Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR ORTHOTIC BODY JACKETS

JUNE GIBBS BROWN
Inspector General

JUNE 1994
OEI-04-92-01080

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EXECUTIVE SUMMARY

PURPOSE

To determine whether or not Medicare is appropriately billed for orthotic body jackets.

BACKGROUND

In February 1992, the Office of Inspector General (OIG) received an allegation from a company which provides Medicare billing services to nursing homes. The allegation was that durable medical equipment (DME) suppliers were billing Medicare approximately $1,200 per device for devices consisting of "nothing more than a $50 piece of foam rubber." The bills were submitted to Medicare under HCFA's Common Procedure Coding System (HCPCS) code L0430. This code represents an orthotic device commonly used to treat injuries to the spine such as vertebra fractures and compressions, and to facilitate healing following a surgical procedure on the spine or related tissue.

FINDINGS

Medicare Claims and Allowed Charges for Orthotic Body Jackets Have Increased Substantially Since 1990

Medicare claims paid under HCPCS code L0430 remained relatively steady until 1990. The number of claims submitted to Medicare increased 6,400 percent by the end of FY 1992. Likewise, allowed Medicare charges increased over 8,200 percent. Preliminary data for 1993 shows a 50 percent reduction in claims submitted and Medicare allowed charges. However, the claims and charges are still significantly higher than the 1990 levels.

Ninety-Five Percent of the Orthotic Body Jacket Claims Paid by Medicare Were For Non-Legitimate Devices

Ninety-five percent of the devices claimed under code L0430 did not meet construction requirements and medical purpose of a legitimate body jacket. Many of the devices were primarily used to keep patients upright in a wheelchair.

Medicare Payments For Non-Legitimate Devices Exceeded $7 Million In 1991

Total Medicare payments for non-legitimate devices exceeded $7 million in 1991, and may have increased to as much as $13.7 million in 1992. Medicaid funds were also at risk. Payment of the 20 percent Medicare co-payment by Medicaid could have resulted in as much as $670 thousand of inappropriate payments in 1991.

Non-Legitimate Devices Were Marketed As An Alternative To Restraints

We observed that the significant increase in claims for body jackets occurred shortly after enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The Act gave nursing home residents the right to be free from chemical and physical restraints. DME suppliers marketed non-legitimate body jackets to nursing homes as alternatives to restraints.

Medical Suppliers Used Loopholes in HCFA Guidance and Monitoring To Claim Non-Legitimate Devices As Body Jackets

Suppliers were able to claim devices that were non-legitimate because HCFA guidelines generally defined medical necessity and construction requirements for a body jacket. Suppliers took advantage of the vague definitions to assert that their non-legitimate devices met the requirements of a body jacket. In addition, Medicare regulations only required carriers to conduct postpayment reviews for the upper three percent of codes with the highest Medicare payments. Since body jacket codes were not in the upper three percent, carriers did not rapidly detect the significant increase in code L0430 claims.

Recent HCFA Efforts May Reduce Inappropriate Payments

On October 1, 1993, HCFA started processing DME, orthotics, and prostheses claims through four regional carriers called the Durable Medical Equipment Regional Carriers (DMERCs). One DMERC, called the Statistical Analysis DMERC (SADMERC), will track spending and utilization trends for all DMERCs. DMERCs also developed new coverage and medical review guidelines for orthotic body jackets.

RECOMMENDATIONS

We recommend that HCFA require the DMERCs to closely monitor claims for body jackets. If inappropriate body jacket claims are not discontinued in FY 1994, HCFA should implement more stringent controls. Finally, HCFA should inform suppliers and physicians about the abuse of body jacket codes and stress its intent to prevent such abuse. Through stringent monitoring of orthotic body jacket codes, HCFA will conservatively avoid paying $7 million for non-legitimate devices in the future. Claims that were found inappropriate by this study will be turned over to HCFA for recovery.

AGENCY COMMENTS

The HCFA Administrator commented on our draft report and agreed with our recommendations. HCFA staff believe that the regionalization of durable medical equipment claims processing and the development of medical review policies will strengthen their ability to monitor use the use and payment of orthotic body jackets. We encourage HCFA to take quick corrective action if their monitoring shows that inappropriate body jacket claims have not discontinued.

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INTRODUCTION

PURPOSE

To determine whether or not Medicare is appropriately billed for orthotic body jackets.

BACKGROUND

Medicare Program

Medicare is a Federal health insurance program for individuals age 65 or older and certain categories of disabled people. It is administered by the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS). The Medicare program has two types of insurance, Part A and Part B. Part A (hospital insurance) helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, skilled home health care, and hospice care. Part B (medical insurance) covers physician services, outpatient hospital services, and other medical services and supplies. This report focuses on payments for orthotic body jackets purchased under Medicare Part B.

