

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PROGRAM INTEGRITY PROBLEMS
WITH NEWLY ENROLLED
MEDICARE EQUIPMENT
SUPPLIERS**



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OBJECTIVES

1. To determine the extent to which newly enrolled suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) had their billing privileges revoked or were placed on prepayment claims review.
2. To determine the extent to which newly enrolled suppliers omitted from their Medicare applications required information regarding (a) owners or managers or (b) the criminal histories of owners or managers or any adverse legal actions taken against these individuals.

BACKGROUND

Historically, DMEPOS suppliers have presented significant program integrity problems for the Medicare program. In 2010, the Patient Protection and Affordable Care Act (ACA) strengthened the enrollment-screening process for all Medicare, Medicaid, and Children's Health Insurance Plan providers, including DMEPOS suppliers. The Centers for Medicare & Medicaid Services (CMS) contractor responsible for enrollment of new DMEPOS suppliers is the National Supplier Clearinghouse Medicare Administrative Contractor (NSC). At the time of our review and prior to ACA enactment, NSC assessed the fraud and abuse risk of new supplier applicants and assigned each a risk rating (from low to high), the Fraud and Abuse Indicator of Risk (FAIR). NSC uses the FAIR rating to determine the frequency of unannounced site visits for new enrollees. In February 2011, CMS staff stated that they were developing policies and procedures to transition NSC's FAIR rating system and corresponding monitoring practices to the specific policies and practices required by the ACA.

This report uses the results of contractors' oversight activities as indicators of program integrity problems among DMEPOS suppliers during their first year in Medicare. Our nationally representative sample of 229 DMEPOS suppliers enrolled in Medicare during October–December 2008 includes suppliers representing all FAIR ratings. We examined data from Medicare contractors to identify suppliers that had their Medicare billing privileges revoked by CMS or that CMS placed on prepayment claims review. We also used a proprietary database of public records to identify suppliers that omitted required information from their enrollment applications.

FINDINGS

During their first year in Medicare, 26 percent of high- and medium-risk suppliers and 2 percent of low/limited-risk suppliers had their billing privileges revoked or were placed on prepayment claims review.

CMS revoked the Medicare billing privileges of 21 percent of high- and medium-risk suppliers in their first year of enrollment. Although NSC conducted postenrollment site visits within the timeframes required by CMS, several suppliers in our sample had already received significant Medicare payments before the first site visit. For example, one supplier in our sample received almost \$800,000 from Medicare prior to NSC's first postenrollment site visit. CMS placed 9 percent of high- and medium-risk suppliers on prepayment claims review for reasons such as billing for services not ordered by a physician or not rendered, having unusual billing patterns, and failing to respond to CMS or contractor requests for information. CMS revoked the Medicare billing privileges of 2 percent of low/limited-risk suppliers. CMS did not place any of the sampled low/limited-risk suppliers on prepayment claims review.

Thirteen percent of high- and medium-risk suppliers and 4 percent of low/limited-risk suppliers omitted ownership or management information from their Medicare enrollment applications. Our review of public records revealed that these suppliers did not disclose the name of at least one owner or manager. Further, 11 of the 20 sampled suppliers that omitted ownership or management information remained in Medicare through December 2010. This suggests that information omitted from enrollment applications can remain undetected for more than a year despite NSC's application reviews and postenrollment site visits.

Four percent of high- and medium-risk suppliers omitted information regarding criminal histories or adverse legal actions from their applications. In their applications, a small number of high- and medium-risk suppliers did not report information regarding criminal histories of their owners or managers and any adverse legal actions taken against these individuals. Examples of omissions include convictions for insurance fraud, theft by deception, and felony aggravated battery.

RECOMMENDATIONS

Although ACA provisions strengthen the enrollment screening of DMEPOS supplier applicants and CMS's oversight authorities, our review demonstrates that further scrutiny of the riskiest applicants is needed to prevent dishonest individuals from receiving Medicare payment. We recommend that CMS:

Conduct postenrollment site visits earlier for new DMEPOS suppliers receiving the most money from Medicare. Although NSC conducted the correct number of site visits of high- and medium-risk suppliers as required by CMS, Medicare had already made significant payments to some suppliers in our sample before they received their first postenrollment site visits from NSC. CMS could use the FAIR rating to prioritize certain newly enrolled suppliers and require NSC to conduct postenrollment site visits earlier, possibly within a month, for newly enrolled high- and medium-risk suppliers that submit large dollar amounts of claims.

Apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required. Our findings demonstrate that omissions of the names of owners or managers can allow a supplier to gain billing privileges when it might otherwise be denied Medicare participation. Such omissions could circumvent ACA-required fingerprint-based criminal background checks because CMS would not be running checks on omitted individuals. CMS should improve processes to detect information that suppliers may have deliberately omitted. CMS should focus such investigative activities on suppliers deemed high- or medium-risk by an in-depth assessment, such as the FAIR rating.

