

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**DUPLICATE MEDICAID AND  
MEDICARE HOME HEALTH  
PAYMENTS:  
MEDICAL SUPPLIES AND  
THERAPEUTIC SERVICES**



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Inspector General

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# *Office of Inspector General*

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## E X E C U T I V E S U M M A R Y

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### OBJECTIVE

1. To determine, in five States, the extent to which both Medicaid and Medicare paid home health providers for the same medical supplies and therapeutic services.
2. To identify the controls that these five States have established that are intended to prevent duplicate payments.

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### BACKGROUND

Home health services seek to restore health and minimize the effects of illness and disability, thereby enabling beneficiaries to reside in community settings and avoid institutionalization. These services include nursing care, speech therapy, and physical therapy. Both Medicaid and Medicare pay home health providers for services specified in the plans of care for beneficiaries; however, both should not pay for the same medical supplies or services for the same beneficiary.

Medicaid is the payor of last resort; therefore, Medicaid should pay for home health services only if Medicare or another payor does not pay for them. Medicare pays home health providers through the Prospective Payment System (PPS) for qualified home health services provided during episodes of care.

We examined Medicaid and Medicare home health claims in five States: Florida, Maryland, North Carolina, Ohio, and Texas. During the period of our review, these Medicaid programs paid a total of \$184 million for 2.2 million claims for home health supplies and services coverable by Medicare. We matched Medicaid home health claims against Medicare home health PPS claims using Social Security numbers and dates of service and identified duplicatively paid home health claims; we did not rely on the dual eligibility indicator field, which may have been incorrect. For the purposes of this study, we defined a duplicate payment as any Medicaid payment for a PPS-covered service or supply on a date falling within a Medicare episode of care. We did not attempt to determine medical necessity or appropriateness.

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### FINDINGS

**In four of the five States reviewed, Medicaid inappropriately paid \$1 million in 2005 for nonroutine medical supplies and therapeutic**

**services that were paid by Medicare.** Of the 84,061 inappropriately paid claims, 98 percent were for nonroutine medical supplies and 2 percent were for therapeutic services. All inappropriately paid claims were for supplies and services included on the publicly available list of Medicare-covered PPS services for 2005.

**Medicaid paid \$6.6 million for routine supplies on the same dates as home health services; Medicare coverage of routine supplies cannot be determined from claims data.** Because Medicare PPS covers the cost of routine medical supplies that are customarily used in small quantities during the course of a therapeutic or assistive home health service, it is possible that these medical supplies were included in the Medicare payment and Medicaid should not have paid for them. However, claims data do not indicate whether a routine supply was provided during the course of another service. Therefore, the State Medicaid agency cannot determine whether Medicaid or Medicare should pay for these routine supplies leading to a potential vulnerability.

**All States reported having controls to prevent duplicate payments, but these did not eliminate all inappropriate payments.** All five States relied on Medicare eligibility indicators and payment system edits to compare claims for home health services to Medicare eligibility information; however, incomplete eligibility information and payment system edit overrides may still allow inappropriate payments.

**Despite Medicaid being the payor of last resort, State officials reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid.** Most inappropriately paid claims were likely paid after Medicare made the initial payments for the episodes, and Medicaid paid 10 percent of inappropriate claims after the final Medicare payments. The order of claims submission dates and payment dates indicates that some home health providers are submitting Medicaid claims for medical supplies and therapeutic services when they have already received Medicare payments. States requiring Medicare denial notices had fewer inappropriately paid claims.

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## RECOMMENDATIONS

Our results show that Medicaid inappropriately paid for some home health supplies and therapeutic services for which Medicare also paid.

Therefore, we recommend that CMS:

**Ensure that Medicaid does not pay providers for Medicare-paid nonroutine medical supplies and therapeutic services.** CMS could accomplish this by: working with States and the Regional Home Health Intermediaries to determine the costs and benefits of requiring providers to request from Medicare denial of payment notices that would then be submitted to the Medicaid program, addressing the cause of the inadequate Medicare eligibility data, determining the utility of allowing providers to override Medicaid payment denials for home health services, requesting States to reeducate providers on the requirement that Medicaid be the payor of last resort, and making current Medicare home health payment information available directly to States.

**Clarify CMS policy on Medicare PPS coverage of routine medical supplies.** CMS should clarify what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service and provide greater specificity on when routine medical supplies are paid for under Medicare PPS. Specifically, definitions of “required in quantity” and “recurring need” with respect to whether routine supplies should be considered nonroutine are needed.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS stated that it “did not disagree” with our first recommendation and recognized the importance of preventing duplicate Medicaid and Medicare billings. CMS offered what it believes is a simplification of one of our suggestions to address the first recommendation, which involves Medicare sending a copy of the denial of payment notice to the State Medicaid program. CMS concurred with our second recommendation to clarify policy on coverage of routine medical supplies under Medicare’s home health PPS.

