
**MEDICARE INTERMEDIARY
REIMBURSEMENT TO HOME
HEALTH AGENCIES FOR DURABLE
MEDICAL EQUIPMENT**



OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

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**Richard P. Kusserow
INSPECTOR GENERAL**

EXECUTIVE SUMMARY

PURPOSE

This inspection was undertaken to assess Medicare payment vulnerabilities associated with home health agency (HHA) billings to Medicare intermediaries for durable medical equipment (DME). It also examined the financial liability for coinsurance of beneficiaries receiving equipment when it is furnished as part of Medicare's home health benefit.

BACKGROUND

Reimbursement for durable medical equipment provided to Medicare beneficiaries receiving home health services can be made either under the Part A Hospital Insurance home health benefit provision or the Part B Supplementary Medical Insurance DME benefit. Medicare rules allow HHAs to choose whether or not to furnish equipment to their patients. Those that do can furnish DME to their patients either "directly" (HHA owns equipment) or "under arrangement" with DME suppliers. The HHAs then bill Medicare for this equipment to 1 of 10 regional intermediaries designated by the Health Care Financing Administration (HCFA) to process home health agency bills. When DME suppliers provide equipment directly to beneficiaries, the claim is sent to the Part B carrier in their area.

Presently, there are about 6,000 Medicare-certified HHAs. According to home health industry publications, an increasing number of HHAs are furnishing equipment to an expanding home health patient population. In 1984, based on the most recent data available (from 3,100 HHAs), Medicare intermediary reimbursement to HHAs for DME was \$41 million. Medicare Part B reimbursement in 1985 to DME suppliers was about \$880 million. Most of the Part B supplier reimbursement was for beneficiaries who did not require home health services.

In recent years, the General Accounting Office (GAO), the Office of Inspector General (OIG), and HCFA have all identified several problems associated with HCFA's coverage and payment policies for DME under the Medicare Part B benefit. To address these concerns, HCFA instructed its Part B carriers, but not its intermediaries who process HHA claims, to implement three significant program safeguards to prevent excessive or unnecessary payments. The first requires carriers to determine, based on the prescribing physician's estimate of the duration of medical need, whether it would be less costly to purchase equipment rather than make extensive monthly rental payments.

The second safeguard addresses Medicare coverage of home oxygen equipment. Prior to 1985, home oxygen was presumed by Part B carriers to be medically necessary as long as it was prescribed by a physician. Now, initial home oxygen claims must be accompanied by a statement from the prescribing physician that other forms of treatment have been tried, have not been successful, and that oxygen therapy is required. Importantly, the initial claim must include the results of a laboratory test evaluated by the prescribing physician and supporting the

need for the equipment. In addition, HCFA has recently issued instructions to carriers on the pricing of high-cost oxygen concentrators. A recent OIG inspection report on home oxygen cites escalating costs for concentrators and makes recommendations to resolve pricing issues.

The third payment safeguard addresses cases where the quality of items of equipment does not vary significantly from one supplier to another. Carrier payment for these items may not exceed the lowest charge level (LCL) at which the items are widely and consistently available. The LCL limits have applied to standard hospital beds and standard wheelchairs for several years. Effective May 1987, Part B carrier payment for an additional 80 DME items became subject to LCL limits.

METHODOLOGY

This study included interviews of officials from 5 of the 10 home health regional intermediaries, analysis of financial and medical records obtained from 9 HHAs served by those 5 intermediaries, and a review of the Part B payment histories of a sample of beneficiaries served by those HHAs. Intermediaries' bill review procedures and payment processes were compared to those of Part B carriers, for a sample of DME items. This sample, however, was not selected randomly and therefore its results are not generalizable. The purpose was to determine and evaluate differences between carriers and intermediaries. Beneficiary coinsurance liability for DME bills processed by intermediaries was calculated and compared to what their liability would have been if carriers had instead processed those bills.

FINDINGS

Our review of billing documents for 133 items of equipment found that both the Medicare program and its beneficiaries paid more for DME when bills are paid by fiscal intermediaries as a home health benefit than they would have if the bills were processed by carriers as a Part B benefit. This is due to differences in bill review and payment processes and inconsistencies between Medicare's home health benefit policies and its Part B policies.

