



June 16, 2010

**TO:** Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare & Medicaid Services

**FROM:** /George M. Reeb/  
Acting Deputy Inspector General for Audit Services

**SUBJECT:** Review of Jurisdiction C Medicare Payments for Selected Durable Medical  
Equipment Claims With the KX Modifier for Calendar Year 2007  
(A-04-09-04039)

Attached, for your information, is an advance copy of our final report on Jurisdiction C Medicare payments for selected durable medical equipment claims with the KX modifier for calendar year 2007. We will issue this report to CIGNA Government Services (CGS), the durable medical equipment Medicare administrative contractor for Jurisdiction C, within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [Robert.Vito@oig.hhs.gov](mailto:Robert.Vito@oig.hhs.gov) or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7800 or through email at [Peter.Barbera@oig.hhs.gov](mailto:Peter.Barbera@oig.hhs.gov). Please refer to report number A-04-09-04039.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

June 22, 2010

Report Number: A-04-09-04039

Ms. Jean Rush  
President, CIGNA Government Services  
2 Vantage Way  
Nashville, TN 37228

Dear Ms. Rush:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Jurisdiction C Medicare Payments for Selected Durable Medical Equipment Claims With the KX Modifier for Calendar Year 2007*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (404) 562-7800, or contact Mark Wimple, Audit Manager, at (919) 790-2765, extension 24, or through email at [Mark.Wimple@oig.hhs.gov](mailto:Mark.Wimple@oig.hhs.gov). Please refer to report number A-04-09-04039 in all correspondence.

Sincerely,

/Peter J. Barbera/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management & Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF JURISDICTION C MEDICARE  
PAYMENTS FOR SELECTED DURABLE  
MEDICAL EQUIPMENT CLAIMS WITH  
THE KX MODIFIER  
FOR CALENDAR YEAR 2007**



Daniel R. Levinson  
Inspector General

June 2010  
A-04-09-04039

# *Office of Inspector General*

<http://oig.hhs.gov>

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## EXECUTIVE SUMMARY

### BACKGROUND

Pursuant to sections 1832(a)(1) and 1861(n) of the Social Security Act (the Act), Medicare Part B provides for the coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) contracted with four durable medical equipment Medicare administrative contractors (DME MAC) to process and pay Medicare Part B claims for DMEPOS. These DME MACs replaced the Durable Medical Equipment Regional Carriers (DMERC). Also, CMS contracts with Palmetto Government Benefits Administrators, LLC (Palmetto GBA), to serve as the National Supplier Clearinghouse. The National Supplier Clearinghouse is responsible for enrolling and reenrolling DMEPOS suppliers.

Under the statutory and policy framework of the Act, the *Medicare National Coverage Determinations Manual* defines DME as equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. For certain DMEPOS, suppliers must use the KX modifier on filed claims. The KX modifier indicates that the claim meets the Medicare coverage criteria and the supplier has the required documentation on file. While suppliers must have a written physician's order and proof of delivery for all DMEPOS, suppliers must have additional documentation on file for items requiring the KX modifier. For example, respiratory assist devices also require documentation that a sleep study was performed before the date on the physician's order.

On January 16, 2007, CMS awarded the DME MAC contract for Jurisdiction C to CIGNA Government Services (CGS). CGS assumed full responsibility for administering the DME MAC work and began processing DMEPOS claims for Jurisdiction C as of June 1, 2007. Palmetto GBA was the Region C DMERC and processed the DMEPOS claims through May 31, 2007. (CMS refers to the DMERCs' coverage areas as "regions" and the DME MACs' coverage areas as "jurisdictions.")

Palmetto GBA and CGS processed approximately \$4 billion in Medicare DMEPOS claims with calendar year 2007 dates of service. This audit focused on \$257,266,589 of Medicare paid claims processed by either Palmetto GBA or CGS for therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2) that included the KX modifier.

### OBJECTIVE

Our objective was to determine whether the KX modifier was effective in ensuring that suppliers of DMEPOS who submitted claims to Palmetto GBA or CGS had the required supporting documentation on file.

## **SUMMARY OF FINDINGS**

The KX modifier was not effective in ensuring that suppliers of DMEPOS who submitted claims to either Palmetto GBA or CGS had the required supporting documentation on file. Of the 100 sampled items, suppliers had the required documentation on file for 45 items. Suppliers did not have the required documentation on file for the remaining 55 items. As a result, Palmetto GBA and CGS made unallowable payments totaling \$4,544 for 55 of the 100 sampled items. Based on our sample, we estimated that Palmetto GBA and CGS paid approximately \$137 million to suppliers who did not have the required documentation on file to support the DMEPOS items with 2007 dates of service.