CMS commented on the methodology of this review, stating that the absence of medical record review limits the findings. However, our claims analysis was sufficient to definitively identify \$1 million in inappropriate Medicaid payments, as well as to identify vulnerabilities that CMS should address to prevent duplicate payments. CMS also stated that our second finding is an assumption rather than fact. Our second finding is factual. We make no assumption about whether these payments were inappropriate.

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## OBJECTIVE

1. To determine, in five States, the extent to which both Medicaid and Medicare paid home health providers for the same medical supplies and therapeutic services.
2. To identify the controls that these five States have established that are intended to prevent duplicate payments.

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## BACKGROUND

### Home Health Services

Home health services are intended to restore health and minimize the effects of illness and disability, thereby enabling beneficiaries to reside in community settings and avoid institutionalization. These services include:

- nonroutine and routine medical supplies;<sup>1</sup>
- therapeutic services—speech, occupational, and physical therapy and medical social services; and
- assistive services—home health aide and skilled nursing services.

Both Medicaid and Medicare pay home health providers for home health services specified in the plans of care for beneficiaries; however, both should not pay for the same medical supplies or services for the same beneficiary.<sup>2</sup> Each program has specific payment structures and limitations on the services covered. This study examined Medicaid and Medicare payments for medical supplies and therapeutic services. A companion study will examine Medicaid and Medicare payments for assistive services.

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<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS). “Medicare Home Health Agency Manual” defines medical supplies as items that, because of their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to conduct home visits or to effectively carry out the services on the plan of care. “Medicare Home Health Agency Manual,” Pub. 11, section 206.4.

<sup>2</sup> Both Medicare and Medicaid cover only home health services ordered on a written plan of care for a specific beneficiary that a physician reviews every 60 days. CMS, “Medicare Home Health Agency Manual,” Pub. 11, section 204.2(F). A plan of care is the medical treatment plan that contains all diagnoses, types of services, supplies, and equipment required; the frequency of visits to be made; and all medication and treatments.

### Coverage and Payment of Home Health Services

States must offer home health services to Medicaid beneficiaries who meet the States' criteria for nursing home coverage.<sup>3</sup> Under the home health benefit, States must provide medical supplies and assistive services.<sup>4</sup> States may provide therapeutic services at their option.<sup>5</sup> All five States included in this study provided therapeutic services during the period of our review.

For medical supplies and services Medicaid covers, Medicaid “. . . will take all reasonable measures to ascertain the legal liability for third parties . . . to pay for care and services available under the plan. . . .”<sup>6</sup> Medicare qualifies as a third-party payor as defined above, and Medicaid should always be the payor of last resort.

For the five States included in our review, Tables 1 and 2 (next page) present total Medicaid claims and expenditures for home health supplies and services coverable by both Medicaid and Medicare in 2005.<sup>7</sup> Medicaid paid a total of \$184 million for 2.2 million claims for these supplies and services (\$37.2 million for nonroutine medical supplies, \$75.6 million for therapeutic services, and \$71.8 million for routine supplies). Excluded from these totals are supplies and services that Medicaid home health programs covered but that the Medicare Prospective Payment System (PPS) did not cover. The 2.2 million claims were for all beneficiaries regardless of dual eligibility.<sup>8</sup>

To be covered as part of the Medicare home health benefit, services must be reasonable, medically necessary, and specified on a plan of care.<sup>9</sup> Other than these requirements, Medicare does not limit the amount of nonroutine medical supplies or therapeutic services that a

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<sup>3</sup> Social Security Act (the Act) § 1902(a)(10)(D).

<sup>4</sup> 42 CFR § 441.15.

<sup>5</sup> Section 1905(a)(7) of the Act, 42 CFR §§ 440.70 and 441.15.

<sup>6</sup> Section 1902(a)(25)(A) of the Act.

<sup>7</sup> We define coverable supplies and services as those that Medicare could pay if the beneficiary was dually eligible; however, as noted in the Methodology section, our population was not restricted to beneficiaries identified as dually eligible on Medicaid claims and included all supplies and services paid by Medicaid regardless of whether the beneficiary was identified as dually eligible.

<sup>8</sup> Maryland enrolls all home health beneficiaries in managed care programs, except for dually eligible beneficiaries. Thus, Maryland's fee-for-service expenditures represent only expenditures for dually eligible beneficiaries.

<sup>9</sup> CMS. “Medicare Home Health Agency Manual,” Pub. 11, sections 203.1(A) and 203.1(B).



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beneficiary can receive through the home health benefit. Nonroutine medical supplies include items such as catheters, dressings, syringes, and needles.