Regional Intermediaries' Bill Review and Claims Payment Processes Are Ineffective in Controlling Program Costs for DME.

- HHAs do not provide specific medical information to intermediaries to permit them to apply HCFA's DME coverage guidelines for special feature equipment such as electric hospital beds. Bills for home oxygen do not contain results of laboratory tests, prescription information or the attending physician's statement regarding other forms of treatment attempted.

- Fifteen percent of DME items reimbursed by intermediaries did not have required documentation that the DME was prescribed by a physician as necessary in the medical management of the patient's condition.
- Six of nine HHAs did not describe on their bills the specific DME items provided; instead, charges for several items were aggregated. The intermediaries paid for these items without applying lowest charge level limits for standard hospital beds and wheelchairs, or HCFA coverage and pricing instructions for oxygen equipment.

Program Payment Safeguards to Avoid Excessive Costs are Compromised by HHA and Supplier Billing Arrangements and Inconsistencies in Program Payment Policy.

- Intermediary reimbursement to the nine HHAs may be as much as 88 percent greater than the amount Part B carriers would have paid suppliers for the identical equipment. In the cases reviewed, total intermediary payments for 1 month's rent for 100 items were \$15,400; had these claims been paid by carriers instead, the program costs would have been only \$8,200.
- When patients still require DME after discharge from home health services, DME suppliers can gain windfall profits by receiving rental payments initially from intermediaries through HHAs, and then later from Part B carriers for the same equipment as if it were being newly rented. In our sample, 26 of 100 DME items previously reimbursed by intermediaries were still required by HHA-discharged patients; suppliers started billing Part B carriers for these items. Twelve of the 26 DME items were needed long enough to reach the purchase price limitations (\$7,062) imposed by carriers under the DME rent/purchase guidelines after intermediaries had already paid \$6,600 for the 26 items (or 93 percent of purchase costs). Thus, Medicare payments were almost twice the amount the rent/purchase provisions of the law intended to pay.

Beneficiary Liability to HHAs for Coinsurance was Substantially More than it Would Be If DME Bills Had Instead Been Processed by Carriers Under Reasonable Charge Limits.

- In one sample month, beneficiaries were liable for \$4,400 in coinsurance to HHAs for DME. Coinsurance liability based upon carrier limits would have been only \$2,000. Medicare beneficiary liability for coinsurance continues indefinitely when DME is provided as a home health benefit, whereas under Part B liability it is constrained by rent/purchase payment limits.
- HHA-discharged patients are placed in continued financial jeopardy when they still need DME and suppliers start billing carriers for needed equipment. Twelve DME items in the sample were billed by suppliers after the home health benefit ended. Under

Part B rules, bills for these 12 items reached carrier purchase price limitations; beneficiary liability amounted to \$1,800 to suppliers. Prior to this, beneficiaries were liable to HHAs for \$2,400 for a total of \$4,200. Had these items been billed to carriers at the start, coinsurance liability would be only \$1,800.

RECOMMENDATIONS

Short Range: The HCFA should recognize that DME "furnished under arrangement" is merely a billing mechanism and should take administrative action to have these claims billed to carriers and made subject to uniform Part B coverage and payment policies.

Long Range: The HCFA should seek legislation to eliminate DME as a home health benefit. Instead, all DME claims would be processed by carriers under Part B.

AGENCY COMMENTS

The HCFA agrees with the need to take action to eliminate the problems arising from the differences in payment methodology between intermediaries and carriers and the need to establish uniformity in applying Medicare coverage and reimbursement guidelines. They are examining the best methodology to accomplish this goal. (See appendix I.)

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INTRODUCTION

BACKGROUND

Durable medical equipment (DME) is generally defined as equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. This definition includes (but is not limited to) such equipment as hospital beds, wheelchairs, walkers, and oxygen therapy equipment.