The types of missing documentation included:

- proof of delivery (14 of 100 items),
- physician's order (40 of 100 items),
- use or compliant use followup documentation (12 of 76 applicable items), and
- physician's statement (8 of 24 applicable items).

For 17 of the 55 items, suppliers were missing multiple required documents.

These errors occurred because Palmetto GBA's and CGS's electronic edits in place were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims. The edits could only determine whether the required KX modifier was on the claim. In addition, CGS added the KX modifier to claims at the request of suppliers who said they had erroneously failed to add it to their claims.

## **RECOMMENDATIONS**

We recommend that CGS, as the current DME MAC:

- recover the \$4,544 in payments for specific DMEPOS items claimed for which the suppliers did not have the required documentation,
- review other payments for DMEPOS related to our unallowable sample items and recover any additional unallowable payments,
- notify CMS of the 14 suppliers who did not meet the supplier standard for maintaining proof of delivery so CMS can take appropriate action, and
- develop a corrective action plan to improve the effectiveness of the KX modifier and potentially save an estimated \$137 million.

## **AUDITEE COMMENTS**

In written comments to the draft report, CGS acknowledged the unallowable payments and listed actions it intends to take in response to our recommendations. CGS's comments are included in their entirety as Appendix D.

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## INTRODUCTION

### BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (the Act) in 1965 provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Pursuant to sections 1832(a)(1) and 1861(n) of the Act, Medicare Part B provides for the coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS contracted with four durable medical equipment Medicare administrative contractors (DME MAC) to process and pay Medicare Part B claims for DMEPOS. These DME MACs replaced the Durable Medical Equipment Regional Carriers (DMERC). Also, CMS contracts with Palmetto Government Benefits Administrators, LLC (Palmetto GBA), to serve as the National Supplier Clearinghouse. The National Supplier Clearinghouse is responsible for enrolling and reenrolling DMEPOS suppliers. CMS will revoke a supplier's billing privileges if it finds that the supplier does not meet the supplier standards (42 CFR § 424.57(c) and (d)).<sup>1</sup>

### **Contracts for Processing Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Claims**

On January 16, 2007, CMS awarded the DME MAC contract for Jurisdiction C to CIGNA Government Services, LLC (CGS). CGS assumed full responsibility for administering the DME MAC work and began processing DMEPOS claims for Jurisdiction C as of June 1, 2007. CGS processes DMEPOS claims for Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia.

Palmetto GBA was the Region C DMERC and processed the DMEPOS claims through May 31, 2007.<sup>2</sup> Palmetto GBA transferred its DMEPOS files to CGS after CMS awarded CGS the DME MAC contract for Jurisdiction C.

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<sup>1</sup> Federal requirements referenced in this document are the ones that were in effect during our audit period.

<sup>2</sup> CMS refers to the DMERCs' coverage areas as "regions" and the DME MACs' coverage areas as "jurisdictions." The Region C DMERC's coverage area also included Kentucky but did not include Virginia or West Virginia.

## **KX Modifier Used for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Claims Processing**

National Coverage Determinations (NCD) describe the circumstances for Medicare coverage nationwide for specific medical service procedures or devices including DMEPOS and generally outline the conditions under which a service or device is considered covered. The *Medicare National Coverage Determinations Manual* (Pub. No. 100-03, chapter 1, section 280.1) defines DMEPOS as equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home.

Contractors develop supplier manuals, Local Coverage Determinations (LCD), and Policy Articles for covered DMEPOS items. These materials specify under what clinical circumstances the DMEPOS item is considered to be reasonable and necessary. For covered DMEPOS items (including therapeutic shoes for diabetics (therapeutic shoes), continuous positive airway pressure systems (CPAP), respiratory assist devices (RAD), and pressure reducing support surfaces (groups 1 and 2) (PRSS)),<sup>3</sup> the LCDs require a KX modifier be added to the claims before they can be paid. By adding the KX modifier, the supplier attests that the claim meets the Medicare coverage criteria and that the specific required documentation, which varies based on the DMEPOS item, is on file at the supplier before submitting the claim to the DME MAC. This documentation requirement includes the written physician's order and proof of delivery that are required for all DMEPOS, as well as additional documentation such as a sleep study for a RAD claim.

Through supplier manuals, LCDs, and Internet postings, the contractors instructed the suppliers to use the KX modifier only if the suppliers have the required documentation on file. However, if the KX modifier is not used with claims for DMEPOS that require it, the claims will be denied.