Take appropriate action regarding DMEPOS suppliers that omit information from applications. We will forward to CMS the names of those suppliers that we identified as having either omitted the names of owners or managers or omitted information regarding the criminal histories of owners or managers and any adverse legal actions taken against these individuals. CMS can then determine whether the omissions were intentional and whether further action is needed. Additionally, in the future, when CMS determines that suppliers have inappropriately omitted required information from their Medicare enrollment applications, CMS should refer these individuals and suppliers to OIG for (if warranted) permissive exclusion.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with our recommendations and stated that it is using authorities granted under the ACA to address potential vulnerabilities. CMS stated that it will instruct NSC to conduct earlier site visits of newly enrolled suppliers, have its new DMEPOS supplier-screening contractor alert NSC and MACs when it identifies individuals affiliated with companies but not reported on enrollment documents, take appropriate action regarding individuals identified by OIG, and continue to refer to law enforcement suppliers that omitted required enrollment information.

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BACKGROUND

DMEPOS are covered under Medicare Part B and include items such as oxygen supplies, wheelchairs, prosthetic limbs, and surgical dressings.¹ Medicare covers DMEPOS only when ordered for a beneficiary by a physician or, in some cases, a nonphysician practitioner.² Medicare reimbursed \$8.8 billion for DMEPOS in 2010.³

Historically, DMEPOS suppliers have presented significant program integrity problems for the Medicare program. Prior Office of Inspector General (OIG) work documented significant problems, including fraudulent Medicare billing by suppliers, particularly in specific high-risk geographic areas.⁴ To help protect Medicare from DMEPOS fraud and abuse, the Centers for Medicare & Medicaid Services (CMS) has over time instituted standards of participation for DMEPOS suppliers, processes for screening new supplier applicants, and

¹ See Social Security Act §§ 1832(a), 1861(s)(6), and 1861(s)(8). The complete list of covered items can be found online at www.cms.gov. Accessed on October 7, 2010.

² *Medicare Program Integrity Manual (PIM)*, Pub. No. 100-08, ch. 5, § 5.2.

³ The figure cited is for reimbursement amounts for all DMEPOS claims in 2010 and is based on OIG analysis of the National Claims History File.

⁴ See, for example, Department of Health and Human Services (HHS) OIG, *South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, OEI-03-07-00150, March 2007; HHS OIG, *Los Angeles County Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits*, OEI-09-07-00550, February 2008; HHS OIG, *South Florida Medical Equipment Suppliers: Results of Appeals*, OEI-03-07-00540, October 2008; HHS OIG, *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009; HHS OIG, *Payments to Medicare Suppliers and Home Health Agencies Associated With "Currently Not Collectible" Overpayments*, OEI-06-07-0080, November 2008; and HHS OIG, *Aberrant Claims Patterns for Inhalation Drugs in South Florida*, OEI-03-08-00290, April 2009.

requirements for contractor monitoring of suppliers. In 2010, the Patient Protection and Affordable Care Act (ACA) strengthened the enrollment-screening process for all providers—including DMEPOS suppliers—participating in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

DMEPOS Supplier Standards of Participation

To participate in Medicare, each DMEPOS supplier must complete an enrollment application and demonstrate that it meets the 30 standards of participation.⁵ CMS can deny enrollment to applicants that do not meet one or more of the standards.⁶ CMS can also revoke the billing privileges of existing Medicare suppliers that do not continue to meet the standards.⁷

DMEPOS applicants must also provide “complete and accurate information in response to questions” on enrollment applications.⁸ Applicants must disclose—among other information—the identity of any person or business that has an ownership or a controlling interest in the business or that functions in a management role.⁹ For each person or business on the application, suppliers must also report any history of certain types of criminal convictions and adverse legal actions taken against the person or business, such as exclusions from a Federal or State health care program, loss of billing privileges, and payment suspensions.¹⁰

DMEPOS Supplier Applicant Screening and Risk Assessment

The CMS contractor responsible for the DMEPOS supplier enrollment process is the National Supplier Clearinghouse Medicare Administrative Contractor (NSC). NSC’s responsibilities include reviewing enrollment applications, conducting unannounced site visits to applicants’ business locations, conducting fraud risk assessments, and issuing Medicare billing numbers to applicants that meet program participation standards.

⁵ 42 CFR § 424.57 and 42 CFR pt. 424, subpart P. The number of standards of participation that apply to DMEPOS suppliers has increased over time.

⁶ 42 CFR § 424.57(b) and (d). (Subsequently, paragraph (d) was moved to paragraph (e).)

⁷ Ibid.

⁸ 42 CFR § 424.57(c)(2). See also 42 CFR § 424.510(d)(2)(i).

⁹ Sections 5 and 6 of Form CMS-855S. CMS requires this information pursuant to 42 CFR §§ 420.206 and 424.510(d)(2)(i).

¹⁰ Sections 3, 5, and 6 of Form CMS-855S.

Enrollment application review. CMS requires NSC to review suppliers’ enrollment applications and supporting documentation for complete and valid information.¹¹ To determine its accuracy, NSC compares some applicant-reported information—such as National Provider Identifier (NPI) and Tax Identification Number—to external sources. However, the accuracy of some reported information cannot be readily determined by NSC. For example, CMS recently stated: “While we require our Medicare contractors to verify data submitted on, and as part of, the Medicare provider/supplier application, our contractors are not able to verify information that may have been purposefully omitted or changed in a manner to obfuscate any previous criminal activity.”¹²

Preenrollment site visits. CMS requires NSC to conduct at least one unannounced site visit to an applicant’s business location to assess compliance with the Medicare standards of participation, with certain types of supplier applicants exempted.¹³ In site visit reports, NSC investigators record their findings about supplier compliance with standards and their assessment of the fraud risk that the applicant poses. The site investigation reports also include site investigator notes from supplier staff interviews; photographs of the business and onsite inventory; and any supporting documentation obtained, such as business and professional licenses.

