NOV 26 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson /S/
Inspector General

SUBJECT: Early Alert Memorandum: Payments to Medicare Suppliers and Home Health Agencies Associated With "Currently Not Collectible" Overpayments, OEI-06-07-00080

SUMMARY

This early alert memorandum describes the associations between selected suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) with debt owed to the Medicare program and other businesses that received Medicare payments.[1] In 2005, DMEPOS suppliers collectively had $352 million in debt deemed "currently not collectible" (CNC) by the Centers for Medicare & Medicaid Services (CMS). In 2006, the amount of DMEPOS supplier debt deemed CNC rose to $402 million. In addition, anecdotal information from the Office of Inspector General (OIG) investigators and assistant United States attorneys indicates that DMEPOS suppliers with outstanding Medicare debt may inappropriately receive Medicare payment by, among other means, operating businesses that are publicly fronted by business associates, family members, or other individuals posing as owners. Information about the associations between DMEPOS suppliers with Medicare debt and other businesses that receive Medicare payment may be useful to CMS in its oversight of the program, to the extent that those associations are a means of avoiding debt repayment or engaging in fraudulent billing.

We selected a random sample of 10 DMEPOS suppliers in Texas that each had Medicare debt of at least $50,000 deemed CNC by CMS during 2005–2006. CMS deems a Medicare overpayment to be CNC if an overpayment to a DMEPOS supplier remains uncollected 210 days after the date of the first demand letter despite recovery attempts by CMS contractors. We attempted to identify all owners and managers of these 10 DMEPOS suppliers with CNC debt. We then used information from public records, DMEPOS supplier and home health agency (HHA) enrollment applications, and Medicare claims to determine whether any of the sample DMEPOS suppliers were associated with other businesses that received Medicare payment during 2002–2007 through shared ownership or management, family relationship, address, or

[1] DMEPOS suppliers are hereinafter referred to as "DMEPOS suppliers" or "suppliers."

telephone number. Although we reviewed DMEPOS suppliers deemed to owe CNC debt in 2005 and 2006, analyzing Medicare payments from 2002 to 2007 allowed us to detect networks of associated businesses that existed both before and after CMS deemed the sample DMEPOS suppliers' overpayments to be CNC.

We found that 6 of the 10 DMEPOS suppliers that we reviewed were associated with 15 other DMEPOS suppliers or HHAs that received Medicare payments totaling $58 million during 2002–2007. Most associated DMEPOS suppliers had lost billing privileges by January 2005 and had accumulated a total of $6.2 million of their own CNC debt to Medicare; however, most HHAs received Medicare payments as recently as December 2007. We also found that most of the DMEPOS suppliers we reviewed were connected with their associated DMEPOS suppliers and HHAs through shared owners or managers. Finally, 11 of the 15 associated businesses' enrollment applications did not include the name of at least one individual listed as an owner or a manager in public records.

Although the associations among DMEPOS suppliers with CNC debt and their associates that received Medicare payments are not, taken alone, sufficient to establish improper or illegal activity, CMS may determine that such associations justify enhanced oversight, e.g., comparison of ownership and management information provided by HHA providers and DME suppliers to information in public records and following up on apparent inconsistencies. Because this initial review examined a small number of DMEPOS suppliers and a limited set of issue questions, we intend to conduct follow-up work regarding the issues and vulnerabilities raised in this memorandum.

BACKGROUND

- DMEPOS are covered under Medicare Part B and include such items as oxygen supplies, wheelchairs, prosthetic limbs, and surgical dressings.[2] [3] Medicare covers DMEPOS only when ordered for a beneficiary by a physician or, in some cases, a nonphysician practitioner.[4] CMS reported that Medicare expenditures for DMEPOS were $9.2 billion in fiscal year 2006.[5] OIG later determined that a sizable percentage of these expenditures were inappropriate overpayments.[6] Overpayments are Medicare payments that a Medicare participating provider or supplier has received in excess of amounts due and payable.[7]

[2] Social Security Act §§ 1832(a), 1834(h), 1861(n), 1861(s)(6), and 1861(s)(8).
[3] The complete list of covered items by Healthcare Common Procedure Coding System can be found online at http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp. Accessed on June 27, 2008.
[4] "Medicare Program Integrity Manual," Pub. No. 100-08, ch. 5, § 5.2.
[5] Figure cited is for DMEPOS 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 July 2, 2008.
[6] An OIG study found in two separate reviews that DMEPOS overpayment errors in fiscal year 2006 were 17.3 percent and 28.9 percent. Department of Health and Human Services, OIG, "Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program" (A-01-07-00508), August 2008.
[7] "Medicare Financial Management Manual," Pub. No. 100-06, ch. 3, § 10.