This audit focused on claims paid by Palmetto GBA and CGS for therapeutic shoes, CPAPs, RADs, and PRSS.

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<sup>3</sup> These DMEPOS are included in the Level II Healthcare Common Procedure Coding System, which is a comprehensive, standardized system that classifies similar medical products into categories for efficient claims processing. It is the standardized coding system used for describing, identifying, and preparing claims for DMEPOS.

**Documentation Requirements for Selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Requiring the KX Modifier**

<b>Documentation Required to be on File at Supplier</b>	<b>Required by</b>	<b>Therapeutic Shoes</b>	<b>CPAP</b>	<b>RAD</b>	<b>PRSS</b>
Physician's Order (written, signed, and dated)	- <i>Program Integrity Manual (PIM)</i> , Pub. No. 100-08, chapter 5 -LCDs	X	X	X	X
Proof of Delivery	-42 CFR § 424.57(c)(12) -PIM, chapter 4	X	X	X	X
Statement of Treating/ Certifying Physician Before Billing	-The Act, § 1861(s)(12) (A-C) -LCDs and Policy Articles	X			X
Polysomnography (sleep study) Before Physician's Order	- NCD - LCDs		X	X	
Use or Compliant Use Followup Statement of Physician and/or Beneficiary	- LCDs		X	X	

**OBJECTIVE, SCOPE, AND METHODOLOGY**

**Objective**

Our objective was to determine whether the KX modifier was effective in ensuring that suppliers of DMEPOS who submitted claims to Palmetto GBA or CGS had the required supporting documentation on file.

**Scope**

Of the approximately \$4 billion in Medicare DMEPOS claims in Jurisdiction C with calendar year 2007 dates of service, Palmetto GBA paid suppliers \$1.2 billion (31 percent) and CGS paid \$2.8 billion (69 percent). This audit focused on \$257,266,589 of these Medicare paid claims for therapeutic shoes, CPAPs, RADs, and PRSS that included the KX modifier. Palmetto GBA, the Region C DMERC, processed the DMEPOS claims through May 31, 2007. However, in connection with the transition to DME MACs, Palmetto GBA transferred its workload to CGS, the current Jurisdiction C DME MAC, which processed DMEPOS claims starting with June 1, 2007 dates of services.<sup>4</sup>

<sup>4</sup> Kentucky was part of the Region C DMERC's coverage area. However, CMS made certain coverage area realignments during the transition to DME MACs, including making Kentucky part of DME MAC Jurisdiction B, which began processing claims on July 1, 2006.

Since Palmetto GBA transferred all of its claims payment files, we were able to obtain its claims payment file information from CGS; however, we were unable to determine the supplier training and education that Palmetto GBA provided.

We limited our review of internal controls to gaining an understanding of the contractors' processing of selected DMEPOS claims that were submitted with the KX modifier. We did not determine whether the sample items met other Medicare coverage criteria, such as medical necessity.

From June 2009 through December 2009, we conducted fieldwork at CGS offices in Nashville, Tennessee, and at suppliers' offices in 13 States.

## **Methodology**

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CGS officials concerning the manual and electronic claims processing procedures for claims for therapeutic shoes, CPAPs, RADs, and PRSS with the KX modifier and CGS's and Palmetto GBA's edits in the claims processing system to ensure that claims were adjudicated;
- interviewed CGS officials concerning the education and training specific to the KX modifier that CGS provided to the suppliers of therapeutic shoes, CPAPs, RADs, and PRSS;
- selected a simple random sample of 100 items from four categories of DMEPOS (Appendix A);
- made unannounced visits to the 97 suppliers<sup>5</sup> to obtain their documentation supporting the use of the KX modifier;
- reviewed the suppliers' documentation for the sample items to determine whether it met the documentation requirements for using the KX modifier; and
- requested CGS's medical review staff review the documentation provided by the suppliers for those sample items that we determined did not meet the documentation requirements for use of the KX modifier.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

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<sup>5</sup> Three of the ninety-seven suppliers had two items in the sample.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The KX modifier was not effective in ensuring that suppliers of DMEPOS who submitted claims to either Palmetto GBA or CGS had the required supporting documentation on file. Of the 100 sampled items, suppliers had the required documentation on file for 45 items.<sup>6</sup> Suppliers did not have the required documentation on file for the remaining 55 items. As a result, Palmetto GBA and CGS made unallowable payments totaling \$4,544 for 55 of the 100 sampled items. Based on our sample, we estimated that Palmetto GBA and CGS paid approximately \$137 million to suppliers who did not have the required documentation on file to support the DMEPOS items with 2007 dates of service.

