Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INAPPROPRIATE MEDICARE PAYMENTS FOR PRESSURE REDUCING SUPPORT SURFACES

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EXECUTIVE SUMMARY

OBJECTIVES

1. To assess the appropriateness of Medicare payments for pressure reducing support surfaces.

2. To determine what program safeguards are in place to ensure proper payments for pressure reducing support surfaces.

BACKGROUND

Pressure reducing support surfaces (support surfaces) are used for the care or prevention of pressure ulcers. A pressure ulcer, also known as a bedsore or decubitus ulcer, is an area of skin that breaks down when a person stays in one position for too long without shifting his or her weight. Pressure ulcers commonly occur among the elderly and among individuals with spinal cord injuries.

The Centers for Medicare & Medicaid Services (CMS) categorizes support surfaces into three groups based on the complexity of their features. This report focuses on group 2 support surfaces, which is the largest group. In 2007, Medicare payments for group 2 support surfaces totaled $109 million, which accounted for 80 percent of all support surface payments. Medicare covers support surfaces under its durable medical equipment (DME) benefit.

To assess the appropriateness of Medicare payments for group 2 support surfaces, we used a contractor to conduct a medical record review of a stratified random sample of 363 claims. We also conducted a separate review of the documentation that suppliers are required to keep on file for each claim. Lastly, we conducted structured telephone interviews with CMS contractor staff who process, review, and analyze DME claims.

FINDINGS

Eighty-six percent of the claims for group 2 support surfaces did not meet Medicare coverage criteria. Based on a review of medical record documentation and supplier documentation, we found that 86 percent of group 2 support surface claims for the first half of 2007 did not meet Medicare coverage criteria. This amounted to an estimated $33 million in inappropriate payments during that time. We considered a claim as not meeting Medicare coverage criteria if it either (1) did not

meet Medicare's clinical coverage requirements, or (2) did not meet Medicare's supplier documentation requirements.

Based on an independent medical review, we found that 80 percent of group 2 support surface claims did not meet Medicare's clinical coverage requirements. In addition, 33 percent of claims did not meet supplier documentation requirements. Over three-quarters of the claims that did not meet supplier documentation requirements also did not meet Medicare's clinical coverage requirements.

Specifically, 38 percent of the claims were undocumented, 22 percent were medically unnecessary, 17 percent had insufficient documentation, and 3 percent had other billing errors. For the claims that did not meet supplier documentation requirements, the supplier delivered the support surface before obtaining the physician order, the supplier did not have a physician order, the supplier was missing the proof of delivery, or the physician order was not dated.

CMS contractors had limited program safeguards in place to prevent improper payments for group 2 support surfaces. CMS contractors reported that they relied primarily on two claims processing edits to prevent improper payments for support surfaces. One of the edits checked for the KX modifier, which a supplier uses to indicate that a claim meets Medicare coverage criteria and that adequate documentation exists. In our sample, all but one of the claims included the KX modifier, even though we found that 80 percent of the claims did not meet clinical coverage criteria. In addition, none of the CMS contractors conducted any widespread medical reviews of support surface claims. Moreover, only half of the CMS contractors responsible for supplier education conducted any educational activities in recent years that focused on group 2 support surfaces.

RECOMMENDATIONS

Based on the findings in this report, we recommend that CMS:

Ensure that claims for group 2 support surfaces meet Medicare coverage criteria and are paid appropriately. To address this recommendation, CMS should:

- Conduct additional prepayment and postpayment medical reviews of group 2 support surface claims;
- Educate suppliers and health care providers, such as home health agencies, about Medicare coverage criteria for support

surfaces. Education should inform suppliers and health care providers about the information that needs to be documented in the medical record for initial and continued coverage. Education should also focus on differences in the coverage criteria between group 1 and group 2 support surfaces;

- Review the use of the KX modifier as a program safeguard; and
- Conduct additional statistical analyses to monitor payments for group 2 support surfaces.

Take appropriate action regarding the claims in our sample that were inappropriate. CMS should follow up on the claims that were undocumented, medically unnecessary, insufficiently documented, or had billing errors in which the money was not already refunded to Medicare. CMS should also follow up on claims in which the supplier delivered the support surface before obtaining the physician order, the supplier did not have a physician order, the supplier was missing the proof of delivery, or the physician order was not dated. Finally, CMS should follow up on the suppliers that could not be located. To help CMS address this recommendation, we will forward information about these claims in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all five of our recommendations. CMS stated that it will share our findings on inappropriate claims with its contractors for potential additional prepayment edits and prepayment medical review. It also noted that it will revise review instructions to clarify that the contractors may initiate widespread service-specific prepayment review without first conducting "probe" reviews for problem areas identified by various parties, including the Office of Inspector General. CMS also stated that it will issue a Medicare Learning Network Matters article to remind suppliers and health care providers about Medicare coverage criteria for support surfaces. Further, it mentioned that it is currently reviewing the utility and use of the KX modifier, including its application in DME. It also stated that it plans to share our recommendation about conducting additional statistical analyses with the appropriate contractors for their consideration in ongoing monitoring of these claims. Lastly, CMS indicated that once it reviews the inappropriate claims and better understands the nature of these claims, it will forward them to the appropriate contractors.

We support CMS's efforts to address these issues and encourage it to continue to make progress in these areas.

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The Centers for Medicare & Medicaid Services (CMS) categorizes support surfaces into three groups based on the complexity of their features. This report focuses on group 2 support surfaces, which is the largest group. In 2007, Medicare payments for group 2 support surfaces totaled $109 million, which accounted for 80 percent of all support surface payments.

Medicare covers support surfaces under its durable medical equipment (DME) benefit. CMS reported that Medicare expenditures for DME were $9.2 billion in fiscal year (FY) 2006.[1] A sizable percentage of these expenditures were inappropriate overpayments.[2]

[1] Figure cited is for DME claims for the 12-month period ending September 30, 2006. Available online at https://www.cms.hhs.gov/apps/er_report/preview_er_report_print.asp?from=public&which =long&reportID=6. Accessed on December 5, 2008.

