Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR INCONTINENCE SUPPLIES

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1995
OEI-03-94-00771

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This report was prepared in the Philadelphia regional office under the direction of Robert A. Vito, Regional Inspector General. Principal project staff:

REGION III

Robert A. Katz, Lead Analyst
Robert A. Baiocco, Program Analyst
Linda M. Ragone, Program Analyst
Cynthia R. Hansford, Program Assistant

HEADQUARTERS

Stuart Wright, Program Analyst

REGION IV, OAS

Bernard Rach, Project Leader

For additional copies of this report, please contact the Philadelphia Regional Office at (800) 531-9562.

EXECUTIVE SUMMARY

PURPOSE

This report provides information on inappropriate billings and payments for incontinence supplies in the Medicaid program.

BACKGROUND

The Medicaid program is jointly-funded by Federal and State Governments to provide medical care for low-income individuals. The program is administered by the Health Care Financing Administration (HCFA) under authority of Title XIX of the Social Security Act. In Fiscal Year 1993, Medicaid expenditures totaled approximately $126 billion for 33 million recipients.

The Medicaid program varies considerably in each State. Within broad national guidelines, States establish eligibility, coverage, claims processing, and payment policies. Some Medicaid recipients are eligible for Medicare in addition to their Medicaid coverage. In these instances, Medicare is the primary payer for covered services. In accordance with a State's particular plan, Medicaid assumes responsibility for the recipients' premiums, deductibles, and coinsurances. Payments made by Medicaid for these dually eligible individuals are called "crossover" payments.

Incontinence is the inability to control urinary and bowel functions. Under the Medicaid program, States have the option to cover incontinence care supplies and related equipment. Based on prescriptions furnished by patients' physicians, such supplies and equipment could include disposable pads, irrigation syringes, saline solutions, and collection devices.

We recently reviewed Medicare payments for incontinence supplies. We found that questionable billing practices may have accounted for almost $100 million or half of incontinence allowances in 1993. We also found that suppliers engage in questionable marketing practices to nursing homes and that Medicare beneficiaries may be receiving unnecessary or noncovered supplies. We conducted this current review to inform HCFA if similar practices existed in the Medicaid program. We concentrated on 14 States which represent approximately 76 percent of 1993 Medicare payments for incontinence supplies.

This inspection was conducted as part of "Operation Restore Trust," a pilot program that coordinates Federal, State, and local anti-fraud activity in five States. The program will target abuses in home health agencies, nursing facilities, and durable medical equipment, including incontinence supplies.

FINDINGS

Half of the States in our sample identified improper Medicaid billings for incontinence supplies.

Seven Medicaid State agencies encountered improper billings for incontinence devices and supplies. These States identified a wide variety of improper claims such as billings for recipients who were not incontinent, billings for supplies that were never delivered, and billings for excessive quantities of diapers for nursing home patients. Overpayment amounts identified included $107 million in California and almost $2 million in New York.

States do not generally review the appropriateness or necessity of incontinence services paid by them on crossover.

States do not generally review the appropriateness or necessity of their crossover payments. Since Medicare, as the primary payer, has made the payment determination, many States accept Medicare's decisions as valid and do not question the propriety of such payments.

Medicare does not require carriers to notify Medicaid State agencies of improper Medicare payments made on behalf of Medicaid beneficiaries.

The Medicare program does not have guidelines requiring carriers to notify Medicaid State agencies of improper Medicare payments. Thus, States are often unaware of improper crossover payments, and, as a result, may be unable to collect inappropriately paid Medicaid monies.

RECOMMENDATIONS

We recommend that HCFA (1) alert Medicaid State agencies about this vulnerability regarding incontinence supplies, and (2) take appropriate steps to ensure that Medicaid State agencies are notified of improper Medicare payments which contractors discover have been made on behalf of a Medicaid beneficiary.

While this report is limited to a review of Medicaid payments for incontinence supplies, we believe that the problems identified associated with potentially improper crossover payments are not limited to these supplies. If Medicaid State agencies are not informed of the existence of improper Medicare payments on behalf of a Medicaid beneficiary, Medicaid is powerless to avoid or recoup the related improper Medicaid crossover payment. Thus, our second recommendation is applicable to all Medicare services provided to Medicaid recipients, not just incontinence supplies.

We cannot precisely estimate the dollar savings to the Medicaid program that would result from implementing these recommendations, but, based on the information we have gathered it probably amounts to several million dollars per year.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate HCFA's positive response to our recommendations. The HCFA plans to focus attention on this matter as part of their overall fraud and abuse prevention and detection strategy. Additionally, they plan to amend the Medicare Carriers Manual to require that carriers notify Medicaid State agencies about improper payments made on behalf of Medicaid beneficiaries. We support HCFA in these initiatives. The full text of HCFA's comments can be found in Appendix A.