Medicare Part B claims are processed by private insurance companies, called carriers, under contract with HCFA. Carriers are responsible for ensuring that coverage requirements are met before approving payment. Carriers use a coding system to process Medicare claims and determine payment amounts. HCFA developed the coding system, called the HCFA Common Procedure Coding System (HCPCS) in 1983 to bring about uniformity in defining and billing for medical services and supplies. A supplier places a HCPCS code on a Medicare claim form to designate what type of supply was rendered to a beneficiary.

Allegation of Inappropriate Billing

In February 1992, the Office of Inspector General (OIG) received an allegation from a company which provides Medicare billing services to nursing homes. The allegation was that suppliers were billing Medicare approximately $1,200 per claim for devices consisting of "nothing more than a $50 piece of foam rubber." The bills were submitted to Medicare under HCPCS code L0430. Code L0430 is for a device that is defined by HCFA as a "Thoracic Lumbar Sacral Orthosis (TLSO), Anterior-Posterior-Lateral Control (Body Jacket) with interface material custom fitted."

SCOPE

We focused on HCPCS code L0430 because our analysis of 1991 data for all body jacket codes showed that code L0430 had the most significant increase in number of claims. We conducted our inspection between May and October, 1993.

METHODOLOGY

We reviewed all claims for code L0430 contained in HCFA's 1991 Common Working File which is a one percent random sample of all Medicare claims. This sample consists of 120 claims. We dropped 25 of the 120 claims from our sample because carriers disallowed them for payment. This left us with a sample size of 95 paid claims.

To determine the purpose of a body jacket and how one should be constructed, we consulted five licensed orthotists, three of whom were members of the American Orthotic and Prosthetic Association (AOPA). Orthotic practitioners must have either a BS or BA degree in Orthotics. Then, they must serve a one-year internship prior to taking written, oral, and practical examinations. Finally, orthotic practitioners must take required continuing education courses to maintain certification. AOPA is a national organization which represents more than 800 allied health care firms that provide orthotic and prosthetic services.

To determine what type of devices were supplied to beneficiaries in our sample, we obtained descriptions from suppliers, nursing homes, and DHHS OIG Office of Investigations (OI). Because some suppliers were under investigation by OI, we used OI as a source of information rather than contact those suppliers directly. To inspect the construction and purpose for devices sold under code L0430, we visited two suppliers not under OI investigation and two nursing homes. Using the licensed orthotists and AOPA criteria for the construction and purpose of a body jacket, we determined whether or not the devices supplied to beneficiaries in our sample, and billed to Medicare, were body jackets.

To determine whether or not Medicare beneficiaries in our sample had a medical need for a body jacket, we obtained information from Medicare claims, physician prescriptions, and Certificates of Medical Necessity (CMNs). Sixty-four of the claims in our sample were accompanied by CMNs. The prescribing physician's address is typically listed on the CMN. Of the 64 CMNs, 55 listed the physician's address. We contacted these 55 physicians to verify beneficiaries medical need for body jackets. Forty of the 55 physicians responded to our questionnaire.

To determine marketing practices of the suppliers that sold devices to beneficiaries in our sample, we interviewed 44 nursing home administrators by telephone and visited 2. We also reviewed marketing brochures for each supplier.

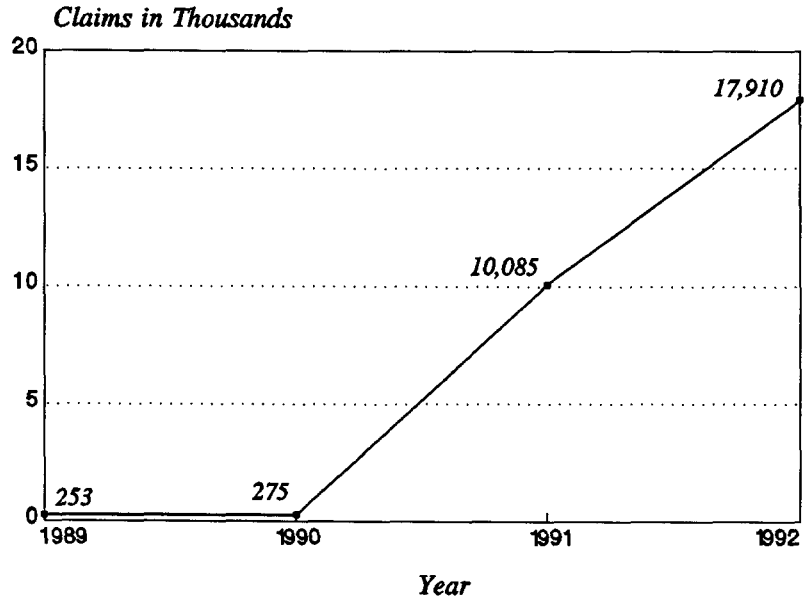
This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

