



JUN 26 2007

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A (A-01-05-00511)

Attached is our final report on our review of payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) made on behalf of beneficiaries in skilled nursing facility (SNF) stays covered under Medicare Part A.

Under the prospective payment system, DMEPOS furnished during beneficiaries' SNF stays is generally included in the SNFs' Medicare Part A payments. Therefore, Medicare Part B payments by any of the four durable medical equipment regional carriers (DMERC) to suppliers for such items are overpayments.

Our previous reports identified \$194.5 million in Part B overpayments to suppliers on behalf of beneficiaries in Part A-covered SNF stays during calendar years (CY) 1996–2000. Of this amount, \$49.2 million consisted of overpayments to DMEPOS suppliers during CYs 1996–1999. To prevent such overpayments, we recommended that the Centers for Medicare & Medicaid Services (CMS) establish edits in its Common Working File. CMS began implementing these edits in CY 2002, and they became fully operational in CY 2003. When SNFs submit their claims before DMEPOS suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When suppliers submit their claims before SNFs submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to DMEPOS suppliers for CYs 1999–2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

For CYs 1999–2002, Medicare Part B made \$100.8 million in potential overpayments to DMEPOS suppliers on behalf of beneficiaries in Part A-covered SNF stays. These overpayments occurred because CMS did not yet have the Common Working File edits in place. As a result, the DMERCs were unable to initiate recovery actions.

For CY 2003, our computer match identified potential DMEPOS overpayments valued at \$15.4 million. Our statistical sample showed that the DMERCs had not recovered approximately 69 percent of these overpayments. This problem occurred because two of the four DMERCs did not implement procedures to process and recover the backlog of overpayments created by the new edits. As a result, we estimate that the DMERCs did not recover \$11.2 million of the \$15.4 million in potential CY 2003 overpayments.

We recommend that CMS:

- direct the DMERCs to review the \$100.8 million in potential overpayments for CYs 1999–2002 and make appropriate recoveries,
- direct the DMERCs to initiate recovery of the estimated \$11.2 million in CY 2003 overpayments, and
- ensure that all DMERCs have established proper controls to recover overpayments that the Common Working File edits identify.

In its comments on our draft report, CMS concurred with the recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-01-05-00511 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENTS FOR DURABLE
MEDICAL EQUIPMENT,
PROSTHETICS, ORTHOTICS, AND
SUPPLIES MADE ON BEHALF OF
BENEFICIARIES IN SKILLED
NURSING FACILITY STAYS
COVERED UNDER MEDICARE
PART A**



Daniel R. Levinson
Inspector General

June 2007
A-01-05-00511

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

Section 1888(e) of the Social Security Act established a Medicare prospective payment system for skilled nursing facilities (SNF). Under the prospective payment system, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) furnished during beneficiaries' SNF stays is generally included in the SNFs' Medicare Part A payments. Therefore, Medicare Part B payments by any of the four durable medical equipment regional carriers (DMERC) to suppliers for such items are overpayments.

Our previous reports identified \$194.5 million in Part B overpayments to suppliers on behalf of beneficiaries in Part A-covered SNF stays during calendar years (CY) 1996–2000. Of this amount, \$49.2 million consisted of overpayments to DMEPOS suppliers during CYs 1996–1999. To prevent such overpayments, we recommended that the Centers for Medicare & Medicaid Services (CMS) establish edits in its Common Working File. CMS began implementing these edits in CY 2002, and they became fully operational in CY 2003. When SNFs submit their claims before DMEPOS suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When suppliers submit their claims before SNFs submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

OBJECTIVES

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to DMEPOS suppliers for CYs 1999–2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

SUMMARY OF FINDINGS

For CYs 1999–2002, Medicare Part B made \$100.8 million in potential overpayments to DMEPOS suppliers on behalf of beneficiaries in Part A-covered SNF stays. These overpayments occurred because CMS did not yet have the Common Working File edits in place. As a result, the DMERCs were unable to initiate recovery actions.