Overpayments Deemed "Currently Not Collectible"
When a Medicare overpayment is made, CMS and its contractors make recovery attempts, which involve contacting the DMEPOS supplier through a series of written demand letters and/or by telephone. If the DMEPOS supplier fails to make any payment within 210 days of the first demand letter, CMS classifies the debt as CNC. CMS then refers CNC debt to the Department of the Treasury, which makes its own efforts to collect the overpayment.[8]

Medicare Participation Requirements for Suppliers and Home Health Agencies
To participate in the Medicare program, all providers and suppliers must complete an enrollment application and adhere to a series of requirements set forth in 42 CFR Part 424, Subpart P; DMEPOS suppliers must adhere to additional requirements at 42 CFR § 424.57. Pursuant to these requirements, all providers and suppliers must submit an enrollment application to CMS, which is self-reported but must contain "complete, accurate, and truthful responses to all information requested."[9] Application forms for both DMEPOS suppliers and HHAs require applicants to disclose the identity of any person or business that has an ownership, financial, or controlling interest in the business, or that functions in a management role.[10] For each person or business, applicants must also report adverse legal actions, including payment suspensions, billing number revocation, or exclusion from a Federal or State health care program.[11]

The regulation specific to DMEPOS suppliers requires that a supplier repeat the application process for each business location. (See Appendix A for a more detailed description of the enrollment process.) Further, the regulation requires, among other things, that DMEPOS suppliers certify that they meet, and will continue to meet, 25 standards specified by regulation; report any changes in information on their enrollment application within 30 days of the change; and renew their application every 3 years to continue submitting claims to Medicare.[12]

Likewise, regulations applicable to HHAs (and all providers and suppliers) specify that they must report not only any changes in information on their enrollment application within 90 days of the change, but also changes in ownership or control within 30 days.[13] In addition, HHAs must "resubmit and recertify the accuracy of its enrollment every 5 years," and CMS may choose to perform more frequent "off-cycle revalidations" to assess the validity of enrollment information "when warranted."[14]

CMS may deny enrollment or revoke billing privileges for lack of compliance with enrollment requirements or supplier participation standards.[15] Furthermore, in instances in which CMS denies a provider or supplier enrollment, or revokes their Medicare billing number, Federal

[8] "Medicare Financial Management Manual," Pub. No. 100-06, ch. 4, § 80.2.
[9] 42 CFR § 424.510(d)(2)(i). See also 42 CFR § 424.57(c)(2).
[10] Sections 5 and 6 of Forms CMS-855S and CMS-855A.
[11] Sections 3 and 6 of Forms CMS-855S and CMS-855A.
[12] 42 CFR § 424.57.
[13] 42 CFR § 424.520(b). See also 42 CFR § 424.540(a)(2).
[14] 42 CFR §§ 424.515 and 424.515(d).
[15] 42 CFR §§ 424.530(a), 424.535(a), and 424.57(d).

regulations stipulate that CMS "review . . . all other related Medicare enrollment files that the denied provider or supplier has an association with (for example, as an owner or managing employee) to determine whether the denial warrants an adverse action of the associated Medicare provider or supplier."[16]

Recent Program Integrity Initiatives

CMS has recently implemented several additional safeguards to protect against improper DMEPOS supplier enrollment, including additional quality standards, pursuant to section 302(a)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. No. 108-173). In addition, pursuant to section 1834(a)(16)(B) of the Social Security Act, CMS issued a notice of proposed rulemaking, but has not issued the final rule, that would require DMEPOS suppliers to submit a surety bond.[17] The surety bond requirement is intended to limit the Medicare program risk to fraudulent DMEPOS suppliers, enhance the Medicare enrollment process, and ensure that the Medicare program recoups erroneous payments that result from fraudulent or abusive billing practices. Also, the MMA established a DMEPOS competitive acquisition program but, implementation has been delayed until 2009 by recent legislation.[18] Finally, CMS published a proposed rule that seeks to clarify several of the DMEPOS supplier standards "to ensure that DMEPOS suppliers understand how CMS interprets the DMEPOS supplier standards." The rule proposes to add new standards which, among other things, would prohibit a DMEPOS supplier from sharing a practice location with another Medicare supplier.[19]

METHODOLOGY

Scope

This study examines: (1) a small random sample of DMEPOS suppliers in Texas that had at least $50,000 in Medicare overpayments deemed CNC by CMS during 2005–2006 and (2) other DMEPOS suppliers and HHAs that received Medicare payments during 2002–2007 and were associated with the sample DMEPOS suppliers.