MEDICARE CLAIMS AND ALLOWED CHARGES FOR ORTHOTIC BODY JACKETS HAVE INCREASED SUBSTANTIALLY SINCE 1990

Medicare claims for body jackets paid under HCPCS code L0430 remained relatively steady until 1990. The number of claims submitted to Medicare increased from 275 in 1990 to 17,910 in 1992--a 6,400 percent increase. Figure 1 illustrates the increase.

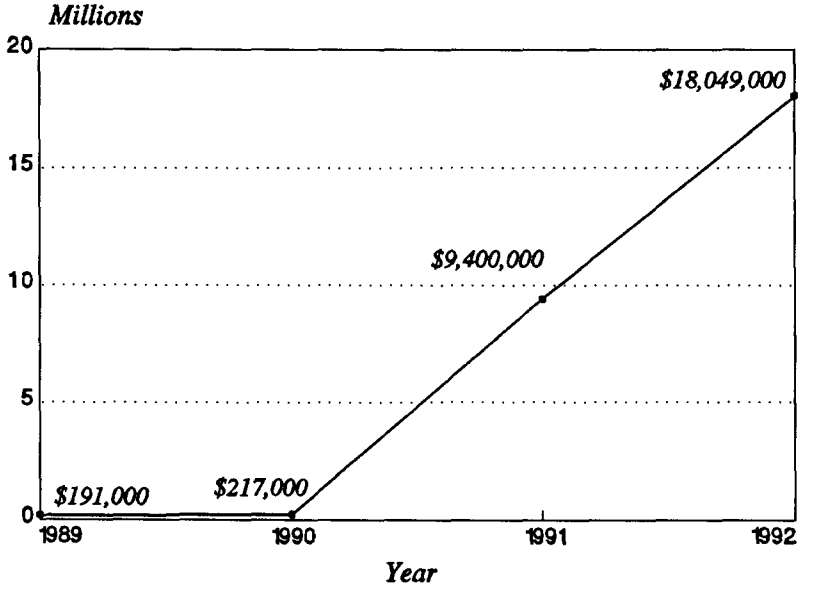
FIGURE 1



Total Medicare allowed charges for code L0430 also increased significantly since 1990. Total allowed charges increased from $217 thousand in 1990 to $18 million in 1992--a 8,200 percent increase[2]. Figure 2 illustrates the dramatic increase.

[2]The disparity between percentage increases for claims and allowed charges is attributed to differences allowed on individual claims and increases in allowed amounts in recent years.

FIGURE 2



Through September 1993, HCFA reports that about 5,000 claims were submitted to Medicare and $5.2 million was allowed for orthotic body jackets. According to HCFA, the 1993 allowed amounts represents about 60 percent of the expected total for the year. Therefore, we project that approximately $8.6 million will be allowed in 1993. This represents a decrease of about 50 percent from the 1992 levels. However, the projected number of claims submitted and allowed charges still are significantly higher than the 1990 levels.

