DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

December 3, 2002

Common Identification Number: A-06-02-00036

Dr. James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Dear Dr. Farris:

Attached is a copy of our final report entitled, "Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Louisiana."

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

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me at (214) 767-9206 or e-mail at gsato@oig.hhs.gov.

To facilitate identification, please refer to Common Identification Number A-06-02-00036 in all correspondence relating to this report.

Sincerely Yours,

Gordon Sato

Gordon Sato
Regional Inspector General
for Audit Services

Enclosures – 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 LOUISIANA

JANET REHNQUIST
Inspector General

DECEMBER 2002
A-06-02-00036

Office of Inspector General

http://oig.hhs.gov/

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVE

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 on behalf of incarcerated beneficiaries 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 Louisiana was 1 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,* in which we found that the Medicare program had paid $32 million in fee-for-service payments 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: (1) there must be a state or local law requiring all such individuals, or groups of individuals, with the same legal status repay the cost of medical services, *and* (2) the state or local government entity must enforce this requirement by diligently pursuing collection.

FINDINGS

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 selected 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.

Louisiana law requires individuals who are in custody in parish or state correctional facilities or state-operated psychiatric hospitals to repay the cost of medical services. As a result, if the parish or state pursues collection of medical expenses, Medicare payments would be allowable. However, three parishes and one state hospital have policies not to bill and pursue collection on behalf of Medicare beneficiaries.

Medicare payment for 40 of the 100 claims sampled in Louisiana was proper. Payment for an additional 35 of the claims sampled in Louisiana were allowable because the payments were made on behalf of 17 beneficiaries who were not in custody during the time services were provided. These 75 payments totaled $108,474.

However, we found that Medicare payments for 15 claims totaling $522 were unallowable, because:

- Seven claims were for prisoners in parish prisons with policies that did not allow Medicare to be billed on behalf of prisoners;

- Three claims were for prisoners in a state hospital with a policy that did not allow Medicare to be billed on behalf of prisoners;

- Four claims were for prisoners in parish prisons where the parish is responsible for all medical bills, and the prisoners have no legal obligation to pay for medical services; and

- One claim was submitted to Medicare on behalf of a Federal prisoner whereas this claim should have been submitted to Federal Prisons.

In addition, 3 other claims totaling $166 were not allowable because:

- Two claims had no supporting medical documentation; and

- One claim was for a service not provided.

Although these three claims were considered unallowable, the reasons were unrelated to the fact that the beneficiaries were or were not incarcerated at the time of the service.

For the remaining 7 claims totaling $395, we were unable to determine if the claims were allowable. These seven claims were paid on behalf of five beneficiaries. We could not determine the exact whereabouts of three of the five beneficiaries and could not obtain provider information for the remaining two beneficiaries. Passage of time and transfers between facilities contributed to making the process of determining the custody status of these beneficiaries at the time of service a cumbersome and difficult task. 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 it is appropriate to bill Medicare for these services.

RECOMMENDATIONS

We believe when fully implemented the planned CWF edit 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 the conditions under regulations at 42 CFR 411.4 (b) required for payment are, indeed, being met.

In a written response to our draft report, the CMS Regional Administrator agreed with the findings and recommendations, and indicated that the CMS issued a Program Memorandum to Intermediaries and Carriers to establish a national CWF edit that will deny unallowable claims for incarcerated beneficiaries. The edit implementation date noted on the memorandum is April 1, 2003. In the interim, the CMS Regional Office will work with the contractors in its region to educate providers and suppliers on the requirements set out in 42 CFR 411.4(b) and on the proper use of the modifier or condition code. (For complete text, see appendix A.)

BACKGROUND

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:

> *(a) General rule: Except as provided in 411.8(b) (for services paid by a governmental 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 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.

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' 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 Louisiana that included 1,633 claims totaling $1,254,806. Using the Louisiana listing, we selected a random statistical sample of 100 fee-for-service claims totaling $109,557 paid during January 1, 1997 through December 31, 1999 for review.

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of our review was to determine whether Medicare fee-for-service claims paid on behalf of incarcerated beneficiaries during the 3-year period of January 1, 1997 through December 31, 1999 were in compliance with Federal 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.

- Discussed with CMS officials in Region VI the Medicare criteria involving incarcerated beneficiaries and ascertained if Region VI contractors were aware of any specific laws related to incarcerated beneficiaries.

- Reviewed applicable Louisiana 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 parishes, 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 Contractors for Louisiana 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.

- Contacted the FBOP to determine if any beneficiaries, whose incarceration status on the date of service could not be determined, were confined in a Federal prison.

