Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ORTHOTIC PROCEDURE CODE CLAIMS PAID TO MEDASSIST-OP, INC. BY MEDICARE DURING THE PERIOD JANUARY 1, 1994 TO DECEMBER 31, 1996

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1999
A-02-97-01039

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

November 2, 1999

Our Reference: Common Identification Number: A-02-97-01039

Paul Hughes, M.D.
Medical Director
Durable Medical Equipment Region A Carrier
60 East Main Street
Nanticoke, Pennsylvania 18634

Dear Dr. Hughes:

This Operation Restore Trust report provides you with the results of our review of Medassist-OP, Incorporated, (Medassist) located in Palm Harbor, Florida. The primary objective of our review was to determine whether the orthotic "L" procedure code claims submitted by Medassist for beneficiaries residing in New York and New Jersey met Medicare reimbursement guidelines. As part of this objective, we focused on whether services were rendered for the procedure codes claimed and if the correct procedure codes were claimed.

SUMMARY OF FINDINGS

We randomly selected 113 claims submitted by Medassist for Medicare reimbursement during the period January 1, 1994 though December 31, 1996. Our review disclosed that Medassist did in fact provide products and services for all the claims in our sample, but in 99 percent of the cases (112 of 113 claims), the billing did not meet Medicare reimbursement guidelines. We determined that Medassist improperly:

- submitted 79 claims whereby the product supplied did not meet the definition of the procedure code billed to Medicare. Medassist upcoded the claims;
- misrepresented services on 27 claims when they billed one product under two separate procedure codes;
- submitted three claims for durable medical equipment (DME) for residents of nursing homes; and
- received reimbursement for three claims in excess of the least costly alternative pricing methodology.

As a result, Medassist was overpaid at least $1,616,222 for the period January 1, 1994 through December 31, 1996. Using the 90 percent confidence interval, we believe the overpayment is between $1,616,222 and $1,771,397. We recommend that the DME Region A Carrier (DMERC) recover the overpayment identified by our audit, more closely monitor the claims submitted by Medassist and conduct periodic in-depth reviews of its claims.

In comments dated October 20, 1999, the DMERC fully concurred with our findings and recommendations.

INTRODUCTION

Background

An orthosis is a device, sometimes called a brace, applied to the outside of the body that supports a body part. The practice of providing orthoses is called orthotics, which literally means the systematic pursuit of straightening or correcting. The devices are usually made of rigid materials and are customized for an individual's use. People who need orthotics range from the severely disabled, such as paraplegics or quadriplegics, to someone who requires an ankle brace for better gait. A person may need to wear the orthotic all the time for life, or every day until the condition improves, or some other time frame as prescribed by the physician. Since each orthotic is fitted for a particular patient's use, an orthotic device cannot be used properly by anyone else.

Medassist is a DME provider located in Palm Harbor, Florida which specializes in orthotic devices. Medassist utilizes field representatives to operate in 35 states throughout the country. However, our review was limited to claims submitted to Medicare on behalf of beneficiaries residing in New York or New Jersey.

Data obtained from the Statistical Analysis DMERC (SADMERC) revealed that Medassist was the number one orthotic "L" code provider in New York State and the number three provider in New Jersey based on Medicare paid amounts for the approximate 2-year period ended June 30, 1996. The "L" codes are used to claim reimbursement for orthotic items. Although there are 465 different orthotic procedure codes available for providers to use, Medassist only submitted claims for 23 orthotic procedure codes designated for the lower body limb, upper body limb and spinal area.

Objectives, Scope and Methodology

The objective of our audit was to determine the propriety of orthotic "L" procedure code claims paid to Medassist by Medicare Part B for beneficiaries residing in New York or New Jersey. As part of this objective, we focused on whether: (1) services were rendered for the procedure codes billed, (2) the correct procedure codes were claimed, and (3) the beneficiaries were residents of nursing homes.

