Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENT FOR DURABLE MEDICAL EQUIPMENT BILLED DURING SKILLED NURSING FACILITY STAYS

JUNE GIBBS BROWN
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

To determine if incorrect Medicare payments are being made for durable medical equipment services billed to Medicare Part B during a skilled nursing facility stay.

BACKGROUND

Federal law states that durable medical equipment (DME) may only be billed to Part B of the Medicare program if the equipment is provided in the beneficiary's residence. However, the law specifies that a skilled nursing facility cannot be considered a residence. For this reason, equipment billed to Part B during a beneficiary stay in such a facility is incorrectly paid.

Four regional carriers, called Durable Medical Equipment Regional Carriers, now process claims for durable medical equipment and other items covered under Part B of Medicare. Establishing these carriers provides an opportunity to develop guidelines that address equipment abuses or program weaknesses. Examining equipment billed during a skilled nursing facility stay, at this time, provides an opportunity to develop a baseline for future comparison of these carriers' effectiveness.

For this evaluation, data were obtained from a one-percent sample from the Common Working File database. All part B durable medical equipment services, for all beneficiaries identified as having a skilled nursing facility stay during 1991, were included in the sample. An analysis of information on the 1022 items of equipment contained in the sample, and obtained from the carrier, was completed. Similar information was obtained from the 1992 data base, although the major focus of this report is 1991.

FINDINGS

Approximately $8.9 million in 1991 and $10.8 million in 1992 was incorrectly allowed for durable medical equipment billed during skilled stays.

The inability of the suppliers and carriers to accurately determine the beneficiary's location during a skilled stay, leads to incorrectly paid equipment claims.

- *Ninety-nine percent of durable medical equipment bills, submitted by suppliers for patients in skilled nursing facilities, represent the location as "home" or "other."*

- *There is some evidence that differences exist in screening activities used by "high charge" and other carriers to detect incorrect DME billing.*

Most incorrect equipment billings during a skilled stay represent items prescribed for use prior to, or after, a skilled stay. A review of certificates of medical necessity was undertaken. This review indicated 77 percent of the items billed represented continued billings for previously prescribed items or new prescriptions for use after discharge.

Approximately half of the patients in our sample were not discharged to their homes, meaning incorrect payments for equipment might continue. Incorrect billing for equipment may continue for some time after the skilled stay. This may occur due to the patient's receiving care in a non-residential setting after discharge.

RECOMMENDATIONS

We recommend that HCFA take action in the following areas to minimize the opportunity for incorrect Durable Medical Equipment payments.

Improve the place of service coding system. The HCFA could:

- Utilize data from the Statistical Analysis DME regional carrier to identify and review suppliers who consistently use the "other" place of service category, and take appropriate actions based on the reviews.
- Disseminate materials which indicate the limited circumstances under which "other" may be appropriately used to bill DME.
- Educate the four new Durable Medical Equipment Regional Carriers (DMERCS) on the accurate use of place of service codes.
- Require the new carriers to provide on-going education to the suppliers on the accurate use of place of service codes.
- Suggest that the new carriers develop an item for inclusion in their database, that is transmitted to the Common Working File, to provide a continuing history of the patient's location.

Improve the supplier knowledge of beneficiary location. The HCFA could:

- Ensure that the four new carriers instruct suppliers of their responsibility for determining the beneficiary location, before billing Part B equipment.
- Ensure that the DMERCs undertake sample reviews of suppliers claims and exchange their findings with the other DMERCs, so that all can take appropriate action on the supplier's claims.

Review the Durable Medical Equipment Regional Carriers processes. The HCFA could:

- Assess the effectiveness of the new Common Working File edit of Part B equipment and skilled nursing facility charges, and evaluate whether additional edits should be developed to review all skilled stay bills, upon submission, for overlap with durable medical equipment billing.
- Encourage the DMERCs to examine this problem. The OIG, in collaboration with HCFA, may also review this area in the future to examine the impact of implementing the new DMERC processes.

AGENCY COMMENTS

We solicited and received comments from the Health Care Financing Administration (HCFA) on our draft report.

The HCFA concurred with the intent of our three recommendations. In addition, they suggested alternative steps that could also be taken to achieve the intent of our recommendations. We have incorporated the suggestions proposed by HCFA in the listing of options presented in our recommendations.

See Appendix B for the full text of the HCFA comments.

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INTRODUCTION

PURPOSE

To determine if incorrect Medicare payments are being made for durable medical equipment (DME) services billed to Medicare Part B during a skilled nursing facility stay.

BACKGROUND

Federal law states that DME may only be billed to Part B[1] of the Medicare program if the equipment is provided in the beneficiary's residence. However, the law specifies that a Skilled Nursing Facility cannot be considered a residence.[2] For this reason, DME billed to Part B during a beneficiary stay in a SNF is incorrectly paid.