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INTRODUCTION

PURPOSE

This report provides information on inappropriate billings and payments for incontinence supplies in the Medicaid program.

BACKGROUND

The Medicaid Program

Medicaid is a jointly-funded health insurance program between Federal and State Governments to provide medical care for low-income individuals. The program is administered by the Health Care Financing Administration (HCFA) under authority of Title XIX of the Social Security Act. Nationally, Medicaid expenditures totaled approximately $126 billion for 33 million recipients in Fiscal Year 1993.

The Medicaid program varies considerably from State to State. Within broad national guidelines, States establish eligibility standards, determine the scope of services, promulgate claims processing policies, and set payment rates for various medical services. Each State designs and manages its Medicaid program through a designated agency.

In some cases, Medicaid recipients are eligible for Medicare in addition to their Medicaid coverage. In these instances, Medicare is the primary payer for covered services. After Medicare carriers process a claim for a dually eligible beneficiary, they send an electronic notification to the States. In accordance with a State's particular plan, Medicaid assumes responsibility for the recipients' premiums, deductibles, and coinsurances. Payments made by Medicaid for these dually eligible beneficiaries are called "crossover" payments.

Incontinence Supplies

Incontinence is the inability of the body to control urinary and bowel functions. Under the Medicaid program, States have the option to cover incontinence care supplies and related equipment and accessories. Based on prescriptions furnished by patients' physicians, such supplies and equipment could include disposable pads, irrigation syringes, saline solutions, and collection devices.

Carrier Claims Processing

In June 1992, HCFA issued a final rule designating four Durable Medical Equipment Regional Carriers (DMERCs) to process all claims for durable medical equipment, prosthetics, orthotics, and supplies. In October 1993, the DMERCs began replacing the 32 carriers which had previously processed DME claims. The geographical areas

formerly serviced by the carriers were phased in under the DMERCs on a staggered basis. To ensure consistency in medical review policies, each DMERC issues identical coverage and reimbursement policies that implement Medicare guidelines.

Office of Inspector General Studies on Incontinence Supplies

We recently completed two studies on incontinence supplies provided to Medicare beneficiaries. One of these was entitled, *Marketing Of Incontinence Supplies* (OEI-03-94-00770). We found that (1) information from nursing homes indicates that suppliers engage in questionable marketing practices, (2) beneficiaries may be receiving unnecessary or noncovered supplies, and (3) many nursing homes do not provide the Medicare-reimbursed supplies to the specific beneficiary for whom the supplies were billed.

The second of these studies was entitled, *Questionable Medicare Payments For Incontinence Supplies* (OEI-03-94-00772). We found that (1) Medicare allowances more than doubled in 3 years despite a drop in the number of beneficiaries using incontinence supplies, (2) four types of incontinence supplies accounted for most of the increase in Medicare allowances, and (3) questionable billing practices may have accounted for almost $100 million or half of incontinence allowances in 1993.

We then conducted a third study to determine if similar practices existed in the Medicaid program. This report is the result.

Operation Restore Trust

This inspection was conducted as part of "Operation Restore Trust," a pilot program that coordinates Federal, State, and local anti-fraud activity in five States. The program will target abuses in home health agencies, nursing facilities, and DME equipment, including incontinence supplies. The project's initial focus will be in California, Florida, Illinois, New York, and Texas.

METHODOLOGY

Since there is no national database of Medicaid payments for incontinence supplies and related accessories, we reviewed a sample of Medicaid State agencies based on Medicare utilization rates. We selected 14 States where incontinence payments under Medicare were the highest: Alabama, California, Florida, Georgia, Illinois, Louisiana, Massachusetts, Missouri, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, and Texas. These 14 States represent approximately 76 percent of 1993 Medicare payments for incontinence supplies. All five of the Operation Restore Trust States were included in our sample.

We contacted the 14 Medicaid State agencies as well as the Medicaid Fraud Control Units in these States to determine (1) the extent of Medicaid payments, including crossover payments, and (2) improper payments for incontinence devices and supplies.

We also requested details of every reported fraud and abuse case. We received information from 13 of the 14 States sampled. All of the responding States cover incontinence supplies; however the coverage policies are not identical.

To determine how overpayments in crossover claims are recovered, we contacted the Medicare contractor fraud units in carriers which cover geographical areas served by the Medicaid State agencies. These units oversee fraud and abuse detection and prevention activities within the carriers. We also contacted the fraud units in the four DMERCs for information. To determine if the responses from the fraud units were representative of overall carrier procedures, we also contacted carrier personnel involved in overpayment and recovery activities in general. In all, we received responses from 14 carriers and four DMERCs.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

HALF OF THE STATES IDENTIFIED IMPROPER MEDICAID BILLINGS FOR INCONTINENCE SUPPLIES.

