

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Health Care Financing Administration
Controls Are Not Preventing Duplicate
Payments**



**JUNE GIBBS BROWN
Inspector General**

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OEI-04-97-00460**

OFFICE OF INSPECTOR GENERAL

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OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General, and Christopher H. Koehler, Deputy Regional Inspector General. Principal OEI staff included:

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June Gibbs Brown
Inspector General

Health Care Financing Administration Controls are not Preventing Duplicate Payments,
OEI-04-97-00460

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The Health Care Financing Administration (HCFA) and contractor staff expressed concerns that regional home health intermediaries and durable medical equipment regional carriers were being inappropriately billed twice for medical equipment and supplies. At their request, we initiated an evaluation to quantify the extent of the duplicate payments.

We found vulnerabilities that allowed for duplicate payments to be made for supplies and equipment provided to Medicare home health beneficiaries. First, intermediaries do not know what supplies they are paying for because the coding system allows providers to submit claims for a wide variety of supplies using non-descriptive codes. Second, only about 3 percent of home health providers are subjected to complete audits that would potentially reconcile supply claims. Finally, HCFA Common Working File (CWF) edits do not check for duplication of payments on most equipment and supplies.

The actual inappropriate payments, slightly over \$530,000 in 1997, were relatively small compared to other payment error vulnerabilities in the Medicare program. Of this, \$379,510 was for supplies and \$150,722 was for equipment.

The vulnerabilities for supplies may be eliminated when Medicare implements the prospective payment system for home health, scheduled for October 2000. At that time, payment for supplies will be included in the prospective payment rate. However, the vulnerabilities for supplies will remain until the prospective payment system goes into effect.

The vulnerabilities for equipment will continue indefinitely, unless steps are taken to eliminate them. We suggest that HCFA examine its payment, coding, and editing practices to enable carriers and home health intermediaries to avoid duplicate equipment payments. For example, HCFA could require all medical equipment bills be submitted to the durable medical equipment regional carriers using the HCFA common procedure coding system. Another potential solution would be to expand CWF system edits to detect duplicate billings between both entities. The HCFA may also want to assess other potential cost effective solutions.

BACKGROUND

The HCFA has primary responsibility for protecting the Medicare Trust Fund from fraud, waste, and abuse. To accomplish this goal, HCFA contracts with private insurance companies to process Medicare claims and conduct program integrity functions.

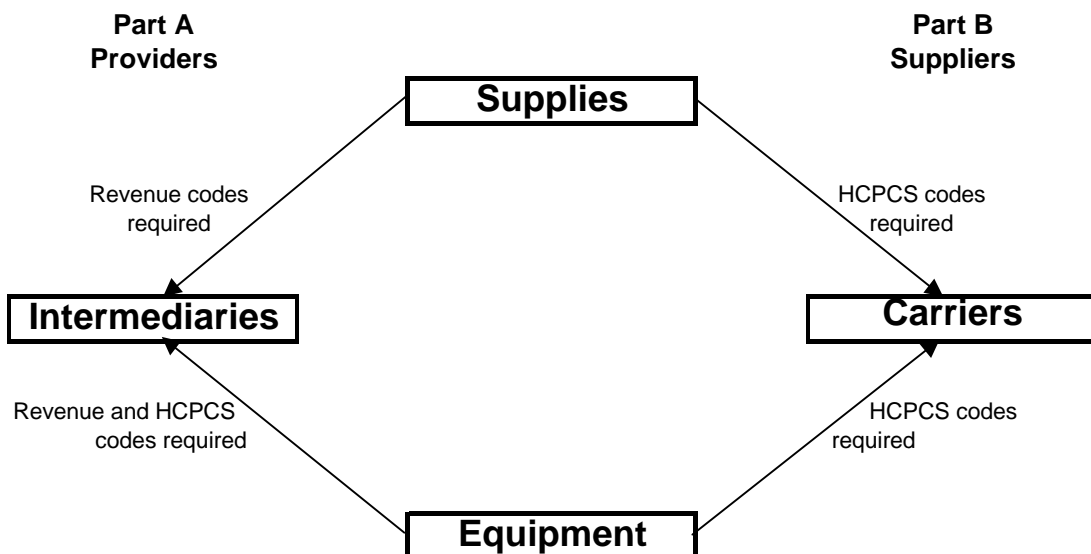
Claims Jurisdiction and Responsibility

The HCFA contracts with five regional home health intermediaries to process claims for home health care. Which intermediary processes home health claims generally depends on the State in which the home health agency is located. Home health providers file claims under both Part A and Part B.

The HCFA contracts with four durable medical equipment regional carriers to process claims for durable medical equipment, prosthetics, orthotics and supplies. Which carrier processes equipment and supply claims is governed by a beneficiary's place of residence. Suppliers are required to file claims under Part B.