While DME *billed during* a nursing home stay is not payable, carrier rules may allow some DME to be *paid during* a portion of an individual's SNF stay. First, DME used in a beneficiary's residence for a portion of a month, prior to a SNF stay, may be billed and paid; however, the DME may not be re-billed during a Part A SNF stay.[3] Secondly, an item of DME may be billed on the day of discharge from a SNF to a "residence."

Four regional carriers now process claims for DME, prosthetics, orthotics, and certain other items covered under Part B of Medicare. The establishment of DME carriers provides an opportunity to develop guidelines to address DME abuses or program weaknesses.[4] An examination of DME billed during a SNF stay, at this time, provides an opportunity to develop a baseline for future comparison of Durable Medical Equipment Regional Carriers' (DMERCs) effectiveness. Corrective systems are also identified to limit vulnerabilities found in this inspection.

SCOPE

This inspection is the first of a series examining payment for services in nursing homes. Subsequent reports will address other topics and include nursing home services provided under both the Medicare and Medicaid program.

METHODOLOGY

Data for this inspection were obtained from a one-percent sample from the Common Working File database (See Table 1). All sample beneficiaries identified as having a Part A SNF stay during 1991 were included in the sample. All Part B DME services commencing from the first through the last covered day of the SNF stay, which represented 1022 items, were included for analysis. Projections can be made to the

TABLE 1

Part B DME Allowed During A SNF Stay From The 1991 One Percent Common Working File Sample				
Category of DME	HCPC Codes In Category For 1991	Items Of DME From 1991 CWF	Total 1% Charges	100% Projected Charges
Wheel Chairs	23	265	$16,046	$1,604,600
Wheel Chair Accessories	8	20	$929	$92,900
Rollabout Chair	1	13	$709	$70,900
Hospital Beds	10	154	$18,446	$1,844,600
Bed Side Rails	1	2	$21	$2,100
Walkers	6	148	$9,816	$981,600
Walker Attachments	2	15	$563	$56,300
Canes	2	9	$231	$23,100
Crutches	2	2	$77	$7,700
Commode Chairs/Pans	5	83	$5,714	$571,400
Oxygen Concentrators	9	82	$21,809	$2,180,900
Portable Gas/Oxygen Systems	2	39	$1,861	$186,100
Nebulizers and IPPB Machines	4	46	$2,351	$235,100
Oxygen Contents	1	1	$215	$21,500
Pressure Pads/Mattresses	9	48	$2,841	$284,100
Heating Pads	1	1	$69	$6,900
Traction and Bar Devices	5	47	$2,260	$226,000
Patient Lifts	2	14	$1,117	$111,700
Suction Pump/Home	1	7	$550	$55,000
Continuous Airway Pressure Device	1	2	$211	$21,100
Neuromuscular Stimulator	1	2	$191	$19,100
IV Poles	1	11	$263	$26,300
Ambulatory Infusion Pump	1	2	$332	$33,200
Home Blood Glucose Monitor	1	3	$438	$43,800
Repair, Non-routine Service, DME Miscellaneous	2	6	$1,607	$160,700
TOTAL	**101**	**1022**	**$88,667**	**$8,866,700**

universe of Medicare beneficiaries, since all DME billed during a SNF stay were included in the sampling frame. Similar information was obtained from the 1992 Common Working File, although the major focus of this report is 1991.[5]

The information obtained from the database included relevant patient identifying information, coded place of service, carrier identification, nursing home identification, the location by State, and the patient discharge disposition at the end of the SNF stay. Part B claims information was also collected.

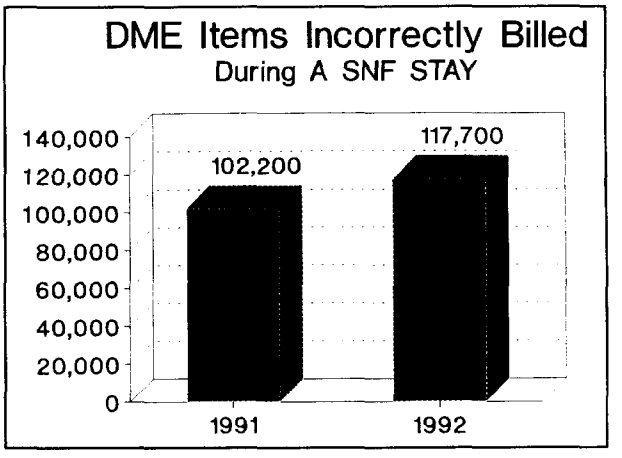
Information concerning Part B claims processing for DME claims, as well as measures taken to avoid incorrect payment of DME, was also obtained from the carriers. A copy of the claim, certificate of medical necessity, and payment information for each piece of billed DME contained in the 1991 database were requested from the carriers. Of the 1022 items requested, information was returned for 964 items. However, only 637 items had useable information on certificates of medical necessity and 712 on payment disposition.