NINETY-FIVE PERCENT OF ORTHOTIC BODY JACKET CLAIMS PAID BY MEDICARE WERE FOR NON-LEGITIMATE DEVICES

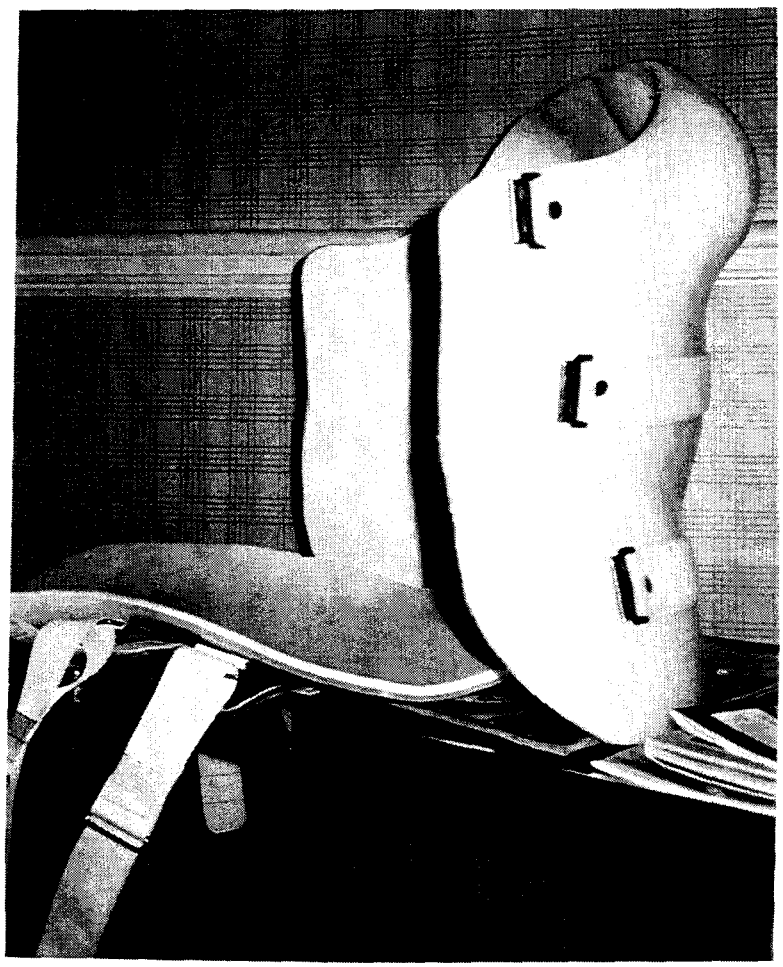
Ninety-five percent of our sampled claims (90 of 95) submitted under code L0430, were for devices which were not orthotic body jackets. Hereafter, we will refer to these as non-legitimate devices. The remaining 5 percent (5 of 95) were for legitimate body jackets. We noticed that the legitimate body jackets in our sample were supplied by certified, licensed orthotists whose primary occupation is supplying orthotic and prosthetic devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics.

According to the licensed orthotists and members of AOPA we consulted, a body jacket should be made of rigid plastic material that conforms to the body and provides a high degree of immobility. It should also be custom fitted, which means that it can be adjusted to meet the specific needs of a patient. Body jackets are most commonly used to treat spinal and muscular diseases such as scoliosis and muscular dystrophy. They are also used to treat injuries to the spine such as vertebra fractures and compressions, and to facilitate healing following a surgical procedure on the spine or related tissue.

A legitimate body jacket is illustrated in Figure 3. This body jacket is made of a rigid plastic material. It applies pressure to certain points along the abdomen and back, limiting motion in the spine. It is custom fitted because it has three adjustable straps that can be tightened or loosened to apply more or less pressure to certain points along the abdomen or back, depending on the needs and shape of a patient.

FIGURE 3

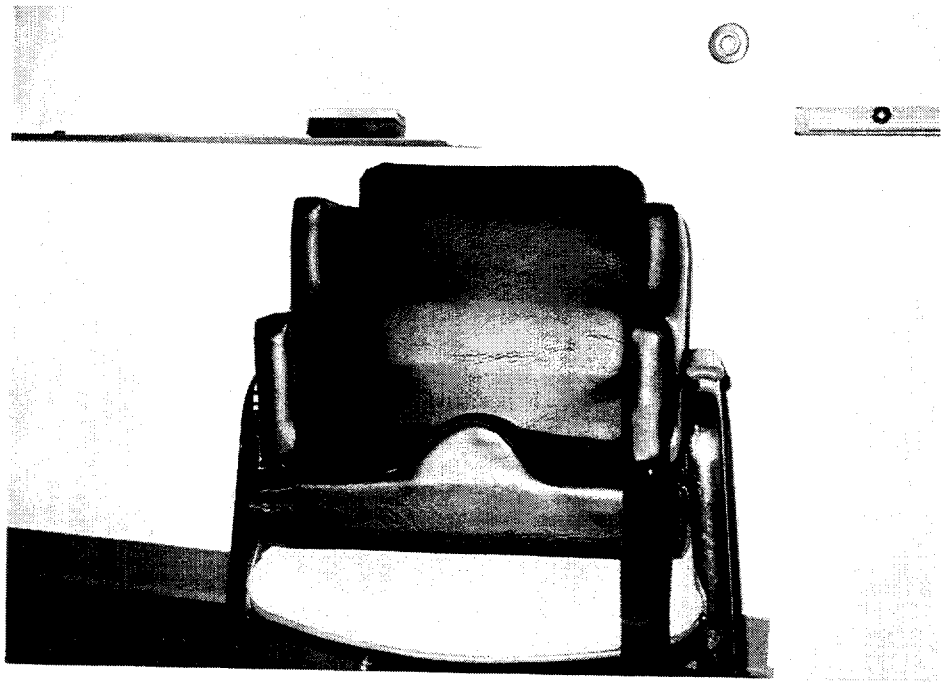
LEGITIMATE BODY JACKET



We visited three beneficiaries residing in nursing homes to inspect devices they had purchased through Medicare as body jackets. One of the devices we inspected is shown in Figure 4 below. The other two devices we inspected, as well as 87 other devices supplied to sampled beneficiaries, were almost identical to the device in Figure 4. According to the licensed orthotists and AOPA members we consulted, the device in Figure 4 is not a legitimate body jacket. It is not properly constructed and does not serve the medical purpose of a body jacket.