[2] CMS's Comprehensive Error Rate Testing (CERT) contractor calculated Medicare's DME payment error rate to be 7.5 percent in FY 2006. A subsequent Office of Inspector General (OIG) audit to determine the adequacy of the CERT contractor's medical review of DME claims calculated a higher DME error rate in the CERT sample—either 17.3 percent or 28.9 percent, depending on the extent of documentation reviewed. OIG, "Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program," A-01-07-00508, August 2008.

Support Surface Categories

The three support surface groups have varying characteristics and include the following:

- Group 1 support surfaces are generally designed to be placed on top of standard hospital or home mattresses and include pressure pads and mattress overlays (foam, air, water, or gel).
- Group 2 support surfaces, which can be special mattresses used alone or placed directly over a bedframe, include powered air flotation beds, powered pressure reducing air mattresses, and nonpowered advanced pressure reducing mattresses.
- Group 3 support surfaces are complete bed systems, known as air-fluidized beds, which simulate the movement of fluid by circulating filtered air through silicone-coated ceramic beads.

If a physician determines that a support surface is medically necessary, the physician writes a prescription indicating the type of support surface the beneficiary needs. Once a support surface is selected, prescribed, and ordered, a DME supplier delivers the item to the beneficiary and bills Medicare monthly for the rental.

The supplier uses a Healthcare Common Procedure Coding System (HCPCS) code on a Medicare claim to designate the type of equipment it provided to the beneficiary.[3] To bill for group 2 support surfaces, suppliers may use any of the five HCPCS codes listed in Table 1.[4] The most commonly billed HCPCS code was for powered pressure reducing air mattresses (E0277), which represented 93 percent of all group 2 support surface claims in the first half of 2007.

[3] HCPCS is a standardized coding system developed and updated by CMS to ensure uniform identification of and billing for medical products, supplies, and services furnished by physicians and other health care professionals.

[4] Group 2 support surfaces may also be billed under a sixth HCPCS code. We excluded this code (E1399) from our review because suppliers may also use this code to bill for group 2 support surface accessories and other DME items that are not related to support surfaces.

Table 1: Group 2 Support Surface HCPCS Codes		
HCPCS	**Support Surface Name**	**2007 Average Fee Schedule Amount**
E0193	Powered air flotation bed (low air loss therapy)	$886
E0277	Powered pressure reducing air mattress	$693
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	$436
E0372	Powered air overlay for mattress, standard mattress length and width	$529
E0373	Nonpowered advanced pressure reducing mattress	$603

Source: "HCPCS Code Fee Schedule," 2007.

Medicare Coverage for Support Surfaces

Medicare covers group 2 support surfaces under Part B as capped rental DME.[5] Accordingly, Medicare pays suppliers for a specified number of months of continuous use if the equipment remains medically necessary.[6] After the 13th month, the supplier must transfer the title of the group 2 support surface to the beneficiary.[7]

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including support surfaces. Section 1862(a)(1)(A) of the Act states that Medicare will cover only services considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.[8] Further, Section 1833(e) of the Act requires that providers furnish "such information as may be necessary in order to determine the amounts due" to receive Medicare payment.[9]

In addition, four DME Medicare Administrative Contractors (MAC), under contract with CMS, develop policies known as Local Coverage Determinations (LCD). The LCDs specify the clinical circumstances under which an item is considered to be reasonable and necessary. All

[5] 42 CFR § 414.229.

[6] Social Security Act § 1834(a)(7)(A)(i)(I), 42 U.S.C. § 1395m(a)(7)(A)(i)(I); 42 CFR § 414.229(d).

[7] Social Security Act § 1834(a)(7)(A)(ii), 42 U.S.C. § 1395m(a)(7)(A)(ii); 42 CFR § 414.229(2)(ii).

[8] Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A).

[9] Social Security Act § 1833(e), 42 U.S.C. § 1395l(e).

four DME MACs issued four identical LCDs for group 2 support surfaces, making the policy uniform nationally.[10] The LCD includes Medicare coverage criteria for initial use and continued use of group 2 support surfaces. It does not provide specific criteria for the five HCPCS codes. Appendix A includes relevant excerpts from the LCD.

Initial Medicare coverage criteria. The LCD states that Medicare covers a group 2 support surface for initial use if the patient meets any of the three situations described in Table 2. These three situations include a combination of six different clinical criteria. Several of these criteria relate to the stage and progress of the patient's pressure ulcers. Pressure ulcers can range from stage I to stage IV, depending on their size and severity. See page 23 (Appendix A) for a complete explanation of pressure ulcer staging.

The LCD also stipulates that there must be a care plan in the medical record, established by the physician or home care nurse, that includes the following: patient and caregiver education on the prevention and management of pressure ulcers; regular assessment by a nurse, physician, or other licensed practitioner; appropriate turning and positioning; appropriate wound care for the ulcer type; appropriate management of moisture and incontinence; and nutritional assessment and intervention consistent with the overall plan of care.

[10] The four LCDs are entitled "LCD for Pressure Reducing Support Surfaces—Group 2." The four relevant LCD policy numbers are L11564, L5068, L11579, and L27009. We used the version of the LCDs that was effective during our sample timeframe. Since all four LCDs are the same, we refer to them as "the LCD" for purposes of this report.

Table 2: Criteria Used To Determine Initial Coverage for Group 2 Support Surfaces

Situation 1: Patient must meet criteria 1, 2, and 3.

(1) The patient has multiple stage II pressure ulcers located on the trunk or pelvis.

(2) The patient is on a comprehensive ulcer treatment program for at least the past month that included the use of a group 1 support surface.

(3) The ulcers have worsened or remained the same over the past month.

Situation 2: Patient must meet criterion 4.