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

FINDINGS

Approximately $8.9 Million In 1991 And $10.8 Million In 1992 Was Incorrectly Allowed For DME Billed During SNF Stays.

Total incorrect payments for DME billed during a SNF stay in 1991 were $88,667. Projected to the entire SNF population, these figures represent $8.867 million in incorrect payments and 102,200 DME items incorrectly billed in 1991. In 1992 the projected amount of DME incorrectly paid during a SNF stay represented 117,700 items at a cost of $10.790 million. This represents a 15 percent increase from 1991 to 1992 in the number of DME items incorrectly billed and allowed during a SNF stay.



Twenty-three percent of the incorrectly allowed DME payments were associated with co-insurance and deductibles, representing an unnecessary burden for beneficiaries.

We reviewed the payment history for 712 of the 1022 claims from 1991, to examine the Medicare and beneficiary financial responsibility for the incorrectly allowed DME. Based on this review, 23 percent, or $2.04 million of the incorrectly allowed DME charges, represented deductibles and co-insurance paid by the beneficiary, other insurance programs, or the State (in the case of some Medicaid recipients) in 1991.[6] This represents inappropriate deductible or co-insurance payments made by each beneficiary for equipment billed during their SNF stay.

Carriers who processed claims for the larger industrial States allowed greater incorrect payments for DME.

The carriers with the greatest amounts of incorrectly allowed DME billed during a SNF stay, were those that processed claims for the larger industrial States, as noted in Table 2. These items of DME represent over half of all incorrectly allowed DME charges and items. This simple finding may indicate that the greater volume of incorrectly billed items increases the effort required to determine if each item of DME is billed correctly. There are implications from this finding for the newly formed DMERC's, since each carrier will be responsible for a greater volume of claims, covering a larger geographical area. One implication for the four DMERC's is the need for some ongoing system to compare DME billing with SNF billing during a specified time frame, as well as a system of tracking beneficiaries admitted to a SNF, to reduce incorrect billings and payments.

TABLE 2

Ten Carriers Representing The Largest Charges And Number Of DME Items Billed During A 1991 SNF Stay			
Carrier	Jurisdiction	Total Charges*	Items of DME*
Health Care Service Corp-Med Part B	Illinois	$7427	75
Pennsylvania Blue Shield	Pennsylvania, Delaware, New Jersey, D.C. Virginia, Maryland	$6990	72
California Physicians Service	California	$6900	84
Transamerican Medicare	California	$5433	71
Nationwide Mutual Insurance Company - Medicare	Ohio & West Virginia	$4994	51
Blue Cross Blue Shield of Texas	Texas	$4292	43
Empire Blue Cross and Blue Shield	New York	$4136	41
Medicare Part B -Florida BCBS	Florida	$4012	50
Blue Cross Blue Shield of	Michigan	$3980	53
CIGNA Medicare Admin.	Tennessee & North Carolina	$3025	42

* These figures represent data from the 1% Common Working File

The Inability Of The Suppliers And Carriers To Accurately Determine The Beneficiary's Location During A SNF Stay Leads to Incorrectly Paid DME Claims.

Ninety-nine percent of DME bills, submitted by suppliers for patients in Part A SNF stays, represent the location as "home" or "other."

Incorrect payments for DME were almost evenly divided between place of service codes representing "home" (50%), and "other" (49.2%). Both of these codes represent an incorrect payment, since the services were billed during a SNF stay. The remaining .8 percent of the incorrect payments were identified as occurring in a SNF, a nursing facility or during End Stage Renal Disease treatment. Finally, the 1991 and 1992 data indicate that the same number of items were coded "SNF" in each year.

Prior to September 16, 1991, there were 14 codes to indicate the place where the Medicare service was rendered. Many of these codes, including "other," represented more than one possible place of service. After September 16, 1991, HCFA greatly expanded the number of available codes to allow designation of at least 27 possible places

of service. In addition, no code represented more than one setting. These coding changes provided the opportunity to better represent the actual place of service and decrease the incorrectly paid DME during a SNF stay. However, the code "99," "other," continued to be listed as an option for place of service. When examining the 1991 and 1992 SNF DME data, we found that the utilization of the code "99" or "other" declined from 49.2% in 1991 to 22% in 1992.[7] However, as noted in the first finding, the number of items incorrectly allowed during a SNF stay increased.