For CY 2003, our computer match identified potential DMEPOS overpayments valued at \$15.4 million. Our statistical sample showed that the DMERCs had not recovered approximately 69 percent of these overpayments. This problem occurred because two of the four DMERCs did not implement procedures to process and recover the backlog of overpayments created by the new edits. As a result, we estimate that the DMERCs did not recover \$11.2 million of the \$15.4 million in potential CY 2003 overpayments.

RECOMMENDATIONS

We recommend that CMS:

- direct the DMERCs to review the \$100.8 million in potential overpayments for CYs 1999–2002 and make appropriate recoveries,
- direct the DMERCs to initiate recovery of the estimated \$11.2 million in CY 2003 overpayments, and
- ensure that all DMERCs have established proper controls to recover overpayments that the Common Working File edits identify.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendations. We have included CMS's comments as Appendix G.

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INTRODUCTION

BACKGROUND

Skilled Nursing Facility Prospective Payment System and Consolidated Billing

Section 1888(e) of the Social Security Act (the Act) established a Medicare prospective payment system for skilled nursing facilities (SNF) for cost-reporting periods beginning on or after July 1, 1998. Under the prospective payment system, Medicare Part A pays SNFs through per diem, prospective, case-mix-adjusted payment rates that cover virtually all of their costs for furnishing services to Medicare beneficiaries. In addition, under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most of the services provided to Medicare beneficiaries in SNF stays covered under Medicare Part A, including services that outside suppliers provide under arrangement. The outside suppliers must then bill the SNFs for services rendered.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Furnished to Skilled Nursing Facility Residents

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), which includes wheelchairs, hospital beds, oxygen, and medical and surgical supplies, is usually covered under Medicare Part B. However, DMEPOS furnished to Medicare beneficiaries during SNF stays is generally included in the SNFs' Medicare Part A prospective payments. Therefore, Medicare Part B payments to suppliers for such items are overpayments.

Durable Medical Equipment Regional Carriers

The Centers for Medicare & Medicaid Services (CMS) contracts with four durable medical equipment regional carriers (DMERC)¹ to process and pay Medicare Part B claims for DMEPOS. Each of the four DMERCs is responsible for processing claims submitted by suppliers in designated States and U.S. territories.

Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions

Our previous audits identified \$194.5 million in Medicare Part B overpayments made on behalf of beneficiaries during SNF stays covered under Medicare Part A.² (See Appendix A.) We recommended that CMS establish edits in its claims-processing systems to prevent Part B overpayments and provide education and guidance to SNFs and suppliers. CMS concurred with our recommendations.

¹During 2006, after our review period, CMS began the transition from DMERCs to durable medical equipment Medicare administrative contractors (DME MAC) in accordance with the Medicare contracting reform provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

²The most recent of those audits (A-01-02-00513), issued in 2004, did not include a review of payments to DMEPOS suppliers.

In calendar year (CY) 2002, CMS began implementing computerized edits in its Common Working File, and these edits became fully operational in CY 2003. When SNFs submit their claims before DMEPOS suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When suppliers submit their claims before SNFs submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to DMEPOS suppliers for CYs 1999–2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

Scope

We identified and reviewed nationwide overpayments made by the four DMERCs for claims with dates of service in CYs 1999–2003.

Our objectives did not require an understanding or assessment of the complete internal control structure at CMS, the DMERCs, or the suppliers. We limited consideration of the internal control structure to the payment controls in place within the Common Working File and the DMERCs' claims-processing systems. We did not assess the completeness of data extracted from CMS's National Claims History file.

We performed fieldwork from October to early December 2005 at the four DMERCs, which were located in Dallas, Pennsylvania; Indianapolis, Indiana; Columbia, South Carolina; and Nashville, Tennessee. We also contacted 74 Part B suppliers by mail and telephone from October 2005 through March 2006.

Methodology

To accomplish our objectives:

- We reviewed applicable laws, regulations, and Medicare program guidance.
- We used data from CMS's National Claims History file to perform a nationwide computer match to identify potential DMEPOS overpayments that the DMERCs had not recovered. We matched SNF stays covered under Medicare Part A during CYs 1999–2003 to Part B DMEPOS services provided to SNF residents during those years. Recoveries made after March 2004 are not reflected in the data used to perform our computer match. (See Appendix B for a description of our computer match methodology.)

