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February 22, 1983

Ms. Barbara Gagel
Regional Administrator
Health Care Financing Administration
Region V
175 West Jackson Boulevard
Suite A-835
Chicago, Illinois 60604


Dear Ms. Gagel:

Subject: Review of Medicare and Medicaid Duplicate Payments in Michigan (GAO/HRD-83-43)

As part of our continuing review of medical payments under the Medicare and Medicaid programs, we reviewed the practices and procedures used by the Michigan Medicare carrier (Blue Cross/Blue Shield of Michigan) and Medicaid administrator (State of Michigan Medical Services Administration) to prevent duplicate payments to physicians with more than one provider identification number. We also reviewed the practices and procedures they used to remove unlicensed physicians from the Medicare and Medicaid rolls. We found that:

--Duplicate payments of $39,023 (actual) and $14,549 (estimated) were made to Medicare providers having multiple provider numbers.

--Duplicate payments of $24,893 were made to Medicaid providers having multiple provider numbers.

--Estimated overpayments of $74,850 were made to surgical assistants and anesthesiologists for Medicare covered services.

--Improper payments of $13,000 were made to unlicensed physicians for Medicare covered services.

According to the carrier's and the State's payments records, few of these erroneous payments had been voluntarily returned by the providers or Medicare beneficiaries or otherwise recovered.

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The Medicare carrier has indicated that actions have been taken to correct the matters discussed in this report. The State Medical Services Administration is redesigning its provider enrollment system to implement a single number system which will detect potential duplicate billings. We are reporting the results of our review so you may monitor the progress of these corrective actions. Details of our review follow.

## OBJECTIVES, SCOPE AND METHODOLOGY

The objective of our review was to determine if duplicate payments are being made to Michigan physicians under the Medicare Part B and Medicaid programs. Specifically, we wanted to know if the Medicare carrier and the State have proper controls over the issuance of provider numbers and if some physicians are receiving duplicate payments because they submitted the claims using different provider numbers.

We also checked to see if the physicians were properly licensed. We reviewed the procedures used by the carrier and the State to assure that physicians were licensed by the State medical licensing boards to provide medical services. Also, we compared the Medicare and Medicaid provider listings to the boards' listings to determine if the physicians had valid and current licenses.

We reviewed the procedures used by the carrier and the State for processing claims. This review included determining how single and multiple provider identification numbers are issued and controlled, how incomplete claims are handled, what computer edits are in place to detect potential duplicates, and the actions taken in reviewing claims suspended for manual review.

At our request, the carrier developed and applied a computer program to its beneficiary files, for the period October 1, 1980 through June 30, 1982, to identify potential duplicate payments. During this period, the carrier processed claims for over 34 million services provided to Medicare beneficiaries.

Application of the computer program by the Medicare carrier identified over 34,000 pairs of services that met our criteria for potential duplicates. However, over 25,000 of these pairs were for services under $50. Because a carrier is not required to collect improper payments under $50, we limited our review to the remaining 9,000 pairs that were for services over $50. We examined in detail 260 of these potential duplicates to determine whether duplicate payments had, in fact, been made. In selecting the 260 pairs, we concentrated on those we believed would have a high probability for being duplicates.

To analyze the Medicaid claims, we obtained 25 reels of computer tape that contained claim histories for Medicaid recipients for the year ending June 30, 1982. These reels contained claims for over 9.9 million services paid on behalf of Michigan Medicaid recipients. We then developed a computer program to identify potential duplicate payments meeting specific criteria.

Our review was made at the carrier's offices in Detroit, Michigan; State offices in Lansing, Michigan and at the Health Care Financing Administration headquarters in Washington, D.C. The review was performed in accordance with generally accepted Government Auditing Standards. We did not perform a reliability assessment of the carrier's or the State's electronic data processing systems for making payments.

## DUPLICATE MEDICARE PAYMENTS COULD BE REDUCED BY IMPROVED MANUAL REVIEW

We examined 260 potentially duplicate claims and identified 149 which were improperly paid $38,199 during the 21-month period October 1, 1980 through June 30, 1982. In addition, we found that the Michigan carrier paid $824 to a physician who provided medical services to a patient in Ohio. The Ohio Medicare carrier was billed and also paid for the same service.

In determining why duplicate payments were made, we found that most were either caused by physicians assigning different provider numbers to two claims for the same service, or by the carrier assigning an incorrect number to a claim that was submitted without a provider number. This can happen because a physician may have one or more numbers. For example, a Medicare provider can have a separate provider number for each office location.