Carriers policies regarding screening of DME claims vary.

We surveyed the 40 current Medicare Part B carriers to examine their efforts to determine if a person receiving DME is located in a SNF. Twenty-nine of the 39 carriers answering this question indicated they have a process to verify if the "place of service" code is consistent with any other information on the claim, or known about the beneficiary. However, if the place of service indicates home, many carriers do not have further edits to determine if the information on the claim is correct. This indicates a lack of knowledge by the supplier of the beneficiary location at the time the supplier bills,[8] or a false claim submission, since the DME represented in this database was billed during an individual's SNF stay.

To further examine the use of the code "99," representing "other," carriers were also asked for specific examples of the correct use of "other." Six of the 40 carriers indicated there are times when "99" would be accepted as correct; four stated "99" is accepted when referring to a pharmacy as the point of sale or the DME supplier's place of business. Additionally, two accepted "99" when used to describe a retirement home, or when used to represent the beneficiary's home. Thirty of the carriers indicated the use of code "99" did not reduce the ability of a carrier to pay accurately. Finally, 13 of 37 carriers said providers are using place of service "99" inappropriately.

There is some evidence that differences exist in screening activities used by "high charge" and other carriers to detect incorrect DME billing.

We also compared the efforts to control incorrect DME payments of the ten carriers with the largest DME charges[9] paid during SNF stays with the remaining carriers (see Table 3). On questions that pertained to knowledge of the location of the beneficiary receiving DME, the "high" charge carriers always indicated fewer routine efforts to 1) determine DME recipient location, 2) examine the consistency of the coded Place Of Service (POS) with other information, and 3) examine bills with POS "99" for the appropriateness of another code. The "high" charge carriers were also less likely to believe that providers used POS "99" inappropriately, or to have undertaken any focused review of incorrect DME payments. Additionally, these carriers were more likely to be able to provide an example of when a DME payment would be made for a beneficiary in a SNF. It appears that the carrier efforts, as shown in Table 3, may have an impact on decreasing incorrectly allowed DME payments.