The HCFA's claims submission requirements differ for submitting medical equipment and supply claims to intermediaries and carriers. Figure 1 highlights such similarities and differences.

FIGURE 1
Claims Submission Requirements



Medical Equipment Claims

The HCFA requires home health providers to use both HCFA Common Procedure Coding System (HCPCS) codes and revenue codes when billing intermediaries for medical equipment. The HCPCS codes generally relate to specific items while revenue codes are used to group supply items. Providers are reimbursed for medical equipment according to the HCPCS fee schedule.

The HCFA also requires suppliers to use HCPCS codes when billing carriers for medical equipment. The codes are itemized and reimbursed according to the HCPCS fee schedule.

Medical equipment processed through the intermediaries share the same HCPCS codes as medical equipment processed through the carriers.

Supply Claims

The HCFA guidelines require home health providers to use revenue codes to bill intermediaries for medical supplies. Suppliers, on the other hand, are required to use HCPCS codes when billing carriers for supplies.

Program Safeguards

The HCFA requires intermediaries and carriers to conduct focused medical reviews on a certain percentage of processed claims. Present practices limit the reviews to providers and suppliers with aberrant billing histories. Intermediaries, when reviewing aberrant providers, request detailed descriptions and medical justifications for billed services and supplies.

Intermediary and carrier claims are processed through a CWF. The CWF is used to obtain, maintain, and distribute beneficiary specific Medicare data. The CWF uses a Part A/B crossover edit that alerts intermediaries and carriers to potential duplicate payment situations. The CWF's system edit for potential duplicate payments is triggered when dates of service and procedure codes are the same for intermediary and carrier claims. Questionable claims are then manually reviewed to ensure appropriate payment.

Prospective Payment System

The Balanced Budget Act of 1997 requires HCFA to implement a prospective payment system for home health agencies. The new payment system is scheduled for October 1, 2000. The statute requires that payment for most items and services be made to the agency that established a plan of care. Medical equipment is not included in the prospective payment system.

METHODOLOGY

We conducted a national inspection of home health providers' and medical equipment suppliers' equipment and supply claims. We analyzed equipment and supply billings for Calendar Year 1997.

We interviewed HCFA central office and regional staff to determine what controls were in place to prevent duplicate payments. Additionally, we visited one intermediary and one carrier to discuss billing and payment processes and vulnerabilities. We also reviewed HCFA policies, carrier manuals, and the proposed home health prospective payment system regulation. Finally, we reviewed prior Office of Inspector General and General Accounting Office (GAO) reports and interviewed officials who prepared them.

We used a 5 percent sample of the 1997 National Claims History file and identified 50,946 Medicare beneficiaries with medical equipment or supply claims processed through intermediaries and carriers. These beneficiaries had over \$26 million in intermediary charges for equipment and supplies. We randomly sampled 500 beneficiaries, 50 with equipment claims and 450 with supply claims.

We compiled applicable equipment and supply claims data for each sampled beneficiary. To quantify duplicate billings, intermediary and carrier medical review staff reviewed and analyzed our data. Attachment A provides further details on our methodology.

QUESTIONABLE PAYMENTS

We identified \$5,789 as possible duplicate payments for equipment and supplies for 33 beneficiaries in our sample. The amount of questionable payments totaled \$2,326 for equipment and \$3,463 for supplies. The following examples illustrate such questionable payments.

- ▶ One beneficiary had a wheelchair billed to a carrier and a similar wheelchair billed to an intermediary for two overlapping months. The rental charges for the second wheelchair totaled about \$240.
- ▶ Both a carrier and intermediary paid for surgical dressings for the same beneficiary for the same month. The questionable payments totaled \$480.
- ▶ In September 1997, an intermediary processed diabetic supply claims for a beneficiary. During the same month, a carrier reimbursed a supplier \$71 for the same diabetic supplies.
- ▶ A home health provider billed an intermediary for various equipment including a leg rest, walker, and commode in July 1997. A carrier paid \$278 for the same equipment during the same month and for the same beneficiary.

We projected the \$5,789 in questionable payments made to suppliers for our sampled beneficiaries to the Medicare population that had both Part A and Part B claims as described

in our methodology. We estimated that the amount of payments made in error to the suppliers was approximately \$530,000 (+/- \$57, 200 at the 95% confidence level).

VULNERABILITIES

In a 1995 report,¹ GAO recommended controls to prevent duplicate payments by intermediaries and carriers for supplies. The HCFA did not implement the recommendations because it believed a proposed Medicare Transaction System would alleviate the identified problems. However, the new system was not implemented. Therefore, HCFA did not tighten controls to prevent duplicate payments for equipment and supplies. Thus, HCFA's payment process for equipment and supplies is still vulnerable to duplicate billing.