Medical Insurance Program Part B DME Benefit - Most equipment for home use is obtained from independent equipment suppliers. When these independent suppliers place the equipment in a beneficiary's home, claims are submitted to Medicare Part B carriers, who pay 80 percent of the reasonable charge; patients are responsible to the DME supplier for any unmet Part B deductible and the 20 percent coinsurance. Part B reimbursement to suppliers for DME was approximately \$880 million in 1985. The patients served by these independent suppliers may or may not be home health agency (HHA) patients; most actually are not.

Hospital Insurance Program Home Health DME Benefit - HHAs electing to provide DME to their patients have the option to provide equipment either "directly" or "under arrangement" with suppliers. In this context, "directly" means that the HHA actually owns the equipment and rents it to its patients. "Under arrangement" is a term for those situations where the HHA pays a DME supplier to provide equipment to its patients. Regardless of how the HHA furnishes DME, directly or under arrangement, it receives reimbursement from its intermediary.

Medicare Expenditures - The most current HCFA data for approximately 3,100 HHAs, with fiscal years ending on or before December 1984, show \$41.2 million in DME costs. This represents a 123 percent increase since mid-1982, when a GAO study of 2,385 HHAs' cost reports showed \$18 million. Current expenditures for DME billed by HHAs are likely to be much higher since there are presently some 6,000 Medicare-certified home health agencies. Home health industry publications indicate that increasing numbers of HHAs are furnishing DME to a rapidly growing home health population.

Part B Carrier Safeguards for DME Reimbursement - During 1985, HCFA implemented two significant program payment safeguards to prevent excessive payment for DME. One pertains to savings to be derived from purchase rather than rental of equipment (*Medicare Carriers Manual part 3, sect. 5101.2*); the other establishes criteria for determining coverage of home oxygen therapy (*Medicare Coverage Issues Manual 60-4*). Home oxygen equipment is exempt from rent/purchase rules. These payment safeguards apply to equipment under the Part B DME benefit; they do not apply to equipment covered under the home health benefit. Early in 1985, the Health Care Financing Administration (HCFA) instructed carriers to implement statutory provisions requiring payment of DME based upon a determination as to whether purchase of the equipment would be less costly than monthly rentals. The carrier makes this

determination based upon physicians' estimates of the expected duration of the medical need for the DME.

The second significant safeguard implemented by HCFA deals with home oxygen equipment and related consumable supplies of gaseous and liquid oxygen. According to HCFA data, in 1985 oxygen costs represented 66 percent (\$530 million) of total DME payments. Under pre-1985 Medicare policy, oxygen therapy equipment in the patient's home was covered when it was prescribed by the patient's physician. With the 1985 policy change, a physician's prescription is no longer sufficient by itself to obtain coverage. Now, initial claims for oxygen services must also include a written statement from a physician indicating that other forms of treatment have been tried, have not been sufficiently successful, and oxygen therapy is required. The initial claim must also be supported by a statement of the physician who recently examined the patient specifying: the diagnosis of the disease requiring home use of oxygen, oxygen flow rate, an estimate of the frequency and duration of use, and duration of need. Importantly, initial claims must include the results of a laboratory study ordered and evaluated by the prescribing physician which supports the need for the equipment.

The HCFA has also provided instructions to Part B carriers designed to avoid excessive payment for oxygen equipment and supplies. Notable among these instructions is the requirement to base reimbursement for costly oxygen concentrators on factors associated with oxygen usage; nine incremental usage levels of reimbursement have been established within the HCFA Common Procedures Coding System (HCPCS). The HCFA has also issued guidelines to Part B carriers regarding the pricing of oxygen concentrators using the criteria of inherent reasonableness. A recent OIG report concluded that nationwide implementation of these pricing guidelines could result in savings of over \$100 million annually. The HCFA has also instructed carriers to determine reimbursement for an oxygen system (concentrator, liquid or gaseous) so that payment does not result in greater reimbursement than an alternative system unless the medical needs of the patient require the more expensive system.

