Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE PAYMENTS FOR SERVICES PROVIDED TO CALIFORNIA RESIDENTS IDENTIFIED AS INCARCERATED

JANET REHNQUIST
Inspector General

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A-09-02-00050

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services
Region IX

Memorandum

DATE: October 9, 2002

TO: Elizabeth C. Abbott
Regional Administrator
Centers for Medicare and Medicaid Services

FROM: Lori A. Ahlstrand
Regional Inspector General
for Audit Services

SUBJECT: Audit of Medicare Payments for Services Provided to California Residents Identified as Incarcerated (A-09-02-00050)

This report provides you the results of our review of Medicare payments for services provided to California residents identified as incarcerated. The objective of our audit was to determine whether Medicare fee-for-service claims paid in California for beneficiaries identified as incarcerated during the period January 1, 1997 through December 31, 1999 were in compliance with federal regulations and Centers for Medicare and Medicaid Services' (CMS) guidelines. California was 1 of 10 states selected for review.

We audited a random sample of 100 Medicare fee-for-service claims for beneficiaries identified as incarcerated during the 3-year audit period to determine whether these payments were appropriate. We found that our sample of 100 claims included 58 allowable claims, 12 unallowable claims and 30 claims for which the allowability of the claim could not be determined.

We identified 12 claims totaling $1,467 in our sample of 100 claims that were unallowable because the claims did not meet Medicare reimbursement requirements. Nine claims were submitted for Department of Mental Health (DMH) beneficiaries who were committed under California Penal and Welfare and Institutions Codes, which did not meet Medicare reimbursement requirements. The remaining three unallowable claims were for beneficiaries incarcerated at state prisons. Medicare paid for these 12 unallowable claims because the prisoner data from the Social Security Administration (SSA) was not contained in CMS' records, which are used by the Medicare contractors to process claims.

We did not evaluate the remaining 30,892 claims in the audit universe. If CMS decides to reevaluate the remaining claims, we suggest performing a cost benefit analysis, which takes into consideration the 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.

As a result of a prior Office of Inspector General report, we have been informed that CMS plans to establish an edit in the common working file that will deny claims for incarcerated beneficiaries. Claims meeting the conditions of 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.

We recommend that CMS:

1. Make a concerted effort to educate suppliers and providers on the meaning of the modifier or condition code and circumstances relating to their proper use,

2. Monitor claims with the modifier or condition code to assure that federal guidelines are met, and

3. Monitor DMH claims to ensure that only commitment codes that meet Medicare criteria are paid and that uniform collection procedures are enforced.

In its written response to our draft report, CMS concurred with our recommendations. At this point, they have taken no action. Once changes have been made to the common working file to deny claims for incarcerated beneficiaries, CMS will work with the contractors to implement our recommendations. The CMS's response is included as an appendix to our report.

INTRODUCTION

BACKGROUND

At the request of Senator Grassley, Senate Finance Committee, we undertook a review of Medicare payments for medical services provided to incarcerated beneficiaries. 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 (CIN: A-04-00-05568)," in which we found that the Medicare program had paid $32 million in fee-for-service benefits on behalf of 7,438 beneficiaries identified as incarcerated by the SSA.

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 Code of Federal Regulations (CFR) section 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 services 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 made 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 who are in the custody of the state or local government entity to repay the cost of the 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.

The 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).

Section 202(x)(1)(A) of the Social Security Act requires 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 maintains a database of incarcerated individuals with the assistance of jails, prisons, other penal institutions or correctional facilities, departments or divisions of corrections or correctional services, and certain mental health facilities.

We performed a data match between a file of incarcerated Medicare beneficiaries provided by SSA and CMS' National Claims History file for claims paid between January 1, 1997 and December 31, 1999. Based on this data match, we compiled a database of claims paid on behalf of beneficiaries whose SSA payments were suspended due to incarceration on the dates of service. We created a listing from this database of California beneficiaries that included 30,992 claims totaling $6,680,655. Using the California listing, we selected a random statistical sample of 100 fee-for-service claims totaling $29,778 for medical services performed during the period January 1, 1997 through December 31, 1999.

OBJECTIVE, SCOPE AND METHODOLOGY

We conducted our review in accordance with generally accepted government auditing standards. Our objective was to determine whether Medicare payments for services provided to beneficiaries reported to be incarcerated during the 3-year period January 1, 1997 through December 31, 1999 were in compliance with federal regulations and CMS guidelines. We performed our review during the period October 2001 through August 2002.

To achieve our objective, we performed the following steps:

- Reviewed applicable federal laws and regulations, Medicare reimbursement policies and procedures, and pertinent provisions of the Social Security Act pertaining to incarcerated beneficiaries.

- Met with CMS officials in Region IX to ascertain if they had provided the contractors with any Medicare guidelines regarding health care services furnished to incarcerated beneficiaries.

- Reviewed applicable California laws and regulations pertaining to health care cost liabilities for incarcerated beneficiaries and other individuals in the penal system.

