

**Memorandum**

Date JUL 23 2001
From *Michael Mangano*
Michael F. Mangano
Acting Inspector General

Subject Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities (A-01-00-00509)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities." The objective of our nationwide review was to determine the adequacy of durable medical equipment regional carrier (DMERC) procedures and controls over Medicare Part B payments for durable medical equipment (DME) made on behalf of beneficiaries who were residents of skilled nursing facilities (SNF). In this regard, Federal law, regulations, and guidelines prohibit Medicare Part B payments on behalf of a beneficiary who is in a qualifying Medicare Part A SNF stay (or a hospital inpatient) for the entire month.

Our review covered the 3 Calendar Years (CY) 1996 through 1998, just prior to full implementation of the prospective payment system (PPS) for SNF services. We found that all four DMERCs paid for DME when the beneficiary was in a Medicare Part A SNF stay for the entire month covered by the DME payment. Our review focused on 485 procedure codes for DME that were not payable when the beneficiary was in a Medicare Part A SNF stay. These procedure codes identified DME in three categories: inexpensive or routinely purchased (IRP) items; capped rentals; and oxygen and oxygen equipment. Based on our computerized match of DME and SNF payment records and related validation procedures for the 3 CYs reviewed, we estimate that DMERCs inappropriately paid approximately \$35 million for Medicare Part B DME. In addition, coinsurance payments of approximately \$9 million related to these DME items may have also been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance.

Under PPS, SNFs are paid through per diem prospective case-mix adjusted rates applicable to all covered SNF services. In addition, under the consolidated billing requirement, SNFs must furnish all services (including DME) directly, or under arrangement with outside suppliers and outside suppliers must then bill SNFs for the services rendered. Notwithstanding the consolidated billing requirement, Federal law, regulations, and guidelines also prescribe that costs for DME that are purchased or rented for a beneficiary's home use are unallowable costs if the beneficiary resides in a facility that primarily provides skilled nursing care. These laws, regulations, and guidelines applied prior to the SNF consolidated billing requirement,

and they continue to apply after the implementation of the consolidated billing requirement. Payments for DME provided to a beneficiary for home use, which coincided with a Medicare Part A SNF stay, are the subject of this report.

We found two weaknesses in DME claims processing systems that contributed to DME overpayments, both prior to and after implementation of SNF PPS and the consolidated billing requirement. First, information on SNF stays was frequently not posted to the Common Working File (CWF) prior to the payment of DME claims and, therefore, was not considered in the payment decision on DME claims. A majority of the DME claims paid by the DMERCs indicated that the beneficiaries were “home” when the DME was provided. Without additional information regarding the beneficiaries’ status (such as knowledge of a Medicare Part A SNF stay), DMERCs will continue to pay such DME claims from an outside supplier, even with the implementation of SNF PPS and the consolidated billing requirement. In fact, a computer match of CY 1999 data identified DME payments for dates of service which overlapped with the dates of service for a Medicare Part A SNF stay. Second, the scope of DME claims edits varied significantly among DMERCs and, at most, covered only two (IRP items and capped rentals) of the three categories of DME in which we identified overpayments.

We recommend that the Centers for Medicare and Medicaid Services (CMS):¹

- work with the DMERCs to implement edits to prevent future Medicare Part B DME payments for beneficiaries who are residents of a SNF for the entire month. Because of the amount of time it takes to record hospital and/or SNF stays on CWF and the number of claims which indicate that the beneficiary was at “home,” the results of our tests suggest that these edits may have to be applied on a post-payment basis; and
- require the DMERCs to recover the overpayments, which we estimate to be approximately \$35 million. We intend to provide CMS with a computerized file that will help them to identify the actual overpayments.

The CMS generally concurred with our recommendations and has agreed to take corrective action. We appreciate the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachments

¹Formerly known as the Health Care Financing Administration.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PART B
PAYMENTS FOR DURABLE MEDICAL
EQUIPMENT PROVIDED TO
BENEFICIARIES IN SKILLED
NURSING FACILITIES**



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Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities (A-01-00-00509)

To

Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

This report presents the results of our nationwide review of Medicare Part B payments for durable medical equipment (DME) provided to Medicare beneficiaries in skilled nursing facilities (SNF). The objective of our nationwide review was to determine the adequacy of durable medical equipment regional carrier (DMERC) procedures and controls over Medicare Part B payments for DME made on behalf of beneficiaries who were residents of SNFs. In this regard, Federal law, regulations, and guidelines prohibit certain Medicare Part B DME payments on behalf of a beneficiary who is in a qualifying Medicare Part A SNF stay (or a hospital inpatient) for the entire month.