- We used the results of the computer match for CYs 1999–2002 to determine potential overpayments made before the edits were fully implemented. We used the results of the computer match for CY 2003 to determine potential overpayments made after the edits were implemented.
- We selected a statistical sample of 100 potential overpayments made to 81 suppliers for CY 2003 to validate the results of the computer match and to quantify the unrecovered overpayments. (See Appendix C.) We reviewed available data from the Common Working File for the selected overpayments and the corresponding SNF claims.
- We contacted representatives from 74 of the 81 suppliers that billed for the sampled CY 2003 overpayments to validate payments and to request their comments concerning the underlying causes of improper billing. (See Appendix D.) The remaining seven suppliers are no longer in the Medicare program, and we were unable to locate their current representatives. We validated payments to the seven suppliers with the DMERCs.
- We obtained an understanding of the DMERCs’ policies and procedures for handling overpayments that the Common Working File edits identified.
- We reviewed the DMERCs’ documentation to determine whether the postpayment edits identified each sampled item as an overpayment and whether a DMERC recovered the overpayment after our computer match identified it.
- We used a stratified variable appraisal program to estimate the dollar value, and a stratified attribute appraisal program to estimate the number, of nationwide CY 2003 overpayments to suppliers that the DMERCs had not recovered. (See Appendix E.)
- We analyzed the results of our computer match to identify characteristics of potential DMEPOS overpayments made on behalf of beneficiaries in Part A-covered SNF stays. We used place-of-service codes to determine whether these overpayments represented services provided for use in the beneficiary’s home or in a SNF. (See Appendix F.)

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

For CYs 1999–2002, Medicare Part B made \$100.8 million in potential overpayments to DMEPOS suppliers on behalf of beneficiaries in Part A-covered SNF stays. These overpayments occurred because CMS did not yet have the Common Working File edits in place. As a result, the DMERCs were unable to initiate recovery actions.

For CY 2003, our computer match identified potential DMEPOS overpayments valued at \$15.4 million. Our statistical sample showed that the DMERCs had not recovered approximately 69 percent of these overpayments. This problem occurred because two of the four DMERCs did

not implement procedures to process and recover the backlog of overpayments created by the new edits. As a result, we estimate that the DMERCs did not recover \$11.2 million of the \$15.4 million in potential CY 2003 overpayments.

PROGRAM REQUIREMENTS

According to the “Medicare Claims Processing Manual,” Publication 100-04, Chapter 6, section 110.2.1, when edits identify an overpayment after the supplier has been paid, the Common Working File electronically transmits a notice (called an unsolicited response) to the DMERC that originally processed the payment. The manual states that when the DMERC receives an unsolicited response, it must initiate an adjustment to deny the original payment and follow requirements for recovering the overpayment.

The Federal Claims Collection Act of 1966 (31 U.S.C. § 3711), as implemented by 31 CFR § 901.1, requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor when necessary, issue demands for repayment, and effect recoupment. CMS regulations (42 CFR §§ 405.370–405.378) specify the Medicare contractors’ responsibilities with respect to overpayments and debt, including issuance of written demand letters, assessment of interest, and recoupment. CMS’s “Medicare Financial Management Manual” also provides guidance on recovering overpayments.

POTENTIAL OVERPAYMENTS FOR CALENDAR YEARS 1999–2002

Our computer match identified potential overpayments to DMEPOS suppliers totaling \$100.8 million for CYs 1999–2002. These overpayments occurred because CMS had not yet implemented the Common Working File edits to prevent and detect Part B payments on behalf of beneficiaries in Part A-covered SNF stays. As a result, the DMERCs were unable to recover the overpayments.

