

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS FOR  
SERVICES PROVIDED TO  
INCARCERATED BENEFICIARIES IN THE  
COMMONWEALTH OF VIRGINIA**



**JANET REHNQUIST  
INSPECTOR GENERAL**

**JULY 2002  
A-03-02-00003**

# *Notices*

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**Memorandum**

Date July 31, 2002

From Regional Inspector General for Audit Services

Subject Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the Commonwealth of Virginia (CIN: A-03-02-00003)

To Sonia A. Madison  
Regional Administrator  
Centers for Medicare & Medicaid Services

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 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 Commonwealth of Virginia was one 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 to Incarcerated Beneficiaries*, in which we found that the Medicare program had paid \$32 million in fee-for-service benefits 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 that there must be a State or local law requiring all such individuals, or groups of individuals, repay the cost of medical services *and* the incarcerating entity must enforce this requirement by diligently pursuing collection.

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 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.

During our reviews in the 10 States, we found that Medicare payments are allowable for some categories of beneficiaries who are in custody under penal statute while unallowable for other categories of beneficiaries in custody under penal statute. This has occurred because regulations and CMS guidelines require that the State or local law requiring repayment of the costs of medical services and the enforcement requirements

may apply to categories of individuals, rather than to all individuals. A category of beneficiaries is comprised of beneficiaries with the same legal status (e.g., not guilty by reason of insanity (NGRI)). Therefore, the allowability of a Medicare payment depends on the beneficiary's specific category of legal status even though he or she is in custody under a penal statute. During our review we found this was an important distinction.

Virginia is required to pay for the health care costs for prisoners who are incarcerated under the Department of Corrections jurisdiction. However, Virginia law requires that patients admitted to any State hospital pay their own expenses for medical and psychiatric care and treatment. Payment for 81 of the 100 claims sampled in Virginia were made on behalf of beneficiaries placed in State-operated psychiatric hospitals after they were found to be NGRI. Because the legal status of prisoners in psychiatric hospitals is different than a prisoner in custody of the Department of Corrections, Medicare claims for these patients were proper. These 81 claims totaled \$22,589.

However, we found that Medicare payments for 8 claims totaling \$6,550 were improper because, at the time the service was provided, the beneficiaries came under the jurisdiction of the Department of Corrections or local jurisdictions. The Commonwealth of Virginia or the local government was responsible for their health needs. In three of these instances the beneficiary was in custody of a local facility and required treatment of a pre-existing condition. Under the local policy, these facilities assumed responsibility for conditions occurring after the inmates enter the facilities, but the policy made inmates financially responsible for pre-existing conditions. Since there was no State or local law establishing this policy, Medicare payments of these claims were improper.

We were unable to determine the exact whereabouts of the beneficiaries at the time the services were rendered for the remaining 11 claims. Therefore, we could not determine Medicare allowability. Passage of time, transfers between facilities, aliases, and the sometimes use of different Social Security Numbers contributed and made the process of determining the custody status of the beneficiary 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 that the conditions for Medicare payment have been met. We believe when fully implemented this enhancement 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 that the conditions for Medicare reimbursement are met.

We further believe CMS needs to alert its contractors of the practice of some local correctional facilities in Virginia that are placing the financial responsibility for pre-existing conditions on the inmate and his or her insurer without this being a requirement set forth in law. Although these facilities can require payment from prisoners, payment by Medicare is not allowable since this practice does not meet the requirements for Medicare reimbursement as stated below.

In a written response to a draft of this report, CMS officials reported that as a result of an OIG review, *Review of Medicare Payments to Incarcerated Beneficiaries*, CMS released Change Order Request (COR) 2139 on May 1, 2002. The CMS stated that COR makes changes to CWF with the expressed desire to reject claims for incarcerated beneficiaries. The CMS stated that COR addresses all four recommendations presented in the report. Finally, CMS anticipates sending a letter to contractors emphasizing the importance of the change request and its timely implementation.