Methods

We drew on multiple data sources, including the National Claims History Standard Analytical File (SAF), DMEPOS supplier and HHA enrollment information, public records, enrollment data from the National Supplier Clearinghouse (NSC) and the Online Survey and Certification and Reporting system (OSCAR), CNC debt data from the Durable Medical Equipment Medicare Administrative Contractors (DME MAC), and the Department of Health and Human Services Fraud Investigations Database (FID). Our review took place from September to December 2007 and followed a multistep sequential process.

[16] 42 CFR §§ 424.530(d) and 424.535(e).
[17] 72 Fed. Reg. 42001 (Aug. 1, 2007).
[18] MMA § 302(b)(1) established the Competitive Bidding Program. Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (P.L. No. 110-275), however, delayed further implementation.
[19] 73 Fed. Reg. 4503 (Jan. 25, 2008).

We randomly selected a sample of 10 DMEPOS suppliers in Texas that each had Medicare debt of at least $50,000 deemed CNC during 2005–2006. We chose Texas because the database of public records that we used (described below) contains more data for Texas than for many other States. We chose a minimum debt of $50,000 to ensure that our analysis included DMEPOS suppliers with debt of sufficient size. A total of 807 DMEPOS suppliers in Texas had debt deemed CNC by CMS during 2005–2006, and 134 of these each had CNC debt of at least $50,000. We randomly selected 10 of the 134 DMEPOS suppliers for review. Collectively, these 10 DMEPOS sample suppliers received Medicare payments of $15 million during 2002–2007 and had $8.6 million in CNC debt. The Medicare billing numbers of 8 of the 10 DMEPOS sample suppliers were revoked in either 2003 or 2004. During 2005–2006, these eight DMEPOS suppliers had a total of $6.7 million in CNC debt. The two remaining DMEPOS suppliers we reviewed went into inactive billing status during 2000 and 2001 and had a total of $1.8 million in debt deemed CNC during 2005–2006.[20]

After selecting the sample of 10 DMEPOS suppliers, we obtained their Medicare enrollment applications (Form CMS-855S) from the NSC and reviewed these applications to identify all individuals and organizations that CMS requires to be reported on the application, including those with the following ownership or managerial relationship with the sample DMEPOS suppliers:

- direct or indirect ownership totaling 5 percent or more;
- partnership interest, regardless of the percentage of ownership; and
- operational or managerial control of the DMEPOS supplier, or responsibilities to conduct the day-to-day operations of the DMEPOS supplier.

We then used a database that contains a variety of public records to corroborate and supplement the ownership and managerial information identified on the enrollment applications. Lexis/Nexis Accurint (hereafter referred to as "Accurint") is a database available to law enforcement agencies that culls a broad array of public records and consumer information to facilitate in-depth searches for information on both businesses and individuals. For business searches, Accurint draws from corporate filings, property information, phone listings, professional licenses, and Securities and Exchange Commission filings, among other data. For personal searches, Accurint contains information on Social Security numbers, driver's licenses, and professional licenses. Information on property assets and court proceedings is also available for both individuals and businesses.

Using Accurint, we determined whether the individuals identified as owners or managers of the 10 sample DMEPOS suppliers were associated with any other DMEPOS suppliers or HHAs. We

[20] Although we did not review CMS's overpayment collection process, the overpayments of eight DMEPOS suppliers that we reviewed were not deemed CNC until 18 to 21 months after their billing number was revoked. The other two DMEPOS suppliers we reviewed were inactive for about 5 and 6 years, respectively, prior to their overpayments being deemed CNC.

considered another DMEPOS supplier or HHA to be associated with a sample DMEPOS supplier if it shared an owner or a manager or if it was owned or operated by a family member of an owner/manager of the sample DMEPOS supplier.[21] We noted when sample DMEPOS suppliers also shared telephone numbers and addresses. However, because of our conversations with OIG investigators about the nature of DMEPOS fraud, we considered connections based on shared telephone numbers and addresses to be of secondary importance to connections through shared owners/managers and/or family. To uncover additional associations, we applied the same analysis methods to the associated DMEPOS suppliers and HHAs and found businesses that were indirectly associated with the sample DMEPOS suppliers.