A third payment safeguard which Part B carriers apply to certain items of equipment is known as the "lowest charge level (LCL)." Under this reimbursement principle (section 1842(b)(3) of the Social Security Act), Medicare can limit the amount of payment for DME items which do not generally vary significantly in quality from one supplier to another and can be readily obtained in a locality. In mid-1987, HCFA extended LCL payment limits to 80 newly designated items; previously, only standard hospital beds and standard wheelchairs were subjected to these payment limits. However, intermediary reimbursement to HHAs for DME continues to be made without application of LCL limits.

PURPOSE

This inspection was undertaken to assess Medicare payment vulnerabilities associated with HHAs billing for DME to Medicare intermediaries. More specifically, the inspection was designed to identify program weaknesses which result in inappropriate and excessive payments for DME due to bifurcated coverage and payment policies under the home health benefit as handled by intermediaries and under the Part B administration of carriers. Addition-

ally, the inspection examined the financial liabilities incurred by beneficiaries due to identified incongruities in coverage and payment policies.

METHODOLOGY

Ten regional intermediaries have been designated by HCFA to process claims for approximately 90 percent of HHAs. (A recently published proposed rule will assign the remaining 10 percent, which are mostly hospital-based HHAs, to these regional intermediaries within 9 months after the effective date of the final rule.) Based upon HCFA's most recent cost report data, it is estimated that 7 of the 10 intermediaries will make reimbursement for 96 percent of home health DME expenditures. Five of these seven intermediaries (Blue Cross plans in California, New Mexico and Philadelphia and commercial plans in Florida and New Jersey) were selected for study.

Interviews were conducted with intermediary staff concerning interpretation of HCFA instructions and intermediary application of instructions in functional areas of prepayment review, reimbursement, post payment review and cost report settlement.

Nine HHAs in the service areas of the above five regional intermediaries were selected to provide information on agency business practices in furnishing DME. Written contracts between HHAs and DME suppliers, price lists, and 1986 cost report worksheets were examined. These HHAs also provided billing, reimbursement, and beneficiary coinsurance records on a sample of cases. The sample cases consisted of four equipment items commonly ordered for home health patients (hospital beds, wheelchairs, walkers, and oxygen equipment).

Carriers in the same nine States as the HHAs provided prevailing charge data and beneficiary payment histories on the sample cases obtained from the HHAs. The amount carriers would have paid for sample items was determined and compared with intermediary rental payments. Beneficiary payment histories were reviewed to determine whether carriers and intermediaries were both paying for the same equipment at the same time. Payment histories were also utilized to project the extent of excessive program payments and beneficiary coinsurance liability that can occur when the beneficiary is discharged from home health care but continues to require the use of DME originally provided by the HHA.

FINDINGS

Regional Intermediaries' Bill Review and Claims Payment Processes Are Ineffective in Controlling Costs for DME.

The Medicare Coverage Issues Manual provides both carriers and intermediaries with the coverage status of a number of procedures and services. Analysis of several sections indicates that coverage determinations for items such as home oxygen and hospital beds apply only to items furnished under the Part B DME; intermediaries processing bills for identical items furnished under the home health benefit, however, are not instructed to apply these same coverage guidelines.

For example, section 60-4 states:

Medicare coverage of home oxygen and equipment under the durable medical equipment benefit (section 1861(s)(6)) ... will be considered reasonable and necessary...

... carriers are required to conduct periodic medical necessity reviews...

... carriers may also request documentation of repeat arterial blood gas or oximetry study...

With regard to hospital beds, the manual states:

A physician's prescription, and such additional documentation as the Part B contractors' medical staffs may consider necessary...

... In well-documented cases, the Part B contractors' medical staffs may determine that a variable height feature of a hospital bed... is medically necessary...

... Electric-powered adjustments to lower and raise head and foot may be covered when Part B contractors' medical staffs determine...

When DME suppliers bill Part B carriers, they must submit a physician's prescription with the initial claim, which usually contains a HCPCS code specifically established to describe the item. Most carriers require detailed information from the prescribing physician in order to make proper coverage decisions. For example, coverage of home oxygen is considered reasonable and necessary only for patients who meet medical documentation requirements (including laboratory evidence demonstrating oxygen insufficiency) and are diagnosed as having one of several specified respiratory impairments. The attending physician must indicate that

other forms of treatment have been tried and there is no substitute for oxygen therapy. For a hospital bed, the physician's prescription must establish medical necessity; for special features, the physician must describe the patient's medical condition which requires a variable height feature or electric-powered adjustment.