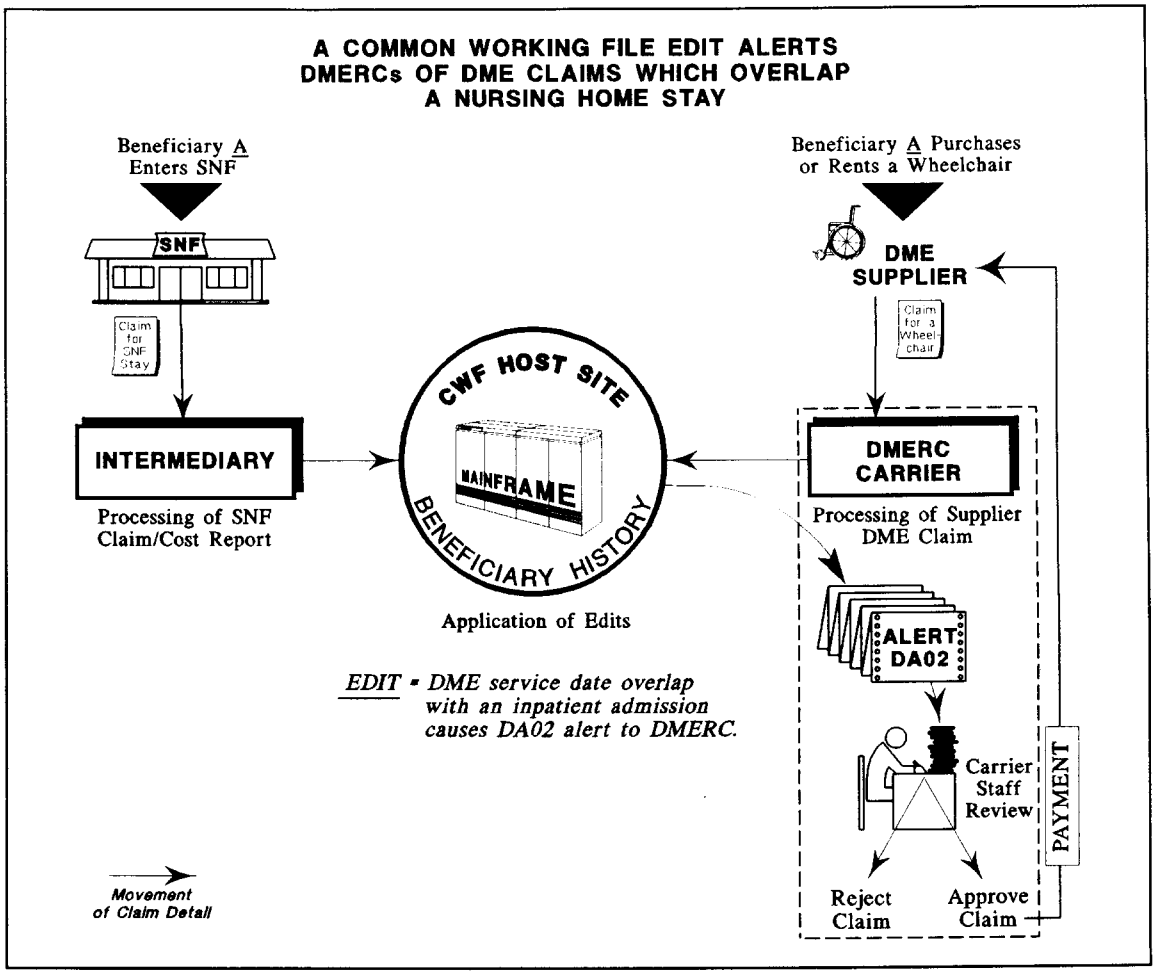
TABLE 3

Comparison Of Responses By Top Ten "HIGH" Charge Carriers And All Other Carriers To Questions Regarding Efforts To Control Incorrect DME Payments		
	Percent of Ten "High" Charge Carriers Responding Yes	Percent of All Other Carriers Responding Yes
When a bill for DME is received and the Place Of Service (POS) marked on the claim does not indicate SNF, are efforts routinely made to determine if the person receiving the DME is in a SNF?	40%	69%
Is any verification done when processing a DME claim to confirm the POS coded is consistent with any other information either on the claim or known about the beneficiary?	66%	76%
If a claim for DME lists the POS as "99" (other), is the POS reviewed to determine if one of the HCFA specified POS codes should be used?	50%	66%
Do you believe that providers are using POS "99" inappropriately?	44%	47%
Have you undertaken any focused review on incorrect payments made for DME in the past three years?	44%	66%
Are there any instances you can think of where a payment for an item of DME would be made even though the beneficiary is in a SNF?	30%	17%
Can you provide a specific example(s) of when POS "99" has been used appropriately for a DME claim?	10%	18%
Does the use of code "99" on claims reduce the carrier's ability to pay accurately?	30%	15%
Does the use of code "99" on claims reduce the carrier's ability to pay in a timely manner?	22%	32%

The HCFA has developed a Common Working File Alert for DME items with service dates overlapping an inpatient admission.

In the summer of 1993, during the transition to DMERC claims payment of DME, HCFA developed an edit for use by the Common Working File. The edit's purpose is to alert the DMERC to the possibility of a DME service coinciding with an inpatient admission. While the Common Working File activates the alert, the DMERC is responsible for reviewing the Part B claim to determine if a DME item was billed for a patient currently receiving inpatient care. After review, the DMERC may either approve or reject the claim for payment.

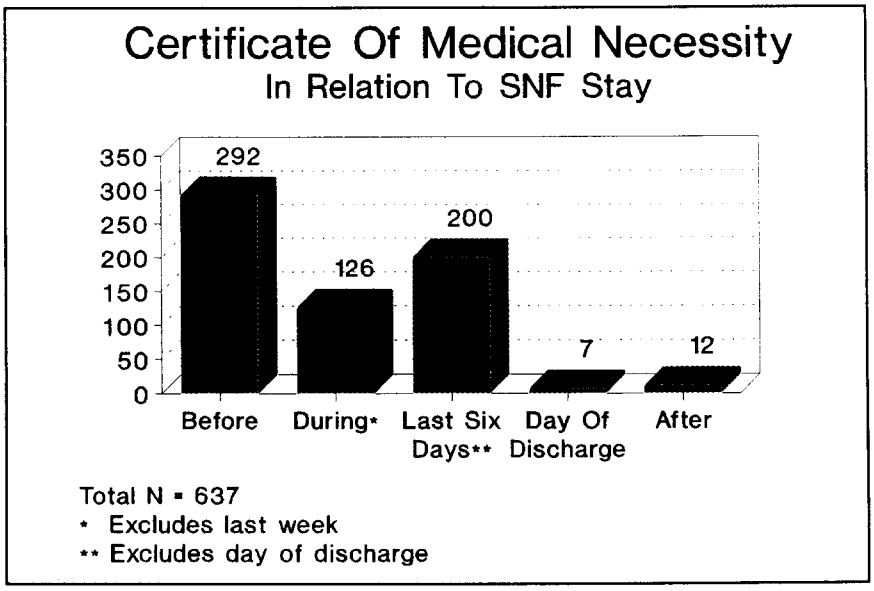
However, there are limitations to the alert that has been developed. This alert depends on a SNF or other inpatient bill being processed prior to the receipt of a Part B DME claim by the DMERC. If a SNF bill is not processed before a DME claim is received, an alert will not occur due to no overlapping service date. There is no reverse edit in place to review all SNF or inpatient claims when they are received, to determine if the beneficiary is also receiving DME. Thus, the current edit process continues to allow incorrect DME payments for SNF patients.