**Table 1: Medicaid Claims and Expenditures for Home Health Nonroutine Medical Supplies and Therapeutic Services Coverable by Both Medicaid and Medicare for All Medicaid Beneficiaries in 2005**

State	Nonroutine Medical Supplies (Dollars)	Nonroutine Medical Supplies (Claims)	Therapeutic Services (Dollars)	Therapeutic Services (Claims)
Florida	\$10,902,160	103,382	\$3,436,109	51,397
Maryland	\$5,333	136	\$53,304	1,239
North Carolina	\$3,170,079	90,659	\$7,750,288	77,631
Ohio	\$9,765,963	90,241	\$12,847,646	184,593
Texas	\$13,351,263	547,933	\$51,554,385	403,037
<b>Total</b>	<b>\$37,194,798</b>	<b>832,351</b>	<b>\$75,641,733</b>	<b>717,897</b>

Source: Office of Inspector General analysis of State Medicaid claims data, 2007.

Medicare also covers routine medical supplies used in small quantities, such as cotton balls, gloves, and incontinence items, when they are provided during the course of a therapeutic or assistive home health service. For the five States included in our review, Table 2 presents total Medicaid claims and expenditures for home health routine medical supplies. See Appendix A for further details on Medicare coverage rules for medical supplies.

**Table 2: Medicaid Claims and Expenditures for Home Health Routine Medical Supplies Coverable by Both Medicaid and Medicare for All Medicaid Beneficiaries in 2005**

State	Routine Medical Supplies (Dollars)	Routine Medical Supplies (Claims)
Florida	\$2,173	37
Maryland	\$0	\$0
North Carolina	\$11,053,572	91,890
Ohio	\$1,068	7
Texas	\$60,782,007	551,527
<b>Total</b>	<b>\$71,838,820</b>	<b>643,461</b>

Source: Office of Inspector General analysis of State Medicaid claims data, 2007.

The Centers for Medicare & Medicaid Services (CMS) maintains a list of the services that Medicare covers and codes to be used in billing for them. This list is publicly available on the CMS Web site and is updated annually. Medicare contractors are notified of these updates through program memorandums.<sup>10</sup>

Effective October 1, 2000, Medicare began paying for home health services through a PPS. Under the Medicare home health PPS, home health providers are paid for all home health services provided to eligible beneficiaries during each 60-day episode of care, provided that the services meet coverage criteria. The Medicare payment for each episode of care may be split into two portions; home health providers typically receive approximately half the payment at the beginning of each episode and the balance at the end of the episode.

#### **Dually Eligible Beneficiaries and Home Health Payments**

As of January 1, 2006, CMS data indicated that approximately 6.1 million individuals were dually eligible for both Medicaid and Medicare.<sup>11</sup> Dual eligibility occurs when an individual meets both Medicaid and Medicare eligibility requirements. When both Medicare and Medicaid cover a particular supply or service, Medicare should pay first for services provided to dually eligible beneficiaries. Medicaid is the payor of last resort and therefore pays only for services that are covered by Medicaid but not covered by Medicare.

#### **Previous Studies and Related Work**

A 2005 Office of Inspector General (OIG) study entitled “Review of Medicaid Home Health Payments Rendered During a Medicare Covered Stay for Dual-Eligible Beneficiaries—State of Connecticut” (A-01-04-00011), identified \$1.8 million in Medicaid payments for Medicare-paid services from 2001 to 2003.

CMS is conducting two projects to identify duplicate Medicaid and Medicare payments. CMS began the Medi-Medi project in 2001 to reduce fraud, waste, and abuse by matching Medicaid and Medicare data to identify improper billing and utilization patterns. Medi-Medi is

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<sup>10</sup> “Home Health Consolidated Billing Master Code List.” Available online at [http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp). Accessed November 6, 2007.

<sup>11</sup> “Overview of the Many Steps That CMS Has Taken To Make Sure All Dual Eligibles Have Medicare Prescription Drug Coverage, January 1, 2006.” Retrieved online at <http://cms.hhs.gov>. Accessed on August 16, 2006; no longer available online.

currently reviewing claims in 10 States: California, Florida, Illinois, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington. When we conducted our analysis, Medi-Medi had not yet reviewed any home health claims in the States included in this study.<sup>12</sup> A pilot program streamlining States' third-party liability efforts is underway in Connecticut, Massachusetts, and New York. In this program, the Regional Home Health Intermediary reviews samples of Medicaid claims to determine whether Medicare should have paid them. If Medicare is identified as the appropriate payor, States receive refunds of their Medicaid payments from CMS.

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## METHODOLOGY

### State Selection

We examined Medicaid and Medicare claims for beneficiaries in five States: Florida, Maryland, North Carolina, Ohio, and Texas. We selected States that represented fee-for-service Medicaid expenditures for home health services in 2004 ranging from \$58,000 to \$126 million. To avoid overlapping with the efforts of the Regional Home Health Intermediary, we avoided selecting States that were participating in that pilot program.