- Held discussions with various state officials including individuals from the California Parole Board and the California Departments of Corrections, Mental Health and Developmental Services.

- Held discussions with officials of the Medicare fiscal intermediary and carrier in California to ascertain the 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 federal, state and local government databases in order to determine the beneficiary's custody status.

We reviewed only those internal controls considered necessary to achieve our audit objective. 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. The objectives of our audit did not require an understanding or assessment of the overall internal control structure of the suppliers and providers.

FINDINGS AND RECOMMENDATIONS

We determined that a sample of 100 Medicare claims for beneficiaries reported as incarcerated included 58 allowable claims, 12 unallowable claims, and 30 claims for which the allowability of the claim could not be determined. The Medicare fiscal intermediary and carrier in California did not detect these unallowable claims because the prisoner data from SSA was not contained in CMS' records, which are used by the Medicare contractors to process claims.

The following table summarizes the results of our review:

Description	Sample Amount	Number of Claims	Number of Beneficiaries
Allowable	**$18,074**	58	54
Unallowable	**$1,467**	12	12
Unable to determine	**$10,237**	30	28
Total	**$29,778**	100	94

ALLOWABLE CLAIMS

Medicare payments made for 58 claims totaling $18,074 met Medicare reimbursement requirements. These 58 claims were allowable and in accordance with federal regulations and CMS guidelines. Forty-five claims were for California DMH beneficiaries. Twelve claims were for beneficiaries who were not in custody on the sampled dates of service. The remaining claim was for a beneficiary in a state mental hospital in New York. See Appendix A for the list of California Penal and Welfare and Institutions Codes that met Medicare reimbursement criteria.

The 45 DMH beneficiaries were committed to 4 state-operated psychiatric hospitals under various California Penal and Welfare and Institutions Codes that met Medicare reimbursement criteria. The Medicare program covers services 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. For our sample dates of service, these DMH beneficiaries received medical treatments at the state psychiatric hospitals and at outside providers. We determined that payments made on behalf of the 45 DMH patients were allowable and consistent with Medicare reimbursement requirements because California law required that incarcerated beneficiaries pay for their own healthcare costs and uniform collection procedures were enforced. Our review of DMH's collection procedures on Medicare and non-Medicare claims showed that collection procedures were adequate and applied uniformly for all claims.

Twelve sample claims were for 11 beneficiaries who were not in custody on the sample dates of service and, therefore, the medical services provided to them are allowable for Medicare reimbursement. We will share our findings with SSA for the beneficiaries who we believe were not incarcerated on the dates of services. The Medicare policy relates only to services for beneficiaries who are in custody. These 12 claims were submitted for beneficiaries who were either on state parole, county probation or held for evaluation at a county jail under a Welfare and Institutions Code, which met Medicare reimbursement requirements.

The remaining beneficiary was in a state mental hospital in New York for the sample date of service. This state mental hospital holds all patients financially responsible for services provided to them and uniform collection procedures were enforced. Therefore, the Medicare payment for the service provided to this beneficiary was allowable because the payment met Medicare reimbursement requirements under
42 CFR section 411.4(b)(1) and (2).

UNALLOWABLE CLAIMS

We identified 12 claims totaling $1,467 in our sample that were unallowable because the claims did not meet Medicare reimbursement requirements. Nine claims were submitted for DMH beneficiaries who were committed under California Penal and Welfare and Institutions Codes that were not allowable under Medicare reimbursement criteria. The codes, which did not meet Medicare reimbursement requirements, included Penal Codes 2962 and 2972 and Welfare and Institutions Code 5008. The remaining three unallowable claims were for beneficiaries incarcerated at state prisons.

Of the nine DMH claims, seven claims were submitted for beneficiaries committed under Penal Codes 2962 and 2972. The allowability of claims for beneficiaries held under Penal Codes 2962 and 2972 is covered under Penal Code 2976(a), which states:

> "The cost of inpatient or outpatient treatment under Section 2962 or 2972 shall be a state expense while the person is under the jurisdiction of the Department of Corrections or the State Department of Mental Health."

The two other DMH claims were submitted for beneficiaries committed under Welfare and Institutions Code 5008. These beneficiaries were being held by the state as being "gravely disabled" individuals. One of the facts that must exist for a person to be considered "gravely disabled" under Welfare and Institutions Code 5008 is that the indictment or information pending against the defendant has not been dismissed. Since the indictment or information was not dismissed, the beneficiary was in custody of the state for a penal code violation.

The remaining three unallowable claims were submitted for beneficiaries who were incarcerated at state correctional facilities on the dates of service. Under Title 15 of Penal Code section 5054, the state is responsible for the health care costs of prisoners who are in the custody of the state correctional system. Section 5054 of the Penal Code states:

> "The supervision, management and control of the State prisons, and the responsibility for the care, custody, treatment, training, discipline and employment of persons confined therein are vested in the director."

The Title 42 section 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 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.

