

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID
SUPPLIERS FOR DURABLE MEDICAL
EQUIPMENT, PROSTHETICS, ORTHOTICS,
AND SUPPLIES PROVIDED TO
BENEFICIARIES DURING
INPATIENT STAYS**

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Office of Inspector General

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Report in Brief

Date: November 2018

Report No. A-09-17-03035

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Prior OIG reviews found that Medicare improperly paid for outpatient services provided to Medicare beneficiaries who were inpatients of acute-care hospitals (ACHs) and other types of inpatient facilities (e.g., long-term-care hospitals). However, these reviews did not cover payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that DMEPOS suppliers (suppliers) provided to beneficiaries during inpatient stays.

Our objective was to determine whether Medicare properly paid suppliers for DMEPOS items provided to beneficiaries during inpatient stays.

How OIG Did This Review

Our review covered \$34 million in Medicare Part B payments to suppliers for 120,614 claims for DMEPOS items provided to beneficiaries during inpatient stays. To identify these items, we identified Part A inpatient claims from ACHs and other inpatient facilities (excluding skilled nursing facilities) with service dates from January 1, 2015, through December 31, 2017 (audit period). We used those claims' beneficiary information and service dates to identify suppliers' DMEPOS claims that had service dates from 1 day after the admission dates up to and including the discharge dates. We excluded claims for DMEPOS items that met certain conditions for pre-discharge delivery (details are shown in the body of the report).

Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays

What OIG Found

Medicare should not have paid suppliers any of the \$34 million for DMEPOS items that were provided during inpatient stays. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$8.7 million paid to the suppliers for the DMEPOS items. Generally, Medicare should not pay a supplier for these items provided to a beneficiary during an inpatient stay. Instead, all items must be provided directly by the inpatient facility or under arrangements between the facility and the supplier. Medicare should pay the inpatient facility, through its inpatient claim, for all items provided to a beneficiary.

Medicare overpaid the suppliers because the system edits that should have prevented or detected the overpayments were not adequate. If the system edits had been designed properly since 2008, Medicare could have saved \$223.1 million, and beneficiaries could have saved \$56.3 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS) direct the Medicare contractors to (1) recover the \$34 million in identified improper payments in accordance with CMS's policies and procedures, (2) recommend that suppliers refund to beneficiaries up to \$8.7 million in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, and (3) identify and recover any improper payments to suppliers after our audit period. We also recommend that CMS (1) take all necessary actions, including seeking legislative authority, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts and (2) correct the system edits to fully prevent or detect overpayments to suppliers for DMEPOS items provided during inpatient stays.

CMS concurred with all but one of our recommendations. Regarding our recommendation that CMS seek legislative authority to require suppliers to refund to beneficiaries incorrectly collected deductibles and coinsurance, CMS stated that it will consider whether to recommend this proposal for inclusion in the President's next budget.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
The Medicare Program	1
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.....	2
Medicare Part A Payments to Acute-Care Hospitals and Other Types of Inpatient Facilities	3
Medicare Part B Payments to Suppliers for DMEPOS Items	4
Prepayment and Postpayment Edits in the Medicare Claim Processing System.....	5
How We Conducted This Review	6
FINDINGS.....	6
Federal Requirements.....	7
Medicare Improperly Paid Suppliers for DMEPOS Items Provided to Beneficiaries During Inpatient Stays.....	8
Edits Were Not Adequate To Prevent Overpayments.....	11
Medicare Could Have Saved \$223.1 Million and Beneficiaries Could Have Saved \$56.3 Million Over the Last 10 Years	12
RECOMMENDATIONS	13
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	13
APPENDICES	
A: Audit Scope and Methodology	15
B: Related Office of Inspector General Reports.....	17
C: CMS's Change Requests for Prepayment and Postpayment Edits	18
D: CMS Comments	19

INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews found that Medicare improperly paid acute-care hospitals (ACHs) for outpatient services they provided to beneficiaries who were inpatients of ACHs and other types of inpatient facilities (e.g., long-term-care hospitals (LTCHs)). (See Appendix B for a list of related OIG reports.) However, these reviews did not cover payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that DMEPOS suppliers (suppliers) provided to beneficiaries during inpatient stays. Generally, Medicare should not pay a supplier for DMEPOS items provided to a beneficiary during an inpatient stay; instead, all items must be provided directly by the inpatient facility or under arrangements between the facility and the supplier. Medicare should pay the inpatient facility, through its inpatient claim, for all items provided to a beneficiary.

OBJECTIVE

Our objective was to determine whether Medicare properly paid suppliers for DMEPOS items provided to beneficiaries during inpatient stays.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, as well as DMEPOS items. Medicare beneficiaries are responsible for certain out-of-pocket costs, such as deductibles and coinsurance, for both Part A and Part B services.

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare administrative contractors in each Medicare jurisdiction to, among other things, process and pay Medicare Part A claims submitted for hospital services. CMS also contracts with durable medical equipment Medicare administrative contractors (DME MACs) to process and pay Medicare Part B claims for DMEPOS items. Two DME MACs process claims for four jurisdictions (each DME MAC has two jurisdictions), which include specific States and territories. Suppliers must submit claims to the DME MAC that services the State or territory in which a Medicare beneficiary permanently resides.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Durable Medical Equipment

Durable medical equipment (DME) is generally defined as equipment that can withstand repeated use, serves primarily a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in a beneficiary's home (*Medicare Claims Processing Manual* (Claims Manual), chapter 20, § 10.1.1). Examples of DME items are oxygen and respiratory equipment and supplies, wheelchairs, and walkers (*Medicare Benefit Policy Manual* (Benefit Manual), chapter 15, § 110.1(B)(1)).

