

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**OKLAHOMA DID NOT  
CORRECTLY PROCESS  
ADJUSTMENTS TO MEDICARE  
CROSSOVER CLAIMS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



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Deputy Inspector General  
for Audit Services**

**October 2017  
A-06-16-08012**

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## Report in Brief

Date: October 2017

Report No. A-06-16-08012

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

Medicaid pays providers for deductibles and coinsurance on behalf of some individuals who are entitled to both Medicare and Medicaid benefits. Medicare claims sent to State Medicaid programs for payment of deductible and coinsurance amounts are referred to as crossover claims. Work performed by the Arkansas Office of the Medicaid Inspector General revealed that Arkansas did not recover payments resulting from Medicare crossover claims that were adjusted after the original claims were processed and paid. We reviewed crossover claims processing in Oklahoma because it uses the same Medicaid Management Information System (MMIS) fiscal agent as Arkansas.

Our objective was to determine whether Oklahoma correctly processed adjustments to Medicare crossover claims.

### How OIG Did This Review

We obtained 5,845 Medicare Part B crossover claim adjustments for claims with services initially provided during January 2016. We worked with Oklahoma to identify and review crossover claim adjustments for which the original Medicare crossover claims were voided by Medicare. Oklahoma initially paid \$11,586 (Federal share \$7,066) in deductibles and coinsurance for the original 367 crossover claims.

## Oklahoma Did Not Correctly Process Adjustments to Medicare Crossover Claims

### What OIG Found

Although Oklahoma received crossover claim adjustments, it did not have any policies and procedures for processing adjustments to Medicare crossover claims. As a result, Oklahoma did not recoup amounts due from providers or pay amounts owed to providers when an adjustment to a crossover claim changed the original deductible or coinsurance payment amounts.

### What OIG Recommends and Oklahoma's Comments

We recommend that Oklahoma develop and implement policies and procedures to ensure adjustments to Medicare crossover claims are correctly processed.

In written comments on our draft report, Oklahoma indicated that it "mildly" concurred with the finding. It agreed that it did not process adjustments from Medicare and stated that its MMIS system denied them for lack of adequate information. Oklahoma included information about the difficulties in processing adjustments, indicating that the issue could be attributed to multiple parties. It also identified system changes it made to its MMIS and stated that its new process should resolve the issues identified in our audit.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

Medicaid pays providers for Medicare deductibles and coinsurance on behalf of some individuals who are entitled to both Medicare and Medicaid benefits (dual eligibles). Medicare claims sent to State Medicaid programs for payment of deductible and coinsurance amounts are referred to as crossover claims. Work performed by the Arkansas Office of the Medicaid Inspector General revealed that the Arkansas Medicaid program did not recover payments resulting from Medicare crossover claims that were adjusted after the original claims were processed and paid.<sup>1, 2</sup> We reviewed crossover claims processing in Oklahoma because the Oklahoma Health Care Authority (State agency) uses the same Medicaid Management Information System (MMIS) fiscal agent as the Arkansas Medicaid program.

### OBJECTIVE

The objective of this review was to determine whether the State agency correctly processed adjustments to Medicare crossover claims.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program.<sup>3</sup> At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Oklahoma, the State agency administers the Medicaid program. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

#### Medicare Program

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with end-stage renal disease (Title XVIII of the Social Security Act (the Act)). Medicare Part A covers institutional services including inpatient hospital services and

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<sup>1</sup> Office of the Medicaid Inspector General, "2016 Annual Report." Available online at <http://omig.arkansas.gov/quarterly-and-annual-reports/>. Accessed on June 30, 2017.

<sup>2</sup> Adjustments are changes to previously processed claims that could result in less or more payment due to the provider.

<sup>3</sup> The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, varies based on a State's relative per capita income.

skilled nursing care, and Part B covers medically-necessary doctors' services and tests, outpatient care, home health services, and durable medical equipment. CMS administers the program and contracts with Medicare Administrative Contractors (MACs) to process and pay Medicare claims submitted by providers, which includes assigning a Medicare internal control number (ICN) and calculating deductibles and coinsurance amounts for each claim.

### **Crossover Claims Processing**

After a MAC processes Medicare claims for dual eligible beneficiaries, it forwards them to the Benefits Coordination and Recovery Center (BCRC).<sup>4</sup> The BCRC then sends the claims, known as crossover claims, to the appropriate State's Medicaid program. The State Medicaid program determines, on the basis of the requirements established in its State plan, whether to pay all or part of the Medicare deductible and coinsurance payment amounts on the crossover claim and then pays the provider through the usual Medicaid payment system. For example, for a Medicare Part B physician claim, the State agency pays 100 percent of the deductible and 46.25 percent of the coinsurance amounts calculated on the crossover claim.

The BCRC also sends adjustments to previously processed crossover claims to the appropriate State's Medicaid program.<sup>5</sup> The State agency should then recoup amounts due from providers or pay amounts owed to providers when an adjustment to a crossover claim changes the original deductible or coinsurance payment amounts.

### **HOW WE CONDUCTED THIS REVIEW**

We obtained 5,845 Medicare Part B crossover claim adjustments for claims with services initially provided during January 2016. We worked with the State agency to identify and review crossover claim adjustments for which the original Medicare crossover claims were voided by Medicare. The State agency initially paid \$11,586 (Federal share \$7,066) in deductibles and coinsurance for the original 367 crossover claims.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

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<sup>4</sup> The BCRC coordinates the crossover claims process between the MAC and the State agency.

<sup>5</sup> Crossover claim adjustments are identified by a unique designation in the BCRC claims data.