Cost Reports

Intermediaries pay supply claims without knowing specifically what they are paying for. To illustrate, HCFA policies allow home health providers to bill for a wide variety of supplies under revenue codes. The revenue codes do not adequately describe the type and amount of supplies billed for under each code. For example, one of the beneficiary claims that we reviewed had \$3399 billed under revenue code 270 for medical supplies. The bill did not provide any other details that would allow the intermediary to determine the appropriateness of the charges. We requested that the provider submit supporting documentation and discovered that the intermediary had paid for such items as 4x4 gauze, tape, ostomy pouches, sterile Q-tips, and gel wipes. The supplies were all appropriate in this example.

Furthermore, according to HCFA and intermediary staff, intermediaries would obtain and analyze supporting documentation for supplies only if providers were subjected to a complete audit. Intermediaries annually conduct complete audits on about 3 percent of home health providers.

Common Working File

All claims processed through intermediaries and carriers are also processed through a CWF. The HCFA uses the CWF to compare all claims with historical beneficiary data to verify eligibility for benefits and payment. The HCFA also uses the CWF to conduct many types of automated edits to determine if payment for claims should be approved or rejected. The CWF edits, however, do not prevent duplicate payments for equipment and supplies billed to intermediaries and carriers.

Supply claims processed through intermediaries and carriers do not share a common identifier. Therefore, identifying potential duplicate situations for supplies is very difficult. Although the CWF edits do not rely on an exact code match, the time period that the edit covers is too restrictive to identify duplicate payments. For example, the CWF edit would only identify a

¹ Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements, GAO/HEHS-95-171

potential duplicate payment if a carrier was billed for supplies for a specific date of service and an intermediary received a claim for an appropriate supply revenue code for the exact same date of service and same Medicare beneficiary.

Claims for equipment, on the other hand, use HCPCS codes whether billed to intermediaries or carriers. Even with this common identifier, the time window used for CWF edits, as mentioned above, is too restrictive. Therefore, the CWF edits do not adequately prevent duplicate payments for equipment.

Finally, the CWF does not have duplicate payment edits for the majority of the equipment and supplies processed by intermediaries and carriers.

CONCLUSION AND RECOMMENDATIONS

The HCFA and contractor staff raised concerns about duplicate payments for equipment and supplies under the Medicare home health program. As described in this report, we found vulnerabilities that allowed this to happen. However, the inappropriate payments were small relative to other vulnerabilities in the Medicare program. Furthermore, the prospective payment system for home health, when implemented, may eliminate the problem for medical supplies which will be included in the prospective payment rate. However, the vulnerabilities for supplies will remain until the prospective payment system goes into effect. Medical equipment remains vulnerable as it will not be included in the prospective payment rate.

We suggest that HCFA examine its payment, coding, and editing practices to enable carriers and home health intermediaries to avoid duplicate equipment payments. For example, HCFA could require all medical equipment bills be submitted to the durable medical equipment regional carriers using HCPCS codes. Another potential solution would be to expand CWF system edits to detect duplicate billings between both entities. The HCFA may also want to assess other potential cost effective solutions.

I hope that you find this information responsive to HCFA's request. Please do not hesitate to call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff contact Stuart Wright at (410) 786-3144 with any comments or questions.

COMMENTS

The HCFA concurred with our findings and recommendations. Specifically, that payment, coding and editing practices be modified to enable carriers and home health intermediaries avoid duplicate payments. The full text of their comments is attached in appendix B.

Attachments

Detailed Inspection Methodology

We used a 5 percent sample of the National Claims History file and identified 77,842 Medicare beneficiaries for whom providers had billed intermediaries for equipment and supplies totaling \$33.8 million. Using the same file, we determined that 50,946 of the 77,842 beneficiaries also had equipment or supply claims billed to carriers. These beneficiaries had over \$26 million in intermediary charges for equipment and supplies.

Hence, we started with 50,946 Medicare beneficiaries who could have had questionable equipment and supply claims made on their behalf to both intermediaries and carriers. Out of the 50,946 beneficiaries, we identified 162 who had equipment claims and 50,784 who had supply claims at intermediaries and carriers in calendar year 1997.

Equipment

We randomly sampled 50 of the 162 beneficiaries with equipment claims. Using the National Claims History file, we compiled applicable equipment claims submitted to intermediaries and carriers for Calendar Year 1997. Equipment claims submitted to intermediaries or carriers share a common identifier (HCPCS codes). Intermediary and carrier medical review staff reviewed our data to identify questionable payment situations.