Supplier approval and risk rating. Once NSC determines that a supplier applicant meets the Medicare standards of participation, it grants the new supplier Medicare billing privileges by assigning a unique billing number for each approved business location. At the time of our review and prior to ACA enactment, NSC also assessed the fraud and abuse risk of new supplier applicants and assigned each a risk rating called the Fraud and Abuse Indicator of Risk (FAIR).¹⁴ (We discuss related ACA-required changes beginning on page 5.) Prior to ACA enactment, DMEPOS suppliers were the only Medicare provider type to receive risk-based screening and monitoring as part of their participation.¹⁵

¹¹ NSC Statement of Work (SOW), Att. J.1, § 1.2.2, obtained by OIG from CMS on June 18, 2009.

¹² 76 Fed. Reg. 5867 (Feb. 2, 2011).

¹³ NSC SOW, Att. J.1, § 1.15. Certain Medicare suppliers were exempt from these preenrollment site visit requirements, including suppliers with 25 or more active locations, physicians, and certified Medicare providers (e.g., hospitals, home health agencies).

¹⁴ *PIM*, ch. 10 § 21.4. Formerly known as Fraud Level Indicator. See also NSC SOW.

¹⁵ See *PIM*, ch. 10.

To determine the FAIR rating, NSC scored each applicant using 15 predefined risk factors, such as:

- the applicant’s geographic area,
- the fraud potential of the applicant’s products and services,
- the applicant’s prior Medicare experience, and
- the applicant’s site visit results.¹⁶

Using information from the site visit report and the supplier’s application, NSC assigned one of four FAIR ratings:

- low risk (e.g., national drugstore),
- limited risk (e.g., clinicians in low-fraud areas),
- medium risk (e.g., medium-sized medical supplier in a high-fraud area), or
- high risk (e.g., small supplier with low inventory levels in a historically high-fraud area).¹⁷

NSC tracked each supplier’s individual risk factors and FAIR score on a spreadsheet, known as the FAIR matrix. Once a supplier was approved to participate in Medicare, the newly enrolled supplier’s FAIR rating determined the number of postenrollment site visits that NSC performed to ensure continuing supplier compliance with the participation standards.

Postenrollment Site Visits of DMEPOS Suppliers

At the time of our review, CMS required NSC to conduct at least one postenrollment site visit per year for medium-risk suppliers and at least two for high-risk suppliers.¹⁸ CMS did not require postenrollment site visits for low-risk or limited-risk suppliers, although NSC could decide to conduct a visit if complaints or other factors generated concern about a supplier.¹⁹ CMS also required NSC to update each supplier’s FAIR rating at least annually, based in part on information gathered during site visits.²⁰

¹⁶ NSC SOW, App. J.1, §1.2.1.

¹⁷ *PIM*, ch. 10, § 21.4; NSC SOW, Att. J.1, § 1.2.1.

¹⁸ NSC SOW, Att. J.1, § 1.2.2.

¹⁹ *Ibid.*

²⁰ NSC SOW, Att. J.1, § 1.19.1.

Related Changes From the Affordable Care Act

Section 6401 of the ACA added new requirements at 1866(j)(2) for the Secretary to conduct certain enrollment-screening measures for different types of Medicare providers, including DMEPOS suppliers. In February 2011, CMS promulgated a final rule implementing those provisions effective March 25, 2011, for all new DMEPOS supplier applicants and existing Medicare suppliers revalidating their enrollment information. For all other currently enrolled suppliers, the rule will become effective March 23, 2012.²¹

To implement the new screening measures, CMS will classify all DMEPOS suppliers into one of three risk categories: limited, moderate, or high.²² CMS will assign nearly all newly enrolling DMEPOS suppliers to the “high risk” category and currently enrolled and revalidating DMEPOS suppliers to the “moderate risk” category.²³ Screening will include at a minimum, verification of compliance with Federal and State requirements, licensure checks, and database checks. Each supplier in the moderate and high-risk categories must also undergo an onsite visit.²⁴ High-risk suppliers—both current suppliers and applicants—must submit the fingerprints of all owners with 5 percent or greater direct or indirect ownership, who are then subject to a fingerprint-based criminal history report.²⁵

The risk-rating system to be implemented by CMS puts all new DMEPOS supplier applicants into the high-risk category. In February 2011, CMS staff stated that CMS is developing appropriate policies and procedures to transition NSC’s FAIR rating system and corresponding monitoring practices to the specific ACA-required policies and practices.

A related change resulting from the ACA involves disclosure of information on enrollment applications and updates of enrollment application information by existing suppliers. The ACA requires suppliers to disclose any current or previous affiliation with other providers or suppliers that have certain Medicare, Medicaid, or CHIP

²¹ 76 Fed. Reg. 5865 (Feb. 2, 2011). Any currently enrolled supplier that revalidates its enrollment information on or after March 25, 2011, and before March 24, 2012, is also subject to the rule.

²² 76 Fed. Reg. 5862, 5867 (Feb. 2, 2011).

²³ 42 CFR § 424.518 (b)(1)(x) and (c)(1)(ii), effective March 25, 2011.