In contrast, when HHAs bill intermediaries they submit a standardized form-- Home Health Certification and Plan of Treatment (HCFA-485)-- signed by the attending physician which contains a data element for "Medical supplies and DME ordered." It is common for HHAs to simply use abbreviations or generic names to describe equipment ("HB" for hospital bed, "O₂" for oxygen, "WC" for wheelchair). In comparison to the detailed prescription information required for carrier coverage determinations under Part B, intermediaries require only the physician's signature on the HCFA-485 form.

The intermediaries' staffs do not apply HCFA's coverage criteria to HHA bills for DME. As noted above, HCFA has not specifically instructed them to apply DME coverage criteria to HHA bills; in practice, the intermediaries' nurse reviewers do not receive the necessary medical information from HHAs to determine coverage. Indicative of the lack of attention paid to DME is the fact that 20 of the 133 items reviewed and paid by intermediaries (15 percent) were not documented as being ordered by the authorizing physician. Moreover, 20 bills in the sample cases were for oxygen therapy; none of the "prescriptions" contained information necessary to make a coverage determination. In seven cases, it was specifically noted that beneficiary oxygen usage was "whenever needed" (PRN); application of Part B coverage criteria would have resulted in denial of these claims.

To help to contain and control costs of DME under Part B, HCFA has had legislative authority to set reimbursement at the lowest charge level (LCL) for items which, in its judgment, do not vary significantly in quality from one supplier to another and are widely available in a locality. For several years, only standard wheelchairs and standard hospital beds were subject to Part B lowest charge level reimbursement. In May 1987, an additional 80 items became subject to LCL limits. Reimbursement under Part B is also affected by rent/purchase payment guidelines designed to avoid excessive monthly rental costs associated with long-term rentals.

A 1985 GAO report indicated that payment to purchase low cost (\$120 or less) items such as walkers would save 54 percent of the costs associated with Part B monthly rentals. For items over \$120, such as hospital beds and wheelchairs, savings would amount to 34 percent.

Billing forms submitted by HHAs for individual items of equipment frequently provide as little information for payment as they do for coverage decisions. Examination of bills submitted by HHA's showed that six of nine HHAs (1) do not identify the type of equipment being billed; (2) aggregate total charges for several items; and (3) describe the charge as "DME Rental." Hence, intermediaries are paying for unspecified equipment without regard to prices. Intermediaries processed claims for oxygen concentrators with customary monthly charges ranging from \$620 to \$926, an amount two to three times Part B carrier reasonable charge allowances.

Program Payment Safeguards to Avoid Excessive Costs are Compromised by HHA and Supplier Billing Arrangements and Inconsistencies in Program Payment Policies.

Although most HHAs do not provide or arrange for DME under the home health benefit, an increasing number are electing to do so. Those that do usually have business arrangements with suppliers who place the equipment in patients' homes. Regardless whether the HHA furnishes the DME itself or the equipment is furnished "under arrangement," the HHA, not the supplier, submits bills to the intermediary.

In order to participate in the Medicare program, an HHA must meet a number of specific requirements and sign an agreement. Prior to July 1981, the Medicare Conditions of Participation for HHAs stipulated that only public and nonprofit home health agencies could arrange for outside services with others; proprietary agencies had to provide all services directly. HCFA instructions relating to furnishing services under arrangement are in section 200.2 of the HHA Manual. It appears that this provision is meant to assign responsibility to the HHA to assure the quality of patient care; its application to allow HHAs to bill for DME, which is actually furnished by suppliers, may not be appropriate.

Of particular note, this manual section states:

In permitting home health agencies to furnish services under arrangements it was not intended that the agency *merely serve as a billing mechanism for the other party*. Accordingly, for services provided under arrangements to be covered, the agency must exercise *professional responsibility* over the arranged-for services. (Emphasis added.)