Once we had identified DMEPOS suppliers and HHAs associated with owners/managers of the sample DMEPOS suppliers, we used enrollment data from the NSC and OSCAR to identify Medicare billing numbers. For those with a Medicare billing number, we calculated the amount of Medicare payments that associated DMEPOS suppliers and HHAs received during 2002–2007 using data from the SAF. For DMEPOS suppliers, we also referenced the NSC enrollment data to determine their enrollment status, i.e., active, inactive, or revoked.

We then reviewed the enrollment applications of the associated DMEPOS suppliers and HHAs to determine whether their applications contained the same ownership and managing control information as presented in Accurint. We also checked CNC debt data to determine whether the associated DMEPOS suppliers had any CNC debt. Finally, we obtained information from the FID to determine whether any of the associated businesses were under investigation.

Limitations

Because this study examines a random sample of 10 DMEPOS suppliers in Texas, its findings cannot be projected beyond those DMEPOS suppliers. Although Accurint revealed a variety of business associations, we limited our analysis of businesses associated with the sample DMEPOS suppliers to those that were either DMEPOS suppliers or HHAs because of data availability constraints.

Additionally, Accurint is a provider of third-party data from a variety of public sources, including State civil, property, and criminal records. Verification of the information contained in Accurint is beyond the scope of this review. Because of this limitation, the findings in this memorandum should not be the basis of any action with respect to any DMEPOS supplier or HHA prior to verifying that the information obtained from Accurint is correct.

Further, we had CNC debt data from the DME MACs for all DMEPOS suppliers in 2005–2006, but did not have any CNC debt data for HHAs. Therefore, we could not determine whether associated HHAs had any CNC debt. Lastly, we had enrollment status data for DMEPOS suppliers, but not for HHAs. We used HHA claims themselves as a proxy for enrollment status, i.e., if an HHA received Medicare payment as recently as 2007, we considered its status to be "active."

[21] Accurint identifies individuals who are likely to be relatives based on a proprietary algorithm.

Standards
This study 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.

RESULTS

Six of Ten Suppliers Reviewed Were Associated With 15 Other Suppliers and Home Health Agencies That Received Medicare Payments During 2002–2007

Based on data from public records, enrollment applications, and Medicare claims, we identified instances in which owners or managers of 6 of the 10 sample DMEPOS suppliers were associated with other DMEPOS suppliers or HHAs that received Medicare payments of $58 million during 2002–2007. (See Table 1 on the next page.) Our review did not find associations with DMEPOS suppliers or HHAs for the other four sample DMEPOS suppliers. For the six sample DMEPOS suppliers that were associated with businesses that received Medicare payment, we found a total of 15 associated businesses: eight DMEPOS suppliers and seven HHAs.

The eight associated DMEPOS suppliers received Medicare payments totaling $33 million during 2002–2007. Eighty percent of these payments went to one DMEPOS supplier, which received $26.5 million during this time. The seven associated HHAs received Medicare payments totaling $25 million during 2002–2007. Payments made to these HHAs ranged from $152,000 to one HHA to $11.8 million to another.

Most Associated Suppliers Had Lost Billing Privileges by January 2005 and Accumulated Their Own CNC Debt to Medicare, Although Most Associated Home Health Agencies Received Payments as Recently as December 2007

As of December 2007, five of the eight associated DMEPOS suppliers had revoked billing numbers, two had inactive Medicare billing numbers, and one was actively receiving Medicare payments. Among the two DMEPOS suppliers with inactive billing numbers, one became inactive in November 2003 and the other became inactive in January 2005. According to information in the FID, the one remaining DMEPOS supplier actively receiving Medicare payments in December 2007 was under investigation (as of May 2008) for providing false claims to Medicare. At the time of our review, in addition to the CNC debt owed by the sample DMEPOS suppliers, six of the eight associated DMEPOS suppliers had CNC debt totaling $6.2 million.[22] Of the five associated DMEPOS suppliers that had their Medicare billing number revoked, four were revoked for making a false statement or misrepresenting a material fact on their enrollment application, in addition to committing other violations of the Medicare participation standards.

In contrast, five of the seven associated HHAs received Medicare payments as recently as December 2007. One of the associated HHAs last received Medicare payments in

[22] The six sample DMEPOS suppliers with which these DMEPOS suppliers were associated had CNC debt totaling $7.3 million.

November 2007, and the remaining HHA last received Medicare payments in November 2006. According to the FID, none of the associated HHAs were under active investigation as of May 2008, and, because of the data limitations described above, OIG was not able to determine whether CNC debt is owed by any of these associated HHAs.