## FINDING

### THE STATE AGENCY DID NOT CORRECTLY PROCESS CROSSOVER CLAIM ADJUSTMENTS

Although the State agency received crossover claim adjustments from the BCRC, it did not have policies and procedures in place to correctly process them. As a result, the State agency did not recoup amounts due from providers or pay amounts owed to providers when an adjustment to a crossover claim changed the original deductible or coinsurance payment amounts.

The Act states that a State plan must “provide such methods and procedures relating to . . . the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care . . .” (the Act § 1902(a)(30)(A)). Additionally, the Oklahoma Administrative Code (OAC) states that the Medicaid Operations State Medicaid Director is responsible for implementing medical policies and programs and directing the proper payment of claims (OAC § 317:30-3-1(a)).

For physician and durable medical equipment claims with services initially provided during January 2016, the State agency received 5,845 Medicare Part B crossover claim adjustments. When receiving crossover claims data from the BCRC, the MMIS assigns each claim a unique Medicaid ICN. The State agency does not store the original Medicare ICN in its MMIS. As a result, the State agency cannot automatically link a crossover claim adjustment to the original crossover claim.

A manual process was required during our review to link a crossover claim adjustment to the original crossover claim by comparing claim identifiers such as member ID, date of service, and procedure codes. Once this match was completed, an additional manual process was required to compare the data on the crossover claim adjustment and the original crossover claim to ensure we had an exact match. To calculate the effects of the adjustments, we compared the deductible and coinsurance amounts on the original and adjusted crossover claims. Due to the time and effort involved in the manual processes, we reviewed only a small subset of the crossover claim adjustments to show the potential impact of this issue.

We worked with the State agency to identify 367 crossover claim adjustments for which the original Medicare crossover claims were voided, thereby reducing the deductible and coinsurance amounts to zero. The State agency paid \$11,586 (Federal share \$7,066) in deductibles and coinsurance for the original crossover claims, but did not recoup the payments from the providers because it did not have a process to match adjustments to original crossover claims.

## RECOMMENDATION

We recommend that the State agency develop and implement policies and procedures to ensure adjustments to Medicare crossover claims are correctly processed.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency indicated that it “mildly” concurred with the finding. It agreed that it did not process adjustments from Medicare and stated that its MMIS system denied them for lack of adequate information. The State agency included information about the difficulties in processing adjustments, indicating that the issue could be attributed to multiple parties. It also identified system changes it made to its MMIS and stated that its new process should resolve the issues identified in our audit. See Appendix B for the State agency’s comments in their entirety.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

We obtained 5,845 Medicare Part B crossover claim adjustments for claims with services initially provided during January 2016. We worked with the State agency to identify and review crossover claim adjustments for which the original Medicare crossover claims were voided by Medicare. The State agency initially paid \$11,586 (Federal share \$7,066) in deductibles and coinsurance for the original 367 crossover claims.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We performed fieldwork at the State agency in Oklahoma City, Oklahoma during March through May, 2017.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations, and the State Medicaid plan;
- held discussions with State agency and BCRC officials;
- requested and received from the State agency crossover claim adjustment data for Medicare Part B physician and durable medical equipment claims with services initially provided during January 2016;
- reviewed crossover claim adjustments for which the State agency initially paid deductibles and coinsurance but were subsequently voided by Medicare; and
- discussed our finding with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

## APPENDIX B: STATE AGENCY COMMENTS

REBECCA PASTERNIK-IKARD  
CHIEF EXECUTIVE OFFICER



MARY FALLIN  
GOVERNOR

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

October 3, 2017

Mr. Warren Lundy  
Assistant Regional Inspector General for Audit Services  
200 N.W. 4th Street, Suite 4040  
Oklahoma City, OK 73102

RE: Report Number A-06-16-08012

Dear Mr. Warren Lundy,

This is written in response to your draft report entitled *Oklahoma Did Not Correctly Process Adjustments to Medicare Crossover Claims*; we believe that our response is a mild concurrence for the following reasons.

We agree that Oklahoma did not process adjustments from Medicare. Each of the adjustments coming in was denied by the MMIS for lack of adequate information. While we are aware that Medicare does adjust their claims from time to time, the responsibility to adjust a claim is generally on the provider to ensure the accuracy of the claim submitted to both Medicare and Medicaid. However, knowing that this doesn't always happen, we have engaged a 3<sup>rd</sup> party liability vendor (HMS) to back end audit and take back Medicare claims from the Provider, including crossovers, that were incorrect. However, it has been extremely difficult for HMS to take any actions on these cross over adjustments because the EOMB's are not available to them or us. OHCA has no way of billing Medicare directly or obtaining the EOMB, we are at the mercy of the provider to recoup these claims or to determine which claim is actually the proper claim. Our vendor reports to us that the recoupments were minimal at best, even after the prolonged rebill process.

After many discussions with the Medicare contractor and trying to develop a mechanism to alleviate this problem, OHCA did make system changes. OHCA implemented a process to store every Medicare ID number sent to us via the crossover process. Under Change Order 20246, OHCA now searches our history tables every time we receive an adjustment for an original Medicare crossover claim. At that time, we adjust the claim using our existing adjustment process. This new process should resolve any issues that were found during this audit and was put in place shortly after the field team completed its onsite process.

In conclusion, we have abated the issue addressed by this audit with MMIS changes; however we do believe this error could be attributed to multiple parties.

Respectfully,

A black rectangular redaction box covering the signature of Rebecca Pasternik-Ikard.

Rebecca Pasternik-Ikard  
Chief Executive Officer