FIGURE 4

NON-LEGITIMATE BODY JACKET



Device Is Not Properly Constructed

The device in Figure 4 has the following construction features that are inconsistent with a legitimate body jacket.

1. The device is constructed of soft material which is not rigid and does not conform to a patient's body. It consists of two sides, a back, and bottom piece that are made of a soft foam material covered in vinyl. Each piece is about two inches thick.

2. The device neither conforms to the patient's body nor restricts motion in the spine. We observed that one beneficiary who was using this device was extremely slumped over the arm of his wheelchair.

3. The device is not custom fitted because it does not offer any adjustability to meet the unique shape of an individual or the specific need of a patient.

Device Did Not Serve the Medical Purpose of An Orthotic Body Jacket

HCFA requires that body jacket claims be accompanied by a physician's prescription and/or a certificate of medical necessity. A prescription must include a patient diagnosis, reason the equipment is required, and an estimate of the duration of need. A CMN typically provides more detailed information on a patient's condition than that provided by a prescription. Prescriptions and CMNs must be signed by a physician.

Our analyses of prescriptions, CMNs, and statements by prescribing physicians and nursing home administrators showed that many of the devices in our sample were primarily used to keep patients upright in a wheelchair. Ninety-two percent of the beneficiaries for whom we had CMNs (59 of 64) are listed as wheelchair bound. Sixty-eight percent of the prescribing physicians who responded to our questionnaire (27 of 40) stated that the device they prescribed was used to keep a patient upright in a wheelchair.

The orthotists and AOPA members we consulted stated that it is very unusual for a body jacket to be prescribed for a wheelchair bound person. One orthotist stated that less than 1 percent of elderly people who need body jackets are wheelchair bound.

The 40 physicians who responded to our survey identified the medical conditions of the beneficiaries in our sample. They typically identified schizophrenia, anemia, diabetes, parkinson's disease, alzheimer's disease, and dementia. According to licensed orthotists we consulted, these medical conditions are not normally treated with a body jacket. The physicians assumed suppliers had billed Medicare for wheelchair seating devices rather than custom-fit orthotic body jackets.

MEDICARE PAYMENTS FOR NON-LEGITIMATE DEVICES EXCEEDED $7 MILLION IN 1991

In 1991, about 95 percent (90 of 95) of the devices purchased through Medicare under code L0430 were non-legitimate devices. Total Medicare payments for those devices exceeded $7 million. Furthermore, assuming that the percent of Medicare claims for non-legitimate devices remained at 95 percent in 1992, inappropriate payments would have increased to about $13.7 million.

For orthotics, Medicare pays 80 percent of either the actual charge or the fee schedule amount, whichever is less. A beneficiary, or the beneficiary's secondary insurance, is responsible for paying the remaining 20 percent co-payment. Sixty-six percent of the claims (44 of 67)[3] show that Medicaid was responsible for paying the remaining 20 percent co-payment. Therefore, Medicaid funds were also at risk. State Medicaid fee schedules vary, and we could not determine the precise amount Medicaid paid on each claim. However, payment of the entire 20 percent co-payment by Medicaid could have resulted in $670 thousand of inappropriate Medicaid payments in 1991. We did not determine inappropriate Medicaid payments for 1992 because we did not know how many Medicaid claims were filed.

Appendix A describes in detail how we determined Medicare and Medicaid payments for non-legitimate devices.

NON-LEGITIMATE DEVICES WERE MARKETED AS AN ALTERNATIVE TO RESTRAINTS

Eighty percent of the nursing home administrators (35 of 44) we interviewed said the device was marketed to them as an alternative to restraints. Restraints are prohibited by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). The Act gave nursing home residents the right to be free from chemical and physical restraints. We observed that the significant increase in claims for body jackets occurred shortly after enactment of OBRA '90 legislation.

Ninety-four percent of the beneficiaries for whom we had claims in 1991 (63 of 67) resided in nursing homes. The following statements, taken directly from suppliers' brochures, indicate that suppliers sold the devices to nursing homes as an alternative to restraints, not to treat a medical condition.