The agency's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The agency must accept the patient for treatment in accordance with its admission policies, maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and assure that the required plan of treatment is periodically reviewed by him; secure from the physician the required certifications and recertifications; and see to it that the medical necessity of such services is reviewed on a sample basis by the agency's staff or an outside review group.

In addition to the above provisions, if an HHA's arrangement is with an organization which is not a qualified provider (as is the case with DME suppliers), then there must be a written contract between the two parties. The contract must include, among other items: a description of how personnel will be supervised by the HHA; the contracting organization's standards for personnel (including qualifications, functions, supervision, and in-service training); and a method of determining reasonable costs for services provided by the contracting organization. Again, except for "reasonable costs," these contract-conditions do not appear as though they were meant to apply to equipment suppliers.

Seven of the nine HHAs reviewed in this inspection furnish DME "under arrangement"; the remaining two provide equipment directly. Only three of the seven agencies had written contracts with their suppliers. Review of these contracts provided little explanation of how the HHA-DME supplier business arrangement met the conditions and intent of HCFA's contract requirements. Indeed, while in these arrangements, DME suppliers do not appear to provide any more or less service to beneficiaries receiving DME under the home health benefit than to beneficiaries with whom the DME suppliers deal with directly. These business arrangements appear to serve merely as a billing mechanism for the DME suppliers involved to receive reimbursement through home health agencies.

When DME suppliers bill Part B carriers for covered equipment, the monthly rental payment is subject to an allowed charge computation; the payment is final assuming proper claim adjudication. When HHAs bill Part A intermediaries, their reimbursement is based upon the lesser of costs or charges for equipment. In addition to the amount charged by the supplier, allowable costs include allocation of agency overhead expenses.

The OIG constructed the intermediary reimbursement for monthly rental of 100 items of equipment in our sample. We applied the most recently reported ratio of DME costs to charges against billed charges for these 100 items in the sample month. Our calculations indicate that intermediary reimbursement would have been \$15,400. We then compared the amount carriers would have paid for these 100 items had the claims been submitted to them for payment and deemed to have been covered. Carrier monthly rental payments would have been \$8,000. Hence, intermediary reimbursement to the nine HHAs was 88 percent greater than the amount which carriers would have made to suppliers.

When beneficiaries no longer require home health services but still need equipment, the HHA can continue to bill the intermediary as a Part B DME benefit. None of the seven HHAs furnishing DME under arrangement chose this option. Rather, the suppliers formerly paid by HHAs under arrangement started billing the carrier for the equipment. In our study, of 100 items previously reimbursed by intermediaries, 26 items were still required by beneficiaries after discharge from home health care. In applying HCFA's rent/purchase payment guidelines, carrier purchase payment limits were reached on 12 of these 26 items, which DME suppliers continued to provide to the discharged patients. Carrier payment limits amounted to \$7,100 for the full purchase price. Prior to this, intermediary Part A payments amounted to \$6,600 (or 93 percent of purchase costs). Thus, in permitting DME to be billed "under arrangement," HCFA's payment safeguards are easily circumvented.

Beneficiary Liability to HHAs for Coinsurance Is Substantially More Than It Would Be If Bills Had Been Processed by Carriers Under Reasonable Charge Limits.

Prior to July 1984, DME provided under the home health benefit was not subject to the 20 percent coinsurance which has always applied to equipment covered by the Part B benefit. The dollar amount which home health patients are responsible for is based on the HHAs' sub-

mitted charges for the equipment. When suppliers bill carriers, beneficiaries' coinsurance liability is limited to 20 percent of the allowed charge, as determined by carriers.

The HHAs in our sample submitted charges for \$21,700 for 100 items of equipment in the sample month. Beneficiary coinsurance liability amounted to \$4,340. Had the DME been billed instead to carriers, allowed charges would have been \$10,230; beneficiary liability would have been \$2,046 (or 112 percent less). Many carriers establish monthly rental limits at approximately 10 percent of the purchase price. Under HCFA's Part B rent/purchase instructions, many equipment items reach payment limits within 1 year. At that point, beneficiaries are no longer liable for coinsurance.