Most Incorrect DME Billings During A SNF Stay Represent Items Prescribed For Use Prior To Or After A SNF Stay.

The certificates of medical necessity that we received were examined to determine whether services billed during a SNF stay were provided in the SNF, were continued billings for items in use before the stay, or were billed during the stay for items used after the stay. Any of these represents an incorrect DME payment, but each indicates a different reason for the incorrect payment.

To determine if any of the above mentioned conditions occurred, we reviewed the DME claims information and certificates of medical necessity. Of the 1022 items of DME billed during a SNF stay that were included in the 1991 one percent sample, we obtained certificates of medical necessity from the carriers for 637; or 62% of the total number of DME items billed. This represents $5.358 million, or 60% of the total amount of incorrectly paid DME.



Certificates of Medical Necessity Prior To A SNF Stay

A review of the certificates of medical necessity, obtained from the carriers, showed that 292 (46%) of the items had dates indicating they had been prescribed prior to the SNF stay. Payments made for the items certified as medically necessary before entering the SNF, and for which charges continued to be billed after entering the SNF, represent $2.614 million, or 49% of the incorrectly paid DME with certificates of medical necessity.

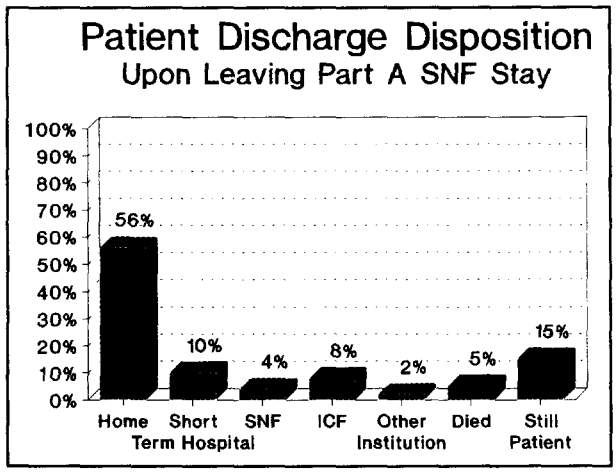
It is logical to assume these items of DME were being used in the beneficiaries' homes prior to obtaining care in the SNF. Although DME used in the home may be paid if it was billed for use prior to entering a SNF, even though the beneficiary resided in a SNF for a portion of the billed month, this DME should not be rebilled during the beneficiary's SNF stay.

Certificates of Medical Necessity During a SNF Stay

Our review of the certificate of medical necessity data showed 333 of the billed DME items were certified as medically necessary during the beneficiaries' SNF stay. While only 7 items had certificates on the date of discharge, 200 items had certificates of medical necessity commencing during the last six days of the beneficiaries' SNF stays (excluding discharge date). This could indicate that these 200 items were prescribed for use at the beneficiaries' homes after discharge from the SNF.

The remaining 126 items may also represent DME that had been prescribed prior to entering the SNF, for which the certificates of medical necessity were renewed during this stay; or, these items could represent DME prescribed and used during the SNF stay. Either situation indicates incorrectly paid DME. A random review of these 126 claims, indicates that many of the certificates of medical necessity do not stipulate whether they are a renewal or a new prescription. However, on the claims that provided a space to stipulate whether this was a new or renewed certificate of medical necessity, all indicated that this was a new certificate for the item of DME.

Approximately Half Of The Patients In Our Sample Were Not Discharged To Their Homes, Meaning Incorrect Payments For DME Might Continue.



We examined the patient disposition status to determine whether incorrect DME billings may continue after the patient is discharged from the SNF setting. Our examination indicated that 44 percent of the beneficiaries either died or did not return to their home upon discharge from the SNF. Thus DME billings may not be appropriate for some time, due to the patient's receiving care in a setting which is not a residence. Furthermore, five percent of the sample represented DME items billed for beneficiaries who died.

RECOMMENDATIONS

Action is needed to minimize the opportunity for incorrect DME payments. The action should address the need to reduce initial incorrect billing, as well as detect any incorrect billing after it occurs.[10] The responsibility for the action, while generally falling within the purview of HCFA, must also include the involvement of the DMERCs and the suppliers. The recommendations that follow pertain to 1) education on the appropriate use of "other," 2) broadening the responsibility for supplier knowledge of beneficiary's location, 3) consistent use of a Common Working File edit to review DME claims for SNF or other inpatient activity and payment rejection, and 4) Review of DMERC processes to reduce incorrect DME billing during a SNF stay.