> "*These do not only maintain functional alignment, they eliminate the need to restrain the resident*"
>
> "*Addresses restorative legislative mandates of OBRA '90*"
>
> "*Restraint-free management tool reduces chance of resident injury and non-compliance with restraint regulations*"

[3]We obtained paper claims for 67 beneficiaries in our sample. The remaining 53 claims were processed electronically and we were not able to obtain paper claims.

MEDICAL SUPPLIERS USED LOOPHOLES IN HCFA GUIDANCE AND MONITORING TO CLAIM NON-LEGITIMATE DEVICES AS BODY JACKETS

HCFA's General Definitions Allowed Suppliers to Claim Non-Legitimate Devices as Body Jackets.

Suppliers were able to claim non-legitimate devices as body jackets because HCFA had not clearly defined medical necessity and construction of a body jacket. HCFA classifies body jackets as back braces in section 2133 of the carriers manual. Back braces are used for the purpose of "supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body." Suppliers took advantage of this general definition to assert that their devices were medically necessary. They said the device met the definition because it supported a patient's back. However, most of the devices in our sample were merely used to assist patients in sitting upright in wheelchairs. According to the orthotists we consulted, a body jacket claimed under code L0430 is more sophisticated and should do more than simply support a wheelchair patient.

Some suppliers used HCFA's general definition[4] for code L0430 to justify that their devices were legitimate. They alleged that the devices were custom fitted because the arm cushions came in different heights. However, the devices did not conform to a patient's body. According to the orthotists we consulted, custom fit means that the device is designed to conform to the shape of a patient's body, and the device must help meet a patient's specific medical need.

Limited Monitoring Allowed Payments for Non-Legitimate Devices

In 1991, when claims for body jackets began to significantly increase, HCFA only required that carriers look for aberrant payment trends for the upper three percent of codes with the highest Medicare payments. Since body jacket codes were not in the upper three percent, carriers did not rapidly detect the increase in code L0430 claims. In addition, while carriers could look at their own payment trends, there was no mechanism to compare trends for all carriers and, therefore determine if the number of orthotic body jackets claimed were excessive.

Most carriers learned of the abusive claims from physicians and beneficiaries, not from their own internal reviews. Once they were told about the abuse, they reviewed payment trends. These payment trends showed the increase in the number of claims and identified suppliers who were submitting large numbers of body jackets claims. In early 1992, when carriers began to detect claims for non-legitimate devices, they established medical reviews to curtail payments. For example, some carriers in our sample contacted physicians, some required that a picture of the device accompany a

[4]Thoracic Lumbar Sacral Orthosis, Anterior-Posterior-Lateral Control (body jacket) with interface material custom fit.

claim, some coded all L0430 claims under a lower reimbursed code, and a few simply required that a prescription accompany the claim. Some suppliers were referred to the OIG for investigation. However, medical suppliers claims for non-legitimate devices continued to increase through 1992. In 1993, preliminary data on body jacket claims and payments indicate a decrease of about 50 percent from the 1992 level. However, the claims and payments remain significantly higher than the 1990 level.

RECENT HCFA EFFORTS MAY REDUCE INAPPROPRIATE PAYMENTS

HCFA recently took steps to reduce inappropriate payments for body jackets, as well as other orthotic, prosthetic, and DME items. In June 1993, HCFA notified the regional fraud and abuse coordinators of the abuse of body jacket codes who, in turn, notified the carriers. On October 1, 1993, HCFA started processing DME, orthotics, and prostheses claims through four regional carriers called the Durable Medical Equipment Regional Carriers (DMERCs). The DMERCs will process claims formally processed by 33 carriers. HCFA plans to phase-in all claims by June of 1994. One DMERC, in addition to claims processing functions, will track spending and utilization trends for all DMERCs. This DMERC will be referred to as the Statistical Analysis DMERC (SADMERC).

For payment through the DMERCs, HCFA identified 100 DME, orthotic, and prostheses items which had the highest level of Medicare payments. Further, the DMERCs developed coverage and medical review guidelines to be published in a DMERC manual. Code L0430 was identified as one of the top 100 items. The guidelines give DMERCs basic characteristics of a body jacket, a definition of custom fit, and coding guidelines. The guidelines also give medical indications for a body jacket such as "to reduce pain by restricting mobility of the trunk," or "to otherwise support weak spinal muscles and/or a deformed spine."

In addition, HCFA required that the DMERCs perform postpayment review activities. Through enhanced computer capabilities, the DMERCs will have access to national and local carrier claims data. This will enable DMERCs to compare local data to national data for all codes. As a result, drastic increases in claims such as those experienced for body jackets in 1991 and 1992 can be detected and reviewed early for propriety of payment. In the past, data was run off a mainframe computer and could only be accessed semi-annually. The new system will be available on personal computers and will allow greater flexibility for reviewing and determining that payments are appropriate.