Because the carrier makes computer checks, known as edits, to detect potential duplicate payments, most of these duplicate claims were initially rejected for payment and given to a claims examiner for review. We believe, in the majority of these cases, the examiner did not adequately review both the suspended and previously paid claim prior to making the determination to pay the suspended claim.

The carrier's review procedures do not require, in all cases, that claims examiners be given copies of both claims when they make their review. When copies of both claims are not obtained, examiners have greater difficulty in determining whether the second claim should be paid. We were able to make correct determinations on the claims we reviewed only after looking at copies of both claims.

Forty percent of the duplicate claims were caused by physicians submitting claims under two different provider numbers for the same service. For example, in some cases physicians were not paid timely for claims submitted and they then resubmitted them under another provider number and were paid. The initial claims

were then eventually paid because the claims examiners bypassed the computer internal edits which reject claims for the same service. As a result, duplicate claims were paid.

Another 28 percent of the duplicate claims were for patients who submitted claim forms and physician's receipts without including the physician's provider number on the claim. To process these claims, the carrier assigned a provider number to the claim. In most of these cases, the carrier assigned an incorrect number. A second claim was then submitted by the patient or the unpaid physician with the correct provider number. Both claims were paid, resulting in a duplicate payment for the same service. Again, the basic cause was that the claims examiner bypassed the computer edits to allow payment of the second claim.

Still, another 15 percent of the duplicate claims were from physicians who showed incorrect or no provider numbers on their claims. In these cases, the carrier assigned the wrong provider number, thereby causing another physician to be improperly paid. Because the physician who provided the service did not receive payment, a second claim was submitted and was also paid.

Finally, the majority of the remaining 17 percent of the duplicate claims were submitted correctly by the physicians, but the carrier assigned an incorrect provider number and thereby improperly paid another physician. Again, in these instances the physicians not being paid resubmitted their claims and were also paid.

Duplicate payments can also result if Medicare carriers in different states are billed for the same service. In this regard, we performed a limited test of the Michigan carrier's out-of-state provider payment controls. Specifically, after identifying two physicians who were Medicare providers and practiced in Michigan and Ohio, we compared their Medicare provider payment history records for the two states. We found that one of the two physicians submitted duplicate claims to both the Ohio and Michigan carriers for a patient he treated in Ohio. The Ohio carrier paid $670 and the Michigan carrier paid $824.

According to regulations, a claim should be submitted for payment to the carrier in the state where the service was provided. Therefore, because the provider treated the patient in Ohio, the Michigan carrier should not have paid the claim.

The carrier plans to review the duplicate payments we identified and take collection action.

## MEDICAID DUPLICATE PAYMENTS COULD BE ELIMINATED BY SINGLE PROVIDER NUMBERS

We identified 805 Medicaid duplicate services, valued at $24,893, which were paid by the State to providers who used different provider numbers. This happened because the State does not use prepayment computer edits to suspend potentially duplicate claims for manual review. This type of duplicate payment should be eliminated by the single provider number system that the State expects to have installed by July 1983 as part of a redesign of its provider enrollment subsystem.

Application of our computer program to the Medicaid files identified 32,129 pairs of line items that were potential duplicate payments. We then concentrated our efforts on identifying those duplicates that were submitted by the same provider using different provider numbers. As a result, we identified 151 providers who submitted 805 potentially duplicate claims valued at $24,893. Forty-five providers submitted 577 of these claims valued at over $21,000.

We made a detailed review of 30 of the claims from the 45 providers and determined that they were, in fact, duplicates. We discussed these with State officials, who agreed they should be collected, and provided them a listing of all 577 claims for further review and possible collection. In addition, 4 of these 45 providers had been identified by the State's surveillance and utilization reviews for closer observation.

## MEDICARE OVERPAYMENTS FOR SURGICAL ASSISTANCE AND ANESTHESIA SERVICES COULD BE REDUCED BY IMPROVED MANUAL REVIEWS

In our review for duplicate payments, we noted a class of Medicare services that often resulted in overpayments rather than duplicate payments -- namely, Medicare surgical assistance and anesthesia services. We reviewed 99 statistically selected pairs of claims for surgical services out of a universe of 784 pairs identified as potential duplicates. We found 81 cases where there were overpayments. Based on these cases we estimate total overpayments in the universe of 784 pairs to be $74,850. These overpayments occurred because the services were improperly coded by either the carrier or the providers and the computer edits were bypassed by claims examiners to allow payment.