RECOVERY OF OVERPAYMENTS FOR CALENDAR YEAR 2003

Our computer match identified 263,753 potential DMEPOS overpayments valued at \$15.4 million for CY 2003. To validate these data, we reviewed a statistical sample of 100 overpayments and found that the DMERCs had not recovered 67 overpayments as of the completion of our fieldwork at the DMERCs (early December 2005). Based on the sample results, we estimate that the DMERCs had not recovered 181,981 (approximately 69 percent) of the 263,753 overpayments that our computer match identified. We estimate the value of the unrecovered CY 2003 overpayments to be approximately \$11.2 million.

The DMERCs did not recover all CY 2003 overpayments because they experienced a backlog of unsolicited responses as a result of the postpayment edits. After receiving these unsolicited responses, the DMERCs needed to review and, if necessary, manually adjust the overpayments. However, two of the four DMERCs did not implement procedures to deal with the backlog and recover overpayments in a timely manner. These two DMERCs cited the following reasons for their delays:

- One DMERC attributed its delay to confusion about CMS's instructions to install an automated adjustment process but not to activate the process until January 1, 2004. Until activation of the automated process, the DMERCs were expected to process adjustments manually. This DMERC implemented the automated adjustment process as instructed but did not implement procedures for manually processing adjustments. During our fieldwork, the DMERC stated that it was working on both its current and backlogged unsolicited responses.
- The second DMERC cited problems with the Common Working File edits as the primary reason for its backlog of unsolicited responses. According to the DMERC, the edits did not initially incorporate all of the diverse payment requirements and policies for all types of providers and suppliers. As a result, the DMERC had to manually review the results of the edits to determine their validity before it could begin adjusting and recovering the overpayments. During our fieldwork, the DMERC stated that it was formulating a plan to address its backlog.

The remaining two DMERCs implemented procedures to deal with the backlog of CY 2003 unsolicited responses and to promptly recover identified overpayments.

RECOMMENDATIONS

We recommend that CMS:

- direct the DMERCs to review the \$100.8 million in potential overpayments for CYs 1999–2002 and make appropriate recoveries,
- direct the DMERCs to initiate recovery of the estimated \$11.2 million in CY 2003 overpayments, and
- ensure that all DMERCs have established proper controls to recover overpayments that the Common Working File edits identify.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendations. CMS stated that it recovers overpayments consistent with its policies and procedures and requested that we furnish the data necessary to review claims and recover the overpayments. CMS also provided information on actions taken to ensure that DMERCs have established proper controls to recover overpayments that the Common Working File edits identify. We have included CMS's comments as Appendix G.

CMS also provided technical comments, which we addressed in this final report. As CMS requested, we furnished the data necessary to initiate its review and recovery effort.

APPENDIXES

**PREVIOUS OFFICE OF INSPECTOR GENERAL REPORTS ON
MEDICARE PART B PAYMENTS MADE ON BEHALF OF BENEFICIARIES
DURING PART A SKILLED NURSING FACILITY STAYS
(Dollars in Millions)**

<u>Report Title and Number</u> ¹	<u>Period Covered by Review</u>	<u>DMEPOS Included</u> ²	<u>Total Overpayments Identified</u>	<u>DMEPOS Overpayments Identified</u>	<u>Issue Date</u>
“Review of Compliance With the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities” (A-01-99-00531)	10/1/98–4/30/99	Yes	\$0	\$0	March 27, 2000
“Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System” (A-01-00-00538)	CY 1999 ³	Yes	47.6 ⁴	3.7	June 5, 2001
“Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities” (A-01-00-00509)	CYs 1996–1998	Yes	35.0	35.0	July 23, 2001
“Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities for Time Periods Between the Full Month Periods Covered by Our Prior Report and the Date of Discharge From the Skilled Nursing Facility” (A-01-01-00513)	CYs 1996–1998	Yes	10.5	10.5	October 17, 2001
“Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000” (A-01-02-00513)	CYs 1999–2000	No	108.3	0	May 28, 2004

¹These reports are available at <http://oig.hhs.gov>, except for report number A-01-01-00513, which was issued as an addendum to report number A-01-00-00509.

²DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

³CY = calendar year.

