims totaled \$53,820.

We identified two claims totaling \$2,328 that we considered to be unallowable according to Medicare reimbursement requirements. The claims were submitted on behalf of beneficiaries who were inmates in local detention centers at the time of service. We have determined these claims to be unallowable because in the absence of third party coverage, neither the county detention centers nor their health care contractors make any attempt to collect health care costs from inmates.

We could not determine the allowability of 28 claims totaling \$4,133. We were unable to determine the whereabouts, at the time the services were rendered, of 12 beneficiaries who had 27 claims in our sample totaling \$4,057. We could not test the due diligence requirement for one claim totaling \$76 because the health care contractor for Baltimore County, where the beneficiary was incarcerated at the time of service, has been purchased by another company and records were not available. The following table summarized the results of our review:

<i>Description</i>	<i>Sample Amount</i>	<i>Number of Claims</i>	<i>Number of Beneficiaries</i>
<i>Allowable</i>	\$53,820	70	24
<i>Unallowable</i>	2,328	2	2
<i>Unable to determine</i>	4,133	28	13
Total	\$60,281	100	39*

*The actual number of unique beneficiaries in our sample is 33. Some beneficiaries were included in more than one category.

Allowable

Our review showed that Medicare payments for 70 claims totaling \$53,820 met Medicare reimbursement requirements. Of the 70 claims, 35 claims for 14 beneficiaries were made on behalf of the beneficiaries placed in state-operated psychiatric hospitals at the time of service because they were found to be NGRI.

Maryland law requires that patients admitted to any state hospital pay their own expenses for their medical and psychiatric care and treatment. Title 16-102 of Maryland Health Care Code states that:

(a) Policy. - It is the policy of this State to obligate each recipient of services and, to the extent provided in this title, those legally responsible for the recipient to pay, if financially able, for the cost of care that is received by the recipient of services. Unless otherwise provided by statute, the recipient of services and chargeable person shall be responsible for payment regardless of whether the recipient of services was admitted voluntarily, involuntarily, or by court order. If the recipient of services is involuntarily admitted to a public facility and released after evaluation, for failure to meet the standards for involuntary commitment, the recipient of services or chargeable person shall not be responsible for the cost of care.

(b) Priorities for responsibilities; uncollected costs. - The total cost of care of each recipient of services is, in the first instance, the responsibility of the recipient of services and, as provided in this title, the chargeable person. Any uncollectible costs for services provided to the recipient shall become the responsibility of this State.

Our review of collection procedures of Medicare and non-Medicare claims showed that collection procedures were adequate and applied uniformly for all claims. We believed that payments made on the beneficiaries' behalf were allowable and consistent with Medicare reimbursement requirements because NGRI patients were liable for their health care costs under the Maryland Code and uniform collection procedures were enforced.

An additional 35 claims were proper because the beneficiaries were not in custody under penal statute at the time services were rendered. Payments for 27 claims for 5 beneficiaries were for beneficiaries who were found to be NGRI but had been released on probation to halfway homes on the dates of service, and were therefore, not in custody. According to a state DHMH official, the department is not financially responsible for conditionally released beneficiaries after they are released from the state psychiatric hospitals. For the remaining eight claims (five beneficiaries), evidence suggested they were not in custody at the times of service. We checked the state and local correctional facility databases where providers were located to determine if these beneficiaries were in custody on these dates of service. Our review showed that there is no evidence indicating that these beneficiaries were in custody on the dates of service. For example, we found cases indicating that the beneficiaries were residing at home when services were provided. We will share our findings with SSA for the beneficiaries who we believe were not incarcerated on the dates of service.

Unallowable

We identified two claims totaling \$2,328 that we considered to be unallowable according to Medicare reimbursement requirements. The claims were submitted on behalf of beneficiaries who were inmates in local county correctional facilities at the time of services. We have determined these claims to be unallowable because in the absence of third party coverage, neither the county detention centers nor their health care contractors make any attempt to collect health care costs from inmates.

Title 42 CFR Part 411.4(b) states that the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities unless there is a law requiring that all individuals repay the cost of medical services while in custody; and enforce that requirement by pursuing collection for repayment. Unless the state or other government component operating the prison established that these requirements are met, it is presumed to be responsible for the medical needs of its inmates.

Maryland has a law that states inmates in local correctional facilities are liable for their health care costs. Title 11, Section 203, of the Maryland Correctional Services Code states in part that:

- (b) *Reimbursement for medical care: An inmate in a local correctional facility, who is sick, injured, or disabled shall:*
 - (1) *Reimburse the county, as appropriate, for the payment of medical expenses; and*
 - (2) *Provide the managing official with any information relating to: (i) the existence of any health insurance, group health plan, or prepaid medical care coverage under which the inmate is insured or covered; (ii) the inmate's eligibility for benefits under the Maryland Medical Assistance Program; (iii) the name and address of any third party payor; and (iv) any policy or other identifying number relating to items (i) through (iii) of this item.*

Although the Medicare requirements regarding state or local law for health care cost liabilities for inmates were met, we believed that the due diligence requirement was not met because neither the counties nor their health care contractors make any effort to collect unless an inmate has third party insurance coverage. In our opinion, the counties or their health care contractors are responsible for these claims.