Our review covered the 3 Calendar Years (CY) 1996 through 1998, just prior to the full implementation of the prospective payment system (PPS) and the consolidated billing requirement for SNF services. We found that during these 3 CYs, all four DMERCs paid for DME when the beneficiary was in a Medicare Part A SNF stay for the entire month covered by the DME payment. Our review focused on 485 procedure codes for DME, which were not payable when the beneficiary was an inpatient in a SNF. These procedure codes identified DME in three categories: inexpensive or routinely purchased (IRP) items; capped rentals; and oxygen and oxygen equipment. Based on our computerized match of DME and SNF payment records and related validation procedures for the 3 CYs reviewed, we estimate that DMERCs inappropriately paid approximately \$35 million for Medicare Part B DME. In addition, coinsurance payments of approximately \$9 million related to these DME items may have also been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance.

We found two weaknesses in DME claims processing systems that contributed to DME overpayments, both prior to and after implementation of SNF PPS and the consolidated billing requirement. First, information on SNF stays was frequently not posted to the Common Working File (CWF) prior to the payment of DME claims and, therefore, was not considered in the payment decision on DME claims. A majority of the DME claims paid by the DMERCs indicated that the beneficiaries were "home" when the DME was provided. Without additional information regarding the beneficiaries' status (such as knowledge of a Medicare Part A SNF stay), DMERCs could continue to pay such DME claims from outside

suppliers even though SNF PPS has been implemented and consolidated billing is now required. In fact, a computer match of CY 1999 data identified DME payments for dates of service that overlapped with the dates of service for a Medicare Part A SNF stay. Second, the scope of DME claims edits varied significantly among DMERCs and, at most, covered only two (IRP items and capped rentals) of the three categories of DME in which we identified overpayments.

We recommend that the Centers for Medicare and Medicaid Services (CMS):¹

- work with the DMERCs to implement edits to prevent further DME payments when the beneficiary is an inpatient in a SNF for the entire month. Because of the length of time it takes to record hospital and/or SNF stays on CWF and the number of claims which indicate that the beneficiary was at “home,” the results of our tests suggest that these edits may have to be applied on a post-payment basis; and
- require the DMERCs to recover the overpayments, which we estimate to be approximately \$35 million. We intend to provide CMS with a computerized file that will help them to identify the actual overpayments.

The CMS generally concurred with our recommendations and agreed to take corrective action (see APPENDIX). Specifically, CMS: (1) will remind DMERCs to install edits to prevent payments for DME/oxygen for a Medicare Part A patient in a SNF, (2) is working to install Parts A /B crossover edits in CWF that should address the issues highlighted in our draft report, (3) believes it would be impractical for DMERCs to perform post-payment reviews of DME claims, and (4) is exploring the use of a program safeguard contractor to identify overpayment situations and take appropriate action. Further, CMS officials advised us that they will direct DMERCs to recover the estimated \$35 million in overpayments identified in our report.

INTRODUCTION

BACKGROUND

Part B of the Medicare program pays for DME through the claims processing systems maintained by four DMERCs. Each of the DMERCs is responsible for processing DME claims submitted by suppliers located in designated States and United States Territories.

Section 1861(n) of the Social Security Act defines DME as including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient’s **home** (including an institution used as his home other than an institution that meets the requirements of a hospital or a

¹Formerly known as the Health Care Financing Administration.

SNF). The 42 CFR 414.202 defines DME as equipment furnished by a supplier or a home health agency that:

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to an individual in the absence of an illness or injury; and
- (4) Is appropriate for use in the **home**.

Section 2100.3 of the Medicare Carriers Manual provides that “...an institution may not be considered a beneficiary’s home if it:

A. Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons or

B. Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in subsection A or B, he is not entitled to have payment made for rental or purchase of DME since such an institution may not be considered his home.”

This limitation on Medicare payments is applied when the beneficiary is in a hospital and/or SNF for the entire month covered by the DME payment. Regarding partial month SNF stays, section 4105.3 of the Medicare Carriers Manual provided that: “If the patient is at home as of the first day of a rental month and, for part of the same rental month, is in an institution which cannot qualify as his or her home...payment may be made for the entire rental month...”²

The CMS officials disclosed that this blanket prohibition that Congress imposed on any separate Medicare Part B payment for DME furnished while the beneficiary is in a Medicare Part A SNF stay reflects the assumption that the responsibility for furnishing such items to its residents is an inherent function of this type of institution, and that payment for such

²This criteria was moved from section 4105.3 of the Medicare Carriers Manual to chapter 5, item 4 of the Medicare Program Integrity Manual, effective November 22, 2000.