The types of missing documentation included:

- proof of delivery (14 of 100 items),
- physician's order (40 of 100 items),
- use or compliant use followup documentation (12 of 76 applicable items), and
- physician's statement (8 of 24 applicable items).<sup>7</sup>

Additional details on the results of the sampled items are provided in Appendixes B and C.

These errors occurred because Palmetto GBA's and CGS's electronic edits in place were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims. The edits could only determine whether the required KX modifier was on the claim. In addition, CGS added the KX modifier to claims at the request of suppliers who said they had erroneously failed to add it to their claims.

## **MISSING REQUIRED DOCUMENTATION**

### **Proof of Delivery**

Pursuant to the supplier standard (42 CFR § 424.57(c)(12)), the supplier "[m]ust be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery." Also, the PIM, chapter 4, section 4.26, requires suppliers to maintain proof of delivery documentation in their files for 7 years. Section 4.26.1 outlines proof of delivery requirements for different methods of delivery. Section 4.26 also states that, for "any services, which do not

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<sup>6</sup> One of these forty-five sampled items was from a supplier who was no longer active.

<sup>7</sup> For 17 of the 55 sampled items, suppliers were missing multiple required documents.

have proof of delivery from the supplier, such claimed items and services shall be denied and overpayments recovered.”

For 14 of the 100 items, suppliers did not have proof of delivery documentation on file to support billing for the DMEPOS. In all 14 instances, at least one of the following deficiencies occurred: the delivery documentation was missing, the delivery documentation was not signed and dated by the beneficiary or his or her designee, or the documentation for shipped items such as tracking numbers or the supplier’s invoice was missing.

### **Physician’s Order**

The PIM, chapter 5, sections 5.2.1 and 5.2.2, state that all DMEPOS suppliers are required to keep on file a physician’s order. The treating physician must sign and date the order. Section 5.2.3 states that if the supplier does not have a written order signed and dated by the treating physician before billing Medicare, the item will be denied.

For 40 of the 100 items, suppliers did not have a physician’s order on file to support billing for the DMEPOS. In all 40 instances, at least one of the following deficiencies occurred: the order was missing, the order was not signed and dated by the physician, or the DMEPOS item was not listed on the order.

### **Use or Compliant Use Followup Documentation**

The LCDs for the CPAP effective March 1, 2006, June 1, 2007, and July 1, 2007, and the LCDs for the RAD effective April 1, 2006, June 1, 2007, and July 1, 2007, state that, for an E0601 (CPAP) and an E0470 (RAD) to be covered beyond the first 3 months of therapy, the supplier must ascertain no sooner than the 61st day after initiating therapy that the CPAP is being used and that the RAD is being compliantly used. For the CPAP, either the beneficiary or the treating physician must confirm that the beneficiary is continuing to use the CPAP, and the supplier must maintain documentation that the requirement has been met. For the RAD, the supplier must obtain signed statements from both the treating physician and the beneficiary stating that the RAD is being compliantly used.<sup>8</sup> The LCDs state that continued coverage of the device will be denied if the requirements are not met.

For 12 of the 76 applicable items in our sample, suppliers did not have the use or compliant use followup documentation on file to support billing for the DMEPOS. In all 12 instances, at least one of the following deficiencies occurred: the use or compliant use followup documentation was missing, the use or compliant use followup was done within 60 days after initiating therapy, the statement(s) required to be completed by the treating physician and/or the beneficiary were missing for the RAD, or the item was billed after the first 3 months but before the supplier obtained use or compliant use followup documentation.

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<sup>8</sup> The LCD defines “compliantly used” for a RAD as an average usage of 4 hours out of 24 hours.

## **Physician's Statement**

Pursuant to the Act, § 1861(s)(12)(A), the physician must certify that the patient meets specific criteria for therapeutic shoes. The LCDs and Policy Articles for therapeutic shoes and PRSS, groups 1 and 2, state that DMEPOS items are covered if the supplier obtains a signed and dated statement from the certifying or treating physician<sup>9</sup> saying the patient meets specific criteria.<sup>10</sup> The physician's statement must be signed and dated some time during the year before the date of service for therapeutic shoes, and the Policy Articles state that the items will be denied if the requirements are not met.