### State Medicaid Agencies

We conducted structured interviews with Medicaid agency staff in each of the five selected States. During these interviews, we collected information and requested documentation regarding the home health services that each State provided through its Medicaid program. We also collected information on the postpayment audits that each State conducted and the controls that each State had in place intended to prevent Medicaid payments for home health services that Medicare paid.

### Claims Data and Analysis

*Medicaid Data.* We collected all final-action Medicaid Management Information System claims data for home health services in the five selected States for 2005. From these data, we extracted beneficiary identifiers, service dates, procedure codes, and payment amounts for all claims. A lack of complete Medicare eligibility indicators in the

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<sup>12</sup> Florida, North Carolina, Ohio, and Texas were included in our study and are participating in Medi-Medi.

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Medicaid claims data prevented us from calculating expenditures for only the dually eligible population.

*Medicare Data.* We used the National Claims History file to identify paid Medicare claims data representing episodes of care provided to beneficiaries in the five selected States for 2005. From these data, we extracted Health Insurance Claims Numbers (HICN) and service dates for all paid episodes and matched the HICNs from the claims against the Enrollment Database<sup>13</sup> to obtain each beneficiary's Social Security number.

*Medicaid-Medicare Data Match.* We matched claims for all beneficiaries who had home health claims, rather than limiting our data collection to beneficiaries with dual eligibility indicators, to ensure that we captured all beneficiaries receiving services that both programs paid for regardless of whether the indicator was present. Because Medicare covers routine medical supplies provided during the course of a therapeutic or assistive service, we determined how many of the routine supply claims fell on dates on which the beneficiaries also received therapeutic or assistive services.<sup>14</sup>

In each of the five selected States, we did the following:

- (1) We merged the Medicaid home health claims with the Medicare home health claims using Social Security numbers. The Medicaid claims had either specific service dates or date ranges, while the Medicare claims always had date ranges. The Medicaid dates and date ranges were matched against the Medicare date ranges for each beneficiary to identify potential duplicate claims. We then excluded any claims for services not covered under the PPS, because Medicaid payments for such services would not be duplicative.
- (2) We identified paid claims for Medicaid medical supplies and services that occurred within Medicare episodes of care, analyzed payment trends for types of services and dates of payments, and calculated

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<sup>13</sup> The CMS Enrollment Database contains current and historical Medicare enrollment and entitlement information for all beneficiaries ever enrolled.

<sup>14</sup> For this review, our only examination of assistive services was related to dates of service so that we could determine whether routine supply claims fell on the same dates as assistive services and therefore were likely covered by Medicare.

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duplicate payment amounts.<sup>15</sup> We also reviewed the dates of claims submission, receipt, and payment from each provider to determine temporal relationships between Medicaid and Medicare claims.

- (3) We conducted conference calls with the selected States to inquire about the reasons for duplicate payments. We also spoke with CMS officials to verify policy.

### **Limitations**

This study was limited to fee-for-service Medicaid and Medicare PPS payments for the same home health medical supplies and therapeutic services. We did not attempt to determine the medical necessity or appropriateness of any of the services provided, nor did we review the beneficiaries' plans of care.

### **Standards**

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

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<sup>15</sup> For the purposes of this study, we define a duplicate payment as any Medicaid payment for a PPS-covered therapeutic service or nonroutine medical supply on a date falling within a Medicare episode of care.

## ► FINDINGS

### **In four of the five States reviewed, Medicaid inappropriately paid a combined \$1 million in 2005 for nonroutine medical supplies and therapeutic services that were paid by Medicare**

Four of the five States included in our review made \$1 million in Medicaid payments for 84,061 claims in 2005 for nonroutine medical supplies

and/or therapeutic services that were paid by Medicare. Maryland had no inappropriately paid claims. These payments represent nearly 1 percent of the \$113 million that these States spent on reviewed home health nonroutine medical supplies and therapeutic services, and 6 percent of the 1.5 million total claims.<sup>16</sup>

All inappropriately paid claims were for supplies and services included on the publicly available list of Medicare-covered PPS services for 2005. Of these inappropriately paid claims, 98 percent were for nonroutine medical supplies, and 2 percent were for therapeutic services. Texas represented 58 percent of the total expenditures for home health nonroutine medical supplies and therapeutic services that we reviewed, but 89 percent of the total dollars inappropriately paid.

#### **States inappropriately paid \$802,039 for 82,081 claims for nonroutine medical supplies**

Texas accounted for 96 percent of the inappropriate expenditures for nonroutine medical supplies, followed by North Carolina and Florida (see Table 3 on the following page). Of Texas's nonroutine claims, 92 percent were billed with procedure code A4335 (nonroutine incontinence supplies).

Texas officials stated that a claims-level review would be the only way to determine why it had a disproportionate number of inappropriately paid medical supply claims when compared to those of the other four States. Texas did, however, lack indicators of dual eligibility for more than 99 percent of its inappropriately paid claims. Texas officials stated that Medicare or other third-party liability information may have been added to the eligibility file after the claims were paid.