⁴As noted in report number A-01-02-00513, we reduced the \$47.6 million to \$40.7 million to account for improper payments refunded by suppliers subsequent to this review, as well as refinements in our matching methodology.

**COMPUTER MATCH METHODOLOGY TO IDENTIFY
POTENTIAL OVERPAYMENTS****SKILLED NURSING FACILITY DATA**

For CYs 1999–2003, we:

- extracted claims information from the National Claims History file;
- limited the population to claims with revenue center code 0022, denoting a prospective payment;
- eliminated claims involving hospital swing beds (type of bill 18X);
- eliminated claims for managed care organization enrollees (condition code 04); and
- sorted claims by beneficiary and admission date and grouped the sorted claims together to create skilled nursing facility (SNF) stays.

**DURABLE MEDICAL EQUIPMENT, PROSTHETICS,
ORTHOTICS, AND SUPPLIES DATA**

For CYs 1999–2003, we:

- extracted paid claims information from the National Claims History file based on beneficiary health insurance claim numbers from SNF claims data;
- eliminated \$0 paid lines of service;
- eliminated lines of service for maintenance and servicing (Healthcare Common Procedure Coding System modifier “MS”);
- eliminated lines of service for items excluded from the consolidated billing provision, including dialysis services and supplies, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices;
- eliminated lines of service with “from” dates of service on or before the SNF stay admission date;
- eliminated lines of service with “from” dates of service on or after the SNF stay discharge date;
- eliminated lines of service for services rendered during the noncovered portion of the SNF stay; and

- eliminated, by prorating, the portion of rental payments that did not fall within the SNF stay for rental periods that began during and ended after a Part A stay.

SAMPLING METHODOLOGY

OBJECTIVE

Our sampling objective was to determine the amount of CY 2003 overpayments for DMEPOS that the durable medical equipment regional carriers (DMERC) had not recovered.

POPULATION

The population consisted of potential CY 2003 overpayments for DMEPOS made on behalf of beneficiaries in Part A SNF stays.

<u>Stratum</u>	<u>Number of Claims</u>	<u>Payment Amount</u>
1 – Overpayments \$40.00 or less	162,061	\$2,272,764
2 – Overpayments \$40.01 to \$110.00	65,477	4,778,598
3 – Overpayments \$110.01 or greater	<u>36,215</u>	<u>8,364,413</u>
Total	263,753	\$15,415,775

SAMPLE DESIGN

The audit used a stratified random sample design consisting of the three strata shown above. We defined an error as an overpayment that was not recovered by a DMERC.

SAMPLE SIZE

The sample consisted of 100 overpayments: 40 from the first stratum, 30 from the second stratum, and 30 from the third stratum.

SUPPLIERS' BILLING PRACTICES

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES PROVIDED IN THE HOME

Seventy-eight percent of the overpayments that we identified involved DMEPOS provided for use in the beneficiary's home.¹ In these cases, suppliers generally billed Medicare Part B because they were unaware that the beneficiary was in a SNF. The Common Working File edits are one means by which suppliers can determine that beneficiaries are in SNF stays covered under Part A. However, the 74 suppliers that we contacted recognized that relying on the edits to identify overpayments was not an adequate means of preventing improper billing.

The suppliers told us that, to avoid incorrect billing, they needed timely notification that a beneficiary had entered a SNF. The suppliers used a variety of procedures to obtain this information, including:

- advising the beneficiary, at the time rental equipment is delivered, to contact the supplier in the event that the beneficiary is no longer using the equipment or has been admitted to a SNF;
- requiring the beneficiary to sign a delivery ticket or including an explanation on the delivery ticket of why a signature was not obtained;
- making follow-up phone calls to verify delivery to the beneficiary's home;
- reviewing delivery documentation before billing;
- using routine deliveries of additional supplies and servicing of equipment to identify situations in which the beneficiary is no longer at home;
- coordinating deliveries with, and obtaining the discharge date from, SNF personnel when DMEPOS is ordered for a beneficiary's use at home after discharge from the SNF;
- periodically contacting each beneficiary who uses rental equipment, oxygen, or supplies to verify beneficiary status or arrange for delivery or shipment of supplies; and
- using phone calls from the beneficiary to identify any changes in status.