UNABLE TO DETERMINE ALLOWABILITY OF CLAIMS

We were unable to determine the whereabouts of the beneficiaries, at the time the services were rendered, for 30 claims in our sample totaling $10,237. Therefore, we were unable to determine the allowability of the claims. We contacted the Federal Bureau of Prisons, state and local correctional facilities and had them review their databases to determine if the beneficiaries were in custody. We also contacted the state parole board in order to determine if any of the beneficiaries were on parole. We also reviewed the DMH database to determine if these beneficiaries were in state psychiatric hospitals on the dates of service. We could find no record of these beneficiaries in custody at a correctional facility or mental hospital in California for the sampled dates of service.

CONCLUSIONS

Our review in California determined that 12 claims totaling $1,467 from our sample of 100 claims did not meet Medicare reimbursement requirements. We did not make any determinations on the remaining 30,892 claims in the universe. If CMS decides to reevaluate these remaining claims, we suggest performing a cost benefit analysis which takes into consideration the 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.

Because the prisoner data from SSA was not contained in CMS' records and the Medicare contractors lacked internal controls, i.e., computer edits, these contractors did not detect the

unallowable claims. We have been informed that, based on our April 25, 2001 report, CMS plans to establish an edit in the common working file 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 claims 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.

RECOMMENDATIONS

Since the modifier or condition code will be pivotal in paying or denying claims for incarcerated beneficiaries, we recommend that CMS, through its regional offices as well as its contractors, make a concerted effort to educate suppliers and providers on the meaning of the modifier or condition code and circumstances relating to their proper use. Also, after implementation, we recommend that claims with the modifier or condition code be monitored to assure the conditions in 42 CFR section 411.4(b) are met.

We found that Medicare payments made during our audit period on behalf of certain DMH beneficiaries committed to state-operated psychiatric hospitals in California were allowable for Medicare reimbursement while other payments for DMH beneficiaries were unallowable based on the reasons for commitment. Therefore, we believe that CMS, through its regional offices, needs to closely monitor future DMH claims. Specifically, they need to monitor the reasons why these beneficiaries are committed to ensure that only commitment codes that meet Medicare criteria are paid and that uniform collection procedures are enforced.

CMS COMMENTS

In its written response to our draft report, CMS concurred with our recommendations. The CMS indicated that at this time they have taken no corrective action. However, once changes have been made to the common working file to deny claims for incarcerated beneficiaries, CMS will work with the contractors to implement our recommendations. The text of the CMS comments is included as Appendix B to this report.

APPENDICES

Appendix A

California Penal and Welfare and Institutions Codes That Meet Medicare Reimbursement Criteria

Code Section	Legal Class	Description	Liability for Payment
PC-1026	22	Plea of Not Guilty by Reason of Insanity	Patient, estate, spouse or parents of minor.
PC-1370	24	Incompetent to Stand Trial	Patient, estate, spouse or parents of minor.
PC-1372(e)	44	Extended Incompetent to Stand Trial	Patient, estate, spouse or parents of minor.
PC-1610	62	Revocation of Sexually Violent Predator	Patient, estate, spouse or parents of minor.
W&I-4825	96	Short-term Admission from Regional Center for Medical or Dental Services (Porterville), for Dental Services (Napa)	Patient or his estate.
W&I-5150	14	72-hour Detention for Evaluation	Patient, estate, spouse or parents of minor.
W&I-5358	09	Conservatorship	Patient, estate, spouse or parents of minor.
W&I-5880	00	Emergency Detention (See DMH L.C.99)	Patient, estate, spouse or parents of minor.
W&I-6000(a)	75	Mentally Retarded Adult/Minor Certified by Regional Center	Patient or his estate.

Appendix B

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
SAN FRANCISCO - REGION IX

Memorandum

Date September 24, 2002

From Lourdes Maloney, Associate Regional Administrator
Division of Beneficiary Services

Subject Audit of Medicare Payments for Services Provided
To California Residents Identified as Incarcerated
(A-09-02-00050)

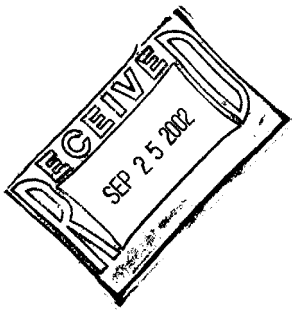
To Lori A. Ahlstrand
Regional Inspector General for Audit Services

This is in response to your memorandum dated August 30, 2002 regarding the subject Audit Report. We concur with the three recommendations found on page 2 of the report. At this point, we have taken no action on these recommendations. Once the changes have been made to the common working file (CWF) to deny claims for incarcerated beneficiaries, we will work with the contractors operating in our Region to implement these recommendations

We will ask our contractors to issue a bulletin article and to publish instructions on their websites on the proper use of the modifier or condition code that will override the CWF edit. In addition, we will ask our contractors to make direct contacts with Department of Mental Health providers regarding the proper use of the modifier and the condition code. We will instruct our contractors to monitor claims with the modifier or condition code based on whatever national instructions are issued.

Your staff can contact Dave Danek at (415) 744-3656 with any questions on this matter.

Lourdes Maloney



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