Table 1: Provider Type, Medicare Payments, Debt, and Billing Status for DMEPOS Suppliers and HHAs Associated With DMEPOS Suppliers With CNC Debt

Sample DMEPOS Suppliers	Associated Business	DMEPOS Supplier	Home Health Agency	Medicare Payments Received 2002–2007	Currently Not Collectible Debt[a]	Billing Status[b]
Supplier A						
	A1		•	$3,836,339	#	Active
Supplier B						
	B1	•		$331,151	$326,387	Revoked
	B2	•		$791,386	$930,989	Revoked
	B3		•	$11,882,096	#	Active
	B4		•	$6,353,730	#	Active
	B5		•	$152,157	#	Active
	B6		•	$862,674	#	Inactive
	B7		•	$521,112	#	Active
Supplier C						
	C1	•		$2,236,664	$2,357,015	Revoked
Supplier D						
	D1	•		$434,380	**$34,258**	Revoked
Supplier E						
	E1	•		$2,541,744	$2,594,996	Revoked
	E2		•	$1,187,631	#	Active
Supplier F						
	F1	•		$3,500	$48,342	Inactive
	F2	•		$26,521,875	$0	Active
	F3	•		$309,826	#	Inactive
Totals		**8**	**7**	**$57,966,265**	**$6,291,987**	**Active= 7 Revoked= 5 Inactive= 3**

Source: OIG analysis, 2008.
a=We did not have any CNC debt data for associated HHAs.
b=HHAs were considered "active" if they received Medicare payments in 2007.
#=Data not available.

Most Sample Suppliers Were Connected to Associated Businesses Through Shared Owners/Managers

Analysis of public records revealed that 11 associated DMEPOS suppliers and HHAs were connected to sample DMEPOS suppliers through shared ownership/management, e.g., the owner/manager of the sample DMEPOS supplier also owned/managed the associated DMEPOS supplier or HHA. (See Table 2 on the next page.) Five associated businesses were connected through a family member, e.g., a mother owned the sample DMEPOS supplier and her son managed a separate DMEPOS supplier. Some sample DMEPOS suppliers and associated businesses also shared business or residential addresses (10) or business telephone numbers (4).

In some cases, we identified a web of relationships among the individuals involved with the sample DMEPOS suppliers and the associated businesses, as well as between the associated businesses themselves. (See Appendix B for illustrations of such associations.) For example, a relative (and cohabitant) of the owner of DMEPOS Supplier A owned and operated an HHA at DMEPOS Supplier A's address and used DMEPOS Supplier A's business telephone number. In another case, the principal owner of DMEPOS Supplier B also owned five other DMEPOS suppliers or HHAs, four of which operated out of the same office building. In this same case, a manager at one of the businesses also managed four associated businesses.

Table 2: Nature of the Association Between 6 Sample DMEPOS Suppliers and 15 Associated DMEPOS Suppliers or Home Health Agencies

Sample DMEPOS Suppliers	Associated Business	Owner/ Manager	Family Member	Address	Telephone Number
Supplier A					
	A1		•	•	•
Supplier B					
	B1	•		•	
	B2	•		•	
	B3	•		•	
	B4	•		•	
	B5	•		•	
	B6	•		•	
	B7	•			
Supplier C					
	C1	•			
Supplier D					
	D1		•	•	
Supplier E					
	E1		•	•	
	E2		•	•	
Supplier F					
	F1	•	•		•
	F2	•			•
	F3	•			•
Totals		**11**	**5**	**10**	**4**

Source: OIG analysis, 2008.

Eleven Associated Supplier and Home Health Agency Enrollment Applications Did Not Include the Name of at Least One Owner or Manager Listed in Accurint

To enroll in the Medicare program, providers and suppliers must complete an enrollment application, which requires applicants to disclose the identity of any person or business "with ownership, financial, or controlling interest in the company," as well as all individuals who

function in a management role.[23] If a DMEPOS supplier or an HHA submitted false or misleading information with respect to ownership or control, its billing privileges would be subject to revocation, among other administrative and criminal penalties.[24]

Eleven of fifteen associated DMEPOS suppliers' or HHAs' enrollment applications did not contain the name of at least one owner or manager listed in Accurint. Seven of the eleven were HHAs and four were DMEPOS suppliers. Six of these eleven applications did not contain the name of two or more owners or managers. Based on Accurint data, some of these owners or managers who were not listed on enrollment applications appear to be relatives of the listed owners or managers of sample DMEPOS suppliers.

