



DEPARTMENT OF HEALTH & HUMAN SERVICES

OCT 30 2002

Office of Inspector General
Office of Audit Services

TO: Rose Crum-Johnson
Regional Administrator
Centers for Medicare & Medicaid Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

FROM: Charles J. Curtis *C. Curtis*
Regional Inspector General
for Audit Services, Region IV

SUBJECT: Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Florida (CIN: A-04-02-05012)

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries* in the State of Florida. At the request of Senator Grassley, Senate Finance Committee, we undertook a nationwide 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 for services provided to incarcerated beneficiaries during the 3-year period of January 1, 1997 through December 31, 1999.

In written comments, the Centers for Medicare & Medicaid Services (CMS) generally concurred with our recommendations and agreed to take corrective actions. The CMS comments are included as an appendix to our report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or your staff may call Mary Ann Moreno, Audit Manager, at (305) 536-5309, extension 24 or e-mail at mmoreno@oig.hhs.gov.

To facilitate identification, please refer to report number A-04-02-05012 in all correspondence relating to this report.

Attachment – as stated

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



JANET REHNQUIST
Inspector General

OCTOBER 2002
A-04-02-05012

Notices

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHSIOIGIOAS. Authorized officials of the HHS divisions will make final determination on these matters.





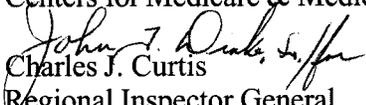
DEPARTMENT OF HEALTH & HUMAN SERVICES

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TO: Rose Crum-Johnson
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FROM: 
Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

SUBJECT: Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Florida (CIN: A-04-02-05012)

This final report provides you the results of our *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Florida*. This review is part of a nationwide review requested by the Senate Finance Committee.

EXECUTIVE SUMMARY

OBJECTIVE

At the request of Senator Grassley, Senate Finance Committee, we undertook a nationwide 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 for services provided to incarcerated beneficiaries during the 3-year period of January 1, 1997 through December 31, 1999 were in compliance with federal regulations and the Centers for Medicare and Medicaid (CMS) guidelines. The State of Florida was 1 of the 10 states selected for review.

FINDINGS

Payments for 71 of the 100 claims sampled in Florida were allowable. Seventy of the claims were allowable because the beneficiary was not incarcerated at the time of service. One claim was allowable because the facility pursued collection of the debt. These 71 claims totaled \$24,349.

Of the remaining 29 claims, 24 were unallowable. These unallowable claims totaled \$3,714. Nineteen of the unallowable claims were state mental health facilities and county jails. Due diligence was not used in pursuing collection of costs for these health care services, as required by law. The remaining five claims relating to state prisons and federal agencies were unallowable because each has fiscal responsibility for the health care of persons in its custody.

We were unable to determine the locations of five beneficiaries at the time the services were rendered. The five claims totaled \$241. As a result, we could not determine Medicare allowability. Determining the custody status of the beneficiary at the time of service is a cumbersome and difficult task that was complicated by factors including passage of time, transfers between facilities, and use of aliases and multiple social security numbers.

RECOMMENDATIONS

As a result of our prior Office of Inspector General (OIG) 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 therefore recommend that CMS:

- make a concerted effort through its contractors to educate suppliers and providers on the meaning of the modifier or condition code indicating incarceration and circumstances 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 Code of Federal Regulations (CFR) 411.4(b)(2) are met.
- alert its contractors that in instances where Florida county jails and/or mental health facilities are billing Medicare for inmate health care costs, these facilities must pursue collection of health care costs owed for all individuals in custody with the same vigor that they pursue the collection of other debts.

In written response to our draft report, CMS concurred with our recommendations concerning education and monitoring of claims by its contractors. Once their Central Office establishes the CWF edit and modifier, these recommendations can be implemented. The CMS believes that the last recommendation of alerting the contractors of the due diligence clause for jails and mental health facilities will require specific examples for State officials to monitor. The complete text of CMS's comments is included as Appendix A to this report.

We will provide CMS, for their referral to the state, with specific examples of instances in which due diligence was not pursued.

Glossary of Abbreviations and Acronyms

CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
FBOP	Federal Bureau of Prisons
HHS	Department of Health and Human Services
OIG	Office of the Inspector General
SSA	Social Security Administration

INTRODUCTION

BACKGROUND

At the request of Senator 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 for beneficiaries reported to be incarcerated in 10 states during the 3-year period of January 1, 1997 through December 31, 1999 were in compliance with federal regulations and CMS guidelines. The State of Florida was 1 of the 10 states selected for review.

Under current federal law and regulations, 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 state that:

- (a) General rule: Except as provided in 411.8(b) (for services paid by a government entity), Medicare does not pay for a 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 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 that the government entity must enforce the requirement to pay and seek collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity).