Unable to Determine

We could not determine the allowability of 28 claims (13 beneficiaries) totaling \$4,133. We were unable to determine the whereabouts, at the time the services were rendered, of 12 beneficiaries who had 27 claims in our sample totaling \$4,057. We checked the FBOP, state and local correctional facility databases. The state maintained a database that contained incarceration records for state operated correctional facilities but not local correctional facilities. We contacted county correctional facilities where providers were located to determine if these beneficiaries were in custody on these dates of service. We also checked the state DHMH database to determine if these beneficiaries were in state psychiatric hospitals on the dates of service.

- ✓ We found limited information on nine beneficiaries, including one Federal prisoner. The information was inconclusive to determine the whereabouts of the beneficiaries on the dates of services in our sample.

- ✓ For the remaining three beneficiaries, we could find no record of any encounters with correction facilities. Two of the three beneficiaries resided in Maryland mental hospitals, and the third beneficiary resided in a Washington, D.C. psychiatric hospital. The hospitalization dates were outside of the dates selected in our sample.

Since we were unable to determine if the beneficiaries were in custody at the time the services were rendered, we were unable to determine the allowability of the Medicare claims. Passage of time, lack of centralized statewide database of incarceration, aliases, and the sometimes use of different Social Security Numbers contributed and made the process of determining the custody status of the beneficiary at the time of service a cumbersome and difficult task.

Also, we were unable to determine the allowability for the remaining claim totaling \$76 submitted on behalf of a beneficiary who was incarcerated in Baltimore County Detention Center on the date of service. We could not test the due diligence requirement for this claim because the health care contractor for Baltimore County, at the time the service was rendered, has been purchased by another company and records were not available.

CONCLUSIONS AND RECOMMENDATIONS

Our review in Maryland determined that 2 claims out of our sample of 100 claims did not meet Medicare reimbursement requirements. We did not examine the remaining 1,400 claims in the universe. If CMS decides to consider readjudication of these remaining claims, we believe a cost benefit analysis should be done taking into consideration the low error rate, the age of the claims, and the difficulties we encountered in determining the whereabouts of beneficiaries due to the age of the claims.

We found during our audit period that Medicare payments on behalf of NGRI beneficiaries in state-operated psychiatric hospitals in Maryland were allowable because of provisions in Maryland law that requires these individuals to pay for their medical care and the hospitals implement this provision with due diligence. However, we believe that CMS through its regional offices needs to monitor these claims in the future to ensure these conditions for payment continue to be met.

As a result of our April 25, 2001 report, we have been informed that CMS plans to establish an edit in CWF that will deny claims for incarcerated beneficiaries. Claims meeting the conditions for payment will not be subject to this edit if the supplier or provider submitting the claim certifies, by using a modifier or condition code on the claim, that he or she has been instructed by the state or local government component that the conditions for Medicare payment have been met. The modifier or condition code will be pivotal in paying or denying claims for incarcerated beneficiaries.

We, therefore, recommend that the CMS regional office:

- Require its contractors to monitor future claims made on behalf of NGRI beneficiaries to ensure the conditions for payment continue to be met.
- Make a concerted effort through its contractors to educate suppliers and providers on the meaning of the modifier or condition code and circumstance relating to its proper use.
- Require its contractors to monitor claims with the modifier or condition code after implementation to assure the conditions required in 42 CFR 411.4 (b) are met.

CMS' Response

By memorandum dated November 12, 2002, CMS officials responded to a draft of this report. The CMS reported that it was in the process of instructing its contractors to educate suppliers on the use of code modifiers to identify incarcerated beneficiaries. In addition, CMS stated that Change Request 2022 requires contractors to advise suppliers and providers of the involved policy and procedures on an annual basis.

The CMS indicated that its contractors are required to use a variety of techniques to monitor claims to identify potentially non-covered services, including services to incarcerated beneficiaries. The PIM sets forth a number of techniques to monitor and identify aberrant billing situations. For example, Chapter 2.1 of the PIM requires contractors to use data analysis to "Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk." The CMS believes that these techniques and procedures provide adequate safeguards to minimize the risk of inappropriately paying for services to incarcerated beneficiaries.

OIG Comment

In our opinion, the corrective actions proposed by CMS will, if implemented, address our concerns.



Stephen Virbitsky

APPENDIX



Memorandum

Centers for Medicare & Medicaid Services
Region III
Suite 216, The Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Date: NOV 12 2002

To: Regional Inspector General of Audit Services

From: Regional Administrator
Philadelphia Regional Office

Subject: Review of Medicare Payments for Services to Incarcerated Beneficiaries in the State of Maryland (CIN: a-03-02-00004)

Thank you for the opportunity to comment on the Report. As you noted, CMS has taken steps to address the concerns raised in the subject report. We are currently in the process of issuing instructions to our contractors to educate suppliers on the use of code modifiers to identify incarcerated beneficiaries. Change Request 2022 requires the contractors to, among other things, advise suppliers and providers of the involved policy and procedures on an annual basis.

Contractors are required to use a variety of techniques to monitor claims to identify potentially noncovered services, including services to incarcerated beneficiaries. The Medicare Program Integrity Manual (PIM) sets forth a number of techniques to monitor and identify aberrant billing situations, such as billing for incarcerated beneficiaries. For example, Chapter 2.1 of the PIM requires contractors to use data analysis to "Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk." We believe these techniques and procedures provide adequate safeguards to minimize the risk of inappropriately paying for services to incarcerated beneficiaries.



Sonia A. Madison