CONCLUSION

Because of our limited sample size, we cannot conclude that the associations between DMEPOS suppliers with debt owed to the Medicare program and other businesses that received Medicare payments cited in this early alert memorandum also exist in the larger population. Also, additional research and investigative work would be needed to confirm whether DMEPOS suppliers and HHAs associated with our sample DMEPOS suppliers are involved in fraudulent activities. Accordingly, our results should not be viewed as conclusive evidence of either impropriety or illegal activity.

Nonetheless, our analysis shows associations between 6 sample DMEPOS suppliers with Medicare debt totaling $7.3 million and 15 other DMEPOS suppliers and HHAs that received Medicare payments totaling $58 million during 2002–2007. Although nearly all associated DMEPOS suppliers had lost their billing privileges or have discontinued billing Medicare, five of the seven associated HHAs received Medicare payments as recently as December 2007. These results indicate that the associations between DMEPOS suppliers and HHAs may be less frequently detected than those between DMEPOS suppliers alone. Our findings also show that some enrollment applications for DMEPOS suppliers and HHAs associated with our sample DMEPOS suppliers did not contain the names of all owners or managers. These results suggest that individuals associated with Medicare debt could inappropriately receive Medicare payments by omitting owner/manager information on their enrollment application and working through other DMEPOS suppliers and HHAs.

Given these associations, CMS may deem it appropriate to conduct a similar review of DMEPOS suppliers with CNC debt to identify associations with other suppliers or home health agencies receiving Medicare payments. Specifically, CMS could compare its list of suppliers with CNC debt against public records to determine if the owners or managers of these suppliers appear to own or manage other suppliers or home health agencies. If these owner/manager associations are identified, CMS could review the associated businesses' enrollment applications to determine if complete and accurate information was reported, and follow up on any apparent inconsistencies.[25]

[23] Forms CMS-855S and CMS-855A. CMS requests this information pursuant to authority under 42 CFR § 420.206.

[24] 42 CFR §§ 424.530(a)(4) and 424.535(a)(1) and (4).

[25] Pursuant to 42 CFR § 424.515(d), CMS has the authority to conduct such "off-cycle revalidations" to assess the validity of enrollment information.

If CMS confirms that ownership or management information has been misreported on enrollment applications, it may consider whether denial or revocation of the DMEPOS supplier or HHA's enrollment is appropriate.

Because this initial review examined a small number of DMEPOS suppliers using a limited set of issue questions, OIG intends to conduct follow-up work regarding the issues and vulnerabilities raised in this memorandum.

This early alert memorandum is being issued directly in final form because it contains no recommendations. If you have comments or questions about this early alert memorandum, please provide them within 60 days. Please refer to report number OEI-06-07-00080 in all correspondence.

APPENDIX A

Durable Medical Equipment Supplier and Home Health Agency Enrollment Primer

Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and home health agencies (HHA) go through similar, but distinct, processes to enroll in the Medicare program. To enroll in Medicare, each must first obtain a National Provider Identifier (NPI) number from the National Plan and Provider Enumeration System. This requires completing an application with identifying information, such as the individual or business name, business location, and any provider identification numbers held prior to the establishment of the NPI. After receiving the NPI, the process for DMEPOS suppliers and HHAs differs.
DMEPOS suppliers must obtain a billing number from the National Supplier Clearinghouse (NSC). NSC is responsible for issuing Medicare billing numbers to DMEPOS suppliers, revoking billing numbers, and verifying compliance with the participation standards. To obtain a billing number, the DMEPOS supplier must complete Form CMS-855S. This detailed form requires the DMEPOS supplier to provide the following types of information:

1. identifying information—business location, type of supplies sold, services offered, incorporation and accreditation information;

2. adverse legal actions—convictions, exclusions, revocations, or suspensions;

3. ownership interest and/or managing control information—all organizations or individuals with 5-percent ownership or more; managing control of the DMEPOS supplier; or a partnership interest, including the adverse legal history for these organizations or individuals with ownership interest or managing control; and

4. listing of authorized or delegated officials.[26]

In addition, the DMEPOS supplier must submit supporting documents along with Form CMS-855S. Supporting documents include:

1. Federal/State/local professional and business licenses, certifications, or registrations;
2. liability insurance policy;
3. tax identification number;
4. completed form for electronic funds transfer;
5. NPI notification;
6. adverse legal action documentation;
7. bank statements waiving Medicare offsets as loan collateral; and
8. copy of delegated official's Form W-2.

[26] Section 15 of Forms CMS-855S and CMS-855A. An "authorized" official is an appointed official to whom the organization has granted the legal authority to enroll it in the Medicare program; make changes or updates to the organization's status in the Medicare program; and commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program. A "delegated" official is an official who is delegated by an authorized official to report changes and updates to the DMEPOS supplier's enrollment record.