Prosthetics and Orthotics

Prosthetics are devices that replace all or part of (1) an internal body organ or (2) the function of a permanently inoperative or malfunctioning internal body organ (Claims Manual, chapter 20, § 10.1.2). Examples of prosthetics are artificial limbs, parenteral and enteral nutrition supply kits,¹ breast prostheses for postmastectomy patients, and devices that replace all or part of the ear or nose (Benefit Manual, chapter 15, § 120(A)).

Orthotics are rigid and semirigid devices, often called braces, which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body. Examples of orthotics are leg, arm, back, and neck braces (Benefit Manual, chapter 15, § 130).

Supplies and Related Drugs

Supplies include those items that are necessary for the effective use of DME. Related drugs may be drugs and biologicals that can be (1) put directly into the DME to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment (Benefit Manual, chapter 15, § 110.3) or (2) prescribed to be taken orally or through injections (Benefit Manual, chapter 15, § 50.2). Examples of drugs include inhalation drugs and tumor chemotherapy agents used with an infusion pump (Benefit Manual, chapter 15, § 110.3). For the purpose of this report, we consider wound-care supplies or fillers to be supplies. Wound-care supplies or fillers are used for openings on the body caused by surgical procedures, wounds, ulcers, or burns. Examples of wound-care supplies or fillers are adhesive tape, roll gauze, and bandages (Benefit Manual, chapter 15, § 100).

¹ Patients who cannot be sustained through oral feeding rely on either enteral or parenteral nutrition therapy, depending on their medical condition. Medicare guidelines classify enteral and parenteral nutrition items as prosthetic devices. For the purpose of this report, we refer to these items as "feeding supply kits."

Medicare Part A Payments to Acute-Care Hospitals and Other Types of Inpatient Facilities

Medicare Part A pays ACHs through the Inpatient Prospective Payment System (IPPS), which is a prospective payment system (PPS) specific to ACHs (42 CFR § 412.1). Federal regulations specifically exclude LTCHs, inpatient rehabilitation facilities (IRFs), and inpatient psychiatric facilities (IPFs) from the IPPS (42 CFR § 412.23). Instead, Medicare pays these types of inpatient facilities through a PPS or a per diem PPS specific to that type of facility. In addition, critical access hospitals (CAHs) are not subject to the IPPS and are paid on a reasonable cost basis (Social Security Act (the Act) § 1814(l)). Under each payment method, the Medicare payments made to the facilities are payments in full for all inpatient hospital services, including DMEPOS items.

Our review covered DMEPOS and related drugs that suppliers provided to beneficiaries who were inpatients of ACHs paid under the IPPS and facilities excluded from the IPPS. See the box for descriptions of the types of inpatient facilities covered by our review.²

Each type of inpatient facility covered by our review must (1) provide directly all services and items furnished during an inpatient stay or (2) arrange for items to be provided to beneficiaries by suppliers and include these items on its inpatient claims submitted to Medicare. Medicare should not pay a supplier for items furnished to a beneficiary when the beneficiary is still an inpatient (i.e., has not been formally discharged to home) (Claims Manual, chapter 3, § 10.4).

Types of Inpatient Facilities

Acute-Care Hospital

An ACH is a facility that provides inpatient acute care that is needed for a relatively short period.

Long-Term-Care Hospital

An LTCH is a separate facility that focuses on patients with medically complex conditions or multiple conditions that require, on average, an inpatient stay of greater than 25 days.

Inpatient Rehabilitation Facility

An IRF is a separate facility or subunit of a hospital for which the primary purpose is to provide intensive rehabilitation services, such as physical, occupational, or speech therapy, to its inpatient population.

Inpatient Psychiatric Facility

An IPF is a freestanding or specialized hospital-based unit that meets the urgent needs of those experiencing an acute mental health crisis.

Critical Access Hospital

A CAH is a hospital that is accessible to beneficiaries in rural communities and has no more than 25 beds for inpatient care services.

² Skilled nursing facilities (SNFs) are also considered inpatient facilities. However, we did not include SNFs in our review.

Medicare Part B Payments to Suppliers for DMEPOS Items

Use of DMEPOS During Inpatient Stays

Section 1861(n) of the Act limits Medicare Part B coverage under the DME benefit to those items that are furnished for use in a beneficiary's home. Because an institution that is used as a home may not be a hospital, CAH, or SNF, Medicare does not make separate payment for DME when a beneficiary is in one of these institutions (42 CFR § 410.38). The institution is expected to provide all medically necessary DME items during a beneficiary's Medicare Part A-covered stay.

DMEPOS items that inpatient beneficiaries use during a Medicare Part A-covered stay are included in the inpatient PPS rate and are not separately billable (Claims Manual, chapter 20, § 01). In addition, when prosthetics and orthotics are provided during inpatient care, they are included in the inpatient PPS rate (Claims Manual, chapter 20, § 130.1, and chapter 3, § 10.4.A). The institution is

expected to provide all medically necessary DMEPOS during a beneficiary's Part A-covered stay. Medicare should not make a separate payment to the supplier for a DMEPOS item. Instead, the supplier, under arrangements³ with an ACH or another inpatient facility, can look to the ACH or the other facility for payment for the item it provided to the beneficiary who was an inpatient.

Medicare Part A Coverage

The inpatient facility provides all medically necessary DME items during a Medicare Part A-covered stay. DMEPOS items provided during inpatient stays are **included in the Part A PPS rate and are not separately billable.**

Delivery of DME, Prosthetics, and Orthotics Before Beneficiary Discharge From an Inpatient Facility

In some cases, a supplier may deliver, and bill separately for, a medically necessary DME item, a prosthetic, or an orthotic—but not supplies—to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home before the beneficiary is discharged. Payment for this type of predischARGE delivery of an item is appropriate when certain conditions are met, including that (1) the supplier delivers the item to the beneficiary solely for training or fitting of the item, and the item is for subsequent use in the beneficiary's home, and (2) the discharge is to a qualified place of service and not to another facility (e.g., an inpatient facility or a SNF) that does not qualify as the beneficiary's home (Claims Manual, chapter 20, § 110.3.1).