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<sup>16</sup> These percentages should not be interpreted as error rates. As explained in the methodology, we are unable to determine total expenditures or total claims for only the dually eligible population. The percentages above represent proportions of total expenditures and claims for Medicare-coverable services for all beneficiaries, not dually eligible beneficiaries only.

<b>Table 3: Inappropriately Paid Medicaid Nonroutine Medical Supplies</b>		
<b>State</b>	<b>Dollars</b>	<b>Claims</b>
Florida	\$16,009	212
Maryland	\$0	0
North Carolina	\$15,847	450
Ohio	\$0	0
Texas	\$770,183	81,419
<b>Total</b>	<b>\$802,039</b>	<b>82,081</b>

Source: OIG analysis of State Medicaid claims data, 2007.

**States inappropriately paid \$219,125 for 1,980 claims for therapeutic services**

Ohio and Texas accounted for 93 percent of the inappropriate expenditures for therapeutic services, with North Carolina paying 7 percent of the identified inappropriate payments (see Table 4 below). Sixty-six percent of the identified therapeutic services were for physical therapy; Ohio accounted for 63 percent of the inappropriate expenditures for physical therapy claims. Ohio, Texas, and North Carolina used local codes for billing physical therapy claims. Although these were not the same as the codes included on the listing of Medicare PPS covered services, Medicare covers all therapeutic services provided to a beneficiary during home health episodes irrespective of the code used to bill that service. Thus, the Medicaid payments for these claims are duplicative.

<b>Table 4: Inappropriately Paid Medicaid Therapeutic Service Claims</b>		
<b>State</b>	<b>Dollars</b>	<b>Claims</b>
Florida	\$0	0
Maryland	\$0	0
North Carolina	\$14,891	149
Ohio	\$67,694	967
Texas	\$136,540	864
<b>Total</b>	<b>\$219,125</b>	<b>1,980</b>

Source: OIG analysis of State Medicaid claims data, 2007.

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**Medicaid paid \$6.6 million for routine supplies on the same dates as home health services; Medicare coverage of routine supplies cannot be determined from claims data**

Two States paid \$6.6 million for 74,648 claims for routine medical supplies on the same dates as therapeutic or assistive services. Texas represented 85 percent of

the total expenditures for home health routine medical supplies, but accounted for 98 percent of the expenditures for these claims (see Table 5 below). All of these claims were for various sizes of incontinence briefs and liners, which are typically covered by Medicare as routine medical supplies. Because Medicare PPS covers the cost of routine medical supplies that are customarily used in small quantities during the course of a therapeutic or assistive home health service, it is possible that these medical supplies were included in the Medicare payment and Medicaid should not have paid for them. However, claims data do not specify whether a routine supply was provided during the course of a therapeutic or assistive service or just on the same day as a service. Therefore, without reviewing medical records, neither OIG nor the State Medicaid programs can determine whether these medical supplies were in fact provided during the course of a therapeutic or assistive service.<sup>17</sup>

**Table 5: Paid Medicaid Claims for Routine Medical Supplies on the Same Dates as Home Health Services**

State	Amount Paid	Number of Claims
Florida	\$0	0
Maryland	\$0	0
North Carolina	\$164,231	1,780
Ohio	\$0	0
Texas	\$6,486,272	72,868
<b>Total</b>	<b>\$6,650,503</b>	<b>74,648</b>

Source: OIG analysis of State Medicaid claims data, 2007.

States paid an additional \$8.3 million for 93,082 claims for routine medical supplies that home health providers billed during Medicare episodes of care but that did not fall on the same dates as therapeutic or assistive services. The “Medicare Benefit Policy Manual” states, “There

<sup>17</sup> Reviewing medical records was outside the scope of this study.



are occasions when [routine supplies] would be considered nonroutine and thus would be considered a billable supply, i.e., if they are required in quantity, for recurring need, and are included in the plan of care.”<sup>18</sup> However, the Manual does not define “required in quantity” or “recurring need” with respect to whether routine supplies should be considered nonroutine. Lacking this definition, OIG cannot determine whether any or all of these claims should have been covered by Medicare as nonroutine supplies.

**All States reported having controls to prevent duplicate payments, but these did not eliminate all inappropriate payments**

Prior to our review, all five States had established payment system edits to compare claims for home health services to Medicare

eligibility information. However, incomplete eligibility information and payment system edit overrides may still allow inappropriate payments.

**States reported problems with eligibility information**

Medicare eligibility information was incomplete on many inappropriately paid claims. As previously stated, more than 99 percent of the inappropriately paid claims for Texas did not have a Medicare eligibility indicator populated—the field was empty. Maryland reported that the Medicare eligibility data may not indicate that a beneficiary became eligible for Medicare until a year after Medicare coverage began. CMS officials confirmed that because of retroactive eligibility determinations, Medicare eligibility data may not be up-to-date.