Florida pays the health care costs for prisoners under the Department of Correction jurisdiction. Florida does not have a law requiring prisoners to pay for their own health care costs while in the custody of the state correctional system. However, the state law requires inmates to pay for their health care costs while in custody of county or mental health facilities. Therefore, Medicare would pay for the cost of health care services if the facilities pursue collection of health care debts for all individuals in custody.

The financial responsibility for medical expenses of county and municipal prisoners as set forth, in part, by Florida Statute 951.032 states that:

“A county detention facility or municipal detention facility incurring expenses for medical care, treatment, hospitalization, or transportation may seek reimbursement for the expenses incurred...”

Similarly, Section 916.107(2)(a) of the Florida statute addressing “Mentally Deficient and Mentally Ill Defendants” states that:

“The policy of the State is that the Department Services shall not deny treatment to any client because of the inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing services for clients able to pay for the services, including reimbursement from insurance or other third party payments, shall be made by facilities providing services pursuant to this chapter and in accordance with the provisions of s. 402.33.”

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 OIG compared a file of incarcerated Medicare beneficiaries provided by SSA to CMS’s National Claims History file of claims paid between January 1, 1997 and December 31, 1999. Based on this comparison, we compiled a database of claims paid on behalf of beneficiaries whose SSA payments were in suspension [due to incarceration] on the dates of service. We created a listing for Florida that included 3,343 paid claims totaling \$1,385,806. Using the Florida listing, we selected a random statistical sample of 100 fee-for-services claims totaling \$28,304 paid January 1, 1997 through December 31, 1999.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to determine whether Medicare payments for services provided to Florida 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 and state laws and regulations, Medicare reimbursement policies and procedures, and pertinent provisions of the Social Security Act to determine fiscal responsibility for incarcerated beneficiaries;
- met with CMS officials in Region IV 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;
- 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;
- held discussions with officials of the Medicare fiscal intermediary and carrier in Florida to ascertain if they have controls in place to detect claims submitted on behalf of incarcerated beneficiaries;
- reviewed a sample of Medicare and non-Medicare claims to determine if collection procedures were adequate and applied uniformly for all claims;
- checked the federal, state and local correctional facility databases to determine incarceration status at the date(s) of service; and
- identified where the health care providers who billed for the Medicare services were located and contacted county and local jails in the surrounding area to obtain incarceration information.

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 Florida did not have controls in place to detect claims submitted on behalf of incarcerated beneficiaries.

We found 71 of the 100 sampled claims in Florida were allowable. Seventy of the claims for 36 beneficiaries were allowable because the beneficiary was not incarcerated at the time of service. One claim was allowable because the facility pursued collection of the debt.

Of the 24 unallowable claims, 19 were improper because the facilities did not use due diligence in pursuing collection of the cost of health care services. One was improper because the beneficiary was incarcerated in a state prison. The remaining four were improper because the beneficiaries were housed or being held for federal agencies such as the U.S. Marshal’s office, the Drug Enforcement Agency and the Federal Bureau of Prisons.

In addition, for five claims we were unable to determine the custody status of the beneficiaries at the time of medical services. The following table summarizes 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>	\$24,349	71	37
<i>Unallowable</i>	3,714	24	18
<i>Unable to Determine</i>	241	5	4
<i>Total</i>	\$28,304	100	59

ALLOWABLE CLAIMS

Our review showed that Medicare payments for 71 claims totaling \$24,349 met Medicare reimbursement requirements. Seventy of the claims were allowable because the beneficiary was not incarcerated at the time of service. One claim was allowable because the facility pursued collection of the debt. We will share our findings with SSA for the beneficiaries who we believe were not incarcerated on the date of service.

Many of the beneficiaries are repeat offenders who move in and out of jail. For example, in our review of one beneficiary, with 9 different claims totaling \$16,227, we noted 26 separate arrests between December 1987 and December 1999. In each instance, the individual was not incarcerated on the date of the Medicare service.

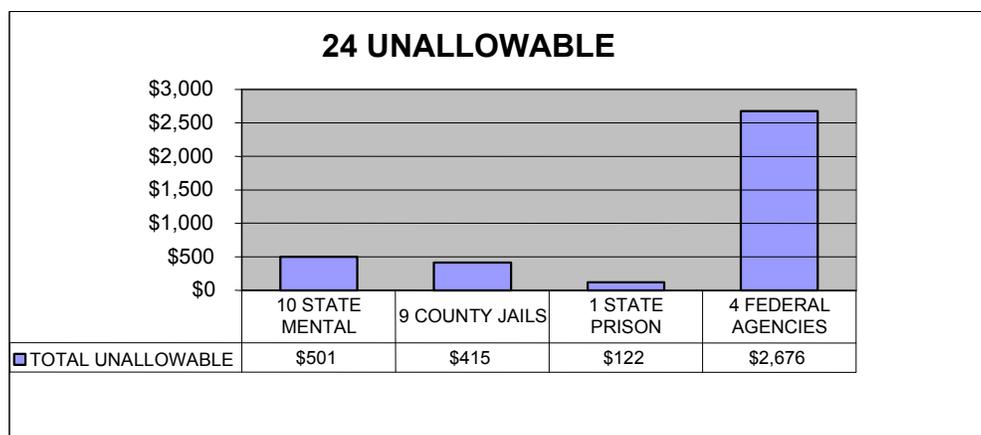
UNALLOWABLE CLAIMS

We identified payments for 24 claims totaling \$3,714 that were unallowable under Medicare reimbursement requirements. Title 42 CFR Part 411.4(b)(1) and (2) 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 for such services and the penal authorities enforce that requirement by pursuing collection for repayment. Unless the state or other government component operating the prison establishes that these requirements are met, it is presumed to be responsible for the medical needs of its inmates.