RECOMMENDATIONS

Preliminary data for the first half of 1993 for body jacket claims and allowed charges show a decline from the 1992 level by about 50 percent. We did not determine the cause of the decline. However, it may have resulted from actions taken by carriers late in 1992 to assure propriety of payments for orthotic body jacket claims, and from market saturation.

HCFA's recent establishment of the DMERCs and related guidance should help further reduce payments for non-legitimate devices in the future. However, the number of claims and allowed charges remains significantly higher than the 1990 level, and it is likely that non-legitimate devices are still being paid by Medicare. If the percentage of inappropriate body jacket claims being paid by Medicare remains as high as it was in 1991, Medicare could stand to lose at least $7 million annually. Therefore, we recommend that HCFA require the DMERCs to

Closely monitor claims for body jackets. A monitoring system that includes the following could be implemented by the SADMERC.

- Routinely analyze payment trends for body jacket codes to identify abusive patterns and aberrant providers.
- Provide other DMERCs an early warning of abusive practices.
- Develop methods to closely monitor suppliers who have engaged in abusive practices.

If inappropriate orthotic body jacket claims are not discontinued in FY 1994, HCFA should implement more stringent controls such as

- requiring physicians to obtain prior approval from DMERCs for body jackets, and/or
- programming computer systems to identify and allow payment for code L0430 claims only when they match appropriate medical diagnoses.

Finally, HCFA should inform the medical community about non-legitimate devices coded under HCPCS code L0430 and indicate its intent to closely monitor the use of body jacket codes, as a deterrent to further abuse.

Claims that we found inappropriate during our study will be turned over to HCFA for recovery.

AGENCY COMMENTS

The HCFA Administrator agreed with our recommendations. He stated that regionalization of durable medical equipment claims processing and development of medical review policies will strengthen HCFA's ability to monitor use of and payment for orthotic body jackets. We encourage HCFA to take immediate corrective action if their monitoring shows that inappropriate body jacket claims have not discontinued.

In response to HCFA's technical comments, we made appropriate revisions to the report. Appendix B contains the full text of the HCFA Administrator's comments.

APPENDIX A

MEDICARE PAYMENTS FOR NON-LEGITIMATE DEVICES

1991 Payments for Non-Legitimate Devices

1. Add total allowed amounts in the HCFA Part B Extract Statistical System (BESS) 1 percent file and then subtract all allowed amounts for the legitimate claims to determine total allowed for non-legitimate claims.

   $92,262 (Total allowed entire 1 percent file)
   - 4,499 (Total allowed for legitimate claims)

   $87,763 (Total allowed non-legitimate claims)

2. Multiply total allowed for non-legitimate claims by 100 to get total allowed in universe.

   $87,763 x 100 = $8,776,300 (Average allowed in universe)

3. Multiply total allowed in the universe by 80 percent to determine total Medicare payments for non-legitimate devices.

   $8,776,300 x .80 = $7,021,040 (Total Medicare payments for non-legitimate devices)

Confidence Intervals:

Universe Size	Sample Size	Estimated Overpayment	Lower 95% Confidence Interval	Upper 95% Confidence Interval
12,000	120	$7,021,040	$6,261,629	$7,780,450

1992 Payments for Non-Legitimate Devices

1. Total allowed amount for HCPCS code L0430 in the 100 percent HCFA BESS file was $18,049,881.

2. From the 1991 data, we found 95 percent (standard error of .021) of the payments were made for non-legitimate devices.

3. Apply this percentage (95 percent) to the 1992 allowed amounts to get the total allowed amount for non-legitimate devices.

   $18,049,881 x .95 = $17,147,386 (Allowed for non-legitimate devices)

4. Apply the 80 percent Medicare portion to determine total Medicare payments for non-legitimate devices.

   $17,147,386 x .80 = $13,717,909 (Total Medicare payments for non-legitimate devices)

Confidence Intervals:

Estimated Overpayment	Lower 95% Confidence Interval	Upper 95% Confidence Interval
$13,717,909	$13,125,872	$14,338,824

1991 MEDICAID PAYMENTS FOR NON-LEGITIMATE DEVICES

1. Add total Medicaid allowed amounts in the HCFA BESS 1 percent file.

   $34,353 (Total Medicaid allowed non-legitimate claims)

2. Multiply total Medicaid allowed for non-legitimate claims by 100 to get total allowed in the universe.

   $34,353 x 100 = $3,435,800 (Total allowed in universe)