- Contacted the Louisiana Department of Corrections (LDOC) and the Louisiana Department of Mental Health and Hospitals, Office of Mental Health (OMH) to determine if any beneficiaries, whose incarceration status on the date of service could not be determined, were in custody of these state entities.

- Contacted local jurisdictions to determine if any beneficiaries, whose incarceration status on the date of service could not be determined, were in custody of local authorities.

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 objective 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 December 2001 through October 2002.

RESULTS

Because CMS does not obtain incarceration data from the SSA to identify incarcerated beneficiaries, the Medicare contractors for Louisiana did not have controls in place to detect claims submitted on behalf of incarcerated beneficiaries.

We found the Medicare payments for 75 of 100 claims were appropriate. Of the 75 claims, 35 claims were allowable because the beneficiary was not incarcerated at the time of the service. Another 18 claims were for beneficiaries incarcerated in parish or state correctional facilities. Medicare payment for these claims was allowable because the parish or state met criteria for billing Medicare under Louisiana law. The remaining 22 allowable claims were for beneficiaries who were in custody of state-operated psychiatric facilities. Louisiana law deems these beneficiaries to be "patients" rather than "prisoners". As such, these beneficiaries are responsible for their health care costs. The Medicare program will be responsible for coverage as long as there is a law requiring the individual in custody to pay for medical services and the government entity enforces the requirements for all individuals in custody with the same legal status.

We determined that 15 of the 100 Medicare payments were unallowable under Medicare reimbursement requirements. For these 15 claims totaling $522:

- Seven claims were for prisoners in parish prisons with policies that did not allow Medicare to be billed on behalf of prisoners;
- Three claims were for prisoners in a state hospital with a policy that did not allow Medicare to be billed on behalf of prisoners;
- Four claims were for prisoners in parish prisons where the parish is responsible for all medical bills, and prisoners have no legal obligation to pay for medical services; and
- One claim was submitted to Medicare on behalf of a Federal prisoner whereas this claim should have been submitted to Federal Prisons.

In addition, 3 other claims totaling $166 were not allowable because:

- Two claims had no supporting medical documentation; and
- One claim was for a service not provided.

Although these three claims were considered unallowable, the reasons were not related to the fact that the beneficiaries were incarcerated at the time of the service.

Finally, for seven claims we were unable to determine the allowability at the time the services were rendered. These seven claims were paid on behalf of five beneficiaries. We could not determine the exact whereabouts of three of the beneficiaries and could not obtain provider information for the remaining two beneficiaries. The following table summarizes the results of our review:

Description	*Sample Amount*	*Number of Claims*	*Number of Beneficiaries*
Allowable	$108,474	75	43
Unallowable	688	18	15
Unable to determine	395	7	5
Total	$109,557	100	63[1]

ALLOWABLE CLAIMS

We determined that Medicare payments made for 75 claims totaling $108,474 met Medicare reimbursement requirements. Of these 75 claims:

[1] Although we had 61 unique beneficiaries in our sample, the total here is 63. Two beneficiaries in our sample fell within two separate categories.

- 35 were submitted on behalf of 17 beneficiaries not in custody;

- 18 were submitted on behalf of 14 beneficiaries who were in custody in prisons; and

- 22 were submitted on behalf of 15 beneficiaries placed in state-operated psychiatric hospitals.

We will share our findings with SSA for the 35 beneficiaries who we believe were not incarcerated on the date of service. For 40 claims, we found the individuals were in custody in facilities that required beneficiaries to pay for medical expenses. For any beneficiary in custody in a state or parish correctional facility, Louisiana law requires that inmates reimburse medical expenses incurred by the LDOC or sheriff. Louisiana law also requires persons who are in mental facilities pursuant to judicial commitments to pay for medical expenses. Because collection of these medical expenses was pursued, Medicare reimbursement was allowable.

UNALLOWABLE CLAIMS

We identified payments for 15 claims totaling $522 that were unallowable under Medicare reimbursement requirements. Title 42 CFR 411.4 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 this requirement is enforced by pursuing collection for repayment. Unless the state or other government component operating the prison establishes that these requirements are met, it is presumed the prison will be responsible for the medical needs of its inmates. For the state of Louisiana, Medicare payments are allowable for beneficiaries who are in custody in parish or state correctional facilities or state-operated psychiatric hospitals if the parish or state pursues reimbursement for these payments. However, three parish correctional facilities and one state hospital have policies not to bill and pursue collection on behalf of Medicare beneficiaries.