DME is already included in the SNF's basic Medicare reimbursement rate. As a result, CMS officials advised us that any separate Medicare payment under Part B would be redundant.

To substantiate CMS officials' comments, we reviewed the Medicare Part A cost reports for five SNFs in Massachusetts in order to confirm whether SNFs were providing routine DME to their residents and whether the associated costs were included in their Part A rates. We found that all five SNFs provided routine DME to their patients and claimed the related costs on their Medicare Part A cost reports.

OBJECTIVES, SCOPE, AND METHODOLOGY

We conducted our review in accordance with generally accepted government auditing standards. The objective of our review was to determine the adequacy of DMERC procedures and controls over Medicare Part B payments for DME made on behalf of beneficiaries who were residents of SNFs. In this regard, Federal law, regulations, and guidelines prohibit certain Medicare Part B DME payments on behalf of a beneficiary who is in a qualifying Medicare Part A SNF stay (or a hospital inpatient) for the entire month. We limited our review to Medicare Part A SNF stays, even though the same payment restrictions apply to hospital inpatient stays as well.

Our review covered the 3 CYs 1996 through 1998, just prior to the full implementation of the PPS and the consolidated billing requirement for SNF services. Under PPS, SNFs are paid through per diem prospective case-mix adjusted rates applicable to all covered SNF services. In addition, under the consolidated billing requirement, SNFs must furnish all services (including DME) directly or under arrangement with outside suppliers, which must then bill SNFs for the services rendered. Notwithstanding the consolidated billing requirement, Federal law, regulations, and guidelines prescribe that costs for DME that are purchased or rented for a beneficiary's home use are unallowable costs if the beneficiary resides in a facility that primarily provides skilled nursing care. These laws, regulations, and guidelines were applicable prior to the SNF consolidated billing requirement, and they continue to apply after the implementation of the consolidated billing requirement.

To accomplish our objective, we identified all DME claims (16.5 million) and payments (\$2.9 billion) for 485 different procedure codes with dates of service during CYs 1996 through 1998. The DMERC officials advised us that these 485 procedure codes were not payable when the beneficiary was in a Medicare Part A SNF stay. These 485 procedure codes identified DME in three categories: IRP items; capped rentals; and oxygen and oxygen equipment. We then compared the dates of service for the DME payments to the dates of service for Medicare Part A SNF stays. This comparison disclosed 1.4 million DME claims and payments of \$193.7 million where the dates of service for DME overlapped with the dates of service for the Medicare Part A SNF stay. To test the validity of the results of our computer match, we selected a statistical sample of 200 claims and

reviewed the source documentation including claims, payment histories, and remittance advices.

In addition, we obtained an understanding of DMERCs' edits related to payments for DME on behalf of beneficiaries who are in a Medicare Part A SNF stay. We then used the results of our statistical sample to assess the effectiveness of these edits. Using a variable sample appraisal methodology, we projected our sample results to estimate the total nationwide impact. To complete our review, we established reasonable assurance on the authenticity and accuracy of the data. Our audit did not assess the completeness of the file from which the data was obtained.

We also noted that the Office of Inspector General's Office of Evaluations and Inspections completed two reviews on 1991 and 1992 payments for DME provided to beneficiaries in nursing homes. The first report (OEI-06-92-00860 issued October 1994) covered Medicare Part B payments for DME provided to residents in SNFs and estimated that \$19.7 million in Medicare overpayments were made during the 2-year period. The second report (OEI-06-92-00862 issued February 1996) covered Medicare Part B payments for DME provided to residents of Medicare and/or Medicaid certified nursing homes. This report estimated that, during 1992, \$35 million in Medicare Part B payments were allowed for DME, even though the beneficiaries were residing in a Medicare and/or Medicaid certified nursing home.

Our audit work was performed in our Boston regional office and CMS headquarters in Baltimore, Maryland between January 2000 and November 2000.

FINDINGS AND RECOMMENDATIONS

We found that during the 3 CYs ended December 31, 1998, all four DMERCs paid for DME when the beneficiary was in a Medicare Part A SNF stay for the entire month covered by the DME payment. Based on our computerized match of 485 DME procedure codes and Medicare Part A SNF payment records and related validation procedures, we estimate that DMERCs inappropriately paid approximately \$35 million of Medicare Part B DME. In addition, coinsurance payments of approximately \$9 million related to these DME items may have also been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance.