In our opinion, the COR does not address the need for CMS to alert contractors to the practice of some local correctional facilities that place the financial responsibility for pre-existing conditions on the inmate. We summarized the CMS' response along with our comments after the conclusion and recommendation section of the report. The full text of CMS' response is included as an APPENDIX to this report.

## INTRODUCTION

### BACKGROUND

Under current Federal law and regulations, payments for 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 that:

- (a) General rule: Except as provided in 411.8(b) (for services paid by a government entity), Medicare does not pay for 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 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 services. 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. Guidelines in CMS contractor manuals state the government entity must enforce the requirement to pay and seek collection from all individuals in custody with the same legal status (e.g., NGRI).

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's 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 Virginia that included 3,585 claims totaling \$1,561,725. Using the Virginia listing, we selected a random statistical sample of 100 fee-for-services claims totaling \$29,783 paid between January 1, 1997 and December 31, 1999.

## **OBJECTIVE, SCOPE AND METHODOLOGY**

Our objective was to determine whether Medicare payments for services provided to beneficiaries reported to be incarcerated during the period January 1, 1997 through December 31, 1999 were in compliance with 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.
- Met with CMS officials in Region III to discuss Medicare criteria involving incarcerated beneficiaries and to ascertain if any supplier or provider had contacted them to inquire about Medicare guidelines for health care services furnished to incarcerated beneficiaries.
- Reviewed applicable Virginia 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 counties, where the individuals in our sample were incarcerated, have laws requiring inmates to pay for the cost of their health care.
- Met with various State officials including individuals from the Virginia Department of Corrections, Department of Health, Mental Retardation and Substance Abuse, and the Virginia Compensation Board.
- Held discussions with officials of the Medicare fiscal intermediary and carrier in Virginia 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.
- Checked the FBOP database to determine if any beneficiaries, whose incarceration status on the date of service could not be determined, were confined at the Federal prison.

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 objectives 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 October 2001 through April 2002.

## FINDINGS AND RECOMMENDATIONS

Since prisoner data from SSA was not contained in CMS’s records, the Medicare fiscal intermediary and carrier in Virginia did not have controls in place to detect claims submitted on behalf of incarcerated beneficiaries.

We found 81 percent of the sampled claims in Virginia were appropriate. Eighty-one claims in our 100-claim sample were for beneficiaries who were found to be NGRI and were in State-operated psychiatric hospitals. Virginia law deems these beneficiaries to be “patients” rather than “prisoners”. As such, under Virginia law these beneficiaries are responsible for their health care costs. Under current CMS guidelines, a distinction in legal status of groups of beneficiaries is permissible. 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. This separation of beneficiaries by groups can result in Medicare coverage for one group (in Virginia this group would be the NGRIs deemed to be patients) and the non-coverage of another group (in this case those in State or local correctional facilities). Because of this dichotomy, we found the majority of payments in our review were allowable.

We also found that three local correctional facilities were requiring individuals to be financially responsible for the medical service related to pre-existing conditions at the time they were taken into custody. Meanwhile, medical conditions developing after entry were the responsibility of the facility. However, this practice was based only on the policy of the facility and had no basis in law, which would make Medicare payments improper.

In addition, for some claims we were unable to determine the custody status of the beneficiaries at the time of medical services and we were therefore unable to determine the allowability of the Medicare claim. The following table summarizes the results of our review:

<i>Description</i>	<i>Sample Amount</i>	<i>Number of Claims</i>	<i>Number of Beneficiaries</i>
<i>Allowable</i>	\$22,589	81	41
<i>Unallowable</i>	6,550	8	8
<i>Unable to determine</i>	644	11	6
<i>Total</i>	\$29,783	100	55*

- There were 54 beneficiaries in our sample. One beneficiary had both an allowable and an unallowable claim.