(4) The patient has large or multiple stage III or IV pressure ulcers on the trunk or pelvis.

Situation 3: Patient must meet criteria 5 and 6.

(5) The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).

(6) The patient has been on a group 2 or 3 support surface immediately before a recent discharge from a hospital or nursing facility (discharge within the past 30 days). Coverage for this situation is generally limited to 60 days from the date of surgery.

Source: "LCD for Pressure Reducing Support Surfaces—Group 2."

Continued Medicare coverage criteria. The LCD states that Medicare covers a group 2 support surface for continued use until the ulcer is healed. If healing does not continue, there must be documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management. The LCD further requires that the support surface provided to the patient must not "bottom out," a situation in which the mattress no longer supports the body.

Medical record documentation requirements. Both the "Medicare Program Integrity Manual" (the Manual) and the LCD require that the patient's medical records contain sufficient documentation of medical necessity.[11] The supplier does not need to have documentation in the patient's

[11] CMS, "Medicare Program Integrity Manual" (PIM), ch.5, § 5.7 (as of Rev. 167; effective 10-01-06). "LCD for Pressure Reducing Support Surfaces—Group 2." PIM provisions cited were in effect during the period of this study.

medical record sent to it routinely; however, the Medicare contractor may request this information from the supplier in selected cases.[12] According to the Manual, "The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criterion for an item has been met."[13] If the contractor does not receive the information when requested, or if the information in the patient's medical record does not adequately support the medical necessity of the item, then the supplier may be liable for the dollar amount involved.[14]

Supplier documentation requirements. The Manual stipulates that for all DME, the supplier must keep on file a number of documents before submitting a claim. These documents include a written physician's order, information from the physician concerning the patient's diagnosis, and proof of delivery.[15] The Manual also states that the supplier may not dispense any pressure reducing pads, overlays, mattresses, or beds until it has obtained a written order that is signed and dated by the treating physician.[16] In addition, the LCD states that the supplier must obtain a signed and dated statement from the treating physician describing which criteria in the LCD the patient meets.[17]

The LCD further notes that the supplier is responsible for using the KX modifier appropriately. The KX modifier indicates that the clinical conditions meet the criteria for coverage of a group 2 support surface and that adequate documentation exists in the medical record reflecting these conditions.[18]

Claims Processing and Program Safeguard Activities

In addition to developing LCDs, the four DME MACs are responsible for processing and paying all DME claims. They implement claims processing edits to prevent improper payments. They also conduct outreach and education to suppliers and, subsequent to our data

[12] PIM, § 5.7.

[13] Ibid., § 5.8.

[14] Ibid., § 5.7.

[15] Ibid., § 5.8.

[16] Ibid., § 5.2.3.1.

[17] "LCD for Pressure Reducing Support Surfaces—Group 2," Documentation Requirements.

[18] If the criteria are not met, the supplier must include additional documentation with the claim to justify coverage.

collection, have become responsible for conducting medical reviews of supplier claims.

CMS also contracts with three DME Program Safeguard Contractors (PSC) that cover four jurisdictions. The PSCs are responsible for conducting benefit integrity activities such as fraud investigations of claims.[19] In addition, at the time of our review, the Statistical Analysis Durable Medical Equipment Contractor (SADMERC) provided support to the DME MACs by identifying billing trends and offering guidance on the proper use of HCPCS codes.[20]

Comprehensive Error Rate Testing Program

CMS established the CERT program to monitor the accuracy of payments made in the Medicare Fee-for-Service (FFS) program. The CERT contractor conducts medical reviews periodically on a sample of paid claims to determine a paid claims error rate. The error rate is the percentage of total dollars that Medicare FFS contractors erroneously paid or denied. For FY 2007, the CERT error rate for support surfaces was 18 percent.[21]

Related Work

In 2009, OIG released a report about an independent contractor's review of DME claims from the FY 2008 CERT program.[22] To provide assurance that the DME error rate was accurate, CMS contracted with Palmetto GBA (Palmetto) to review the CERT contractor's payment determinations. OIG determined that Palmetto's results did not provide assurance that the error rate was accurate. OIG found that Palmetto's determinations differed from those of the CERT contractor because of (1) incorrect medical necessity determinations by the CERT contractor and (2) differences in review standards and methodology. These differences were due to the CERT contractor's use of clinical inference, or clinical review judgment, to make medical necessity determinations

[19] At the time of our review, the DME PSCs were responsible for the medical review function that has been transitioned to the DME MACs as of March 1, 2008. CMS is currently implementing a new contracting strategy regarding Medicare fraud, waste, and abuse across all claim types called Zone Program Integrity Contractors.

[20] The Pricing, Data Analysis and Coding Contractor now conducts the activities that had been performed by the SADMERC prior to August 2008.

[21] CMS, "Mid-Year Improper Medicare FFS Payments," May 16, 2008.

[22] OIG, "Independent Contractor's Review of Durable Medical Equipment Claims From the Fiscal Year 2008 Comprehensive Error Rate Testing Program," A-01-09-00500, May 2009.

based on its review of supplier documents, beneficiary claim histories, and limited medical records.

Based on these findings, OIG recommended that CMS require the CERT contractor to develop a corrective action plan to reduce its incorrect determinations and to perform a complex medical review by obtaining and reviewing all medical records from all relevant providers. In its comments to the draft report, CMS concurred with the recommendations. It also issued a memorandum to its contractors stating that it will clarify its manual to be explicit that clinical review judgment may not override statutory, regulatory, ruling, national coverage decision provisions, or local coverage decision provisions; and that all documentation and policy requirements must be met before clinical review judgments apply.[23]

METHODOLOGY

We based this study on data from three sources: (1) a medical record review of a random sample of group 2 support surface claims; (2) a review of supplier documentation for these claims; and (3) structured interviews with staff at the four DME MACs, the three DME PSCs, and the SADMERC.