²⁴ 42 CFR § 424.518 (a) and (b).

²⁵ 42 CFR § 424.518 (c); 76 Fed. Reg. 5862 (Feb. 2, 2011).

program integrity problems, including uncollected debt, payment suspension, exclusion from program participation, and revocation of billing privileges.²⁶ CMS has authority to deny or revoke the Medicare billing privileges of suppliers for submitting false or misleading information on the Medicare enrollment applications.²⁷

Indicators of Program Integrity Problems

This report uses the results of several contractors' oversight activities as indicators of program integrity problems among DMEPOS suppliers during their first year in Medicare. As stated, NSC is responsible for screening supplier applicants and conducting unannounced site visits. Durable Medical Equipment Medicare Administrative Contractors (DME MAC) are responsible for DMEPOS claims processing activities, which can include monitoring supplier billing, identifying and collecting overpayments, and following up on complaints against suppliers. Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) are responsible for conducting a variety of oversight activities, such as prepayment and postpayment medical reviews of claims, provider education, and data analysis, to detect potential overpayments and fraud.²⁸

We focus on two types of CMS enforcement actions that potentially result from these contractors' oversight activities: revocation of billing privileges and prepayment claims reviews.

- **Revocation of Billing Privileges.** A revocation is the termination of a supplier's billing privileges. Revocations can be imposed for noncompliance with the participation standards, supplier misconduct, felony conviction, providing misleading information, or misuse of a billing number, among other reasons.²⁹ Once their billing privileges are revoked, suppliers are barred from participating in Medicare for a minimum of 1 year, but not greater than 3 years, depending on the reason for revocation.³⁰
- **Prepayment Claims Review.** PSCs and ZPICs conduct prepayment claims review when they have evidence that a supplier submitted

²⁶ ACA § 6401; Social Security Act § 1866(j)(5).

²⁷ 42 CFR §§ 424.530(a) and 424.535(a).

²⁸ CMS was transitioning PSCs to ZPICs nationwide at the time of our review.

²⁹ See 42 CFR § 424.535(a) and § 424.57(e) for the complete list of revocation reasons. See also *PIM*, ch. 10, § 13.2.

³⁰ 42 CFR § 424.535(c).

improper or potentially fraudulent claims. Factors leading to prepayment review include unusual supplier billing patterns, knowledge of abuses in the service area, or complaints received from beneficiaries or others. Prepayment reviews vary in scope; they can include all claims from a particular provider, or they can focus on selected services, place of service, or other specific criteria.³¹

METHODOLOGY

Scope and Sample

We selected a stratified random sample of DMEPOS suppliers that enrolled in Medicare for the first time between October 1 and December 31, 2008. We stratified by the supplier's FAIR rating at the time of enrollment. Using the NSC supplier enrollment file, we identified 430 low-risk, 529 limited-risk, 207 medium-risk, and 67 high-risk suppliers.

For sampling and analysis purposes, we combined the groups with FAIR ratings of "low risk" and "limited risk" into one stratum, because NSC staff informed us that it treats suppliers in the two groups virtually the same once they have been approved for Medicare participation. We hereafter refer to this stratum as low/limited-risk suppliers. The low/limited-risk stratum consisted of 91 of the 959 low-risk and limited-risk suppliers. The medium-risk stratum consisted of 71 of the 207 medium-risk suppliers, and the high-risk stratum consisted of all 67 high-risk suppliers. Our total sample consisted of 229 suppliers, and we had a 100-percent response rate.³²

We examined multiple data sources regarding the sampled suppliers, covering the period from the date of their Medicare enrollment through December 31, 2009. Although we refer to the review period as "the first year of enrollment," the actual review period for each supplier spanned up to 15 months, depending on each supplier's enrollment date. For example, a supplier that was enrolled on October 1, 2008, would have been in the program for 15 months by December 31, 2009, whereas a supplier that enrolled on December 31, 2008, would have been in the program for only 12 months.

³¹ *PIM*, ch. 3.

³² We originally selected 92 low/limited-risk suppliers but eliminated 1 supplier from the sample because of an error in the data regarding the supplier's enrollment date.

Data Collection and Analysis

We used multiple data sources for our review.

- *Medicare claims data.* We used CMS's National Claims History File to identify Medicare reimbursements for each supplier in our sample.
- *Data on revocation of Medicare billing privileges.* We used NSC data to identify suppliers in our sample whose billing privileges were revoked during the study period, the revocation dates, and the reasons for revocation.
- *Prepayment claims review data.* We used data from five CMS contractors to identify sampled suppliers placed on prepayment review during the study period and the dates of the reviews.³³
- *Supplier enrollment applications.* We obtained all sampled suppliers' enrollment applications (Form CMS-855S) and any updates to them.
- *NSC site investigator reports.* We obtained all reports completed by NSC site investigators after they conducted an unannounced visit to each sampled supplier's place of business.

Analysis of DMEPOS supplier program integrity problems. To determine the extent to which these newly enrolled suppliers had indicators of program integrity problems, we analyzed each supplier's Medicare enrollment application, reports from NSC's site investigation(s) of the supplier, claims submitted by the supplier, and any CMS enforcement actions taken against the supplier. Our findings focus on two CMS enforcement actions: revocation of suppliers' billing privileges and placement of suppliers on prepayment claims review. Revoking a supplier's billing privileges is one of the strongest enforcement actions that CMS can take. Likewise, placing a supplier on prepayment review indicates that CMS has significant concerns about the legitimacy of that supplier's claims. Collectively, these data sources exhibited indicators of program integrity problems with suppliers during their first year in Medicare.