³ Federal regulations define "arrangements" as those "which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services" (42 CFR § 409.3). CMS does not specify the arrangements between two parties.

Prepayment and Postpayment Edits in the Medicare Claim Processing System

Before payment, all DMEPOS claims are sent to CMS's Common Working File (CWF) for verification, validation, and payment authorization. The CWF contains both prepayment and postpayment system edits that should prevent or detect overpayments for DMEPOS items provided during inpatient stays. Once the CWF has processed a claim for payment, it electronically transmits information to the DME MAC about potential errors on the claim.

The system edits should work as follows:

- **Prepayment Edit.** If the inpatient claim is processed for payment before the DMEPOS claim, once the DMEPOS claim is processed, a prepayment edit rejects the DMEPOS claim. The DME MAC then investigates the DMEPOS claim and denies it for payment.
- **Postpayment Edit.** If the DMEPOS claim is processed for payment before the inpatient claim, once the inpatient claim is processed, a postpayment edit is designed to identify a DMEPOS claim that needs adjustment by the DME MAC that processed the DMEPOS claim so that the payment can be recovered. The DME MAC is responsible for recovering the overpayment for the DMEPOS items provided during an inpatient stay.

CMS implemented and modified these CWF edits through four Change Requests (CRs) during calendar years (CYs) 2011 through 2015. The last modification (CR 8844) occurred in CY 2015. (See Appendix C for a description of each CR.) Based on these CRs, both prepayment and postpayment edits were designed to identify only items classified as DME (not all prosthetics, orthotics, and supplies (POS)) billed during inpatient stays.⁴ In addition, the prepayment edit was designed to detect claims for certain customized prosthetics provided during an inpatient stay and to instruct the DME MAC to allow them for payment according to the SNF consolidated billing requirements.⁵

⁴ In CR 8844, both prepayment and postpayment edits identified items classified as DME. CMS categorized these items as capped rental DME, frequently maintained DME, inexpensive and routinely purchased DME, electric wheelchairs, oxygen equipment, and oxygen supplies. For the purpose of this report, when we refer to DME, we are referring to these categorized DME items.

⁵ The consolidated billing requirements in sections 1862(a)(18) and 1842(b)(6)(E) of the Act state that a SNF is responsible for billing Medicare for most services provided to its residents in a Medicare Part A-covered stay. The SNF must furnish services either directly or under arrangements with outside suppliers. The outside suppliers must bill the SNF for the services provided. However, certain services and DMEPOS items (e.g., customized prosthetics) are excluded from the SNF consolidated billing requirements and are, therefore, separately payable. Customized prosthetics are identified by Healthcare Common Procedure Coding System codes and are updated in annual and quarterly updates by CMS. However, these requirements are not applicable to certain customized prosthetics that are furnished to beneficiaries in a Part A-covered non-SNF inpatient setting.

HOW WE CONDUCTED THIS REVIEW

Our review covered \$34,014,796 in Medicare Part B payments to suppliers for 120,614 claims that were for DMEPOS items provided to beneficiaries during inpatient stays. To identify these items, we first identified Medicare Part A inpatient claims from ACHs, LTCHs, IRFs, IPFs, and CAHs (excluding SNFs) with service dates from January 1, 2015, through December 31, 2017 (audit period). We used the beneficiary information and service dates from those claims to identify suppliers' Part B DMEPOS claims that had service dates from 1 day after the beneficiaries' admission dates up to and including the discharge dates. For the purpose of this review, we considered all these DMEPOS items as billed during inpatient stays. We excluded DMEPOS items billed on the day of discharge when the beneficiary was discharged to home because we considered them allowable to be paid separately by Part B. In addition, we identified claims for DMEPOS items billed during inpatient stays for the previous 7 years, back to CY 2008, to determine whether the prepayment and postpayment edits were adequate to prevent overpayments during that period.

We focused only on the improper Medicare Part B payments. We did not verify whether the ACHs and other inpatient facilities paid the suppliers that provided the DMEPOS items or included those items on their Medicare Part A claims. We did not use medical review to determine whether the DMEPOS items were medically necessary.

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

See Appendix A for the details of our audit scope and methodology.

FINDINGS

For our audit period, Medicare improperly paid suppliers for DMEPOS items provided to beneficiaries during inpatient stays. Specifically, none of the \$34,014,796 we reviewed, representing 120,614 claims, should have been paid; suppliers may not bill separately for DMEPOS items provided to beneficiaries during inpatient stays. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$8,702,539 paid to the suppliers for the DMEPOS items. Medicare overpaid the suppliers because the CWF prepayment and postpayment edits that should have prevented or detected the overpayments were not adequate.

What We Found

Medicare improperly paid **\$34 million** for DMEPOS provided to beneficiaries during inpatient stays.

Beneficiaries were responsible for unnecessary deductibles and coinsurance of **\$8.7 million**.

The prepayment and postpayment edits should have denied these DMEPOS claims but did not do so because they were not designed to include DMEPOS items classified as prosthetics, orthotics, or supplies and related drugs. Furthermore, the prepayment edit was designed to detect claims for certain customized prosthetics provided during or on the day of discharge of an inpatient stay and to instruct the DME MAC to allow those claims for payment by applying the SNF consolidated billing requirements. However, these requirements are not applicable to certain customized prosthetics that are furnished to beneficiaries in a Medicare Part A-covered non-SNF inpatient setting (i.e., ACHs and other inpatient facilities).