In addition, we identified 3 claims totaling $166 that were unallowable for reasons unrelated to whether the beneficiaries were incarcerated or not. Two of the three claims were unallowable because there was no supporting documentation for the claims. The remaining claim was unallowable because the service was not provided.

Parish Jails with Policies that Do Not Allow Billing Medicare

According to the policies of three parish correctional facilities that housed four beneficiaries within our sample, providers were not to bill Medicare for any medical services received by prisoners in their custody. Since these three facilities' policy was not to bill Medicare for medical services provided inmates, these facilities did not enforce 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. However for various reasons, providers erroneously billed

Medicare for services provided these beneficiaries while these beneficiaries were in these parish correctional facilities. Therefore, the Medicare payments made to providers on behalf of these beneficiaries, totaling $244, are improper. Seven claims were submitted for these four prisoners.

- For one claim, the provider's policy is to bill prisoners that are housed in any parish or municipal jail or detention facility or state prison according to their financial status. In this case, since Medicare was identified as the primary insurance the provider billed Medicare.

- For one claim, the provider received the patient's demographic information from a state hospital that allows Medicare to be billed on behalf of incarcerated beneficiaries. This information identified Medicare as the patient's primary insurance and therefore the provider billed Medicare.

- For one claim, the provider also received the patient's demographic information from another hospital. When the information for the beneficiary was downloaded to the provider's system, there was a home address and a Medicare number. There was no indication that the beneficiary was incarcerated; therefore, the provider billed Medicare.

- For the remaining four claims, it was not clear who provided the services for these claims because the contractor's system had already purged the claim information. As such, we were unable to determine why Medicare was billed for these services.

State Hospital with a Policy that Does Not Allow Billing Medicare

According to the policy of one state hospital, if a patient was actually incarcerated or in custody at the time of service, the account will be sent to the Patient Accounts Department to be written off to the 'prisoner care' account. As such, there is no amount due and Medicare would have no obligation to pay for services at this facility. Nevertheless, Medicare payments for three claims totaling $45 were submitted to and paid by Medicare. These payments are unallowable.

These three claims were improperly coded with the letter 'M' and were billed as Medicare patients. These claims should have been coded with the letter 'D' to represent a prisoner and as such would not have been billed to Medicare.

Parish Prisoner Has No Legal Obligation to Pay Medical Expenses

Except as provided in 42 CFR §411.8(b), Federal regulations require that no Medicare payment may be made under Part A or Part B for any expenses incurred for items or services for which a patient has no legal obligation to pay or which is paid for directly or indirectly by a governmental entity. The policy of two parish correctional facilities that housed four beneficiaries within our sample was to pay the insurance co-payment or entire bill sent from the provider to the parish. Because these parishes accepted legal

obligation to pay for services in these two correctional facilities, there would be no obligation for the prisoners to pay for medical services. Therefore, Medicare would not recognize these as legal obligations, thus the Medicare payments for these four claims, totaling $226, were improper.

- For two claims, it was the provider's policy to bill prisoners that are housed in any parish or municipal jail or detention facility or state prison according to their financial status.

- For the other two claims, it was not clear who provided the services because the contractor's system had already purged the claim information. As such, we were unable to determine why Medicare was billed for these claims.

Claim Submitted on Behalf of a Federal Prisoner

According to the billing policies of the LSU Medical Center Healthcare Services Division, Medicare should not be billed on behalf of Federal prisoners. Federal prisoners should be billed using the Federal Prison of United States (U.S.) Marshall Services as Guarantor. These accounts should be billed in full using the Federal Prison or U. S. Marshall Services as a third party commercial insurance. In addition, the exception to Medicare's general rule against payment for "services furnished to individuals in custody of penal authorities" requires the application of "state or local law" as well as the enforcement of requirements by "State or local government entit[ies]" (42 CFR 411.4 (b)), neither of which apply to Federal prisoners. Therefore, the general rule would apply to Federal prisoners, i.e., Medicare does not pay for services furnished to such individuals. The beneficiary for one claim was in custody of a Federal prison; therefore, the Medicare payment of $8 is unallowable.

According to the provider of this claim, the beneficiary was incorrectly identified during the admit/screening process. The beneficiary should have been identified as a Federal prisoner, and thus should have been billed using the Federal Prison or U.S. Marshall Services as Guarantor.

OTHER UNALLOWABLE CLAIMS

Claims with No Supporting Documentation

The provider for two claims in our sample indicated that they could not locate medical records for the date of service requested. Therefore, the Medicare payments for these two claims, totaling $139, are unallowable.