Sample Selection

For the medical record review, we selected a stratified random sample of 400 group 2 support surface claims from CMS's National Claims History file. The population from which we sampled consisted of all paid group 2 claims that: (1) had a service date between January 1 and June 30, 2007; and (2) were submitted to CMS by September 30, 2007. The universe consisted of 76,780 claims that represented $44 million in allowed payments.[24] We selected 200 claims for initial coverage for the first stratum and 200 claims for continued coverage for the second stratum. We determined whether the claim was for initial or continued coverage based on a modifier on the claim that indicated whether it was for the initial month of rental or for subsequent months.

[23] CMS, "Clarification of Medical Review Policy," March 30, 2009.

[24] The amount of allowed payments for group 2 support surfaces in the first half of 2007 was less than the amount in the first half of 2006.

Medical Record Review

We based our analysis on 363 of the 400 claims in our sample. We excluded 13 claims from our analysis because the suppliers were currently under investigation by OIG. In addition, we were unable to locate the suppliers for 24 claims. We received documentation for all of the remaining 363 claims, representing a 94-percent response rate.

We used a contractor to collect and review the medical records associated with each sampled claim. The contractor requested from each supplier all medical records related to the patient's wound care including records from physicians, hospitals, home health agencies, skilled nursing facilities, and wound care clinics. The contractor requested this information for the 60 days before the service date on the claim.

Two registered nurses conducted the medical record review, each of whom had at least 10 years of wound-care experience. The reviewers used a standardized data collection instrument to review the medical records and determine whether each sampled claim met Medicare coverage criteria. The standardized instrument was developed in collaboration with the reviewers and tested on a separate sample of claims. The reviewers conducted their medical record review between March and July 2008. Additional details of the medical review are provided in Appendix B.

Based on the data from the medical review, we determined the percentage of claims that did not meet Medicare coverage criteria. We determined the percentage of claims that were in the following categories: undocumented, medically unnecessary, insufficiently documented, and other billing errors. We looked for statistically significant differences in error rates between initial and continued claims. Lastly, we calculated the projected error rates and dollars paid in error for support surface claims in the first half of 2007.

Supplier Documentation

We conducted a separate review of the documentation that the supplier is required to keep on file for each claim. To accomplish this, the contractor requested from the supplier the physician order and proof of delivery for each sampled claim.

We reviewed the documentation for each of the 363 claims to determine the percentage of claims that did not meet Medicare supplier documentation requirements. Specifically, we determined the percentage of claims that did not have a signed and dated physician

order, a proof of delivery, or a physician order before delivery. We looked for statistically significant differences in error rates between initial and continued claims. We did not include in our review an analysis of whether the supplier had on file statements from the physician regarding the patient's diagnosis and which of the six criteria in the LCD the patient met because these documents were reviewed as part of the medical record review.

Structured Interviews and Supporting Documentation

We conducted structured telephone interviews with staff at the four DME MACs, the three DME PSCs, and the SADMERC. We asked staff at the DME MACs about any edits or other program safeguards in place to prevent improper payments for group 2 support surface claims. We asked staff at the DME PSCs about any medical reviews and fraud investigations of these claims. We asked staff at the SADMERC about any guidance to suppliers on the use of HCPCS codes for group 2 support surfaces. As part of these interviews, we requested and reviewed any supporting documentation of program safeguards that were specific to group 2 support surface claims.

Limitations

We did not independently verify the responses from the CMS contractors that we interviewed.

Standards

Our review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency (now Council of the Inspectors General on Integrity and Efficiency).

Eighty-six percent of the claims for group 2 support surfaces did not meet Medicare coverage criteria

Based on a review of medical record documentation and supplier documentation, we found that 86 percent of group 2 support surface claims for the first half of 2007 did not meet Medicare coverage criteria. This amounted to an estimated $33 million in inappropriate payments during that time. We considered a claim as not meeting Medicare coverage criteria if it either (1) did not meet Medicare's clinical coverage requirements, or (2) did not meet Medicare's supplier documentation requirements.

Specifically, we found that 80 percent of group 2 support surface claims did not meet Medicare's clinical coverage requirements. In addition, 33 percent of claims did not meet supplier documentation requirements. Over three-quarters of the claims that did not meet supplier documentation requirements also did not meet Medicare's clinical coverage requirements.

Eighty percent of group 2 support surface claims did not meet clinical coverage requirements

Our medical record review found that 80 percent of group 2 support surface claims for the first half of 2007 did not meet Medicare's clinical coverage requirements. Table 3 describes the different types of errors, the error rates, and the estimated dollars paid in error. Appendix C provides the confidence intervals for the key estimates.

Table 3: Clinical Coverage Errors for Group 2 Support Surface Claims, First Half of 2007

Type of Error	Percentage of Claims	Allowed Amount
Undocumented	38%	$14,413,237
Medically unnecessary	22%	$8,882,785
Insufficient documentation	17%	$7,022,886
Other billing errors	3%	$745,497*
Total errors	**80%**	**$31,064,405**

Source: OIG analysis of medical review results, 2008.

* Note: Relative precision equals 90 percent.

Thirty-eight percent of all group 2 support surface claims in the first half of 2007 were undocumented. This represented $14.4 million in allowed payments. For these claims, the suppliers either did not submit any medical records to document the claims or they provided records that did not correspond to the time period of our review. Claims that lack documentation to show that the care was reasonable and necessary do not meet Medicare coverage criteria.

Continued claims were more likely to be undocumented than initial claims. Forty-two percent of continued claims were undocumented, compared to 15 percent of initial claims. This difference was statistically significant at the 95-percent confidence level. See Appendix D for statistical correlations.

Twenty-two percent of all group 2 support surface claims in the first half of 2007 were not medically necessary. This represented nearly $8.9 million in allowed payments. For about half of these claims, there was no documentation of any pressure ulcers or there was documentation that showed that the wounds had already healed before the service date on the claim. In one case, a physician clearly prescribed the support surface for back pain.