If the CWF edits had been designed properly since CY 2008, Medicare could have saved \$223.1 million, and beneficiaries could have saved \$56.3 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

FEDERAL REQUIREMENTS

What Medicare Could Have Saved

If the CWF edits had been designed properly since CY 2008:

- Medicare could have saved **\$223.1 million** and
- beneficiaries could have saved **\$56.3 million** in deductibles and coinsurance.

Inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A (the Act § 1812). These include inpatient stays at ACHs, LTCHs, IRFs, IPFs, and CAHs (the Act § 1861). All items provided during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with a supplier and billed to Medicare by the inpatient hospital through its Part A claim. This requirement applies to all hospitals, regardless of whether they are subject to a PPS. Medicare does not pay any supplier other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR §§ 412.404(d)(2), 412.509(b), and 412.604(e)(2)).

Medicare Part B coverage is limited under the DME benefit to those items that are furnished for use in a beneficiary's home (the Act § 1861(n)). An institution that is used as a home may not be a hospital, CAH, or SNF; consequently, Medicare does not make a separate payment for DME when a beneficiary is in one of these institutions (42 CFR § 410.38). The institution is expected to provide all medically necessary DMEPOS during a beneficiary's Medicare Part A-covered stay (Claims Manual, chapter 20, § 01). DMEPOS items that inpatient beneficiaries use during a Part A-covered stay are included in the inpatient PPS rate and are not separately billable (Claims Manual, chapter 20, § 01). In addition, when prosthetics and orthotics are provided during inpatient care, they are included in the inpatient PPS rate (Claims Manual, chapter 20, § 130.1, and chapter 3, § 10.4.A).

In some cases, a supplier may deliver, and bill separately for, a medically necessary DME item, a prosthetic, or an orthotic—but not supplies—to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. Payment for this type of predischarge delivery of an item is appropriate when certain conditions are met (Claims Manual, chapter 20, § 110.3.1), including the following:

- The supplier delivers the item to the beneficiary for training or fitting of the item and its subsequent use in the beneficiary's home.
- The supplier delivers the item to the beneficiary no earlier than 2 days before the day the facility discharges the beneficiary.
- The reason the supplier furnishes the item is not to eliminate the inpatient facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the PPS rate.
- The supplier does not request payment for the item for any day before the date of discharge.
- The beneficiary's discharge must be to a qualified place of service (e.g., to home) but not to another facility (e.g., an inpatient facility or a SNF) that does not qualify as the beneficiary's home.

Beneficiaries generally share in the cost of Medicare Part B by paying deductibles and coinsurance (42 CFR § 489.30(b)). The deductible that beneficiaries pay for Part B coverage can change yearly.⁶ Once the deductible is met, beneficiaries generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible (42 CFR § 489.30(b)). Suppliers should refund to beneficiaries deductible and coinsurance amounts incorrectly collected from them or from someone on their behalf. Medicare laws, regulations, and guidance require providers to refund to beneficiaries incorrectly collected deductible and coinsurance amounts.⁷ However, with respect to suppliers, Medicare's refund requirements are limited to very specific situations⁸ and do not require suppliers to refund to beneficiaries incorrectly collected Part B deductible and coinsurance amounts for items and services for which payment has already been made under Medicare Part A.

MEDICARE IMPROPERLY PAID SUPPLIERS FOR DMEPOS ITEMS PROVIDED TO BENEFICIARIES DURING INPATIENT STAYS

None of the \$34,014,796 we reviewed, representing 120,614 claims, should have been paid because DMEPOS items provided to beneficiaries during inpatient stays are not separately payable. Of these improper payments, 81 percent were for DMEPOS items that were provided during inpatient stays, and 19 percent were for DMEPOS items provided on the day of discharge when the beneficiaries were discharged not to home but to another facility, such as

⁶ The Medicare Part B deductibles for CYs 2015, 2016, and 2017 were \$147, \$166, and \$183, respectively.

⁷ The Act § 1866(a)(1)(C); 42 CFR §§ 489.20(b) and 489.40–489.42; and the Claims Processing Manual, chapter 1, § 30.1.2.

⁸ See, e.g., the Claims Processing Manual, chapter 30, sections 50.13.2 and 50.13.3.

an ACH. Because Medicare made improper payments for DMEPOS items, beneficiaries were held responsible for unnecessary deductibles and coinsurance of \$8,702,539 paid to the suppliers for those items.

As stated in Federal requirements, hospital services and items provided to beneficiaries are paid under Medicare Part A. This requirement applies to inpatient stays at ACHs, LTCHs, IRFs, IPFs, or CAHs. All DMEPOS items provided during a Part A-covered inpatient stay must be provided directly by the inpatient hospital through its Part A claim. Medicare does not pay any supplier other than the inpatient hospital for DMEPOS items provided to a beneficiary while the beneficiary is an inpatient of an ACH or another facility.

The example below illustrates a situation in which a DMEPOS item was provided during an inpatient stay and Medicare should not have paid the supplier.

Example: Improper Payment of a Supplier for a DMEPOS Item While a Beneficiary Was Still an Inpatient of an Acute-Care Hospital

A Medicare beneficiary was admitted to an ACH on February 22, 2015, as an inpatient because of septicemia (blood poisoning, especially that caused by bacteria or their toxins). Concurrently, the beneficiary needed a knee prosthesis after a leg amputation.

A supplier provided the prosthesis to the beneficiary on February 27, 2015, while the beneficiary was still an inpatient at the ACH. Medicare Part B paid the supplier \$18,049 for the prosthesis. The beneficiary was held responsible for deductible and coinsurance amounts totaling \$4,604 paid to the supplier for the prosthesis.