**States’ payment systems may allow payment despite Medicare eligibility**

Even when Medicare eligibility information was complete and correct, payment system edits failed to prevent some duplicate payments from being made. In North Carolina, 98 percent of inappropriately paid claims were for beneficiaries with Medicare eligibility indicators correctly populated. Home health providers in North Carolina can insert condition codes on claims to override the need for a Medicare denial when Medicaid criteria are met (e.g., beneficiary is receiving incontinence supplies but no therapeutic or assistive services). Providers must have documentation supporting the override available

<sup>18</sup> CMS. “Medicare Benefit Policy Manual,” Pub. 100-02, Chapter 7, section 50.4.1.2(E). See Appendix A for further details on the definitions of nonroutine and routine supplies.

upon request.<sup>19</sup> This may explain how the claims in North Carolina that correctly indicated the beneficiaries' eligibility for Medicare were paid; however, we did not request data on what claims providers overrode. A similar process exists in Ohio; if Medicare eligibility is indicated for a beneficiary, the provider may submit an appropriate adjustment code for Medicaid to process the claim.

**Despite Medicaid being the payor of last resort, State officials reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid**

Officials in the reviewed States indicated that they did not have direct access to Medicare PPS payment data, which would provide information about whether and when a beneficiary

was receiving Medicare-paid services. Most inappropriately paid claims were likely paid after Medicare made the initial payments for episodes, and Medicaid paid 10 percent of inappropriate claims after the final Medicare payment. At the time of our review, States lacked direct access to Medicare claims data. If States had direct access, they would be able to determine whether a beneficiary has an open episode of care before processing a Medicaid home health service claim.

The order of claims submission dates and dates of payment indicates that some home health providers are submitting Medicaid claims for medical supplies and therapeutic services when they have already received Medicare payments. This may be true for many inappropriately paid Medicaid claims, given that Medicare makes both an initial and a final payment for each 60-day episode of care. Providers submitting Medicaid claims during open episodes of care may have already received the initial Medicare payments for those episodes.

Maryland and Florida, which had fewer claims paid in error compared to the other States reviewed, require home health providers to show that Medicare denied the claims for beneficiaries with Medicare eligibility information before Medicaid pays. Ohio does not require a denial of payment notice; however, it does require providers to submit claims for dually eligible beneficiaries to Medicaid with adjustment

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<sup>19</sup> In many cases, overriding the denials may be appropriate because Medicaid often covers services that Medicare does not. However, it is also possible that providers may override denials to collect additional Medicaid payments.

## F I N D I N G S

codes showing why payment is due (e.g., Medicare denied the claim).<sup>20</sup> The majority of claims that Medicaid paid during and after Medicare episodes of care occurred in Texas, where the Medicaid program does not require a denial of payment notice from Medicare. North Carolina also does not require a denial of payment notice from Medicare.

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<sup>20</sup> In limited circumstances, Ohio allows Medicaid payments for dually eligible beneficiaries without adjustment codes—for instance, if the provider has previously billed Medicare for the service and has documentation showing that Medicare previously denied the payment.



## R E C O M M E N D A T I O N S

Our results show that Medicaid inappropriately paid for some supplies and therapeutic services for which Medicare had paid. In 2005, the five States reviewed made \$1 million in inappropriate Medicaid payments to home health agencies for therapeutic services and nonroutine medical supplies; two State Medicaid programs paid another \$6.6 million for routine medical supplies on the same dates as Medicare-covered home health services, but it is not possible to determine from the claims data alone whether these payments were appropriate. Although all States had controls in place to prevent duplicate payments, these controls did not prevent all inappropriate payments. Further, States reported that they lacked direct access to Medicare claims data to determine whether Medicare had already paid. As a result, despite Medicaid being the payor of last resort, Medicaid likely made most of the inappropriate home health payments after the initial Medicare payments and 10 percent of the inappropriate payments after the final Medicare payments.

We recommend that CMS:

### **Ensure That Medicaid Does Not Pay Providers for Medicare-Paid Nonroutine Medical Supplies and Therapeutic Services**

CMS could accomplish this through:

- working with States and Regional Home Health Intermediaries to determine the costs and benefits of requiring providers to request from Medicare denial of payment notices that would then be submitted to the Medicaid program,
- investigating and addressing the causes of States' incomplete Medicare eligibility data,
- working with States to determine the utility of allowing providers to override Medicaid denials for home health services for dually eligible beneficiaries,
- requesting States to reeducate providers on the requirement that Medicaid be the payor of last resort and that Medicaid not be billed for services that Medicare covers, and
- making current Medicare home health payment information available directly to States to allow States to determine whether Medicaid providers are billing for beneficiaries during Medicare-covered home health episodes of care.