For one-quarter of these claims, the patient had a stage I or II pressure ulcer, rather than multiple stage II pressure ulcers, as required. In other instances, the pressure ulcers were not located on the trunk or pelvis, as required (e.g., the wound was on the foot) or there was a small stage III or IV pressure ulcer on the trunk or pelvis, when one large or multiple stage III or IV pressure ulcers are required to meet the coverage criteria.

Many of the claims that were not medically necessary met the less-restrictive criteria for group 1 support surfaces. In these cases, the supplier provided a group 2 support surface when the beneficiary only qualified for a more basic and lower-cost group 1 support surface. These claims may be instances in which the supplier provided an upgrade but did not bill for it appropriately.[25] In total, these claims amounted to

[25] For information on the correct billing procedures for an upgrade, see CMS, "Medicare Claims Processing Manual," ch.30, §§ 50.7.4–50.7.5 (as of Rev. 1; effective October 1, 2003).

15 percent of all group 2 support surface claims in the first half of 2007.[26]

An additional 17 percent of all group 2 support surface claims in the first half of 2007 were insufficiently documented. This represented $7.0 million in allowed payments. For half of these claims, there was no documentation of the characteristics of the wound such as the stage of the pressure ulcer or the measurements of the wound. For another one-fifth of the claims, there was no documentation of the healing progress of the pressure ulcer. For several other claims in this category, the reviewers noted that the supplier may not have submitted the medical records from all appropriate providers to substantiate the claim. Medicare may hold suppliers liable if the information in the patient's medical record, as submitted by the supplier, does not adequately support the medical necessity of the support surface.[27]

Initial claims were more likely to be insufficiently documented than continued claims. Twenty-eight percent of initial claims were insufficiently documented, compared to 16 percent of continued claims. This difference was statistically significant at the 95-percent confidence level.

Another 3 percent of the claims in the first half of 2007 were for other billing errors. This represented $745,000 in allowed payments. For these claims, the suppliers stated that they had used the wrong HCPCS code, incorrectly billed for a patient who was deceased or for patients who were in skilled nursing homes or hospitals, or had made other types of errors. In all of these cases, the suppliers had either already refunded the money to Medicare or said that they were planning to do so. In a few cases, it was apparent that the suppliers had contacted Medicare to refund the money only after we had requested the medical records for that claim. In total, we received documentation of a refund for almost half of the claims in this category.

[26] We were unable to calculate the total dollars allowed for these claims. In these instances, the medical reviewers were unable to determine which group 1 support surface was appropriate and therefore we could not determine the corresponding payment amount.

[27] PIM, § 5.7.

Thirty-three percent of group 2 support surface claims did not meet supplier documentation requirements

Based on a review of supplier documentation, we found that 33 percent of all group 2 support surface claims for the first half of 2007 did not meet supplier documentation requirements.[28] Medicare requires the supplier to keep on file a number of documents, including the signed and dated physician order and proof of delivery for each claim.[29] Medicare also requires that the supplier have the physician order before delivering the support surface.[30]

As shown in Table 4, for 16 percent of the claims, the supplier delivered the support surface to the beneficiary before obtaining the physician order. For 13 percent of the claims, the supplier did not have a physician order. For 8 percent of the claims, the supplier did not have proof that the support surface was delivered to the beneficiary. For 1 percent of the claims, the physician order was not dated.

Continued claims were less likely to meet the supplier documentation requirements than initial claims. Thirty-four percent of continued claims did not meet these requirements, compared to 23 percent of initial claims. This difference was statistically significant at the 95-percent confidence level.

Table 4: Supplier Documentation Errors for Group 2 Support Surface Claims, First Half of 2007

Type of Error	Percentage of Claims
Delivery before physician order	16%
Physician order missing	13%
Proof of delivery missing	8%
Physician order not dated	1%
Total	**33%***

*Note: The percentages do not add up to 33 percent because some claims had more than one type of error.

Source: OIG analysis of supplier documentation, 2008.

[28] The supplier documentation analysis is based on 356 claims.

[29] PIM, § 5.8.

[30] Ibid.

CMS contractors had limited program safeguards in place to prevent improper payments for group 2 support surfaces

The DME MACs and PSCs, as well as the SADMERC, had limited safeguards in place to prevent improper payments for group 2 support surface claims.

Staff at the four DME MACs reported that they relied primarily on two claims processing edits to prevent improper payments for support surfaces. The DME MACs each had an edit in place that checked whether the diagnosis code supported the medical necessity of claims.[31] Also, they each had an edit in place that checked for the KX modifier on a claim.[32] Staff at the DME MACs explained that claims that did not have the KX modifier were flagged for possible review. In our sample, all but one of the claims included the KX modifier, even though we found that 80 percent of the claims did not meet clinical coverage criteria.

To varying degrees, staff at the DME MACs also noted that they had other, more general edits in place. These edits included checks to ensure that the beneficiary was covered by Medicare, that there were no duplicate claim submissions, that the beneficiary did not have similar DME, and that payments did not exceed the allowed capped rental payment.

In addition, none of the three PSCs conducted any widespread medical reviews of support surface claims. Staff at two of the PSCs, which covered three regions, reported conducting limited medical reviews for only a small number of suppliers. One of these PSCs reviewed claims for seven suppliers in 2005. The other PSC reviewed claims for five suppliers in 2006.

Moreover, only two of the four DME MACs conducted supplier education activities in recent years that focused on group 2 support surfaces. In March 2007, one DME MAC conducted an "open house" and reviewed group 2 support surface documentation requirements, the criteria for medical necessity, and the use of the KX modifier. Staff at another DME MAC reported that, in April 2005, the previous contractor for the region provided information to suppliers on group 2 support surfaces in

[31] The LCD specifies certain diagnosis codes that support medical necessity.