Criteria

Section 2100.3 of the Medicare Carriers Manual provides that an institution may not be considered a beneficiary's home if it meets at least the basic requirement of the definition of a hospital or SNF. This same section also provides that if an individual is a patient in a hospital or SNF, he is not entitled to have payment made for rental or purchase of DME since such an institution may not be considered his home.

This limitation on Medicare Part B payments applies when the beneficiary is in a hospital or SNF for the **entire month** covered by the DME payment but does not apply when the beneficiary is in an institution for only **part of the month**. In this respect, section 4105.3 of the Medicare Carriers Manual provides that: “If the patient is at home as of the first day of a rental month and, for part of the same rental month, is in an institution which cannot qualify as his or her home...payment may be made for the entire rental month...”

Results of Review

We identified 1.4 million DME claims with payments for dates of service that overlapped the dates of service for Medicare Part A payments for SNF stays. In the 200 DME claims tested, we identified 43 overpayments totaling \$5,083. Each of the 43 overpayments was for DME provided during a month when the beneficiary was in a Medicare Part A SNF stay for the **entire month**. Extrapolating our sample results to the population, we estimate that DMERCs inappropriately paid for approximately \$35 million in Medicare Part B DME claims for services provided during the 3 CYs ended December 31, 1998. Specifically, our estimate of the potential overpayments (point estimate) is \$34,897,447 with a lower limit of \$22,263,010 and an upper limit of \$47,531,884. Based on the 90 percent confidence level, the precision for our estimate is +/- 36.20 percent. In addition, coinsurance payments of approximately \$9 million related to these DME items may have also been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance.

System Weaknesses

We found two primary weaknesses in DME claims processing systems that contributed to DME overpayments, both prior to and after implementation of SNF PPS and the consolidated billing requirement. First, information on SNF stays was frequently not posted to CWF prior to the payment of DME claims and, therefore, was not considered in the payment decision on DME claims. Second, the scope of DME edits varied significantly among DMERCs and, at most, covered only two (IRP items and capped rentals) of the three categories of DME in which we identified overpayments.

The DMERCs rely on information from CWF to identify beneficiaries that are in SNF stays. However, this information has frequently not yet been posted to CWF, and therefore, is not available to DMERCs in time to be used in the processing of DME claims. In this regard, the Contractor Performance Evaluation Program results for all four DMERCs showed that, during the 4 fiscal years ended September 30, 1999, about 97 percent of “clean” DME claims were processed with a payment decision by the DMERCs **within 30 days or less** from the receipt of the claim. Our analysis of 40 claims with overlapping dates of service disclosed that, in 26 of the 40 claims, the SNF data was not posted to CWF until **more than 30 days** after the DME claim was received. Specifically, the number of days from the receipt of DME claims at the DMERC to the posting of SNF claims on CWF ranged from

1 day to 507 days. The average number of days was 76 days and the median number of days was 38 days.

In addition, the majority of DME claims paid by DMERCs indicated that the beneficiaries were “home” when the DME was provided. Without additional information regarding the beneficiaries’ status (such as knowledge of a Medicare Part A SNF stay), DMERCs will continue to pay such DME claims from outside suppliers, even with the implementation of SNF PPS and the consolidated billing requirement. In fact, a computer match of CY 1999 data identified DME payments for dates of service, which overlapped with the dates of service for a Medicare Part A SNF stay.

With respect to systems edits, DMERCs either: (1) did not have edits in place to identify overlapping dates of service for DME payments and Medicare Part A SNF stays for all 485 DME procedure codes in our review or (2) existing edits for those 485 procedure codes were not uniformly applied. Officials of two DMERCs advised us that they did have operational edits for two categories of DME (IRP items and capped rentals). Officials from a third DMERC advised us they had operational edits for only one category of DME (IRP items). The officials from the fourth DMERC advised us that they did not have any operational edits to identify overlapping dates of service. Conversely, our review identified overpayments related to overlapping dates of service for DME payments and Medicare Part A SNF stays in three categories: IRP items, capped rental items, and oxygen and oxygen equipment. We believe that uniform national edits could prevent Part B DME payments on behalf of beneficiaries who are in a Medicare Part A SNF stay.

To test the operational edits, we asked the 4 DMERCs to review 20 (5 each) of the overpayments that we judgmentally identified from our sample results and advise us as to why the overpayments had not been prevented by their claims processing systems. The DMERC officials advised us that 16 claims were not caught by their claims processing systems because the DME claim was paid before the SNF stay was posted to CWF. The remaining four claims were paid because they contained categories of DME that were not covered by the DMERCs’ edits.