Our review showed that 20 claims of the 100 in our sample were for services provided to beneficiaries who were incarcerated in county jails, mental health facilities or state prison facilities on the dates of service. Based on our review, the claims relating to state mental health facilities, state prison and county jails were unallowable because the county jails and/or state mental health facilities did not use due diligence in pursuing collection of the cost of health care services. In our testing of collection efforts, we noted in several instances that the county jails and/or mental facilities could not provide documentation of their collection efforts. Even when we requested documentation on current billings these facilities were unable to provide collection documentation. Based on our review, collection of health care costs by entities were nonexistent or token efforts.

The remaining four claims relating to federal agencies are unallowable as each of these agencies has fiscal responsibility for the health care of persons in their custody.

A summary of the 24 unallowable claims is detailed in the chart listed below.



UNABLE TO DETERMINE ALLOWABILITY OF CLAIMS

We were unable to determine the location, at the time the services were rendered, of four beneficiaries who had five claims in our sample. We checked the FBOP, state and local correctional facility databases that contained incarceration records. These databases contained

no documentation as to the incarceration history of these four beneficiaries. We also determined the locations of the health care providers who billed for the Medicare services and we contacted county and local jails in the surrounding area with no results.

Since we were unable to determine if the beneficiary was in custody at the time services were rendered, we were unable to determine the allowability of the Medicare claims. Passage of time, transfers between facilities, aliases, and sometimes the use of different social security numbers contributed to making the process of determining the custody status of the beneficiary at the time of service a time consuming and difficult task.

CONCLUSIONS

Our review in Florida determined that 24 claims out of our sample of 100 did not meet Medicare reimbursement requirements. We did not make any determinations on the remaining 3,243 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 locations of beneficiaries due to the age of the claims.

RECOMMENDATIONS

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 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:

- make a concerted effort through its contractors to educate suppliers and providers on the meaning of the modifier or condition code indicating incarceration and circumstances 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)(2) are met; and
- alert its contractors that in instances where Florida county jails and/or mental health facilities are billing Medicare for inmate health care costs, these facilities must pursue collection of health care costs owed for all individuals in custody with the same vigor that they pursue the collection of other debts.

AUDITEE’S COMMENTS

In their written response, the CMS Regional Office concurred with the recommendations of ensuring education and monitoring of claims by its contractors. However, they cannot begin these actions until their Central Office establishes the edit and modifier. The CMS was informed by the State of Florida that due diligence is pursued in all instances unless the beneficiary is determined to be indigent. In this regard, CMS requested that specific examples of cases where governmental entities were not pursuing due diligence be provided so that the issue could be monitored. The CMS’s response is included in its entirety as Appendix A to this report.

OIG RESPONSE

We will provide CMS, for their referral to the state, with specific examples of instances in which due diligence was not pursued by governmental entities.

* * * * *

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or Mary Ann Moreno at 305-536-5309, extension 24 or through e-mail at mmoreno@oig.hhs.gov. To facilitate identification, please refer to report number A-04-02-05012 in all correspondence.

Attachments – as stated

APPENDICES

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



October 23, 2002

Bernard Rach
U.S. Department of Health and Human Services
Office of Inspector General
8659 Baypine Rd., Building 3, Suite 203
Jacksonville, FL 32256-7577

Dear Mr. Rach:

This letter is a reply to your draft report issued August 27, regarding your review of Medicare payments for services provided to incarcerated beneficiaries in the State of Florida. We regret the delay in our response.

We agree with the first two Regional Office recommendations that are listed on Page 8 of the draft report. However, we cannot begin these action items until our Central Office establishes the CWF edit and modifier.

Your findings indicate that some of the claims should not be paid by Medicare because Florida State Law does not meet the criteria in 42CFR 411.4(b)(2). State officials have informed the Florida Medicare carrier, First Coast Service Options, that **all** persons in custody in the State of Florida are required to pay for their health care and that the State does pursue collections on these expenses unless the Medicare beneficiary is determined to be indigent. We believe that specific examples will have to be sent to the State officials in order for them to monitor this issue.

If you have any questions, please call Wilma Cooper at (404) 562-7361.

Sincerely,

Rose Crum-Johnson
Regional Administrator

ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

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