Medassist was selected for review as part of our targeting efforts during Operation Restore Trust. Previous reviews by the Office of Inspector General determined significant problems with orthotic claims submitted to Medicare and Medicaid on behalf of nursing home residents. Information received by our office revealed that Medassist was one of the leading marketers/manufacturers of orthotic devices in the nursing home market. In addition, conversations with officials from your staff revealed that early provider education with Medassist failed to correct their practice of submitting improper claims to Medicare. In planning this review, we also learned that New York State terminated this provider from Medicaid for several reasons including that certain of its products did not meet the definition of the procedure codes billed. In addition, SADMERC officials had expressed concern about the use of inappropriate billing procedure codes by Medassist. All these issues heightened our concerns with the claims submitted to Medicare by Medassist. Therefore, it was agreed that we would conduct an audit and coordinate our efforts with your staff.

We ran computer applications against the HCFA National Claims History File to extract the 14,515 orthotic "L" procedure code claims Medassist submitted to Medicare for beneficiaries residing in New York and New Jersey during the period January 1, 1994 through December 31, 1996. The total reimbursement for these claims was $2,407,934. After eliminating the claims previously reviewed by other agencies and unpaid claims, we obtained an audit universe of 8,991 claims totaling $2,265,645. These claims were assigned to three strata based on the dollar-value of the claim. The first stratum contained 6,681claims totaling $977,746 with paid to provider amounts from $0.01 through $300.00. The second stratum contained 2,297 claims totaling $1,274,702 with paid to provider amounts from $300.01 through $700.00. The third stratum contained 13 claims totaling $13,197 with paid to provider amounts in excess of $700.

From the audit universe, we selected a stratified statistical sample of 113 claims made on behalf of 111 beneficiaries. We are reporting the overpayment projected from this sample at the lower bound of the 90 percent confidence interval. APPENDIX A contains the details of our sampling methodology.

During our review, we held discussions with officials from Medassist, the Health Care Financing Administration (HCFA), the SADMERC, New York State and beneficiaries' relatives. In addition, we met with you and your staff to discuss the results of our review and consult on the appropriateness of the procedure codes billed. We also made site visits to the beneficiaries' homes, including nursing homes, to obtain information related to the 113 claims selected. Of the 111 beneficiaries representing the 113 claims, 110 were residents of nursing homes. While at the nursing homes, we:

(1) held discussions with nursing home staff;

(2) reviewed and obtained copies of the beneficiaries' related medical records;

(3) inspected and took photographs of the orthotic items furnished to beneficiaries (if available); and

(4) compared furnished orthotic items with the procedure codes claimed as depicted in the Illustrated Guide to Orthotics and Prosthetics (IGOP).

Further, we conducted a site visit to Medassist to review supporting documentation, discuss its Medicare billing procedures, and to inspect and photograph representative orthotic items billed by Medassist for the claims in our sample.

Our audit was conducted in accordance with generally accepted government auditing standards. We used applicable laws, regulations, and Medicare guidelines to determine whether the items claimed by Medassist met reimbursement requirements. Our audit included such tests and other auditing procedures that we considered necessary. We did not perform a review of Medassist's internal controls nor did we place reliance thereon. Additionally, we did not discuss the results of our review with Medassist officials. Our audit field work was conducted intermittently from August 1997 through April 1998.

Detailed Results of Review

We randomly selected 113 claims submitted by Medassist for Medicare reimbursement during the period January 1, 1994 though December 31, 1996. Our review disclosed that Medassist did in fact provide products and services for all the claims in our sample, but in 99 percent of the cases (112 of 113 claims), the billing did not meet Medicare reimbursement guidelines. We determined that Medassist improperly:

- submitted 79 claims whereby the product supplied did not meet the definition of the procedure code billed to Medicare. Medassist upcoded the claims;
- misrepresented services on 27 claims when they billed one product under two separate procedure codes;
- submitted three claims for DME for residents of nursing homes; and
- received reimbursement for three claims in excess of the least costly alternative pricing methodology.

Based on these results, we estimate that Medassist was overpaid between $1,616,222 and $1,771,397 for products that did not meet reimbursement criteria. The midpoint of the confidence interval amounted to $1,693,810. Our tests were based on stratified random sampling techniques and the ranges shown have a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 4.58. (See APPENDIX B for the details of our sample review).