The highest percentage of overpayment was for surgical assistance. The allowed Medicare rate for physicians assisting surgeons is generally less than the rate allowed for the surgeons. We noted, however, that assisting physicians were paid more than the allowed Medicare rate because their claims were coded as surgery instead of surgical assistance.

The next highest incidence of overpayments was for anesthesia rendered by anesthesiologists who were also paid at the surgeon's rate. This was because the anesthesia claims were improperly coded by the carrier or the provider as surgeon's services and improperly paid at the higher rate. In some instances, these claims were not rejected by the carrier's computer because the surgeons had not yet submitted their claims; therefore, the computer edit could not reject the claims as duplicates. In other instances, claims processed after the surgeon's claim was paid were suspended by the computer. However, during the manual review, the carrier's claims examiners did not reclassify the claims, but bypassed the computer edits and paid them.

Our review of the 99 duplicate pairs of claims also showed there were five cases involving duplicate payments. When projected to the universe of 784 pairs, these cases indicate a total of $14,549 in duplicate payments. These duplicate payments occurred for the same reasons discussed in preceding sections of this report.

The carrier plans to evaluate the need to take action to correct the manual review deficiencies noted above. Also, the carrier will attempt to collect the overpayments identified in our review.

## MEDICARE AND MEDICAID PROVIDER ROLLS SHOULD BE CONTINUALLY REVIEWED FOR UNLICENSED PROVIDERS

The carrier and State have procedures to determine if a physician has a valid Michigan medical license before issuing a Medicare of Medicaid provider number. However, prior to 1982, the carrier and the State were not continually updating their files to assure that physicians whose licenses were revoked, suspended, or inactive were removed from their rolls. As a result, four physicians who did not have valid medical licenses submitted Medicare claims, or someone submitted claims in their behalf, and were improperly paid over $13,000.

Both the carrier and the State rely on reports from the State licensing boards to identify physicians with revoked, expired, or suspended licenses. To determine if the carrier was using these reports to continually update its files, we compared the Medicare provider rolls, as of June 1982, to the State licensing files. Our comparison showed that 171 physicians on the Medicare rolls did not have valid licenses according to the State licensing boards. Because some of these physicians may still have been in the grace period for renewing their licenses, we verified cases involving only those physicians who licenses

expired prior to 1982 and were still being paid under Medicare. Of the 171 physicians, 55 had invalid licenses prior to 1982. Four of these 55 physicians were paid over $13,000, even though one was deceased and the three others had licenses which had expired or were suspended. We provided the carrier a listing of these physicians.

Currently, the carrier is updating all provider files--private and group practice--to determine that all physicians have valid licenses. The carrier is using our listings of physicians with invalid licenses, as well as other licensing data from the State licensing boards, in updating its files. Also, the carrier has provided detailed information to your regional office staff on the $13,000 in payments to unlicensed physicians and will await your direction on what actions to take.

During April 1982, in cooperation with a Detroit newspaper, the State matched physicians and dentists who were on State licensing files to those on its Medicaid rolls as of October 27, 1981. The comparison showed that 235 providers on the rolls did not have valid licenses. The State then removed the physicians from the rolls after determining that they had not renewed their licenses. In April 1982, the State began to routinely remove unlicensed providers from its rolls. We randomly selected 30 Medicaid physicians from an April 1982 Michigan Board of Medicine listing of physicians whose licenses had expired and found they were no longer on the Medicaid rolls.

## CONCLUSIONS

We believe that the carrier and the State should take collection actions on the erroneous payments we identified. In addition, they should review the list of potential erroneous payments we provided them to identify further improper payments that should be collected. We also believe additional savings could occur if the carrier improves its manual review process to detect duplicate and/or improperly coded claims. Finally, we believe that steps need to be taken to ensure that the Michigan Medicare and Medicaid provider rolls are systematically purged of those providers who no longer have valid licenses.

RECOMMENDATION

We recommend you ensure that appropriate corrective actions are taken by the carrier and State to recover the erroneous payments identified, and to update the provider rolls. We also recommend you ensure that the carrier improves its manual review process. We would appreciate being advised of the corrective actions taken, the collections made, and the resulting savings from these actions.

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Copies of this report have been sent to Blue Cross/Blue Shield of Michigan and the Michigan Medical Services Administration. If you need assistance or additional information, please call me (313-226-6044).

Sincerely yours,

Walter C. Herrmann Jr.

Walter C. Herrmann, Jr.
Regional Manager