For 8 of the 24 applicable items in our sample requiring a physician's statement, suppliers did not have the physicians' statements on file to support billing for the DMEPOS. In all eight instances, at least one of the following deficiencies occurred: the physician's statement of medical need was missing, was incomplete, or was not timely.

## **KX MODIFIER SYSTEM EDITS**

The LCDs require DMEPOS suppliers to include the KX modifier on claims submitted for therapeutic shoes, CPAPs, RADs, and PRSS when the "specific required documentation is on file." Use of the KX modifier constitutes a statement that the suppliers have the documentation on file that the policy requires for the particular item or service.

Palmetto GBA and CGS established electronic edits to evaluate the claims submitted by the DMEPOS suppliers. However, the edits were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims. The edits could only determine whether the required KX modifier was on the claim.

In addition, CGS considered suppliers' omissions of the KX modifier to be a "clerical error." When suppliers contacted CGS about claims denied because of a missing KX modifier, CGS added the KX modifier to the claims at the suppliers' requests.

## **EFFECT OF UNALLOWABLE PAYMENTS**

For 55 of the 100 items in our sample, suppliers who did not have the required documentation on file to support their use of the KX modifier received \$4,544 in payments. Based on our sample, we estimated that Palmetto GBA and CGS paid approximately \$137 million in unallowable Medicare payments to DMEPOS suppliers with 2007 dates of service.

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<sup>9</sup> The certifying or treating physician is the physician who treats the underlying condition that requires the use of the DMEPOS.

<sup>10</sup> For therapeutic shoes, LCDs were effective March 1, 2006, June 1, 2007, and July 1, 2007, and Policy Articles were effective June 1 and July 1, 2007. For PRSS (group 1 only), an LCD was effective January 1, 2007, and a different LCD and a Policy Article were effective June 1, 2007. For PRSS (group 2 only), LCDs were effective March 1, 2006, June 1, 2007, and July 1, 2007, and Policy Articles were effective March 1, 2006, and June 1, 2007.

## **RECOMMENDATIONS**

We recommend that CGS, as the current DME MAC:

- recover the \$4,544 in payments for specific DMEPOS items claimed for which the suppliers did not have the required documentation,
- review other payments for DMEPOS related to our unallowable sample items and recover any additional unallowable payments,
- notify CMS of the 14 suppliers who did not meet the supplier standard for maintaining proof of delivery so CMS can take appropriate action, and
- develop a corrective action plan to improve the effectiveness of the KX modifier and potentially save an estimated \$137 million.

## **AUDITEE COMMENTS**

In written comments to the draft report, CGS acknowledged the unallowable payments and described actions it intends to take in response to our recommendations.

CGS said that it would develop a proposal, which includes additional targeted provider education and a verification process for supplier documentation on a prepay basis, to improve the effectiveness of the KX modifier for submission to CMS by June 20, 2010.

In addition, CGS said that it has partnered with the other DME MACs to strengthen controls and increase the effectiveness of the KX modifier. CGS said that the four DME MAC directors made revisions to LCDs, effective December 1, 2009, which require suppliers to file redetermination requests for changes to the KX and other modifiers and to deny claims without the KX modifier. CGS said that these policy changes increase the effectiveness of the KX modifier by requiring the supplier to file an appeal to either add or change the KX modifier and to provide the documentation required to support the use of the KX modifier.

CGS's comments are included in their entirety as Appendix D.

# **APPENDIXES**

## **APPENDIX A: SAMPLING METHODOLOGY**

### **POPULATION**

The population consisted of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items for the year ending December 31, 2007, that DMEPOS suppliers claimed for payment using the KX modifier under Medicare Part B.

### **SAMPLE FRAME**

The sampling frame consisted of 3,024,176 line items totaling \$257,266,589 for the year ending December 31, 2007. These items were for specific categories of DMEPOS (therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2)) claimed for payment using the KX modifier under Medicare Part B.

### **SAMPLE UNIT**

The sample unit was a line item.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 line items.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers with the Office of the Inspector General (OIG), Office of Audit Services (OAS), statistical software.

### **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used OIG/OAS statistical software to estimate the amount of potentially unallowable payments.