APPENDIX A (CONTINUED)

HHAs must also complete a Medicare enrollment application, using Form CMS-855A. This form requires information nearly identical to the CMS-855S, discussed above. The form is submitted to the Regional Home Health Intermediary (RHHI) for the jurisdiction in which the HHA is located. Once the RHHI has determined that the application is acceptable, it notifies both CMS and the State in which the HHA is located. The State then decides whether to conduct a site visit to the HHA. Once the State determines that it will grant permission for the HHA to participate in Medicare, it notifies CMS, and CMS makes the final decision to issue a Medicare Part A billing number.

APPENDIX B

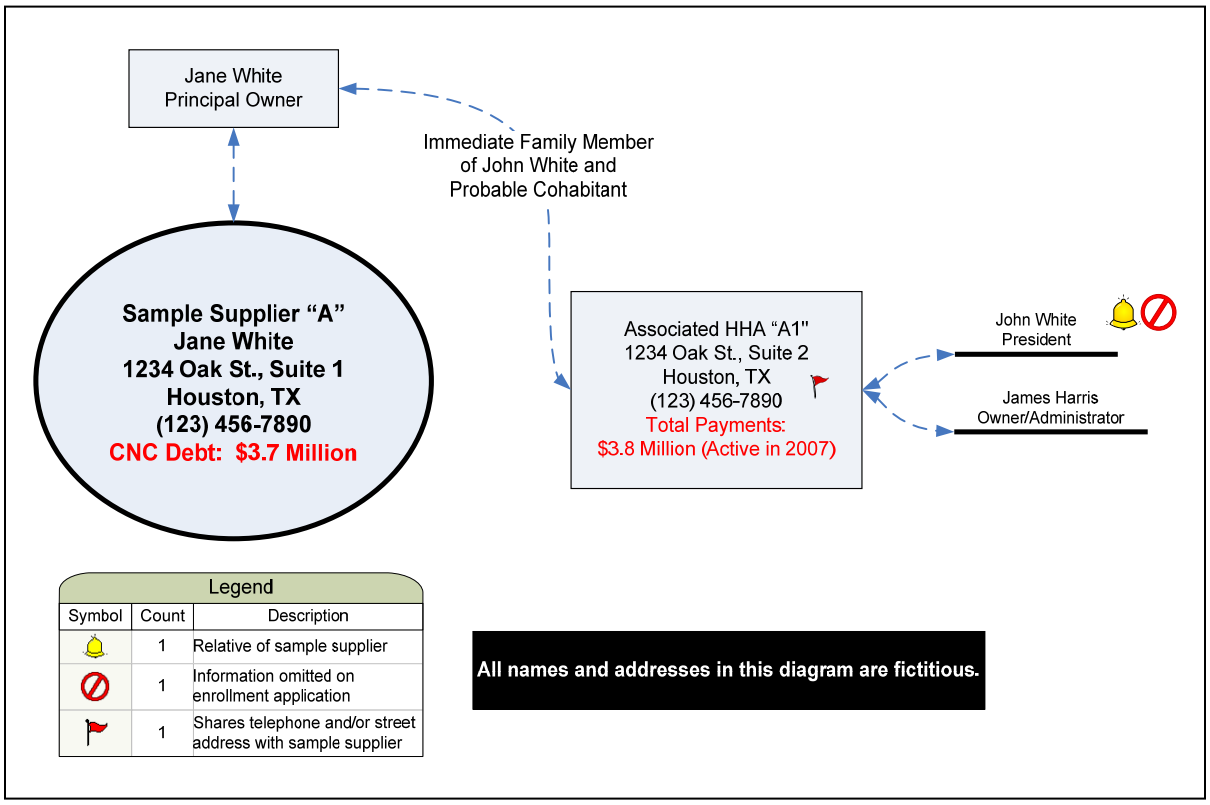
Diagrams Showing Relationships Between Sample Durable Medical Equipment Suppliers and Their Associated Suppliers and Home Health Agencies

The diagrams on the following pages contain detailed information about sample suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and associated DMEPOS suppliers and home health agencies (HHA) described in the early alert memorandum. We substituted fictitious names and addresses for real names and addresses in the diagrams. We used consistent fictitious names and addresses across individuals and businesses. For example, an individual named "John Doe" at one business is the same "John Doe" listed at another business. The same is true for street addresses. In this way, it is possible to see the recurrence of individuals and addresses across a network of associated businesses, despite the use of fictitious names. Surnames were drawn from the U.S. Census Bureau's list of most common names. Information in oval shapes pertains to sample DMEPOS suppliers, including the DMEPOS suppliers' business name, address, and billing number, as well as its total amount of "currently not collectible" (CNC) debt.