Claim for a Service Not Provided

A state-operated psychiatric hospital billed for a service that was not provided. Two claims were filed for one beneficiary for the same date of service. The first claim, which was in our sample, was filed under one code. The second claim was filed under another code. Both codes represent the severity of the diagnosis. According to an official at the

psychiatric hospital, the claim within our sample was billed in error. The services actually provided were for the second claim filed for this beneficiary. Therefore the $27 Medicare claim would be unallowable.

Although the three claims discussed above were considered unallowable, the reasons were not related to the fact that the beneficiaries were or were not incarcerated at the time of the service.

UNABLE TO DETERMINE ALLOWABILITY OF CLAIMS

- We were unable to determine the allowability of services provided to five beneficiaries who had seven claims totaling $395 in our sample. For three of the five beneficiaries, we could not ascertain if these beneficiaries were in a prison or a psychiatric hospital at the time the service was provided. We contacted the FBOP, LDOC, and local jurisdictions during our attempts to locate these beneficiaries. We also contacted the OMH to determine if these beneficiaries were in state psychiatric facilities on the dates of service. For the other two beneficiaries, we could not determine who provided the services. We found some incarceration information on one Federal prisoner having two claims within our sample, but the information was inconclusive as to determine the whereabouts of the beneficiary on the dates the services were rendered.

- We were unable to determine the incarceration status for two beneficiaries having three claims because the contractor did not provide any claim information.

- For the other two beneficiaries, we were able to determine the incarceration status. The two correctional facilities housing these beneficiaries have policies that allow Medicare to be billed on behalf of prisoners. However, we were unable to test due diligence because the contractor did not provide any claim information.

Passage of time and transfers between facilities contributed to making the process of determining the custody status of the beneficiary at the time of service a cumbersome and difficult task.

CONCLUSIONS AND RECOMMENDATIONS

Our review in Louisiana determined that 18 claims out of our sample of 100 claims did not meet Medicare reimbursement requirements. We did not examine the remaining 1,533 claims in the universe. If CMS decides to consider readjudication for 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 made on behalf of beneficiaries in custody of state or parish correctional facilities or state-operated psychiatric hospitals were allowable because (1) Louisiana law requires these individuals to pay for their medical care and (2) these facilities 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 beneficiaries who are in custody in state or parish correctional facilities or state-operated psychiatric hospitals to ensure the conditions for payment continue to be met;

- require its contractors to educate suppliers and providers on the proper use of the modifier or condition code after implementation of the edit; and

- 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.

AUDITEE COMMENTS

In a written response to our draft report, the CMS Regional Administrator agreed with the findings and recommendations, and indicated that the CMS issued a Program Memorandum to Intermediaries and Carriers to establish a national CWF edit that will deny unallowable claims for incarcerated beneficiaries. The edit implementation date noted on the memorandum is April 1, 2003. In the interim, the CMS Regional Office will work with the contractors in its region to educate providers and suppliers on the requirements set out in 42 CFR 411.4(b) and on the proper use of the modifier or condition code. (For complete text, see appendix A.)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
James Randolph Farris, M.D.
Regional Administrator

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November 26, 2002

James Hargrove
Audit Manager
U.S. Department of Health and Human Services
3625 NW 56th Street, Room 101
Oklahoma City, OK 73112

Regarding: Common Identification Number: A-06-02-00036

Dear Mr. Hargrove:

Thank you for the opportunity to comment on your draft report entitled "Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the State of Louisiana." We concur with the findings and recommendations in your report. Our agency has issued national instructions to our contractors to address this issue. In addition, we will take the necessary steps to ensure that the contractors in our region properly implement these instructions with the aim of eliminating improper payments for services to incarcerated beneficiaries.

On November 8, 2002, the Centers for Medicare & Medicaid Services issued Program Memorandum number AB-02-164 to Intermediaries and Carriers. This memorandum establishes a national CWF edit that will deny unallowable claims for incarcerated beneficiaries. The implementation date noted in the memorandum for the edit is April 1, 2003. In the interim, our office will work with the contractors in our region to educate providers and suppliers on the requirements set out in 42 CFR 411.4 (b) and on the proper use of the modifier or condition code. Our contractors will publish educational information in their newsletters and conduct additional educational activities as the activation of the edit nears. We will also ensure that the contractors monitor the actions taken as a result of the modifier or condition code to confirm that they meet the regulatory requirements.

If you have questions or if we can be of further assistance regarding this matter, please contact Art Pagan of my staff at 214-767-4471.

Sincerely,

James Randolph Farris, M.D.
Regional Administrator