**APPENDIX B: SAMPLE RESULTS AND ESTIMATES**

**SAMPLE RESULTS**

<b>Frame Size</b>	<b>Frame Value</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Unallowable Payments</b>	<b>Value of Unallowable Payments</b>
3,024,176	\$257,266,589	100	\$8,478	55	\$4,544

**ESTIMATES OF UNALLOWABLE PAYMENTS**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$137,404,646
Lower limit	103,735,580
Upper limit	171,073,712

**APPENDIX C: ERROR DETAILS**

TYPES OF MISSING DOCUMENTATION	DMEPOS Required For	Total In Sample	Number of Errors					Line Items with Only One Error
			Total	CPAP	TS *	RAD	PRSS	
Proof of Delivery	All	100	14	8	2	2	2	4
Physician's Prescription/Order	All	100	40	25	9	3	3	25
Use or Compliant Use Follow-up Documentation	CPAP, RAD	76	12	8	0	4	0	7
Polysomnogram (Steep Study)	CPAP, RAD	76	0	0	0	0	0	0
Physician's Certifying Statement	TS, PRSS	24	8	0	6	0	2	2
<b>Total Errors (Duplicated Count)</b>			<b>74</b>	<b>41</b>	<b>17</b>	<b>9</b>	<b>7</b>	<b>38</b>

CATEGORIES OF DME	Dollars Tested	Items Tested	Items Allowed †	Items Errors	Dollars in Error	1 Error	2 Errors	3 Errors	Multiple Errors ‡
Continuous Positive Airway Pressure Systems	\$4,813.14	66	33	33	\$2,401.06	25	8	0	8
Therapeutic Shoes for Diabetics	1,926.60	19	7	12	1,244.16	7	5	0	5
Respiratory Assist Devices	1,021.40	10	4	6	419.75	4	1	1	2
Pressure Reducing Support Surfaces (groups 1 and 2)	716.44	5	1	4	478.57	2	1	1	2
<b>Totals</b>	<b>\$8,477.58</b>	<b>100</b>	<b>45</b>	<b>55</b>	<b>\$4,543.54</b>	<b>38</b>	<b>15</b>	<b>2</b>	<b>17</b>

\* Therapeutic shoes are a one-time purchase.

† One of these forty-five sampled items was for a supplier who was no longer active and was considered a non-error.

‡ Seventeen of the fifty-five unallowable sampled items had multiple errors.

CPAP = continuous positive airway pressure systems

TS = therapeutic shoes for diabetics

RAD = respiratory assist devices

PRSS = pressure reducing support surfaces (groups 1 and 2)

**Jean Rush**  
President

May 11, 2010



**CIGNA Government  
Services**

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Peter J. Barbera  
Regional Inspector General for Audit Services  
Office of Audit Services, Region IV  
61 Forsyth Street, S.W., Ste. 3T41  
Atlanta, GA 30303

Dear Mr. Barbera,

On April 13, 2010, CIGNA Government Services (CGS) received Draft Report A-04-09-04039 entitled "*Review of Jurisdiction C Medicare Payments for Selected Durable Claims With the KX Modifier for Calendar Year 2007.*" CGS has reviewed the report and acknowledges the unallowable payments made related to the KX modifier where the supplier did not have the required claim documentation. CGS will take the following actions in response to the recommendations:

- Upon receipt of a listing of unallowable payments from the OIG, CGS will adjust the claims and begin recovery efforts for the \$4,544 in identified overpayments.
- Review the unallowable sample items to determine if additional overpayments can be identified and recovered.
- Report to the appropriate CMS staff, as well as the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) the suppliers identified who violated the supplier standards.
- Develop a proposal to improve the effectiveness of the KX modifier for submission to CMS (Mr. Edward Lain, DME MAC Project Officer) by June 30, 2010. Additional targeted provider education on the KX modifier will be a component of the proposal. The proposal will also include a verification process for supplier documentation on a pre-pay basis.

Supplementing the actions to be taken by CGS, we have partnered with our DME MAC peers to strengthen controls surrounding claims payment for submissions that include the KX modifier. The four DME MAC Medical Directors revised the Local Coverage Decisions (LCDs) and documentation requirements for 17 policies for the use of the KX, GA, GZ and GY modifiers effective December 1, 2009. Prior to this date, the addition, change or removal of these modifiers was considered a clerical error reopening that could be requested via paper/fax submission or over the phone. The coverage and documentation changes effective on December 1, 2009, require that providers now file a redetermination request for changes to these modifiers. Also, claims submitted without these modifiers are denied and must be resubmitted with the required modifiers. These policy changes increase the effectiveness of the KX modifier by requiring that the provider file an appeal to add or change the KX modifier and provide the required documentation to support the use of the KX modifier.



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If you have any questions or additional requests related to the review, please contact Elizabeth Noelting, Compliance Specialist at 615-782-4541.

Sincerely,

// Jean Rush //

Jean Rush  
President  
CIGNA Government Services