Seven of the 13 responding States had encountered improper billing practices for incontinence devices and supplies. The seven States were California, Florida, Louisiana, Massachusetts, New York, Ohio, and Pennsylvania. The States identified a wide variety of improper billings, including: (1) billings for recipients with no incontinence problems, (2) billings for supplies which were never delivered, (3) billings for excessive quantities of diapers for nursing home patients (up to 600 a month in some cases), and (4) billings for supplies which were already paid in a nursing home's daily rates.

Payment amounts associated with these improper billings were not readily available in most States or could not be extracted from data including other types of supplies, such as enteral and ostomy supplies. Two States could provide overpayment data for incontinence supplies: The overpayment amounts were $107 million in California and almost $2 million in New York.

Improper incontinence supply billings were so prevalent that California organized a special task force to attack the problem.

The California Medicaid program (known as Medi-Cal) uncovered widespread fraud in supplier billings for incontinence supplies. As a result, program officials organized a special task force to combat the problem. Multiple suppliers using abusive and fraudulent practices were identified. In one scheme, that some newspapers characterized as "diaperscam," unscrupulous suppliers went door to door enticing Medicaid beneficiaries to provide their signatures and Medicaid identification numbers in exchange for medical supplies. This practice enabled suppliers to bill Medi-Cal for incontinence supplies for recipients who were not incontinent.

STATES DO NOT GENERALLY REVIEW THE APPROPRIATENESS OR NECESSITY OF INCONTINENCE SERVICES PAID BY THEM ON CROSSOVER.

In general, States do not review the appropriateness or necessity of their crossover payments. As primary payer for dually eligible individuals, Medicare determines whether claimed services should be reimbursed. Needless to say, in such circumstances, many States accept Medicare's decisions as valid and do not question the propriety of such payments.

Only one State had reviewed the appropriateness of Medicaid crossover payments for incontinence supplies. Among the States that did not review crossover payments, four maintained that Medicare was responsible for verifying the accuracy and integrity of

these claims. Another four States reported they did not have the technological capability to target these claims for review. The remaining States indicated they had not conducted reviews of crossover incontinence claims since they had not identified aberrant billings or received complaints relating to incontinence supplies. One State representative said suppliers should be required to submit claims for crossover reimbursements directly to Medicaid agencies as this would put the States in a better position to determine the propriety of these payments.

Crossover payments comprise a significant portion of total Medicaid payments for incontinence supplies in some States.

Of the three States that reported significant crossover payments for incontinence supplies, crossover payments were exceedingly larger than regular Medicaid payments for incontinence supplies. The table below compares Florida's Medicaid crossover payments with regular Medicaid payments for incontinence supplies. Crossover payments exceeded regular Medicaid payments for three frequently billed incontinence supplies by more than $1.4 million.

Florida Medicaid Payments for Three Incontinence Supply Codes in Fiscal Year 1994

SUPPLY	MEDICAID-ONLY PAYMENTS	CROSSOVER PAYMENTS
Irrigation syringes (A4322)	$10,458	$455,975
Saline solutions (A4323)	40,365	851,349
Lubricants (A4402)	9,863	209,407
TOTALS	**$60,686**	**$1,516,731**

In Texas, more than $700,000 was paid in crossover payments for the three supplies listed above compared to $45,000 in Medicaid-only payments. Missouri reported crossover payments exceeding $430,000 for all incontinence supplies in Fiscal Year 1994.

Florida has initiated a review of the appropriateness of crossover claims.

The Florida Medicaid agency has recently initiated a plan to review crossover payments for incontinence supplies. When the Medicaid agency was first contacted, they advised us they did not conduct utilization reviews of crossover claims. Furthermore, they said that no suppliers had been identified as submitting questionable claims. However, after our initial contact, 18 suppliers were identified for submitting questionable billings for incontinence supplies to the Florida Medicare carrier. Potential overpayments to these suppliers totaled in excess of $60 million. (The Florida carrier had accounted for over half of all incontinence allowances in 1993 as well as the bulk of questionable payments nationally.) The Medicaid agency had reimbursed crossover claims for a number of these suppliers. Because of the large

number of questionable billings to Medicare, a task force was formed to combat the problem. The task force will also address crossover claims. In addition, the Florida Medicaid agency has sent letters to recipients inquiring about their need for incontinence supplies and asking if they had received the supplies in question.