Sample DMEPOS suppliers "A," "E," and "B" were chosen to provide examples of small, medium, and large networks of associated businesses, respectively. Their networks, while unique, are good representations of the relationships seen in the other sample DMEPOS suppliers' networks. The rectangular shapes pertain to associated DMEPOS suppliers and/or HHAs, including their total payment amounts during 2002–2007. For both the sample and associated businesses, the diagrams identify individuals operating in ownership or managerial roles. In each case, the diagrams identify the relationship between the sample DMEPOS supplier and the associated business. The diagrams also denote whether enrollment applications for associated businesses omitted the name of individuals listed as owners or managers in Lexis/Nexis Accurint, a database containing public records.

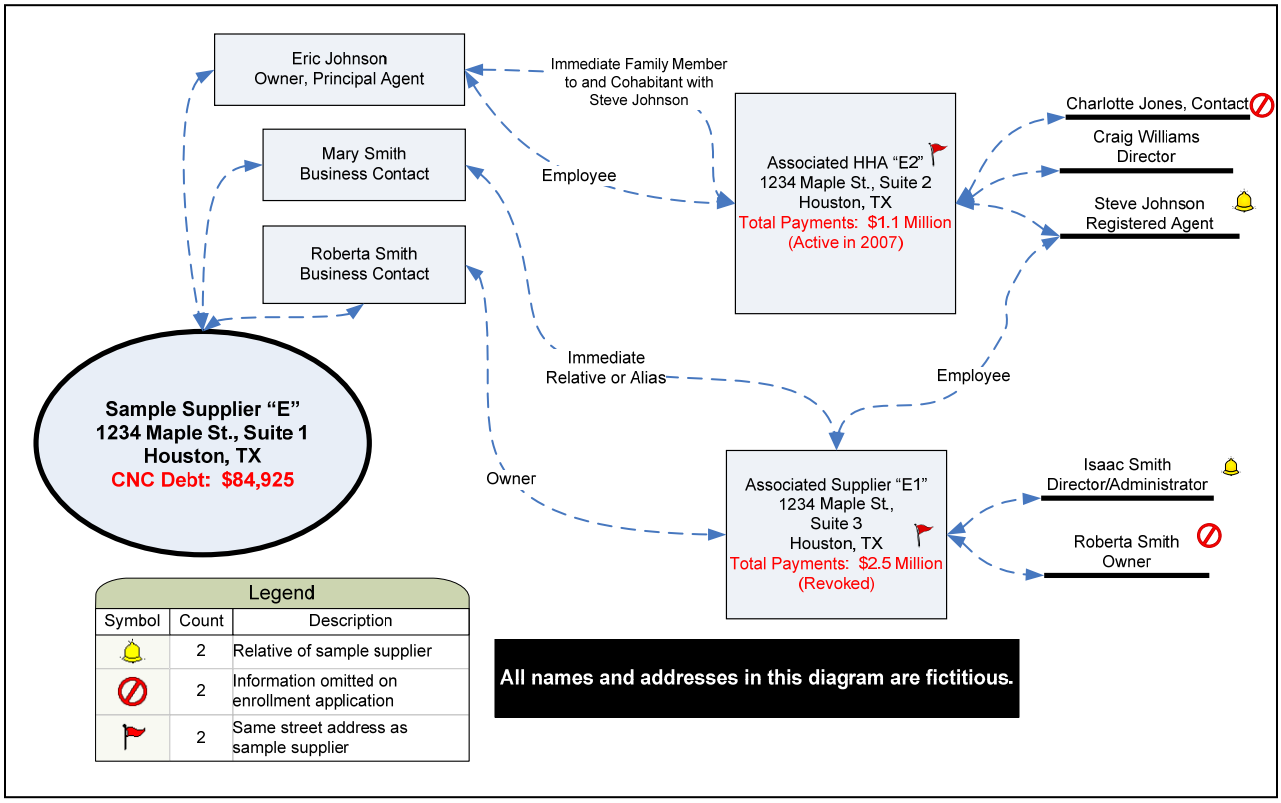
A P P E N D I X B (C O N T I N U E D)

Sample DMEPOS Supplier "A"



A P P E N D I X B (C O N T I N U E D)

Sample DMEPOS Supplier "E"



A P P E N D I X B (C O N T I N U E D)

Sample DMEPOS Supplier "B"