We recommend that HCFA take action in the following areas to minimize the opportunity for incorrect DME payments.

Improve the place of service coding system. The HCFA could:

- Utilize data from the Statistical Analysis DME regional Carrier to identify and review suppliers who consistently use the "other" place of service category, and take appropriate actions based on the reviews.
- Disseminate materials which indicate the limited circumstances under which "other" may be appropriately used to bill DME.
- Educate the DMERCs on the accurate use of place of service codes.
- Require the DMERCs to provide on-going education to the suppliers on the accurate use of place of service codes.
- Suggest that the DMERCs develop an item for inclusion in their database, that is transmitted to the Common Working File, to provide a continuing history of the patient's location.

Improve the supplier knowledge of beneficiary location. The HCFA could:

- Ensure that the DMERCs instruct suppliers of their responsibility for determining the location of a beneficiary, before billing Part B DME.
- Ensure that the DMERCs undertake sample reviews of suppliers claims and exchange their findings with the other DMERCs, so that all can take appropriate action on the supplier's claims.

Review the DMERC processes. The HCFA could:

- Assess the effectiveness of the new Common Working File edit of Part B DME and SNF charges, and evaluate whether additional edits should be developed to review all SNF bills, upon submission, for overlap with DME billing.
- Encourage the DMERCs to examine the problem of DME billed and allowed during SNF stays. The OIG, in collaboration with HCFA, may also review this area in the future to examine the impact of implementing the new DMERC processes.

OIG RESPONSE TO AGENCY COMMENTS

We solicited and received comments from the Health Care Financing Administration (HCFA) on our draft report.

The HCFA concurred with the intent of our three recommendations. In addition, they suggested alternative steps that could also be taken to achieve the intent of our recommendations. We have incorporated the suggestions proposed by HCFA in the listing of options presented in our recommendations.

See Appendix B for the full text of the HCFA comments.

ENDNOTES

1. Nursing home services are divided into two parts: 1) typical inpatient services, such as room and board, provided by the SNF, and 2) other services, provided by outside suppliers and practitioners, which are not part of routine inpatient care. These two types of services are paid for in two different ways. Skilled nursing facility services can only be billed to Medicare when they are considered "extended care services," that is services required as an extension of a prior hospital stay. These SNF services are covered by the Hospital Insurance Program, or Part A. Part A covers basic care, as well as certain additional services provided to a patient in a SNF for up to 100 days. The Supplementary Medical Insurance Program, or Part B, is an optional benefit which may pay for certain services, provided by outside suppliers, that are not included in the Part A payment.

2. Title XVIII, Section 1861(n).

3. Medicare carriers Manual Section 4105.3 states that "no payment may be made for rental for any month throughout which the patient is in an institution which does not qualify as his or her home...". This statement, however, does not indicate that only the dates of stay in a SNF should be considered. Consideration of DME payment can be affected by a prior stay in a hospital, or other non-residence setting, and discharge to a setting other than a residence. Such additional stays could result in the beneficiary being in a non-residence setting for the entire month. Thus, although a SNF stay has dates indicating that the stay began and/or ended during the middle of the month, it may still be inappropriate to pay for DME, as the beneficiary was not in their residence for any portion of the month due to other inpatient stays.

4. Federal Register, Vol. 57, No. 118, Thursday, June 18, 1992, rules and regulations, pg. 27290, final rule for Medicare Program; Criteria and Standards for Evaluating Regional Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

5. The database created for this report originally contained only 1991 information. However, during the course of the inspection, the 1992 CWF one percent random sample became available. A decision was made to include 1992 data when possible. However, claims information for the 1991 data had been requested and obtained prior to the availability of the 1992 database. For this reason, information pertaining to Certificates of Medical Necessity and payments were not obtained for 1992.

6. Information was obtained for 712 of the 1022 items of DME in 1991, or 69.6% of all incorrectly billed DME items. These claims represented $60,426.44 or 68% of all the incorrectly paid DME dollars. If we assume that this portion of the claims is representative of the entire sample, we can project to the Medicare population and determine the cost allocation to Medicare and other individuals, either beneficiaries or other insurance companies and programs. Based on the 712 claims reviewed, the Medicare responsibility for the amount paid represented 77 percent of the incorrectly paid DME. Based on the logic stated above, this would represent $6.827 million when projected to the entire Medicare population. The remaining 23 percent, or $2.04 million

of the incorrectly allowed DME charges, represented deductibles and co-insurance paid by the beneficiary, other insurance programs, or the State (in the case of some Medicaid recipients).