Analysis of supplier omission of required information. To determine the extent to which newly enrolled suppliers omitted required information regarding their owners and managers and these individuals' criminal

³³ AdvanceMed ZPIC, Health Integrity ZPIC, Safeguard Services ZPIC, Safeguard Services PSC, and Tricenturion PSC provided this data.

histories from their enrollment applications, we compared each supplier's reported information to the personal, corporate, and criminal records information stored in Lexis/Nexis Accurint for Government (hereinafter referred to as Accurint) for each of the 229 suppliers in our sample.³⁴ We used Accurint to identify individuals who were not disclosed on the enrollment application, but who were listed in public records as a current owner or manager of the supplier. By matching Social Security Numbers and dates of birth, we checked the criminal histories of owners or managers listed on the enrollment applications to identify whether any reported owners or managers did not fully disclose their criminal histories.³⁵

For purposes of the report, we present certain findings for the high- and medium-risk strata together. We chose this presentation because we identified few notable differences in the rates of program integrity problems between the high- and medium-risk suppliers, whereas the main differences were between low/limited-risk suppliers and the combined group of high- and medium-risk suppliers. Based on the stratified sample design, all findings can be projected to the population of suppliers newly enrolled in Medicare during October–December 2008, unless otherwise noted as applying specifically to sampled suppliers. See Appendix A for statistical estimates and confidence intervals.

Limitations

Our findings about supplier omissions on enrollment applications are subject to an inherent limitation in Accurint's data—namely, that because of State privacy laws, the types of public records stored in Accurint are not uniform across States. As a result, some record types

³⁴ Accurint is a database available to law enforcement agencies that collects a broad array of public records on both businesses and individuals. For business searches, Accurint draws from corporate filings, property information, phone listings, professional licenses, and Securities and Exchange Commission filings, among other data. For personal searches, Accurint contains information on Social Security numbers, driver's licenses, and professional licenses. Information on property assets and court proceedings is also available both for individuals and businesses.

³⁵ We limited the Accurint review (for omitted criminal histories and adverse legal actions) to only high- and medium-risk suppliers. We did this because of the time-consuming nature of the Accurint analysis and because low/limited-risk suppliers—such as larger national chain pharmacies—often listed corporate officers rather than owners on their applications. Additionally, exploratory analysis suggested that we would find few, if any, omissions of criminal history information among low/limited-risk suppliers. Criminal records data from Accurint typically included the specific charge, charge date, and legal outcome.

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(e.g., financial filings) were not available for all sampled suppliers, and the comprehensiveness of criminal records, in particular, varied by State. We did not verify the accuracy of the public records stored in Accurant, as that was beyond the scope of this review.

Another limitation applies to our findings regarding indicators of supplier program integrity problems. CMS and its contractors conduct more oversight of high- and medium-risk suppliers than of low/limited-risk suppliers, and this additional oversight may result in more enforcement actions.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

► FINDINGS

During their first year in Medicare, 26 percent of high- and medium-risk suppliers and 2 percent of low/limited-risk suppliers had their billing privileges revoked or were placed on prepayment claims review

A projected 26 percent of high- and medium-risk suppliers had a CMS enforcement action, and 4 percent both had their billing privileges revoked and were placed on

prepayment review. None of the low/limited-risk suppliers in the sample had been subject to both CMS enforcement actions.

CMS revoked the Medicare billing privileges of 21 percent of high- and medium-risk suppliers, yet some received large Medicare payments prior to revocation

Medicare reimbursed high-risk suppliers \$2.8 million and medium-risk suppliers \$70,582 prior to the revocations of their billing privileges. Combined, this equates to an average of \$191,841 per supplier that had its billing privileges revoked and received any payments from Medicare.³⁶

Revocations occurred after NSC determined that the newly enrolled suppliers no longer met all Medicare supplier participation standards. Among the 28 suppliers in our sample whose billing privileges had been revoked, revocation occurred for 16 because they had not paid the surety bond newly required for DMEPOS suppliers as of July 1, 2009. All 16 of these supplier revocations occurred within a 4-day period when NSC began fully enforcing the new surety bond requirement.

For the remaining 12 of the 28 suppliers in our sample, NSC coded the reason for revocation of billing privileges as “failure to meet all standards.” For this group, revocation often occurred shortly after NSC conducted postenrollment site visits to the suppliers’ places of business; CMS revoked these suppliers’ billing privileges an average of 16 days after a site visit. This timing suggests that revocation stemmed from information gathered during NSC’s site visits.

NSC conducted postenrollment site visits largely within the timeframes required by CMS. For the suppliers that required two unannounced visits during the first year of enrollment, NSC conducted its first postenrollment site visit an average of 163 days (5.4 months) after enrollment. For suppliers that required only one site visit during the

³⁶ CMS revoked the billing privileges of 28 high- and medium-risk suppliers in our sample. Fifteen received Medicare reimbursement prior to revocation. Of those suppliers that received reimbursement, eight were high risk and seven were medium risk.

first year of enrollment, NSC conducted the visit an average of 325 days (10.8 months) after enrollment.