Because Medicare pays an ACH for all services and items, including DMEPOS, provided to a beneficiary as part of its Part A PPS rate, Medicare should not have made a separate Part B payment to the supplier for the prosthesis, and the beneficiary should not have been held responsible for the deductible and coinsurance. Instead, the supplier, under arrangements with the ACH, could have looked to the ACH for payment for the item it provided to the beneficiary who was an inpatient of the ACH.

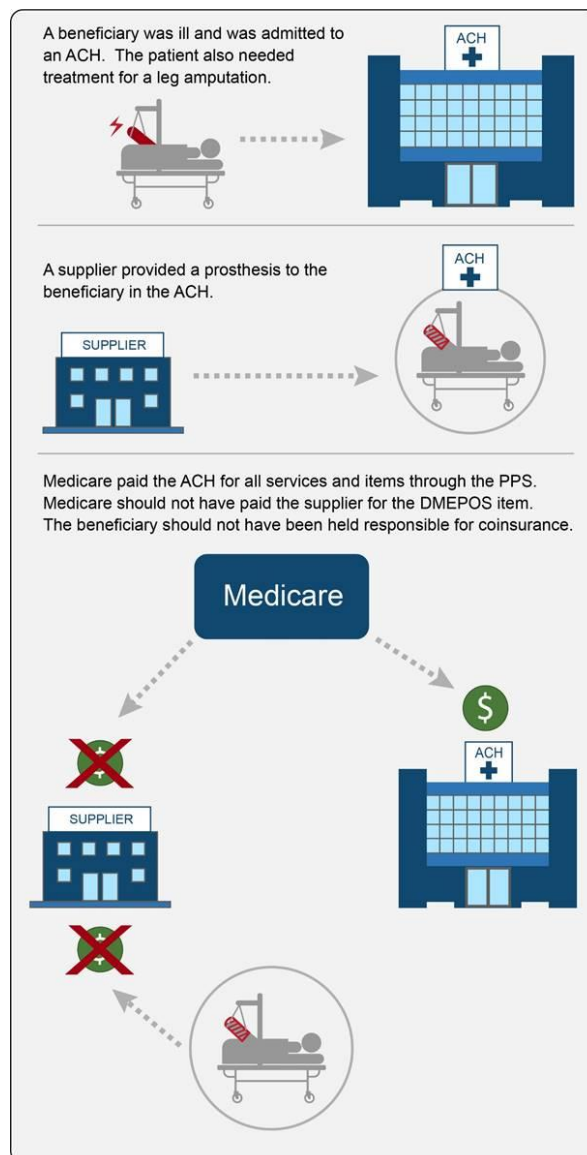
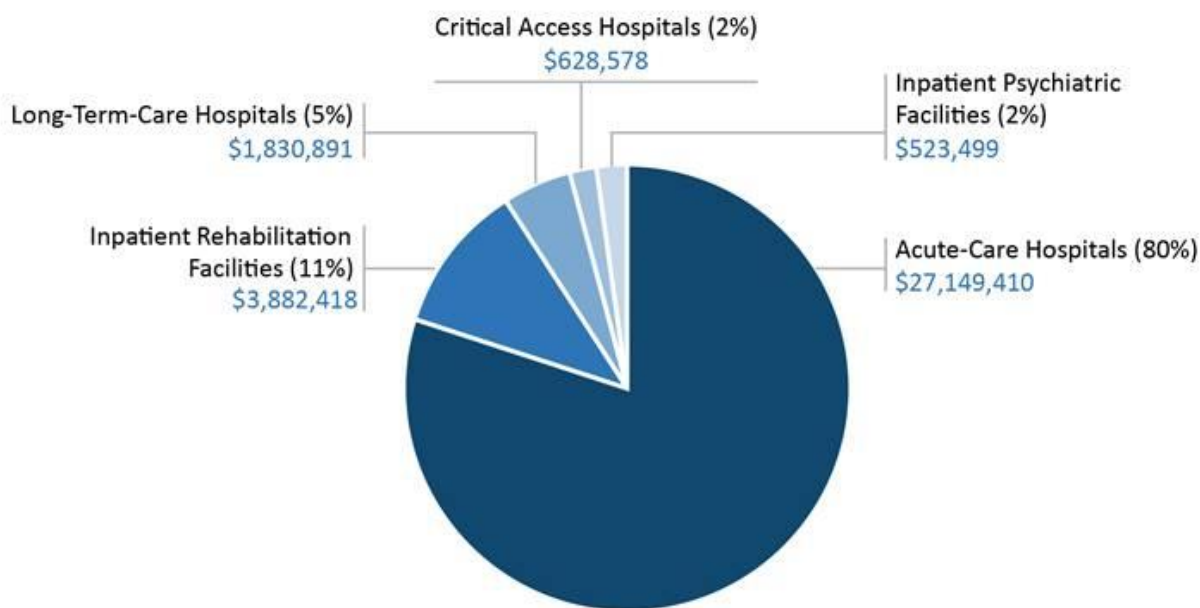


Figure 1 below shows, according to the type of inpatient facility, the percentage of total improper payments that Medicare made to suppliers for DMEPOS items, which should have been included under the Medicare Part A payments made to the inpatient facilities. Eighty percent of the improper payments to suppliers should have been made by ACHs.

Figure 1: Percentage of Total Improper Payments by Type of Inpatient Facility



Medicare improperly paid suppliers for various DMEPOS items that should have been included under the Medicare Part A payments made to the inpatient facilities. These items included prosthetics and orthotics (e.g., artificial limbs, prosthetics and braces, and feeding supply kits); supplies and related drugs (including drugs administered through DME, injections and immunosuppressive drugs, and wound-care supplies and fillers); and DME (e.g., walkers, wheelchairs, and hospital beds). (See Figure 2 on the following page.) Improper payments for artificial limbs, prosthetics and braces, drugs administered through DME, and injections and immunosuppressive drugs represented 75 percent of the total improper payments.