[32] As noted earlier, the supplier uses the KX modifier to indicate that a claim meets Medicare coverage criteria and that adequate documentation exists in the medical record.

its bulletin. This same DME MAC also maintains information on its Web site about the coverage criteria for group 2 support surfaces.

Staff at the SADMERC further reported that they had not conducted any recent analyses of group 2 support surface claims. They did note, however, that an analysis they conducted of Florida suppliers whose Medicare billing privileges were revoked showed that support surfaces made up the top DME group billed by these suppliers.

RECOMMENDATIONS

Based on a review of medical record documentation and supplier documentation, we found that 86 percent of group 2 support surface claims for the first half of 2007 did not meet Medicare coverage criteria. This resulted in an estimated $33 million in inappropriate payments. We considered a claim as not meeting Medicare coverage criteria if it either (1) did not meet Medicare's clinical coverage requirements, or (2) did not meet Medicare's supplier documentation requirements.

Specifically, we found that 80 percent of group 2 support surface claims did not meet Medicare's clinical coverage requirements. In addition, 33 percent of claims did not meet supplier documentation requirements. Over three-quarters of the claims that did not meet supplier documentation requirements also did not meet Medicare's clinical coverage requirements. Lastly, we found that CMS contractors had limited program safeguards in place to prevent improper payments for group 2 support surfaces.

Taken together, the results show that CMS's current program safeguard activities are not sufficient and that additional steps are needed to reduce the high error rate for group 2 support surface claims.

Based on the findings in this report, we recommend that CMS:

Ensure that claims for group 2 support surfaces meet Medicare coverage criteria and are paid appropriately

To address this recommendation, CMS should:

- Conduct additional prepayment and postpayment medical reviews of group 2 support surface claims;
- Educate suppliers and health care providers such as home health agencies about Medicare coverage criteria for support surfaces. Education should inform suppliers and health care providers about the information that needs to be documented in the medical record for initial and continued coverage and point out that claims that do not meet the coverage criteria should not be submitted. Education should also focus on differences in the coverage criteria between group 1 and group 2 support surfaces;
- Review the use of the KX modifier as a program safeguard; and
- Conduct additional statistical analyses to monitor payments for group 2 support surfaces.

Take appropriate action regarding the claims in our sample that were inappropriate

CMS should follow up on the claims that were undocumented, medically unnecessary, insufficiently documented, and had billing errors in which the money was not already refunded to Medicare. CMS should also follow up on the claims in which the supplier delivered the support surface before obtaining the physician order, the supplier did not have a physician order, the supplier was missing the proof of delivery, or the physician order was not dated. Finally, CMS should follow up on the suppliers that could not be located. To help CMS address this recommendation, we will forward information about these claims in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all five of our recommendations. In response to our first recommendation, CMS stated that it will share our findings on inappropriate claims with the DME MACs for potential additional prepayment edits and prepayment medical review. CMS also noted that it will forward the list of questionable claims to the Recovery Audit Contractors (RAC) and DME MACs. The RACs review Medicare claims on a postpayment basis and are tasked with identifying inappropriate payments. CMS further commented that it will revise the MAC review instructions to clarify that all MACs may initiate widespread service-specific prepayment review without first conducting "probe" reviews for problem areas identified by various parties, including OIG.

In response to our second recommendation, CMS stated that it will issue a Medicare Learning Network Matters article to remind suppliers and health care providers, such as home health agencies, about Medicare coverage criteria for support surfaces.

In response to our third recommendation, CMS stated that it is currently reviewing the utility and use of the KX modifier, including its application in DME. This review includes an analysis of claims submitted with the modifier, discussions with contractors, and outreach to other CMS components with policy responsibilities related to the KX modifier.

In response to our fourth recommendation, CMS stated that it will share our recommendation about conducting additional statistical analyses with the appropriate contractors for their consideration in

ongoing monitoring of these claims. CMS further noted that an internal data analysis team recently completed an analysis on support surfaces and that the team will continue to monitor data periodically to look for suspicious trends.

In response to our fifth recommendation, CMS noted that once it reviews the inappropriate claims and better understands the nature of these claims, it will forward them to the appropriate contractors.

We support CMS's efforts to address these issues and encourage it to continue to make progress in these areas. The full text of CMS's comments is provided in Appendix E.

APPENDIX ~ A

Local Coverage Determination for Pressure Reducing Support Surfaces—Group 2

The text quoted below contains the coverage and payment rules and the supplier documentation requirements that were effective between March 1, 2006, and June 30, 2007, for group 2 support surfaces as they appeared in the Local Coverage Determination (LCD) issued by all four Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC). We have included only sections of the LCD that are relevant to our study.

The full text of the LCDs from all DME MACs can be found at http://www.cms.hhs.gov/mcd/search.asp. The four relevant LCD policy numbers are L11564, L5068, L11579, and L27009.

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

A group 2 support surface is covered if the patient meets:

a) Criterion 1 and 2 and 3, or
b) Criterion 4, or
c) Criterion 5 and 6.

1) Multiple stage II pressure ulcers located on the trunk or pelvis [International Classification of Diseases (ICD), 9th Revision] (ICD-9 707.02–707.05).

2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.

3) The ulcers have worsened or remained the same over the past month.

4) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02–707.05).

5) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02–707.05).

6) The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive ulcer treatment described in #2 above should generally include:

i) Education of the patient and caregiver on the prevention and/or management of pressure ulcers.

ii) Regular assessment by a nurse, physician, or other licensed health care practitioner (usually at least weekly for a patient with a stage III or IV ulcer).

iii) Appropriate turning and positioning.

iv) Appropriate wound care (for a stage II, III, or IV ulcer).

v) Appropriate management of moisture/incontinence.

vi) Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements. The support surface provided for the patient should be one in which the patient does not "bottom out" (see Appendices section).

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case. A group 2 support surface billed without a KX modifier (see Documentation section) will usually be denied as not medically necessary.