However, several suppliers in our sample had already received significant Medicare payments before their first postenrollment site visit and the subsequent revocation of their billing privileges. For example, one sampled supplier received almost \$800,000 from Medicare prior to its first postenrollment site visit, which NSC conducted 7 months after the supplier enrolled. Medicare paid another supplier in our sample over \$500,000 before NSC conducted the first postenrollment site visit, 5 months after the supplier enrolled.

CMS placed 9 percent of high- and medium-risk suppliers on prepayment claims review

CMS instituted prepayment claims reviews for reasons such as billing for services not ordered by a physician, billing for services not rendered, having unusual billing patterns, and failing to respond to CMS or contractor requests for additional information. As projected from our sample, high- and medium-risk suppliers placed on prepayment review received \$6.7 million from Medicare during our study period. During the study period, CMS ultimately revoked the billing privileges of 8 of the 17 suppliers in our sample that it placed on prepayment review.

CMS revoked the Medicare billing privileges of a projected 2 percent of low/limited-risk suppliers; none of the low/limited-risk suppliers were placed on prepayment claims review

Low/limited-risk suppliers demonstrated few problems. Those sampled suppliers whose billing privileges were revoked did not receive any Medicare reimbursement prior to revocation. Both suppliers' billing privileges were revoked for nonpayment of the surety bond.

Thirteen percent of high- and medium-risk suppliers and 4 percent of low/limited-risk suppliers omitted ownership or management information from their Medicare enrollment applications

Our review of public records revealed that a projected 13 percent of high- and medium-risk suppliers and 4 percent of low/limited-risk suppliers omitted the name of an owner or a manager. By the end of 2009,

Medicare reimbursed the 9 sampled high-risk suppliers \$2.64 million and reimbursed the 6 sampled medium-risk suppliers \$280,596. Of the four low/limited-risk sampled suppliers that omitted ownership or management information, two received \$5,217 during the study period and the other two did not receive any payments. Further, 11 of the

20 high- and medium-risk sampled suppliers that omitted ownership or management information remained in Medicare at the end of 2010. Combined, these findings suggest that information omitted from enrollment applications can remain undetected despite NSC application reviews and postenrollment site visits.³⁷

The types of supplier omissions varied. In one example, an owner’s spouse was listed as an owner on State incorporation documents but was never disclosed to CMS on the supplier’s enrollment application. In another example, individuals listed on incorporation documents had apparently left the company. For 5 of the 20 high- and medium-risk sampled suppliers that omitted ownership or management information, we found that the omitted owners or managers had prior convictions for serious crimes or had been subject to adverse legal actions. Whether those convictions were the reason that the applicant omitted the owner/manager or whether the omissions reflect honest errors requires further investigation. For the low/limited-risk suppliers in our sample, we did not identify any prior convictions of omitted owners or managers or other adverse legal actions taken against these individuals.

Four percent of high- and medium-risk suppliers omitted information regarding criminal histories or adverse legal actions from their applications

A small number of high- and medium-risk suppliers did not report either criminal histories or adverse legal actions taken

against owners or managers listed on the suppliers’ applications. However, four of the six suppliers in our sample that omitted this information did not submit Medicare claims during our study period. Medicare reimbursed the other two suppliers a total of \$369,054 by the end of 2009.

Examples of adverse legal actions not reported by suppliers in our sample include insurance fraud, theft by deception, felony drug possession, and felony aggravated battery. Convictions like these, if reported, might have resulted in the denial of an applicant’s Medicare enrollment application, and their omission is potential grounds for both revocation of billing privileges and permissive exclusion by OIG.³⁸ For example, one high-risk supplier failed to disclose the prior Medicare exclusion of one of its owners by omitting that fact on the application.

³⁷ We did not classify an individual’s name as “omitted” if the name was added to a supplier’s file at any time during the first year of the supplier’s enrollment.

³⁸ 42 CFR § 424.57(e).

F I N D I N G S

Additionally, the supplier transposed the last two digits of the owner's Social Security number, meaning that when NSC checked the listed Social Security number against the Medicare Exclusions Database, no matches came up. Ultimately, NSC revoked the supplier's billing privileges within 4 months of enrollment. The supplier did not receive any Medicare reimbursement prior to revocation.

Other supplier omissions occurred after enrollment, with suppliers failing to notify NSC within 30 days of adverse legal actions taken against them, as required. If this information is not disclosed, the supplier could continue to receive reimbursement until NSC detects the adverse legal action through other methods. For example, during an unannounced site visit to a high-risk supplier in our sample, the NSC investigator learned from the supplier's landlord that the supplier's owner was incarcerated, which the investigator confirmed with the Federal Bureau of Prisons. Based on the site investigator's notes and our review of public records, the incarcerated owner also owned or managed five other Medicare-participating businesses. This sampled supplier received \$65,000 from Medicare before NSC conducted the postenrollment site visit, discovered the supplier's omission, and revoked its billing privileges 6 months after enrollment.



R E C O M M E N D A T I O N S

The ACA strengthens enrollment screening for all supplier and provider types across Medicare, Medicaid, and CHIP. Prior to ACA enactment, DMEPOS suppliers were the only Medicare provider type to receive risk-based screening and monitoring as part of their Medicare participation. This subjected the highest risk DMEPOS applicants to enrollment screening, unannounced preenrollment site visits, and one or more postenrollment site visits during the first year of program participation.