3. Multiply total allowed in the universe by 20 percent to determine total Medicaid payments for non-legitimate devices.

   $3,435,800 x .20 = $687,160 (Total Medicaid payments for non-legitimate devices)

Confidence Intervals:

Universe Size	Sample Size	Estimated Overpayment	Lower 95% Confidence Interval	Upper 95% Confidence Interval
12,000	120	$687,000	$495,674	$878,325

APPENDIX B

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date APR 22 1994

From Bruce C. Vladeck
Administrator

Subject Office of Inspector General (OIG) Draft Report: "Medicare Payments for Orthotic Body Jackets" (OEI-04-92-01080)

To June Gibbs Brown
Inspector General

We reviewed the above-referenced draft report which analyzed claims and charges for orthotic body jackets. The report correctly identifies a number of instances of overutilization and abuse; as a result, Medicare payments for orthotic body jackets have increased tremendously in recent years.

We are aware of the increased number of claims for body jackets and believe that as a result of regionalization of durable medical equipment claims processing, and the development of regional medical review policies for spinal orthoses, we have strengthened our ability to monitor the use and payment of orthotic body jackets.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please advise us if you would like to discuss our position on the recommendations at your earliest convenience.

Attachment

IG	
SAIG	✓
PDIG	
DIG-AS	
DIG-EI	✓
DIG-OI	
AIG-MP	
OGC/IG	
EXSEC	✓
DATE SENT	4/25

Comments on Office of Inspector General (OIG) Draft Report:
Medicare Payments for Orthotic Body Jackets
(OEI-04-92-01080)

Recommendation 1

The Health Care Financing Administration (HCFA) should require the Durable Medical Equipment Regional Carriers (DMERC) to closely monitor claims for body jackets, including analysis of payment trends, provision of an early warning of abusive practices, and monitoring of suppliers who have engaged in abusive practices.

HCFA Response

We concur, and have instituted several methods to detect payment trends and identify suppliers who have exhibited abusive practices.

As part of its contract responsibilities, the Statistical Analysis (SA) DMERC closely monitors claims for body jackets, produces standard quarterly reports, and provides analysis of data to identify trends and aberrancies. Additionally, the SADMERC conducts postpayment medical review for national suppliers in order to determine if future corrective action is needed.

By producing standard quarterly reports along with monthly ad hoc reports, the SADMERC assists the DMERCs in identifying potential abusive practices, and monitors those suppliers that appear to engage in abusive practices. The SADMERC will continue to be a resource for the DMERCs to detect patterns of abusive billing by suppliers.

In addition to the regionalization initiative (creation of the DMERCs and the SADMERC), HCFA has issued several new codes to better distinguish the various types of products currently on the market. Claims for some classes of orthotic devices, previously paid for by the local carriers, are now denied by the DMERCs. Claims for those devices that are covered by the DMERCs must be submitted with additional medical documentation including, but not limited to, the following: a description of the item and the diagnosis; a description of the spinal problem; the brand name and model number or photo of the actual device; and features of the orthosis and medical necessity of each.

Recommendation 2

If inappropriate orthotic body jacket claims are not discontinued in FY 1994, HCFA should implement more stringent controls, such as requiring physicians to obtain prior approval from DMERCs for body jackets, and/or programming computer systems to identify and allow payment for code L0430 claims only when they match appropriate medical diagnoses.

HCFA Response

We agree that there is a need for stringent controls, and we feel that we have the necessary control mechanisms in place to detect increased use of these products.

While the specific actions recommended were examples or suggestions, we wish to point out that we do not agree that we should seek the legislation necessary to institute a prior approval program for body jackets as a means to impose more stringent controls for inappropriate claims. We anticipate that because of the regionalization and development of regional policy for orthotic body jackets, we will see decreased utilization of the body jackets. We are confident that the regional policies presently in place are at least as good as a prior approval program would be.

Recommendation 3

HCFA should inform the medical community about nonlegitimate devices coded under HCPCS code L0430 and indicate its intent to closely monitor the use of body jacket codes, as a deterrent to further abuse.

HCFA Response

We concur. We will encourage the DMERCs to use their monthly bulletins to inform the medical community of inappropriate use of devices such as orthotic body jackets.

Technical Comments:

Page 10, first full paragraph: change "phase-in claims by March" to June. Decisions have been made recently to delay the transition of several States to the new regional carriers.

Page 10, last paragraph: delete the first sentence, which refers to "focused medical review." That exact wording is not used in the DMERC contract.

Page 11, last sentence of the second paragraph should read, "If inappropriate payments for orthotic body jackets continue to increase, Medicare could stand to lose at least $7 million annually."