CONCLUSIONS AND RECOMMENDATIONS

During the 3 CYs ended December 31, 1998, we estimate that DMERCs inappropriately paid approximately \$35 million of Medicare Part B DME when the beneficiary was in a Medicare Part A SNF stay for the entire month covered by the DME payment. Coinsurance of approximately \$9 million related to these DME payments may have also been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance. We found two primary weaknesses in DME claims processing systems that contributed to DME overpayments, both prior to and after the implementation of SNF PPS and the consolidated billing requirement.

Accordingly, we recommend that CMS :

- , work with the DMERCs to implement edits to prevent future Medicare Part B DME payments for beneficiaries who are residents of a SNF for the entire month. Because of the amount of time it takes to record hospital and/or SNF stays on CWF and the number of claims which indicate that the beneficiary was at “home,” the results of our tests suggest that these edits may have to be applied on a post-payment basis; and
- , require the DMERCs to recover the overpayments, which we estimate to be approximately \$35 million. We intend to provide CMS with a computerized file that will help them to identify the actual overpayments.

AUDITEE COMMENTS

In their comments to our draft report, CMS generally concurred with our findings and recommendations (see APPENDIX). Specifically, CMS:

- will remind DMERCs to install edits to prevent payments for DME/oxygen for a Medicare Part A patient in a SNF;
- is working to install Parts A/B crossover edits in CWF that should address the issues identified in our report;
- believes it would be impractical for DMERCs to perform post-payment reviews of DME claims;
- is exploring the use of a program safeguard contractor to identify overpayment situations and take appropriate action; and
- will direct DMERCs to recover the estimated \$35 million in overpayments identified in our report.

The CMS also advised us that DME is not included in determining payment rates under the SNF PPS. However, our research on this matter indicates that DME costs are included in determining both the “facility rate” and the “federal rate” that are blended together to form the PPS payment rate.

APPENDIX



DATE: MAY 25 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan 
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities* (A-01-00-00509)

Thank you for the opportunity to review the above-mentioned OIG draft report. This report concerns the adequacy of durable medical equipment regional carrier (DMERC) procedures and controls over Medicare Part B payments for durable medical equipment (DME) made on behalf of beneficiaries who were in a Medicare Part A skilled nursing facility (SNF) stay.

Medicare does not pay separately for DME provided to a beneficiary in a Part A SNF stay, nor is DME included in determining payment rates under the SNF prospective payment system (PPS). Rather, as provided by section 1861(n) of the Social Security Act, payment for DME, like payment for furniture and other items which can be reused by the SNF, is included in the SNF's facility rate.

The report reveals that based on the computerized match of DME and SNF payment records and related validation procedures for 1996 through 1998, the DMERCs inappropriately paid approximately \$35 million for Medicare Part B DME. In addition, OIG believes coinsurance payments of approximately \$9 million related to these DME items may have been overpaid by the Medicaid program, beneficiaries, or their supplemental insurance. We believe the report provides an important contribution to our efforts to maintain the financial integrity of the Medicare program.

To address the problems identified by OIG in this report, we are exploring the possibility of using a program safeguard contractor to identify these situations and take the appropriate action. In addition, we will remind the DMERCs that they should have installed edits for place of service to prevent them from paying for DME/oxygen in the SNF location. The actual Medicare Parts A/B crossover edits should address this issue once they have been installed in the common working file (CWF).

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OIG Recommendation

HCFA should work with the DMERCs to implement edits to prevent future Medicare Part B DME payments for beneficiaries who are residents of a SNF for the entire month. Because of the amount of time it takes to record hospital and/or SNF stays on CWF and the number of claims which indicate that the beneficiary was at "home," the results of our tests suggest that these edits may have to be applied on a postpayment basis.

HCFA Response

As stated above, we will remind the DMERCs that they are to install edits to prevent payment of DME/oxygen for a Medicare Part A patient in a SNF. The actual Medicare Parts A/B crossover edits should address this issue once they have been installed in the CWF. We believe it would be impractical for the DMERCs to perform postpayment reviews to identify these situations. Additionally, we are exploring the use of a program safeguard contractor to identify these situations and take appropriate action.

OIG Recommendation

HCFA should require the DMERCs to recover the overpayments, which we estimate to be approximately \$35 million. We intend to provide HCFA with a computerized file that will help it to identify the actual overpayments.

HCFA Response

We concur. HCFA will direct the Medicare DMERCs to recover the estimated \$35 million in overpayments identified in this report. It is understood that after issuing the final report, OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for DMERCs to carry out a recovery action. At that time, we will forward the final report to the regional offices along with the information needed by the DMERCs to recover the overpayments. Also, we will forward the name of the OIG person to be contacted if any questions arise.