We found that a number of newly enrolled high- and medium-risk DMEPOS suppliers still exhibited program integrity problems once enrolled. Some suppliers in our sample received significant Medicare reimbursement before NSC conducted its first postenrollment site visits and CMS took enforcement actions. Further, some high- and medium-risk DMEPOS applicants omitted owner or manager information that, if disclosed on their applications or discovered by CMS and its contractors, might have prevented their entering the program or prevented their continued enrollment. These findings demonstrate enduring program integrity problems among DMEPOS suppliers and illustrate why effective monitoring of this provider group is essential.

Although the ACA strengthens enrollment screening of DMEPOS supplier applicants and CMS oversight authorities, further scrutiny of the riskiest applicants and enrolled suppliers is needed to prevent dishonest individuals from receiving Medicare payment. Therefore, we recommend that CMS:

Conduct postenrollment site visits earlier for new DMEPOS suppliers receiving the most money from Medicare

Although NSC conducted site visits of high- and medium-risk suppliers as required by CMS, Medicare had already made significant payments to some suppliers in our sample before they received their first postenrollment site visits from NSC. CMS could use the FAIR rating to prioritize certain newly enrolled suppliers and require NSC to conduct postenrollment site visits earlier, possibly within a month, for newly enrolled high- and medium-risk suppliers that submit large dollar amounts of claims. CMS could also use prepayment claims reviews for high-billing newly enrolled high- and medium-risk suppliers.

Apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required

Our findings demonstrate that omissions of the names of owners or managers can allow a supplier to gain billing privileges when it might otherwise be denied Medicare participation. Additionally, CMS recognizes that its contractors are not currently able to verify information that may have been purposely omitted or changed in such a manner as to obfuscate it. Consequently, such omissions could circumvent new fingerprint-based criminal background checks added by the ACA.

Therefore, CMS should improve processes to detect information that may be purposely omitted by individuals who are intent on defrauding the program. In doing so, CMS could establish mechanisms to access public records, as we did for this report, to identify all owners and managers who should be listed by new DMEPOS applicants. Given that few low/limited-risk suppliers in our sample omitted such information, CMS should focus such investigative activities on suppliers deemed high or medium risk by in-depth assessments, such as the FAIR rating.

Take appropriate action regarding DMEPOS suppliers that omit information from applications

We will forward to CMS the names of those suppliers that we identified as having omitted (a) the names of owners or managers or (b) information regarding the criminal histories of owners or managers or any adverse legal actions taken against these individuals. CMS can then determine whether the omissions were intentional and whether further action is needed. Additionally, in the future, when CMS determines that suppliers have inappropriately omitted required information from a Medicare enrollment application, CMS should refer these individuals and suppliers to OIG for (if warranted) permissive exclusion.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with our recommendations and stated that it is using authorities granted under the ACA to address potential vulnerabilities.

R E C O M M E N D A T I O N S

In response to our recommendation to conduct postenrollment site visits earlier for new DMEPOS suppliers receiving the most money from Medicare, CMS stated that it has already taken steps to address this issue. In December 2009, the NSC began conducting at least bi-monthly observational site visits on suppliers with a FAIR rating of High. CMS stated that it will instruct NSC to perform, at a minimum, an observational site visit on all suppliers with a FAIR rating of High within 60 days of enrollment and those with a FAIR rating of Medium within 120 days of enrollment.

In response to our recommendation to apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required, CMS stated that beginning December 2011, a new screening contractor will use external referential data to identify individuals affiliated with companies but not reported on enrollment documents and will alert NSC and the MACs accordingly.

In response to our recommendation to take appropriate action regarding DMEPOS suppliers that omit information from applications, CMS stated that it will research and take action, if appropriate, on those individuals identified by OIG. CMS also stated that it will continue to refer to law enforcement agencies for action at their discretion any individuals and suppliers identified as having inappropriately omitted required information from enrollment applications.

For the full text of CMS comments, see Appendix B. We made minor changes to the report based on technical comments.

Estimates and Confidence Intervals

We calculated estimates and corresponding 95-percent confidence intervals using the statistical software program Sudaan, which calculated correct standard errors based on the stratified sample design.

Table A-1: Percent Estimates and Confidence Intervals		
Type of Supplier	Estimated Percentage of Suppliers	95-Percent Confidence Interval
At Least One Enforcement Action		
Low Risk	2.2%	0.6–8.0%
High and Medium Risk	26.1%	20.3–32.8%
Both Enforcement Actions		
High and Medium Risk	3.6%	2.3–5.8%
Billing Privilege Revocation		
Low Risk	2.2%	0.6–8.0%
High and Medium Risk	20.7%	15.4–27.2%
Prepayment Review		
Low Risk	0.0%	0.0–4.0%
High and Medium Risk	9.0%	6.2–12.9%
Omission of Ownership or Management Information		
Low Risk	4.4%	1.7–10.8%
High and Medium Risk	12.9%	9.0–18.2%
Omission of Criminal or Adverse Legal History		
High and Medium Risk	3.6%	1.8–6.9%
Low/Limited-Risk Suppliers (sample size=91) High- and Medium-Risk Suppliers (sample size=138)		

Source: Office of Inspector General (OIG) analysis of 229 newly enrolled suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), 2011.