**Clarify CMS Policy on Medicare PPS Coverage of Routine Medical Supplies**

CMS should clarify what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service and provide greater specificity on when routine medical supplies are paid for under Medicare PPS. Specifically, definitions of “required in quantity” and “recurring need” with respect to whether routine supplies should be considered nonroutine are needed.

*We note that this review was conducted as a statistical match of computerized data. Under the provisions of the Computer Matching and Privacy Protection Act of 1988, we cannot forward the results to CMS or the States for collection of the inappropriate payments.*

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**AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its written comments on the report, CMS stated that it “did not disagree” with our first recommendation and recognized the importance of preventing duplicate Medicaid and Medicare billings. CMS offered what it believes is a simplification of one of our suggestions to address the first recommendation, which involves Medicare sending a copy of the denial of payment notice to the State Medicaid program. CMS concurred with our second recommendation to clarify the policy on coverage of routine medical supplies under Medicare’s home health PPS.

CMS commented on the methodology of this review, stating that the absence of medical record review or further analysis of potential duplicate payments limits the findings. Medical record review and follow-up analysis could provide additional useful information about inappropriate payments. However, our claims analysis was sufficient to definitively identify \$1 million in inappropriate Medicaid payments, as well as to identify vulnerabilities that CMS should address to prevent duplicate payments.

CMS also stated that our second finding is an assumption rather than fact. Our second finding, which states that Medicaid paid \$6.6 million for routine supplies on the same dates as home health services, is factual. We make no assumption about whether these payments were inappropriate. As stated in the finding, “. . . without reviewing medical records, neither OIG nor the State Medicaid programs can determine

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whether these medical supplies were in fact provided during the course of a therapeutic or assistive service.”

CMS stated that the Medicaid and Medicare matches were not exact. The nature of PPS payments, which include all supplies and services that Medicare covers, makes it impossible to find one-to-one matches between Medicaid and Medicare payments. As described in our methodology, it is nonetheless possible to identify duplicate payments using these matches.

CMS also stated that we were unable to calculate expenditures for only the dually eligible population. The lack of accurate dual eligibility indicators on claims data makes this calculation impossible.

Consequently, our first recommendation suggests that CMS investigate and address the causes of States’ incomplete Medicare eligibility data.

Finally, CMS requested further elaboration on Maryland’s success in preventing duplicate payments for home health services. Our discussions with Maryland Medicaid officials did not reveal any significant differences between their efforts to prevent duplicate payments and the efforts of the other four States reviewed. Maryland’s lack of inappropriate payments is due most likely to the significantly smaller number of beneficiaries who were receiving services paid by both Medicaid and Medicare rather than differences in States’ prevention efforts.

We made technical corrections to the report based on CMS’s comments. The full text of CMS’s comments is provided in Appendix B.

### **Medicare Coverage of Nonroutine and Routine Medical Supplies**

Medicare covers nonroutine medical supplies under the following conditions: (1) the home health agency follows a consistent charging practice for Medicare and other patients receiving the item, (2) the item is directly identifiable to an individual patient, (3) the cost of the item can be identified and accumulated separately from other services, and (4) the item is furnished at the direction of the patient's physician and is specifically identified in the plan of care. Examples of nonroutine medical supplies include catheter supplies, dressings, syringes, needles, and certain incontinence supplies.<sup>21</sup>

Routine medical supplies are defined as those that are customarily used in small quantities during the course of most home care visits, which are usually included in the staff's supplies and not designated for a specific patient. Routine medical supplies are included in Medicare Prospective Payment System if they are provided during the course of a therapeutic or assistive service (i.e., a physical therapy or skilled nursing visit). Examples of routine medical supplies include gloves, cotton balls, and certain incontinence supplies. If a supply that is normally considered routine is required in quantity for recurring need and is specified in the plan of care, it may be considered a nonroutine supply.<sup>22</sup>

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<sup>21</sup> Centers for Medicare & Medicaid Services (CMS). "Medicare Benefit Policy Manual," Pub 100-02, Chapter 7, section 50.4.1.3.

<sup>22</sup> CMS. "Medicare Benefit Policy Manual," Pub 100-02, Chapter 7, section 50.4.1.2.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

DATE: **MAR 25 2008**

TO: Daniel R. Levinson  
Inspector General

FROM: Kerry Weems  
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic Services" (OEI-07-06-00640)

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The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on the OIG Draft Report entitled, "Duplicate Medicaid and Medicare Home Health Payments: Medical Supplies and Therapeutic Services" (OEI-07-06-00640). The objectives of the report were to--1) Determine, in five States, the extent to which Medicare and Medicaid paid home health providers for the same medical supplies and therapeutic services; and 2) Identify the controls that these five States have established that are intended to prevent duplicate payments.