Even with these procedures in place, however, suppliers are still at risk of billing incorrectly because of the inherent weakness of a system that relies primarily on beneficiaries and their family members to notify suppliers when a beneficiary is admitted to a SNF. The suppliers that we contacted acknowledged that most of the sampled overpayments occurred because the

¹See sections 1888(e), 1862(a)(18), 1842(b)(6)(E), 1833(d), and 1861(n) of the Act and the "Medicare Claims Processing Manual," Publication 100-04, Chapter 20, sections 110.3 and 211.2.

suppliers were not notified that the beneficiaries had been admitted to SNFs. The suppliers cited a variety of reasons for this lack of notification, including beneficiaries' confusion over ownership of equipment, health-related issues, and concerns that items would be recovered by the supplier and unavailable in the home upon discharge.

PROSTHETICS, ORTHOTICS, AND SUPPLIES PROVIDED IN THE SKILLED NURSING FACILITY

The remaining 22 percent of the overpayments that we identified involved prosthetics, orthotics, and supplies provided for use in a SNF. The suppliers that we contacted stated that they relied on the SNFs to provide information regarding beneficiaries' Part A status to ensure proper billing for these items.

In 2004, the Centers for Medicare & Medicaid Services (CMS) began a national campaign to reeducate SNFs and their suppliers on payment responsibilities for beneficiaries in SNFs. As part of this initiative, CMS provided guidance concerning consolidated billing issues. CMS also published examples of written agreements between SNFs and suppliers that can be used for services provided under arrangement, as well as examples of other documents that can be used to notify outside suppliers that the services provided in SNFs are for the use of beneficiaries in Part A-covered stays. We believe that this guidance will address this inherent weakness that led to incorrect billing.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

Our review of the sample of 100 CY 2003 overpayments found that, at the time we completed our fieldwork at the DMERCs, 67 of the overpayments had not been recovered, as shown in Table 1.

Table 1: Results of Sample

	Sample Items	Sample Items Recovered	Sample Items Not Recovered
Edits identified overpayment, and DMERC did not initiate recovery	64	2 ¹	62
Edits identified overpayment, and DMERC initiated recovery	32	31	1
Edits did not identify overpayment	4 ²	0	4
Total	100	33	67

Table 2 summarizes our sample results by stratum.

Table 2: Sample Results by Stratum

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
Stratum 1 – Overpayments \$40.00 or less	40	\$528	28	\$362
Stratum 2 – Overpayments \$40.01 to \$110.00	30	2,190	22	1,668
Stratum 3 – Overpayments \$110.01 or greater	30	7,630	17	5,088
Total	100	\$10,348	67	\$7,118

VARIABLE PROJECTION

The point estimate based on the sample was \$11,249,446 with a precision of plus or minus \$2,790,391 at the 90-percent confidence level.

¹These improper payments were recovered as a result of suppliers' voluntary refunds rather than the DMERCs' recovery efforts.

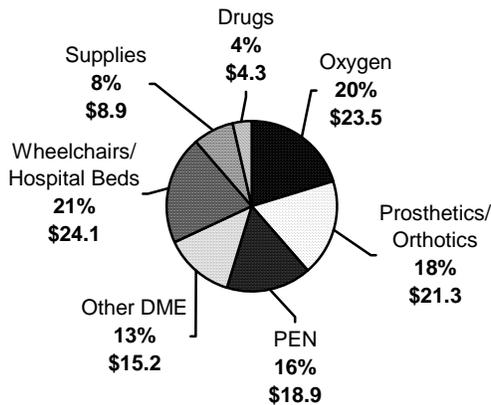
²Our review of these four sampled items did not identify any systemwide problems with the Common Working File edits.

ATTRIBUTE PROJECTION

We estimate that 181,981 (69 percent) of the 263,753 potential CY 2003 overpayments that our computer match identified were not recovered when we completed our fieldwork. We are 90-percent confident that the number of unrecovered overpayments falls between 159,829 and 204,133.