## **ALLOWABLE CLAIMS**

Our review showed that Medicare payments on 81 claims totaling \$22,589 met Medicare reimbursement requirements. These payments were made on behalf of the beneficiaries placed in State-operated psychiatric hospitals because they were found to be NGRI.

Virginia law requires that patients admitted to any State hospital pay their own expenses for their medical and psychiatric care and treatment. Section 37.1-105 of the Virginia Code states that:

*Any person who has been or who may be admitted to any state hospital or who is the subject of counseling or receives treatment from the staff of a state hospital shall be deemed to be a patient for the purposes of this article. The income and estate of a patient shall be liable for the expenses of his care and treatment or training in a state hospital. Any person or persons responsible for holding, managing or controlling the income and estate of the patient shall apply such income and estate toward the expenses of the patient's care and treatment or training.*

Our review of collection procedures of non-Medicare claims showed that collection procedures were adequate and applied uniformly for all claims. We believed that payments made on the beneficiaries' behalf were allowable and consistent with Medicare reimbursement requirements because NGRI patients were liable for their health care costs under the Virginia Code and uniform collection procedures were enforced.

## **UNALLOWABLE CLAIMS**

We identified payments for 8 claims totaling \$6,550 that were unallowable under Medicare reimbursement requirements. Title 42 CFR sections 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.

Virginia pays the health care costs for prisoners under the Department of Corrections jurisdiction. The Commonwealth officials confirmed that Virginia does not have a law requiring prisoners to pay for their own health care costs while in the custody of the State correctional system. Also, there are no local laws that require inmates to pay for their health care costs while in custody. Therefore, local governments are responsible for the health care of their inmates.

Our review showed that 8 of the 100 claims in our sample were for services provided to beneficiaries who were incarcerated in State or local facilities on the dates of service. Of

the eight claims, six claims totaling \$6,486 were for beneficiaries who were incarcerated in local government operated correctional facilities when services were provided.

- ✓ Three claims totaling \$128 were for beneficiaries who had a pre-existing condition. The correctional facilities where these beneficiaries were housed had policies stating that they are not liable for the healthcare costs of inmates with pre-existing conditions. The correctional facilities allowed the inmates to seek outside medical attention. However, this practice was not reflected in law which is one of the conditions required for Medicare payment under 42 CFR 411.4 (b).
  - ✓ One claim totaling \$19 was billed when a correctional facility doctor treated an inmate who needed an outside laboratory test. The correctional facility did not know that the doctor requested the test and the laboratory billed Medicare.
  - ✓ One claim totaling \$6,301 was paid to a hospital, which provided a service that should have been billed to the correctional facility's health care contractor.
  - ✓ We could not determine why Medicare was billed for the remaining claim for \$38.
- Two claims totaling \$64 were for beneficiaries who were incarcerated in State-operated correctional facilities when the services were provided. In both claims, the correctional facility was unaware that a bill had been sent to Medicare. In one case the correctional facility was also unaware that the beneficiary was receiving medical treatment for monitoring a pacemaker via the phone. The second case involved rental of medical equipment. Correctional facility officials were aware of the existence of the equipment but they were not aware of the rental arrangement with Medicare.

#### **UNABLE TO DETERMINE ALLOWABILITY OF CLAIMS**

We were unable to determine the whereabouts, at the time the services were rendered, of 6 beneficiaries who had 11 claims in our sample. We checked the FBOP, State and local correctional facility databases. The State maintained a database that contained incarceration records for State-operated correctional facilities as well as local correctional facilities. We also checked the State Department of Mental Health database to determine if these beneficiaries were in State psychiatric hospitals on the dates of service.

- ✓ We found some incarceration information on three of the beneficiaries, including one Federal prisoner, but the information was inconclusive to determine the whereabouts of the beneficiaries on the dates the services were rendered.

- ✓ For the other three beneficiaries, we could find no record of any encounters with correction facilities or mental hospitals in the Commonwealth of Virginia.