The CMS recognizes that duplicate billing of Medicare and Medicaid by providers is an area of concern, and we have undertaken new and expanded initiatives to combat fraud and abuse in Medicare and Medicaid. Medicaid program integrity provisions in the Deficit Reduction Act of 2005 (DRA) provided additional funding and staffing to better address fraud, waste, and abuse in the Medicaid program. The DRA also provided additional funding to expand the Medicare-Medicaid (Medi-Medi) data match pilot program to all States. Moreover, the DRA created the Medicaid Integrity Program (MIP). This program is overseen by the Medicaid Integrity Group (MIG) within CMS' Center for Medicaid and State Operations (CMSO). We welcome the challenges to reduce Medicaid fraud and abuse and are grateful for the resources to take on this significant program initiative.

**OIG Recommendation**

Ensure that Medicaid does not pay providers for Medicare-paid nonroutine medical supplies and therapeutic services.

**CMS Response**

The CMS does not disagree with this OIG recommendation. However, accomplishing this by requiring that providers request a Medicare "denial of payment" notice, which would then be submitted to the Medicaid program along with their claim, could be simplified. An improvement

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would be to have Medicare send a copy of the denial of payment notice to the State Medicaid program. We also concur with the OIG's recommendation of making current Medicare home health payment information available directly to the States. This would facilitate the States' abilities to identify duplicate claims.

**OIG Recommendation**

Clarify CMS policy on Medicare Prospective Payment System (PPS) coverage of routine medical supplies.

**CMS Response**

The CMS concurs with this recommendation to clarify the policy on coverage of routine medical supplies under Medicare's home health PPS as it relates to what constitutes Medicare-covered routine medical supplies used in the course of a therapeutic or assistive service. The costs of both routine and non-routine medical supplies are accounted for in the Medicare home health PPS 60-day episode rate. Consolidating existing policy guidance on the coverage and reporting of routine and non-routine medical supplies may help address the concerns raised in this report.

We have the following general comments on the draft report:

- Any publicly released statements about the report should emphasize that the study was conducted in only five States and cannot be extrapolated nationally to other States or beyond the timeframe of the report evaluation.
- The report looked at "potential duplicate claims" in five States: Florida, Maryland, North Carolina, Ohio, and Texas. However, only two of the States, North Carolina and Texas, had potential duplicate payments identified. These payments warranted further investigation to substantiate if they were indeed duplicative and inappropriate. Unfortunately, reviewing medical records was outside the scope of this study.
- For purposes of the study, the OIG defined a duplicate claim or payment as any Medicaid payment for a Medicare PPS covered therapeutic service or non-routine medical supply on a date falling within a Medicare "episode of care." The "episode of care" in this case is 60 days. The duplicate claim or payment was determined by a data match occurring anywhere within the 60-day period. The methodology of the study was severely limited because no further analysis was done on the "potential duplicate payments" other than the data match identification.
- A further complication to the results of the study is that the five States reviewed were paying home health claims using a fee-for-service coding system whereas Medicare was using a bundled PPS payment system that does not differentiate the claim. The data matches, on a claim-by-claim basis, were, therefore, not always exact.
- As a consequence of the suspect methodology, the second finding in the report - *Medicaid paid \$6.6 million for routine medical supplies on the same dates as home health services. Medicare coverage of routine supplies cannot be determined from claims data* - is problematical because it

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is more of an assumption than a substantiated fact. Medicare claims do not specify whether a routine supply was provided during the course of a home health service or just within the 60-day episode of care. Without reviewing the associated beneficiaries' medical records, this finding cannot be corroborated.

- Another limitation in the report is that the OIG was not able to determine total expenditures for only the affected dual-eligible population. Consequently, the percentages in the report are proportions of total expenditures and claims for Medicare-coverable services for all beneficiaries, not just dually eligible beneficiaries.
- Page 4, paragraph 5. The statement, "CMS began the Medi-Medi project in 2001 to identify duplicate Medicaid and Medicare payments for selected services..." is not clear. The identification of duplicate payments is an outcome of the program rather than its purpose. The report should state that the purpose of the Medi-Medi project is to reduce fraud, waste, and abuse by matching Medicaid and Medicare data to identify improper billing and utilization patterns. Moreover, the program enhances collaboration with our State partners and identifies program vulnerabilities.
- Page 8, paragraph 1. The report states that "Maryland had no inappropriately paid claims." It would be interesting to find out what Maryland was doing correctly or differently from the other four States that allowed it to avert any duplicate payments. In keeping with the second objective of the report (to identify the controls these five States have established that are intended to prevent duplicate payments), we would encourage you to elaborate on this. Good work like Maryland's should be annotated so that it can be shared with the other States and noted among best practices.

Once again, CMS thanks the OIG for the opportunity to review and comment on this report.



## A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Brian Whitley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael Barrett, Michala Walker, and Julie Dusold; central office staff who contributed include Scott Horning, Kevin Manley, and Jennifer Jones.