Figure 2: Percentage of Total Improper Payments by Type of DMEPOS

CATEGORY	TOTAL PAYMENTS	PERCENT OF PAYMENT
Prosthetics and Orthotics		
Artificial Limbs, Prosthetic Lenses, Braces, etc.	\$14,627,191	43%
Parenteral and Enteral Feeding Supply Kits	2,606,646	8%
Supplies and Related Drugs		
Drugs Administered Through DME	\$5,801,919	17%
Injections and Immunosuppressive Drugs	5,133,128	15%
Wound-Care Supplies, Fillers, and Other Supplies	3,865,279	11%
Durable Medical Equipment		
Walkers, Wheelchairs, Hospital Beds, etc.	\$1,980,633	6%
Grand Total	\$34,014,796	100%

EDITS WERE NOT ADEQUATE TO PREVENT OVERPAYMENTS

Medicare overpaid the suppliers \$34,014,796 because the CWF prepayment and postpayment edits that should have prevented or detected overpayments for DMEPOS items provided to beneficiaries who were inpatients of hospitals were not adequate:

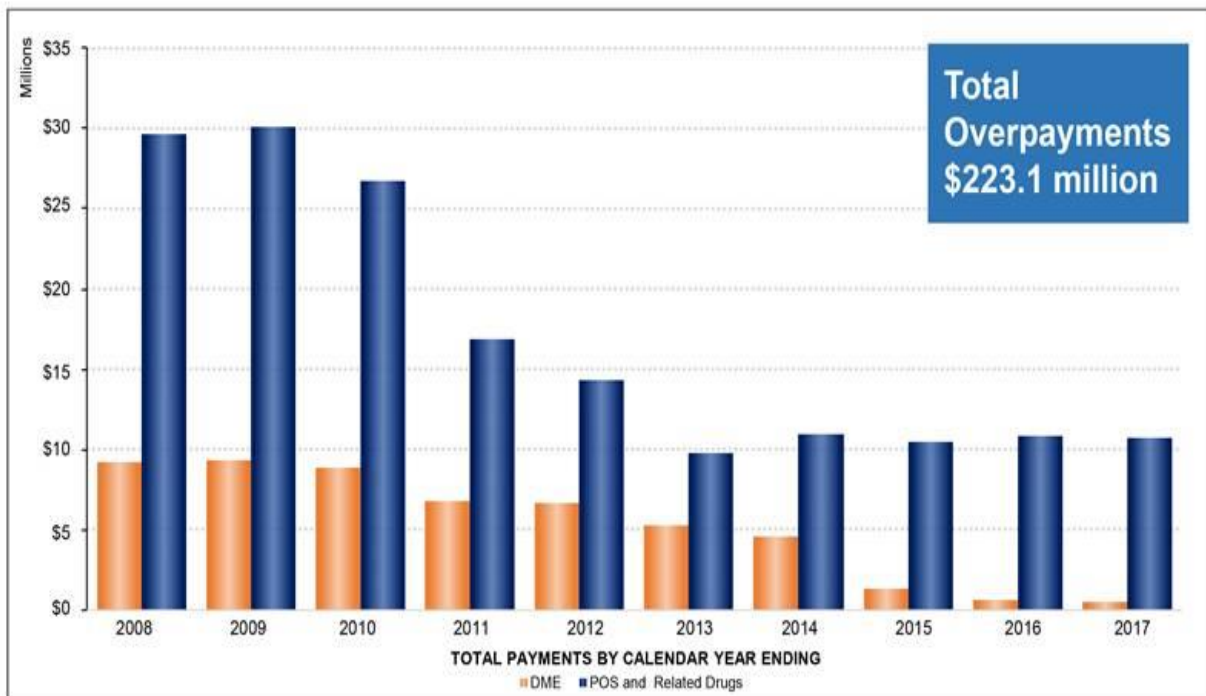
- For \$30,736,385 in payments for prosthetics, orthotics, supplies, and related drugs, the prepayment and postpayment edits were not designed to include these types of items provided by suppliers during inpatient stays.
- For \$1,980,633 in payments for DME items, the prepayment and postpayment edits were designed to detect DME items billed during inpatient stays. Although the edits detected these claims for review, these DME items were still processed and paid or were not recovered by the DME MACs.
- For \$1,297,778 in payments for customized prosthetics, the prepayment edit was not designed properly. Specifically, the edit was designed to (1) detect claims for customized prosthetics provided during or on the day of discharge of an inpatient stay and (2) instruct the DME MAC to allow those claims for payment. Although the SNF consolidated billing requirements state that certain customized prosthetics are allowed

to be paid separately during a beneficiary's Medicare Part A-covered SNF inpatient stay, they are not applicable for a beneficiary in a non-SNF inpatient setting (e.g., an ACH). The edit should have been designed to deny payment for customized prosthetic claims for beneficiaries who were inpatients of ACHs and other inpatient facilities.

MEDICARE COULD HAVE SAVED \$223.1 MILLION AND BENEFICIARIES COULD HAVE SAVED \$56.3 MILLION OVER THE LAST 10 YEARS

In addition to identifying claims for outpatient services that were billed during inpatient stays within our audit period, we identified DMEPOS items that were billed during inpatient stays for the previous 7 years, back to CY 2008, to determine whether the edits were adequate to prevent overpayments during that period. We identified overpayments in each of the 10 years and found that for CYs 2008 through 2014, overpayments significantly decreased for DMEPOS each year. Even though overpayments for DME continued to decrease in the subsequent years, overpayments for POS and related drugs increased for CYs 2015 through 2017 (Figure 3 below).