Continued use of a group 2 support surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management.

Appropriate use of the KX modifier (see Documentation section) is the responsibility of the supplier billing the

[Durable Medical Equipment Regional Carrier] DMERC.[33] The supplier should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the KX modifier still reflects the clinical conditions which meet the criteria for coverage of a group 2 support surface, and that adequate documentation exists in the medical record reflecting these conditions. Such documentation should not be submitted with a claim but should be available for review if requested by the DMERC.

Coding Information

[Current Procedural Terminology] CPT / [Healthcare Common Procedure Coding System] HCPCS Codes

The appearance of a code in this section does not necessarily indicate coverage.

E0193 Powered Air Flotation Bed (Low Air Loss Therapy)

E0277 Powered Pressure Reducing Air Mattress

E0371 Nonpowered Advanced Pressure Reducing Overlay for Mattress, Standard Mattress Length and Width

E0372 Powered Air Overlay for Mattress, Standard Mattress Length and Width

E0373 Nonpowered Advanced Pressure Reducing Mattress

E1399 Durable Medical Equipment, Miscellaneous

HCPCS Modifier

KX - Specific required documentation on file.

ICD-9 Codes that Support Medical Necessity

707.02–707.05
Decubitus Ulcer, Upper Back – Decubitus Ulcer, Buttock

[33] DMERCs have subsequently been replaced by DME MACs.

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be available to the DMERC upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request.

The supplier must obtain information concerning which, if any, of criteria 1–6 listed in the Coverage and Payment Rules section of this policy the patient meets in a signed and dated statement from the treating physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to obtain this information may not be completed by the supplier or anyone in a financial relationship with the supplier. This statement must be supported by information in the patient's medical record which would be available to the DMERC on request. Do not send this form to the DMERC unless specifically requested.

Suppliers must add a KX modifier to a code only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met.

When code E1399 is billed, the claim must include a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical necessity for the item.

Refer to the Supplier Manual for more information on documentation requirements.

Staging of Pressure Ulcers

The staging of pressure ulcers used in this policy is as follows:

Stage I - Observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II - Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III - Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV - Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Bottoming out is the finding that an outstretched hand can readily palpate the bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

APPENDIX ~ B

Additional Details of the Medical Review

Data Collection Instrument

The data collection instrument that the reviewers used to review the medical records was computer-based and included automated skip patterns and quality control checks. The reviewers entered data directly into the system. The instrument included questions based on the criteria in the Local Coverage Determination. For example, it asked about the characteristics of the wound for which the support surface was prescribed and included specific questions depending on the wound type and whether the claim was for initial or continued coverage.

Test Review

To test the data collection instrument, the reviewers conducted a preliminary medical review of 15 claims that we randomly selected from the universe of all claims in the first half of 2007. This sample was separate from the sample of 400 claims that were used for the main review, and all claims were available for selection in both samples. None of the claims was in both samples. Each reviewer reviewed the medical records for 10 claims; both reviewers reviewed five of the same claims. We discussed the results with the reviewers to ensure that they were making consistent determinations about whether the claims met Medicare coverage criteria.

Confidence Intervals for Selected Estimates

Confidence intervals for percentages were made using the logic transformation.

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Percentage of all group 2 support surface claims that did not meet Medicare coverage criteria	**363**	**85.8%**	**80.9%–89.6%**

Source: Office of Inspector General (OIG) analysis of medical review results, 2008.

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Percentage of all group 2 support surface claims that did not meet clinical coverage requirements	**363**	**80.3%**	**74.8%–84.8%**
Percentage of undocumented claims	363	38.2%	32.1%–44.8%
Percentage of medically unnecessary claims	363	22.2%	17.3%–28.1%
Percentage of insufficiently documented claims	363	17.2%	13.0%–22.5%
Percentage of claims that had other types of billing errors	363	2.6%	1.1%–5.8%

Source: OIG analysis of medical review results, 2008.

Confidence Intervals for Selected Estimates (continued)

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Percentage of claims that did not meet Medicare supplier documentation requirements	**363**	**32.8%**	**27.0%–39.2%**
Percentage of claims that were delivered before the physician order	363	16.3%	12.0%–21.8%
Percentage of claims missing the physician order	363	13.0%	9.1%–18.2%
Percentage of claims missing proof of delivery	363	7.6%	4.8%–11.9%
Percentage of claims missing the date on the physician order	363	1.0%	0.2%–3.9%

Source: OIG analysis of supplier documentation, 2008.

Confidence Intervals for Selected Estimates (continued)

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Amount allowed for all group 2 support surface claims that did not meet Medicare coverage criteria	**363**	**$33,486,732**	**$31,151,634–$35,821,830**

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Amount allowed for all group 2 support surface claims that did not meet clinical coverage requirements	**363**	**$31,064,405**	**$28,623,437–$33,505,373**
Amount allowed for undocumented claims	363	$14,413,237	$11,905,511–$16,920,963
Amount allowed for medically unnecessary claims	363	$8,882,785	$6,696,002–$11,069,568
Amount allowed for insufficiently documented claims	363	$7,022,886	$5,097,751–$8,948,022
Amount allowed for claims that had other types of billing errors	363	$745,497	$74,491–$1,416,503

Source: OIG analysis of medical review results, 2008.

Weighted Chi-Square Test for Initial and Continued Claims

Weighted Chi-Square Test for Initial and Continued Claims			
	Claim Type	**Undocumented**	**P-Value**
Difference in percentage of claims that were undocumented, by type of claim	Initial claim	15.1%	< 0.0001
	Continued claim	41.6%	
	Claim Type	**Insufficiently documented**	**P-Value**
Difference in percentage of claims that were insufficiently documented, by type of claim	Initial claim	27.6%	0.0057
	Continued claim	15.7%	
	Claim Type	**Did not meet supplier documentation requirements**	**P-Value**
Difference in percentage of claims that did not meet supplier documentation requirements, by type of claim	Initial claim	22.7%	0.0142
	Continued claim	34.3%	

Source: Office of Inspector General analysis of medical review results and supplier documentation, 2008.