7. Although the use of "other" declined between 1991 and 1992, the use of the code for "home" increased from 50 percent in 1991 to 77 percent in 1992. Thus, 99 percent of the items billed during a SNF stay in 1992 continue to incorrectly represent the patient's location.

8. The Medicare Carriers Manual, Section 4105.3, in discussing incurred expenses for DME, indicates, "The first month's expense for rental is incurred on the date of delivery of the equipment. Expenses for subsequent months are incurred on the same date of the month." This language does not indicate whether suppliers are required to know the location of the beneficiary before billing for subsequent months use of DME.

9. The carriers with the largest DME charges were also the carriers with the greatest number of items paid during SNF stays.

10. The recovery of payments made for incorrectly allowed DME items is not discussed in this report's recommendation section, since the issue was examined only in the SNF population. However, the recovery of overpayments will be addressed in a subsequent report, when the issue is examined in the context of all nursing home settings.

APPENDIX A

1991 Carrier Information For One-Percent Sample Database				
Carrier	Jurisdiction	Total Charges	Items of DME	DME Cost Per Bed Day
Blue Cross and Blue Shield of Alabama	Alabama	$1,169	19	$1.53
Arkansas BCBS	Arkansas & Louisiana	$3,012	39	$1.87
AETNA Medicare	Arizona & Nevada	$2,171	22	$1.93
Transamerican Medicare	California	$5,433	71	$3.30
California Physicians Service	California	$6,900	84	$3.71
BCBS of Colorado	Colorado	$1,166	7	$9.96
The Travelers Medicare-CT	Connecticut	$988	12	$2.22
Medicare Part B -Florida BCBS	Florida	$4,012	50	$2.11
AETNA Medicare	Georgia	$1,116	19	$1.54
AETNA Life Ins, Med. Claim Admin	Hawaii	$100	2	$0.92
IASD Health Services Corp	Iowa	$2,059	30	$2.52
Health Care Service Corp-Med Part B	Illinois	$7,427	75	$2.91
AdminaStar Federal	Indiana	$1,242	14	$2.38
BCBS of Kansas	Kansas, Nebraska & West Missouri	$2,150	20	$3.15
AdminStar of Kentucky	Kentucky	$960	10	$2.13
C & S Administrative Services for Med, Med. Part B	Massachusetts, Maine, New Hampshire & Vermont	$2,288	25	$2.84
BCBS of Maryland	Maryland	$419	5	$2.97
BCBS of Michigan	Michigan	$3,980	53	$1.89
Travelers Medicare	Minnesota	$794	9	$1.59
Blue Cross Blue Shield of Minnesota	Minnesota	0	0	0
General American Life Ins Co.	East Missouri	$2,635	34	$2.51

1991 Carrier Information For One-Percent Sample Database				
Carrier	Jurisdiction	Total Charges	Items of DME	DME Cost Per Bed Day
The Travelers Medicare	Mississippi	$1,358	16	$4.90
BCBS of Montana	Montana	$313	2	$8.23
BCBS of North Dakota	North Dakota, South Dakota & Wyoming	$286	3	$4.40
BCBS of Western New York, Upstate Med. Div. Part B	Western New York, Upstate	$648	9	$1.37
Group Health Incorporated/ Medicare	New York (Queens)	$626	7	$1.60
Empire Blue Cross and Blue Shield	New York	$4,136	41	$2.39
Nationwide Mutual Ins Co - Medicare	Ohio & West Virginia	$4,994	51	$2.66
Aetna Medicare	Oklahoma & New Mexico	$810	8	$4.96
Aetna Oregon	Oregon	$1,841	18	$4.05
Pennsylvania Blue Shield	Pennsylvania, Delaware, New Jersey, D.C., Virginia & Maryland	$6,990	72	$2.41
Seguro De Servicios de Salud de PR	Puerto Rico	$1,184	11	$4.87
Blue Cross and Blue Shield of RI	Rhode Island	0	0	0
BCBS of South Carolina	South Carolina	$346	10	$0.98
CIGNA Medicare Admin.	Tennessee & North Carolina	$3,025	42	$1.62
BCBS of Texas	Texas	$4,292	43	$4.60
BCBS of Utah	Utah	$1,770	17	$2.83
Travelers Ins Co. Medicare B, Virginia	Virginia	$1,086	17	$2.81
Washington State Medicare part B	Washington	$1,639	13	$3.89
Wisconsin Physicians Service	Wisconsin	$352	6	$2.14

APPENDIX B

AGENCY COMMENTS:
HEALTH CARE FINANCING ADMINISTRATION

It should be noted that the full text of the HCFA comments addresses two reports on skilled nursing facility payment issues. The comments pertaining to this report are found on pages one through four.