Figure 3: Payments to Suppliers for DME, POS, and Related Drugs Provided to Beneficiaries in Inpatient Stays for CYs 2008 Through 2017



If the CWF edits had been designed properly since CY 2008, Medicare could have saved \$223.1 million over the last 10 years, and beneficiaries could have saved \$56.3 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

RECOMMENDATIONS

We recommend that CMS:

- direct the DME MACs to:
 - recover the \$34,014,796 in identified improper payments to suppliers in accordance with CMS's policies and procedures,
 - recommend that the suppliers refund to beneficiaries up to \$8,702,539 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, and
 - identify and recover any improper payments to suppliers after our audit period and recommend that those suppliers refund to beneficiaries any deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf;
- take all necessary actions, including seeking legislative authority, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A; and
- correct the CWF edits to fully prevent or detect overpayments to suppliers for DMEPOS items provided during inpatient stays by:
 - including categories that are not currently being detected, such as POS and related drugs, and
 - denying payments to suppliers for claims for customized prosthetics provided to beneficiaries during inpatient stays at facilities other than SNFs.

If the CWF edits had been designed properly since CY 2008, Medicare could have saved \$223.1 million, and beneficiaries could have saved \$56.3 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with all but one of our recommendations and provided information on actions that it planned to take to address our recommendations. Regarding our recommendation that CMS seek legislative authority to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts, CMS stated that it does not have authority under current law, and it will consider whether to recommend this proposal for inclusion in the President's next budget.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix D.

We continue to recommend that CMS take all necessary actions, including recommending a proposal for inclusion in the President's next budget, to require suppliers to refund to beneficiaries incorrectly collected Medicare Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered \$34,014,796 in Medicare Part B payments to suppliers for 120,614 claims that were for DMEPOS items provided to beneficiaries during inpatient stays. To identify these items, we first identified Medicare Part A inpatient claims from ACHs, LTCHs, IRFs, IPFs, and CAHs (excluding SNFs) with service dates from January 1, 2015, through December 31, 2017. We used the beneficiary information and service dates from those claims to identify suppliers' Part B DMEPOS claims that had service dates from 1 day after the beneficiaries' admission dates up to and including the discharge dates. For the purpose of this review, we considered all these DMEPOS items as billed during inpatient stays. We excluded DMEPOS items billed on the day of discharge when the beneficiary was discharged to home because we considered them allowable to be paid separately by Part B. In addition, we identified claims for DMEPOS items billed during inpatient stays for the previous 7 years, back to CY 2008, to determine whether the prepayment and postpayment edits were adequate to prevent overpayments during that period.

We focused only on the improper Medicare Part B payments. We did not verify whether the ACHs and other inpatient facilities paid the suppliers that provided the DMEPOS items or included those items on their Medicare Part A claims. We did not use medical review to determine whether the DMEPOS items were medically necessary.

We did not review the overall internal control structure of CMS because our objective did not require us to do so. Rather, we limited our review of CMS's internal controls to those applicable to DMEPOS claims billed during inpatient stays. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit work from October 2017 through April 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's NCH file to identify Medicare Part A inpatient claims from ACHs, LTCHs, IRFs, IPFs, and CAHs;
- excluded claims for beneficiaries who had exhausted their Medicare Part A benefits or did not have Part A benefits;