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 0 2 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Inappropriate Medicare Payments for Pressure Reducing Support Surfaces" OEI-02-07-00420

Thank you for the opportunity to review and comment on the above-referenced OIG draft report.

Medicare Part B covers pressure reducing support services as durable medical equipment (DME). Pressure reducing support surfaces are categorized into three groups based on the complexity of their features. In 2007, Medicare spent $109 million on group 2 support surfaces, accounting for 80 percent of all support surface payments. The OIG examined a sample of claims from the first half of 2007 and found that 86 percent of group 2 support surface claims did not meet Medicare coverage criteria. Based on their review, a claim did not meet Medicare coverage criteria if it did not either 1) meet clinical coverage requirements or 2) meet supplier documentation requirements.

The OIG estimated the inappropriate group 2 support surface claims amounted to $33 million in inappropriate payments. The OIG also expressed concern that the Centers for Medicare & Medicaid Services (CMS) contractors had limited program safeguards in place to prevent improper payments for group 2 support surfaces.

The OIG found 38 percent of their sample of group 2 support surface claims to be undocumented and 17 percent of group 2 support surfaces to be insufficiently documented. In addition, 22 percent of group 2 support surface claims were found to be not medically necessary. The OIG found that, for many of the medically unnecessary claims, the beneficiary qualified for a more basic and lower-cost group 1 support surface rather than the group 2 support surface.

The OIG made the following recommendations:

OIG Recommendation
Ensure that claims for group 2 support surfaces meet Medicare coverage criteria and are paid appropriately. CMS should:

Conduct additional prepayment and post-payment medical reviews of group 2 support surface claims.

CMS Response
The CMS concurs with the recommendation and will share the OIG findings on inappropriate group 2 support surface claims with the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for potential additional prepay edits and prepay medical review. CMS will inform DME MACs of this issue so that they may consider it when prioritizing their medical review strategies as part of the CMS effort to protect the Medicare Trust Funds.

The CMS will also take appropriate action to forward the listing of questionable claims to the Recovery Audit Contractors (RACs) and DME MACs. The RACs review Medicare claims on a post payment basis and are tasked with identifying inappropriate payments. While CMS does not mandate areas for RAC review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

The CMS will also revise the MAC review instructions to clarify that all MACs can initiate widespread service-specific prepay review without first conducting "probe" reviews for problem areas identified by CMS, Comprehensive Error Rate Testing (CERT), RACs, GAO and/or OIG. We expect to release this new instruction during fiscal year 2009.

OIG Recommendation
Educate suppliers and health care providers, such as home health agencies, about Medicare coverage criteria for support surfaces. Education should inform suppliers and health care providers about the information that needs to be documented in the medical record for initial and continued coverage. Education should also focus on differences in the coverage criteria between group 1 and group 2 support surfaces.

CMS Response
The CMS concurs and will issue an MLN Matters article to remind suppliers and health care providers, such as home health agencies, about Medicare coverage criteria for support surfaces. It will specifically a) address the information that needs to be documented, b) remind suppliers not to submit claims if coverage criteria are not met, and c) highlight the differences in coverage criteria for group 1 and group 2 support surfaces. CMS expects to release this article in the summer of 2009.

OIG Recommendation
Review the use of the KX modifier as a program safeguard.

CMS Response
The CMS concurs with the recommendation and is currently reviewing the utility and use of the KX modifier including its application in DME. This review includes an analysis of claims submitted with the modifier, discussions with contractors, and outreach to other CMS components with policy responsibilities related to the KX modifier.

OIG Recommendation
Conduct additional statistical analyses to monitor payments for group 2 support surfaces.

CMS Response
The CMS concurs and will share this recommendation with appropriate contractors including the Price, Data Analysis and Coding contractor, for their consideration in ongoing monitoring of these claims. It should be noted that an internal data analysis team recently completed an analysis on support surface devices. The team will continue to monitor data periodically to look for suspicious trends, and will conduct analyses on any future referrals regarding these types of devices.

OIG Recommendation
Take appropriate action regarding the claims in our sample that were inappropriate. CMS should follow up on the claims that were undocumented, medically unnecessary, insufficiently documented, and that had billing errors where the money was not already refunded to Medicare. CMS should also follow up on the claims where the supplier delivered the support surface before obtaining the physician order, the supplier did not have a physician order, the supplier was missing the proof of delivery, or the physician order was not dated. Finally, CMS should follow up on the suppliers that could not be located. To help CMS address this recommendation, we will forward information about these claims in a separate memorandum.

CMS Response
The CMS concurs that action should be taken regarding inappropriate claims. CMS cannot commit to specific actions at this time as we do not know how resource intensive the appropriate actions will be. Once CMS has reviewed these claims and better understands the nature of the claims, CMS will forward them to the appropriate contractors.

The CMS requests the OIG to furnish the necessary data (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, and any other relevant materials) so that CMS can initiate actions on each inappropriate claim. In addition, Medicare contractor specific data should be written to separate CD-ROMs or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

Finally, CMS will review the information provided by the OIG and will ensure that the suppliers indentified by OIG continue to meet the supplier standards found in Federal regulations at 42 CFR 424.57(c).

The CMS thanks the OIG for its efforts on this report and for highlighting this potential vulnerability in the Medicare program. CMS is committed to continually reviewing and refining our processes to improve the Medicare program, and we will take the findings of this report under consideration as we continue to strengthen our oversight efforts to further reduce improper payments in the Medicare program. We look forward to continuing to work with the OIG to identify and prevent fraud, waste, and abuse in the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Judy Kellis served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the New York regional office who contributed to the report include Christine Moundas and David Rudich; central office staff who contributed include Robert Gibbons and Scott Manley.