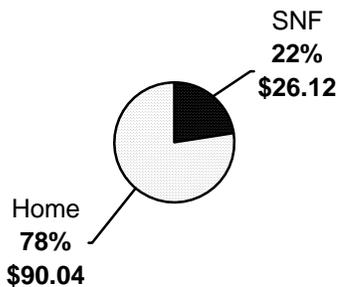
CHARACTERISTICS OF POTENTIAL OVERPAYMENTS

Figure 1: Overpayments by Type of Service
for CYs 1999–2003 (in millions)



Our computer match indicated that Medicare Part B potentially overpaid suppliers \$116.2 million for items furnished to beneficiaries during SNF stays covered under Medicare Part A during CYs 1999–2003. These overpayments were made for the following services: oxygen, prosthetics and orthotics, parenteral and enteral nutrition and supplies (PEN), wheelchairs, hospital beds, medical and surgical supplies, drugs administered through durable medical equipment (DME), and other DME (such as walkers, commode chairs, and canes). (See Figure 1.)

Figure 2: Overpayments by Place of Service
for CYs 1999–2003 (in millions)



Most of the potential overpayments that we identified involved DMEPOS provided for use in the beneficiary’s home. (See Figure 2.) These overpayments involved items that beneficiaries rented prior to their SNF stays, as well as items that beneficiaries purchased or initially rented during stays covered under Medicare Part A. We also identified overpayments for prosthetics, orthotics, and supplies provided for use in a SNF while the beneficiary was in a stay covered under Part A.

RENTAL ITEMS

The “Medicare Claims Processing Manual,” Publication 100-04, Chapter 20, section 211.2, states that if a beneficiary is at home on the first day of a rental month and spends part of the month in a SNF, Medicare will make separate payment for a full month of DME. However, if a beneficiary’s SNF stay covered under Part A overlaps the anniversary date of the DME rental item, the date of the beneficiary’s discharge from the SNF becomes the new anniversary date for

subsequent claims.¹ The supplier must submit a new claim with the date of discharge as the anniversary date when the beneficiary is released from the SNF. The Common Working File edits will reject DME services when the beneficiary is in a SNF stay covered under Medicare Part A on the “from” date of the DME service.

Approximately 60 percent of the potential overpayments for CYs 1999–2003 that our computer match identified were attributable to oxygen equipment and capped rental items. For example:

- A portable gaseous oxygen system was originally delivered to a beneficiary’s home on January 21. The beneficiary was admitted to a SNF on March 20 and discharged on May 22. During the SNF stay, the supplier billed for the monthly rental of the oxygen equipment in the beneficiary’s home with an anniversary date of March 21 and was reimbursed by Medicare Part B.
- A hospital bed was originally delivered to a beneficiary’s home on December 20. On September 12 of the following year, the beneficiary was admitted to a SNF; the beneficiary was discharged on October 17. During the SNF stay, the supplier billed for the monthly rental of the hospital bed in the beneficiary’s home with an anniversary date of September 20 and was reimbursed by Medicare Part B.

The “Medicare Claims Processing Manual,” Publication 100-04, Chapter 20, section 110.3, allows delivery of DMEPOS to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary’s home if (1) the supplier delivers the item solely for the purpose of fitting or training and the item is for subsequent use in the beneficiary’s home; (2) the supplier delivers the item to the beneficiary no earlier than 2 days before the date of discharge; (3) the supplier ensures that the beneficiary takes the item home, or the supplier picks the item up and delivers it to the beneficiary’s home on the date of discharge; and (4) the supplier does not claim payment for the item for any day prior to the date of discharge.²

Our analysis found that less than 4 percent of all potential overpayments for CYs 1999–2003 involved the first month’s rental of a capped rental item with an anniversary date within 1 or 2 days of the beneficiary’s discharge from the SNF. For example:

- A beneficiary was admitted to a SNF on August 20. The supplier delivered a wheelchair to the beneficiary’s home on September 2. The supplier billed for the first month’s rental of the wheelchair in the beneficiary’s home with an anniversary date of September 2 and was reimbursed by Medicare Part B. The beneficiary was discharged from the SNF on September 3.