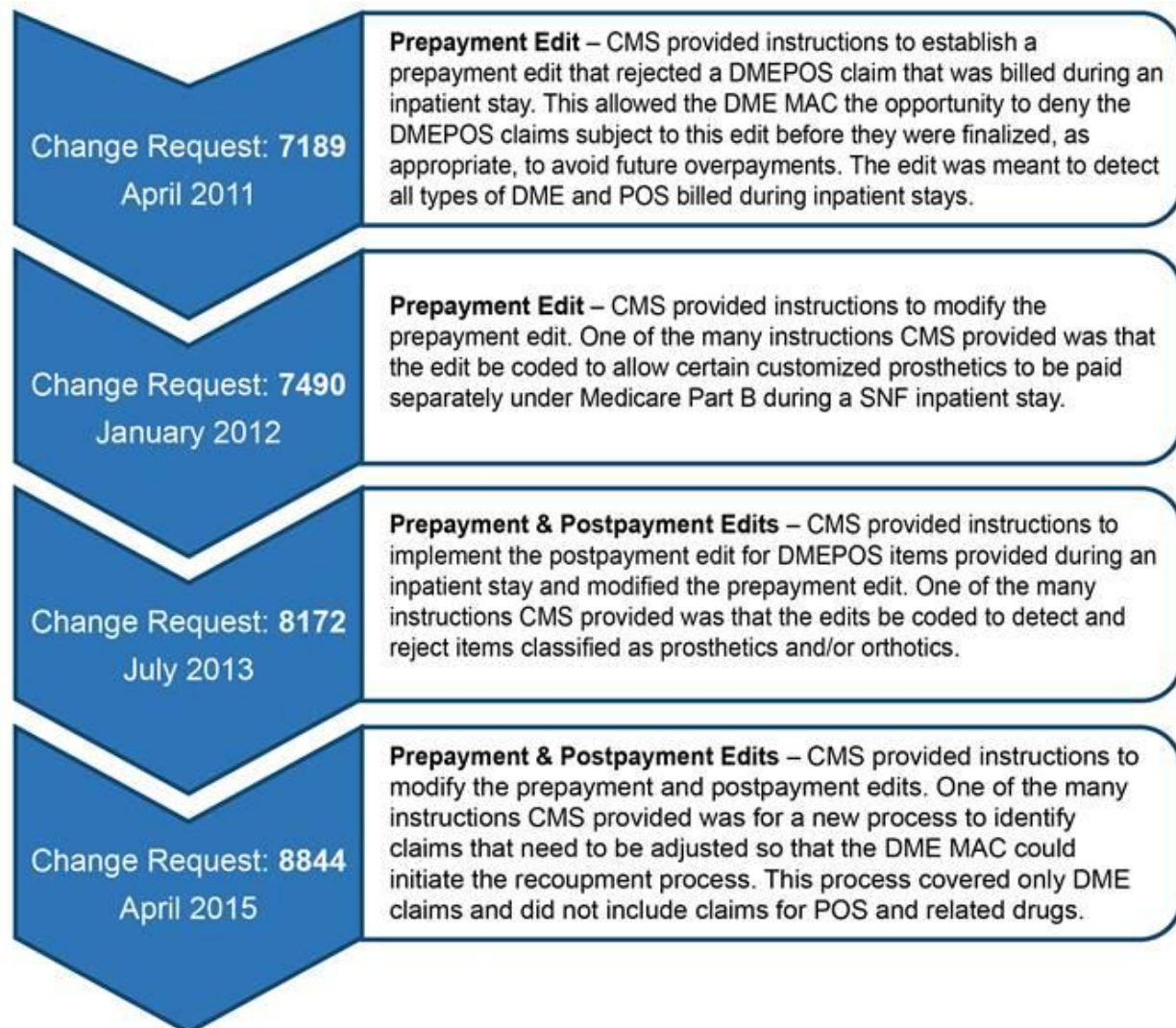
- used CMS's NCH file to identify Medicare Part B DMEPOS claims that had service dates from 1 day after the beneficiaries' admission dates up to and including the discharge dates of the identified Medicare Part A inpatient claims;
- excluded claims for DMEPOS rentals that were billed during inpatient stays;
- identified DMEPOS and related drugs on 120,614 DMEPOS claims;
- reviewed available data from CMS's CWF for the selected DMEPOS claims to determine whether the claims had been canceled or adjusted;
- identified beneficiary deductible and coinsurance amounts, totaling \$8,702,539, related to the DMEPOS items;
- interviewed CMS officials and reviewed documentation provided by them to understand how the CWF edits work and to determine why Medicare made payments for the DMEPOS claims that were billed during inpatient stays;
- provided to CMS our complete list of improperly paid DMEPOS items for our audit period;
- identified additional DMEPOS claims from CYs 2008 through 2014 that were billed during inpatient stays, as well as the related payments for deductibles and coinsurance that were incorrectly collected from beneficiaries or from someone on their behalf; and
- discussed the results of our review with CMS officials.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities</i>	A-09-16-02026	9/18/2017
<i>Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays</i>	A-01-15-00511	6/28/2017
<i>Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay</i>	A-01-10-00508	6/4/2012

APPENDIX C: CMS'S CHANGE REQUESTS FOR PREPAYMENT AND POSTPAYMENT EDITS



APPENDIX D: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT - 3 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays (A-09-17-03035)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy that includes automated system edits within the claims processing system and prepayment and postpayment reviews to reduce and prevent Medicare improper payments. As part of our efforts to protect the integrity of our programs, CMS would recover identified improper payments in accordance with agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for durable medical equipment, prosthetics, orthotics, and supplies. CMS educates health care providers on Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS direct the DME MACs to recover the \$34,014,796 in identified improper payments to suppliers in accordance with CMS's policies and procedures.

CMS Response

CMS concurs with this recommendation. CMS will direct the Durable Medical Equipment Medicare Administrative Contractors to review the claims identified by the OIG and recover the identified improper payments consistent with the agency's policies and procedures.

OIG Recommendation

The OIG recommends that CMS direct the DME MACs to recommend that the suppliers refund beneficiaries up to \$8,702,539 in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. CMS will recommend that the suppliers refund beneficiaries any deductible or coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

OIG Recommendation

The OIG recommends that CMS direct the DME MACs to identify and recover any improper payments to suppliers after the audit period and recommend that those suppliers refund to beneficiaries any deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. CMS will work with the Durable Medical Equipment Medicare Administrative Contractors to identify and recover improper payments to suppliers after the audit period. CMS will recommend that the suppliers refund beneficiaries any deductible or coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

OIG Recommendation

The OIG recommends that CMS take all necessary actions, including seeking legislative authority if necessary, to require suppliers to refund to beneficiaries incorrectly collected Part B deductible and coinsurance amounts for items and services reimbursable under Medicare Part A.

CMS Response

In the absence of authority under current law, CMS will consider whether to recommend this proposal for inclusion in the President's next budget.

OIG Recommendation

The OIG recommends that CMS correct the CWF edits to fully prevent or detect overpayments to suppliers for DMEPOS items provided during inpatient stays by including categories that are not currently being detected, such as POS and related drugs.

CMS Response

CMS concurs with this recommendation. CMS will explore opportunities to enhance the Common Working File edits designed to prevent and detect overpayments to suppliers for Durable Medical Equipment Prosthetics Orthotics and Supplies, and other items provided during inpatient stays, such as including categories that are not currently being detected.

OIG Recommendation

The OIG recommends that CMS correct the CWF edits to fully prevent or detect overpayments to suppliers for DMEPOS items provided during inpatient stays by denying payments to suppliers for claims for customized prosthetics provided to beneficiaries during inpatient stays at facilities other than SNFs.

CMS concurs with this recommendation. CMS will explore opportunities to enhance the Common Working File edits designed to prevent and detect overpayments to suppliers for Durable Medical Equipment Prosthetics Orthotics and Supplies items provided during inpatient stays, including denying payments to suppliers for claims for customized prosthetics provided to beneficiaries during inpatient stays at facilities other than Skilled Nursing Facilities.