Table A-2: Reimbursement of Suppliers on Prepayment Review		
Type of Supplier	Estimated Reimbursement of Suppliers	95-Percent Confidence Interval
High and Medium Risk	\$6,722,258.35	\$5,781,020.95–\$7,663,495.75
High- and Medium-Risk Suppliers (sample size=138)		

Source: OIG analysis of 229 newly enrolled DMEPOS suppliers, 2011.

Table A-3: Averaged Elapsed Time Before First Postenrollment Site Visit		
Type of Supplier	Estimated Days	95-Percent Confidence Interval
Medium Risk	325.30 days	306.69–343.91 days
Medium-Risk Suppliers (sample size=60)*		
* Eleven medium-risk suppliers in our sample did not have postenrollment site visits conducted by the National Supplier Clearinghouse, six were exempt from site visits, and five had their Medicare billing privileges revoked prior to a first site visit.		

Source: OIG analysis of 229 newly enrolled DMEPOS suppliers, 2011.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 02 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Program Integrity Problems with Newly Enrolled Medicare Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" (OEI-06-09-00230)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled, "Program Integrity Problems with Newly Enrolled Medicare Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." The OIG had multiple objectives. First, it seeks to determine the extent to which newly enrolled suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) had their billing privileges revoked or were placed on prepayment claims review. Secondly, it seeks to determine the extent to which newly enrolled DMEPOS suppliers omitted from their Medicare enrollment applications required information regarding (a) owners/managers or (b) the criminal histories of owners/managers or any adverse legal actions taken against those individuals.

The Affordable Care Act strengthens the focus on the integrity of the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) programs and provides important new tools to combat fraud and abuse, including enhanced provider and supplier screening requirements, authority to suspend payments pending investigations of credible allegations of fraud, and, when necessary, authority to impose moratoria on new providers and suppliers.

The DMEPOS benefit has historically been vulnerable to abuse. As such, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group using the authorities granted under the Affordable Care Act. Under the new screening provisions of CMS 6028-FC¹, currently enrolled (revalidating) DMEPOS are considered a moderate-risk provider/supplier and all newly enrolling suppliers of DMEPOS are considered a high-risk provider/supplier. Both risk groups are, therefore, subject to unannounced site visits.

¹ CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

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As explained in CMS 6028-FC, specifically 42 CFR § 424.518, CMS established a myriad of new enrollment requirements and enhanced screening procedures. This section requires enhanced screening of applications and the revalidation of existing enrollees. In addition, CMS recently awarded a contract to a new screening contractor. Upon implementation of the contract in December 2011, screening tools will be employed that will alert Medicare Administrative Contractors (MAC), including the National Supplier Clearinghouse (NSC) MAC, when individuals are identified through external referential data sources as having a managerial or ownership association with a supplier but not reported in the enrollment documents. The NSC will research this information and initiate revocation actions or deny the enrollment if appropriate.

The CMS will also continue to refer suppliers identified as having inappropriately omitted required information on enrollment applications for appropriate additional action.

We appreciate OIG's efforts in working with CMS to help ensure that vulnerabilities are addressed. Our response to each of the OIG recommendations follows.

OIG Recommendation

Conduct post-enrollment site visits earlier for new DMEPOS suppliers receiving the most payment from Medicare.

CMS Response

The CMS concurs with this recommendation. CMS concurs with this recommendation and has already taken certain steps to address this finding. In December 2009, the NSC began conducting observational type site visits on suppliers with a Fraud and Abuse Index of Risk (FAIR) score of High. These site visits were in addition to the annual or semi-annual site visits mandated based upon FAIR score and were completed much earlier and more frequently after initial enrollment or determination of the High FAIR score.

In particular high-risk areas, such as Miami and Los Angeles, observational site visits were conducted no less than bi-monthly, but in many cases were completed even more frequently. In calendar year 2010, 7,585 of these types of site visits were conducted. CMS believes these types of observational site visits are effective and will instruct the NSC to perform, at a minimum, an observational site visit on all suppliers with a FAIR score of High within 60 days of enrollment and those with a FAIR score of Medium within 120 days of enrollment.

OIG Recommendation

Apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required.

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CMS Response

The CMS concurs with this recommendation and is in the process of implementing measures to identify individuals affiliated with companies but not reported on enrollment documents. As stated above, CMS recently awarded a contract to a new screening contractor. The contractor will alert MACs (including the NSC-MAC) when individuals are identified through external referential data sources as having a managerial or ownership association with a supplier but not reported in the enrollment documents.

OIG Recommendation

Take appropriate action with DMEPOS suppliers that omit information on applications.

CMS Response

The CMS concurs with this recommendation. Upon receipt of information from OIG, CMS will research and take action on those identified, if appropriate. CMS will also continue to refer to law enforcement for action at their discretion any additional individuals and suppliers identified as having inappropriately omitted required information on enrollment applications.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

Attachment



A C K N O W L E D G M E N T S

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Tom Browning served as the Project Lead for this study and Jennifer Gist served as the Lead Analyst. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Ben Gaddis and Deborah McGurk. Central office staff who contributed include Kevin Farber, Rob Gibbons, Scott Manley, and Meghan Ruhnke.

Office of Inspector General

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