Supplies

We pulled a stratified random sample of 450 of the 50,784 beneficiaries with supply claims. Supply claims submitted to intermediaries and carriers do not share a common identifier. Carriers use HCPCS codes that identify individual supply items while intermediaries use revenue codes to group many supply items. Therefore, sampling beneficiaries with supply claims required several steps.

First, intermediary and carrier medical review staff compiled a listing of HCPCS codes for supplies that were billable to carriers and would also “likely” be billed to intermediaries using supply revenue codes.

Next, we reviewed claims for the 50,784 beneficiaries and identified 11,994 beneficiaries who had one or more of the “likely” HCPCS codes paid in Calendar Year 1997. The remaining 308,790 beneficiaries did not have any of the “likely” codes paid in 1997. Therefore, we grouped them as “unlikely” supply matches. That is, they had supplies billed at both intermediaries and carriers during calendar year 1997, but the supplies billed to a carrier were not considered the type of supplies that should be billed to an intermediary. However, since we could not determine what specific supplies were billed to the intermediaries because of their use of non-descriptive revenue codes, we did not exclude the “unlikely” population from our sample.

We stratified the 11,994 beneficiaries that we considered “likely” based on dollar ranges of allowed charges. Table 1 illustrates our sample.

TABLE 1 SAMPLE FOR SUPPLIES		
Strata	Population	Sample
SUPPLIES - UNLIKELY	38,790	50
SUPPLIES - LIKELY		
likely matches < \$100	5,340	50
likely matches from \$100 < \$500	3,575	50
likely matches from \$500 < \$3,000	2,580	100
likely matches equal to or greater than \$3,000	499	200
Sub Total of Supplies - Likely	11,994	400
TOTAL	50,784	450

Next, using the National Claims History data, we identified the intermediary that processed each beneficiary’s home health claims. Each intermediary requested the appropriate home health provider to submit the supporting documentation for the 450 beneficiaries sampled from our supply strata. We obtained medical records and lists of billed items, including supply items, from home health providers for 384 of the 450 beneficiaries. Home health providers did not provide requested documentation for the remaining 66 beneficiaries.

Intermediary and carrier nurses reviewed the lists of billed items. Based on the line item descriptions, the nurses identified supply items that were billable to the carriers and assigned them HCPCS codes. Finally, armed with compilations of supply items billed to intermediaries and carriers for the 384 beneficiaries, the nurses identified questionable payments.

We did not reconcile whether the home health provider or the supplier billed appropriately for each questionable payment. Instead, we assumed the carrier payment was the questionable payment. Therefore, we calculated the questionable payments for supplies based on the actual carrier allowed charges.

Confidence Intervals

Sample Size	Questionable Payments	+/-	Lower 95% Confidence Interval	Upper 95% Confidence Interval
500	\$530,232	\$57,200	\$473,032	\$587,432

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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Office of the Administrator
Washington, D.C. 20201

TO: June Gibbs Brown
Inspector General

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FROM: Nancy-Ann Min DeParle *Nancy-Ann DeParle*
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Duplicate Payments for Home Health Equipment and Supplies"

We appreciate the opportunity to comment on the above-referenced report.

The Health Care Financing Administration (HCFA) has been working hard to protect the integrity of Medicare both for today and the future. While we agree that Medicare's vulnerability on this issue is limited, we were nevertheless disturbed by your findings that slightly over \$530,000 of inappropriate payments occurred in 1997 on home health equipment and supplies.

HCFA will continue to work to ensure that providers are paid appropriately while we protect beneficiaries and taxpayers from improper payments caused by both honest errors and unscrupulous activity. Our efforts to date have shown real results. As your annual audits have shown, Medicare has reduced its improper payment rate sharply from 14 percent in Fiscal Year (FY) 1996 to less than 8 percent in FY 1999. We remain committed to improving our systems and achieving further reductions.

In addition to our ongoing work, we would also like to have the opportunity to recoup the funds that were inappropriately claimed in this specific case. Therefore, we request that the OIG share with HCFA the information regarding the specific improper claims identified in the report's survey sample so that HCFA can take the appropriate steps to recoup funds as needed.

Recommendation
HCFA should examine its payment, coding, and editing practices to enable carriers and home health intermediaries to avoid duplicate equipment payment.

We concur with the OIG's recommendation. HCFA will examine, and modify as appropriate, our payment, coding, and editing practices to enable carriers and

home health intermediaries to avoid duplicate equipment payments. We also will consider instituting appropriate billing changes to better protect beneficiaries and taxpayers from improper claims. Changes that will be considered include requiring that all durable medical equipment (DME) claims to be sent to the DME regional carriers. We will also consider whether home health providers should be required to itemize DME by using HCFA Common Procedure Coding System codes when billing the regional home health intermediary.

Technical comment

Page 2, first paragraph: Please modify the last sentence so it reads: Home Health providers file claims under both Part A and Part B.