Since we were unable to determine if the beneficiary was in custody at the time the services were rendered, we were unable to determine the allowability of the Medicare claims. Passage of time, transfers between facilities, aliases, and the sometimes use of different Social Security Numbers contributed and made 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 Virginia determined that 8 claims out of our sample of 100 claims did not meet Medicare reimbursement requirements. We did not examine the remaining 3,485 claims in the universe. If CMS decides to consider readjudication of 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 on behalf of NGRI beneficiaries in State-operated psychiatric hospitals in Virginia were allowable because of provisions in Virginia law that requires these individuals to pay for their medical care and the hospitals 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.

We also found that some local correctional facilities in the Commonwealth of Virginia place the financial responsibility for pre-existing conditions on the inmate. These facilities can require payment from prisoners, however payment by Medicare is not allowable since this practice is not subject to the Federal requirement of 42 CFR 411.4(b)(1). To avoid future improper Medicare payments, local correctional facilities should be informed that this practice does not meet Medicare reimbursement requirements.

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:

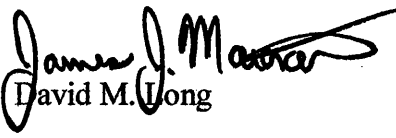
- Require its contractors to monitor future claims made on behalf of NGRI beneficiaries to ensure the conditions for payment continue to be met.
- Alert its contractors to the practice of some local correctional facilities that place the financial responsibility for pre-existing conditions on the inmate. Local correctional facilities should be informed that this practice does not meet Medicare reimbursement requirements.
- Make a concerted effort through its contractors to educate suppliers and providers on the meaning of the modifier or condition code and circumstance relating to their proper use.
- 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.

#### **CMS' Response**

By memorandum dated July 16, 2002, CMS officials responded to a draft of this report. The CMS reported that as a result of an OIG review, *Review of Medicare Payments to Incarcerated Beneficiaries*, CMS released COR 2139 on May 1, 2002. The CMS stated that the COR makes changes to CWF with the expressed desire to reject claims for incarcerated beneficiaries. The CMS stated that the COR addresses all four recommendations presented in the report. Finally, CMS stated that it anticipates sending a letter to contractors emphasizing the importance of the change request and its timely implementation.

#### **OIG Comment**

The COR establishes edits in CWF to reject claims for incarcerated beneficiaries. However, the COR does not address the need for CMS to alert contractors to the practice of some local correctional facilities that place the financial responsibility for pre-existing conditions on the inmate. We believe that CMS needs to alert contractors to ensure that Medicare payments for incarcerated beneficiaries are in compliance with Federal regulations.

  
David M. Long

## APPENDIX



# Memorandum

Centers for Medicare & Medicaid Services

Region III

Suite 216, The Public Ledger Bldg  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

Refer to: R3-DFM(16)  
File Code: A030200003

Date: JUL 16 2002

To: Regional Inspector General for Audit Services  
Philadelphia Regional Office

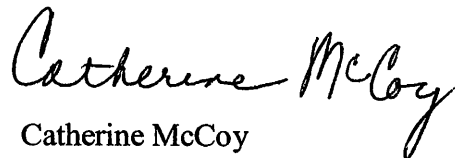
From: Acting Associate Regional Administrator  
Financial Management Division

Subject: Draft Audit Report – CIN A-03-02-00003

Thank you for the opportunity to respond to your draft audit – “Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries in the Commonwealth of Virginia” CIN A-03-02-00003. We have read the report and have the following comments.

As a result of your review, CMS released Change Request 2139 on May 1, 2002. The change request makes changes to CWF with the expressed desire to reject claims for incarcerated beneficiaries. The change request addresses all four of the recommendations found in your report. We also anticipate sending a letter to contractors to emphasize the importance of this change request and their timely implementation of its contents.

Thank you for bringing this matter to my attention. Any assistance that you may need from this office with respect to the issues contained in this report may be directed to Dan Robison of my staff at (215) 861-4197.

  
Catherine McCoy