¹For rental items for which the supplier submits a monthly bill, the date of delivery (the “from” date) on the first claim must be the “from” or “anniversary” date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated on the 15th of the following months (October 15, November 15, etc.).

²We cite only four of the nine criteria for predischarge delivery of DMEPOS because the scope of our review did not include the additional criteria.

PURCHASED ITEMS

Our computer match also identified potential overpayments for purchases of DMEPOS furnished to beneficiaries during a SNF stay covered under Medicare Part A. Approximately 29 percent of these purchases were delivered and billed within 1 or 2 days of the beneficiary's discharge from the SNF. Most of these purchases were for items provided for use in the beneficiary's home.

The majority of purchases made within 1 to 2 days of discharge from the SNF were attributable to items considered "one-time" purchases, such as walkers and commode chairs. For example:

- A beneficiary was admitted to a SNF on June 12. The supplier delivered a commode chair to the beneficiary's home on July 14. The supplier billed for the purchase of the chair with a date of service of July 14 and was reimbursed by Medicare Part B. The beneficiary was discharged from the SNF on July 15.

The remaining purchases made within 1 to 2 days of discharge from the SNF were attributable to items purchased on a continuing basis, such as glucose-monitoring supplies and albuterol.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 11 2007

TO: Daniel R. Levinson
Inspector General

FROM: Leslie V. Norwalk, Esq. 
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A" (A-01-05-00511)

Thank you for the opportunity to review and comment on this draft report on payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) made on behalf of beneficiaries in skilled nursing facilities (SNF) under Medicare Part A. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort the OIG has invested in this report.

Under the SNF prospective payment system, DMEPOS furnished during a beneficiary's SNF stay are generally included in the SNF's Medicare Part A payments. Thus, Medicare Part B payments by the Durable Medical Equipment Regional Carriers (DMERCs), which are now referred to as Durable Medical Equipment Medicare Administrative Contractors (DME MACs), to suppliers for such items are considered overpayments. In this draft report, OIG identified potential Medicare overpayments for claims from calendar years (CYs) 1999 - 2003.

The CMS is committed to improving its efforts to reduce improper Medicare claims payments and to actively pursue recoveries of improper payments. We thank the OIG for its efforts on this report and look forward to the continued support as we address the report recommendations. Our response to the recommendations and technical comments on the report follow.

OIG Recommendation

The CMS should direct the DMERCs to review the \$100.8 million in potential overpayments for CYs 1999 - 2002 and make appropriate recoveries.

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CMS Response

The CMS agrees with the OIG recommendation that CMS direct the DME MACs to review the claims processed and to initiate appropriate recoveries of potential overpayments. CMS recovers the overpayments consistent with the Agency's policies and procedures. CMS requests that OIG provide the data necessary (e.g., provider numbers, claims information including the paid date, HIC numbers, etc.) to help us determine which claims are within the reopening period.

OIG Recommendation

The CMS should direct the DMERCs to initiate recovery of the estimated \$11.2 million in CY 2003 overpayments.

CMS Response

The CMS agrees that the overpayments identified from a review of the claims in question should be recovered. However, CMS recovers the overpayments consistent with the Agency's policies and procedures. As mentioned earlier, CMS requests that OIG furnish for each overpayment the data necessary (e.g., provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, we ask that Medicare contractor-specific data be written to separate compact disks in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

The CMS should ensure that all DMERCs have established proper controls to recover overpayments that the Common Working File (CWF) edits identify.

CMS Response

The CMS currently works with Medicare contractors to ensure that payments are made accurately and to make appropriate recoveries in accordance with the Agency's policies and procedures. CMS has issued instructions to the Medicare contractors to recover overpayments related to unsolicited CWF responses for SNF claims. Furthermore, the DME MACs continue to process all unsolicited responses under the current contract. CMS reviews and monitors the Medicare contractor performance for these areas on an ongoing basis.