MEDICARE DOES NOT REQUIRE CARRIERS TO NOTIFY MEDICAID STATE AGENCIES OF IMPROPER MEDICARE PAYMENTS MADE ON BEHALF OF MEDICAID BENEFICIARIES.

Medicare guidelines do not require carriers to notify Medicaid programs of the existence of Medicare overpayments. Only five of the 18 carriers and DMERCs which responded to our requests report that they routinely notify Medicaid State agencies when they learn of potential crossover overpayments. Only one of the four DMERCs routinely notifies Medicaid. Two other DMERCs notify Medicaid on an irregular basis. None of the responding carriers or DMERCs had written policies concerning the handling of crossover overpayments.

Of the 18 carriers and DMERCs which responded to our requests for information, 17 indicated they are not required by Medicare to notify Medicaid State agencies when they learn of potential crossover overpayments. Only one respondent said they were required to notify Medicaid State agencies. However, this requirement pertained only to Medicaid Fraud Control Units in suspected fraud cases, the respondent explained.

The Medicare Carriers Manual and the Code of Federal Regulations (see 42 CFR 405.375) contain provisions allowing Medicare contractors to withhold Medicare payments to recover Medicaid overpayments that a Medicaid agency has been unable to collect. However, if Medicaid agencies are not notified that crossover claims are potentially improper, they will be unable to initiate collection actions, including this mechanism to collect Medicaid overpayments.

RECOMMENDATIONS

Our findings indicate that Medicaid is vulnerable to questionable billing practices for incontinence supplies. In one State, California, improper payments exceeded $100 million. Other States experienced problems, but to a lesser degree.

We also found that States do not generally review the appropriateness or necessity of incontinence services paid by Medicare, and that Medicare does not require contractors to notify Medicaid State agencies of improper crossover payments made on behalf of Medicaid beneficiaries. Thus, States may inadvertently make unallowable payments for Medicare copayments.

We recommend that HCFA (1) alert Medicaid State agencies about this vulnerability regarding incontinence supplies, and (2) take appropriate steps to ensure that Medicaid State agencies are notified of improper Medicare payments which contractors discover have been made on behalf of a Medicaid beneficiary.

While this report is limited to a review of Medicaid payments for incontinence supplies, we believe that the problems identified associated with potentially improper crossover payments are not limited to these supplies. If Medicaid State agencies are not informed of the existence of improper Medicare payments on behalf of a Medicaid beneficiary, Medicaid is powerless to avoid or recoup the related improper Medicaid crossover payment. Thus, our second recommendation is applicable to all Medicare services provided to Medicaid recipients, not just incontinence supplies.

We cannot precisely estimate the dollar savings to the Medicaid program that would result from implementing these recommendations, but, based on the information we have gathered it probably amounts to several million dollars per year.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We appreciate HCFA's positive response to our recommendations. The HCFA plans to focus attention on this matter as part of their overall fraud and abuse prevention and detection strategy. Additionally, they plan to amend the Medicare Carriers Manual to require that carriers notify Medicaid State agencies about improper payments made on behalf of Medicaid beneficiaries. We support HCFA in these initiatives. The HCFA also provided a technical comment relating to how DMERCs develop national policies. We have revised our report in accordance with this comment. The full text of HCFA's comments can be found in Appendix A.

APPENDIX A

HCFA COMMENTS

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Incontinence Supplies" (OEI-03-94-00771)

OIG Recommendation

OIG recommends that HCFA implement procedures to require Medicare contractors to notify the Medicaid State agencies on a routine basis of improper Medicare payments made on behalf of a Medicaid beneficiary.

HCFA Response

We concur. We will focus our attention on this particular problem as part of our overall fraud and abuse prevention and detection strategy. To ensure that Medicaid State agencies are made aware of improper Medicare payments a fraud alert regarding inappropriate billing for incontinence devices was sent to all Medicaid Fraud Units in March 1994. The Medicare Carriers Manual will be amended to require that Medicare carriers notify the Medicaid State agency on claims retroactively denied to enable Medicaid to recover its payment. Also, we will require carriers to inform agencies to suspend payment, after the claims are approved, so as not to incur crossover payment.

Technical Comments

The report states that each Durable Medical Equipment Regional Carrier (DMERC) issues its own coverage and reimbursement policies that implement Medicare guidelines. This is not entirely correct. To comply with the DMERC contract for fiscal year 1995, the DMERC medical directors are required to collaborate in the development of regional medical review policies for DME, prosthetics, orthotics, and supplies. The final policies that are published by each of the DMERCs in their supplier bulletins must be identical. The DMERCs are required to publish identical policies to ensure consistency in coverage determinations and avoid coverage variations across the four regional carriers.