The Part B rent/purchase instructions have not been applied to DME furnished under a home health plan of care. Beneficiaries remain responsible for coinsurance for as long as the equipment is needed. An OIG analysis of home health billings showed that 10 percent of beneficiaries are under a plan of care for more than 1 year.

The inconsistencies in program policies between the home health DME benefit and Part B DME benefit place beneficiaries in double jeopardy for coinsurance when HHAs cease billing for DME and suppliers commence billing. Twelve DME items billed by suppliers after HHAs discontinued billing reached carrier purchase price limitations; beneficiary liability amounted to \$1,300 to HHAs and \$2,400 to suppliers. The latter amount would have been the liability had the business transaction initially taken place between beneficiaries and suppliers.

Regional Intermediaries Give Review of HHA Reimbursement for DME a Low Priority.

The HHAs receive interim payments for DME from the intermediaries throughout the year, with final settlement made at the end of the agency's accounting year. Agencies must maintain adequate cost data capable of being audited. The first cost report filed by a new agency almost always has a field audit which provides a basis for evaluation of subsequent years' cost reports. Thereafter, intermediaries make final settlement on the basis of desk review, limited-scope audit, or full-scope audit.

According to the intermediaries' audit directors, which type of audit they select is influenced by HCFA's budget allocations, which are translated into an Audit Priority Matrix. Since funding for HHA audits has traditionally been given low priority, the great majority of HHA cost reports are settled via desk review. Notwithstanding the low priority afforded to HHA audits, a major consideration on the scope of audit to be performed is the cost benefit. The HCFA requirements that intermediary audit staff identify 5 dollars in savings for every dollar spent on an audit discourages the intermediaries from auditing DME costs, which are relatively insignificant only when they are compared with the \$2.3 billion (1985) in total Medicare intermediary reimbursement to HHAs.

RECOMMENDATIONS

Short Range: The HCFA should recognize that DME furnished by home health agencies "under arrangement" with DME suppliers is merely a billing mechanism for Part A reimbursement. We recommend that HCFA take administrative action to have these claims submitted instead to carriers and made subject to uniform Part B coverage and payment policies.

Long Range: The HCFA should seek a legislative change to eliminate DME as a home health benefit. All claims for DME provided to Medicare beneficiaries while under a home health agency plan of care should be processed by carriers under the Part B DME benefit.

We submitted our draft report to HCFA and obtained their comments, which are contained in the appendix.



Memorandum

Date . APR 26 1988

From William L. Roper, M.D.
Administrator

Subject OIG Draft Report: Medicare Intermediary Reimbursement to Home Health Agencies
for Durable Medical Equipment - OAI-02-87-00016

To The Inspector General
Office of the Secretary

We have reviewed the OIG draft report on fiscal intermediary reimbursement of durable medical equipment (DME) provided by home health agencies (HHAs). The findings were extremely interesting, and we agree that HCFA needs to take action to eliminate the problems arising from the differences in payment methodology for intermediaries and carriers.

We agree with the motivation behind the OIG recommendation that the carriers process the claims for DME provided through or by HHAs. We recognize that the OIG short range recommendation has the potential of curtailing inconsistencies in program policies that currently exist between the home health DME benefit and Part B DME benefit. We certainly agree with the need to establish uniformity in applying Medicare coverage and reimbursement guidelines and assure fair and reasonable cost-sharing payment for its beneficiaries.

We are, currently, examining the best methodology to accomplish the goal; either through carrier processing or the establishment of consistent coverage and reimbursement decisions by the carriers and intermediaries. In this regard, we need to establish whether HCFA could implement the recommendation administratively under current authorities (as the OIG proposes), or whether we would need a legislative change to do so. We are actively pursuing resolution of this question, and we will keep you apprised of our progress.

We believe the OIG proposal to eliminate DME as a home health benefit is unnecessary and objectionable. While the OIG ties this proposal to the policy of having carriers process the DME claims, we view the issue of administration of the DME benefit as separable from the coverage issue. If we need legislation to implement the OIG recommendation on carriers' processing, we would propose only to amend the statutory provisions on administration of the HHA DME benefit, without touching coverage issues.

Thank you for the opportunity to comment on this report.