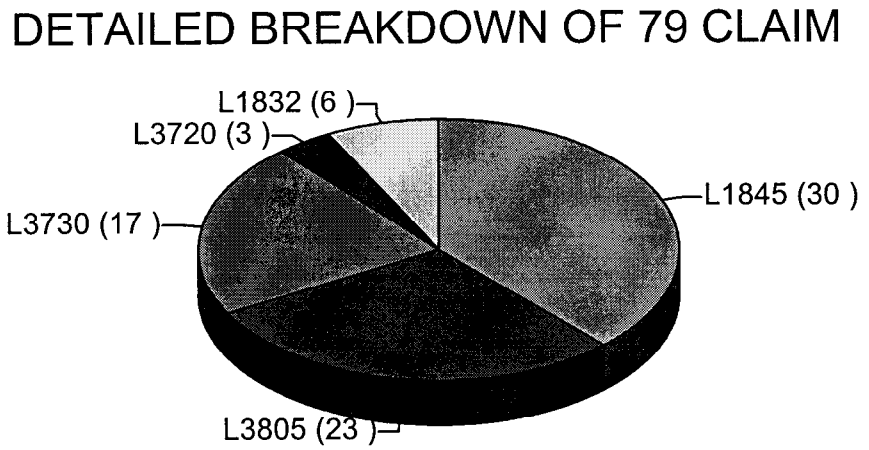
Each of our findings are discussed further in the section that follows.

Upcoding

Medassist submitted a significant number of claims to Medicare that were improper. We determined that 79 of the 113 claims in our review were improper because the off-the-shelf products supplied by Medassist did not meet the definition of the procedure codes they billed to Medicare.

The orthotic "L" procedure codes used by providers are described in the DMERC Supplier Manual and depicted in the IGOP. However, if a product supplied does not meet the description of a specific procedure code, the DME provider should submit a claim to the DMERC using a miscellaneous procedure code. According to DMERC personnel, L2999 is the miscellaneous procedure code that should be used for lower limb devices and L3999 is the miscellaneous procedure code that should be used for upper limb devices. Upon receipt of a claim for one of these miscellaneous procedure codes, the DMERC would research the particular product supplied and individually price the item for reimbursement.

We found that 79 claims should have been billed as miscellaneous procedure codes but instead Medassist billed them using inappropriate codes that resulted in Medassist receiving excess compensation. Medassist improperly used five orthotic "L" procedure codes as depicted below:



The problems noted with each of these codes is discussed below.

a. Upcoded L1845 Claims

Medassist submitted 30 claims in our sample for procedure code L1845. The DMERC Supplier Manual and the IGOP both describe this procedure code as a "knee orthosis, double upright,

thigh and calf with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted." This procedure code required the item to be a custom fitted knee orthosis. However, we found that the items supplied by Medassist were off-the-shelf knee splints used to treat or prevent contractures. We consulted with your staff and agreement was reached that the products supplied by Medassist were not custom fitted and should have been billed using a miscellaneous code.

There was a considerable financial incentive to Medassist in using code L1845. For example, on September 29, 1995, Medassist submitted a claim to Medicare for a knee splint using procedure code L1845 and received reimbursement totaling $536. However, if Medassist had submitted the claim using procedure code L2999, they would have received reimbursement totaling $103. Therefore, by billing the wrong code Medassist received excess reimbursement totaling $433 for this claim.

Similar price differences were found for the other 29 sample errors involving L1845 claims. Therefore, we determined that all 30 claims in our sample for procedure code L1845 were improper and should have been billed using miscellaneous procedure code L2999.

b. Upcoded L3805 Claims

Medassist also submitted 23 claims in our sample for procedure code L3805. The DMERC Supplier Manual and the IGOP both describe this procedure code as a "wrist-hand-finger orthosis, long opponens, no attachment additions." According to the IGOP, this custom-fabricated orthosis was designed to be used to maintain both the transverse and longitudinal arch of the hand and hold the thumb in a functional position. The forearm extension also maintains the wrist in a functional position. This procedure code required the item to be a custom fabricated wrist-hand-finger orthosis. However, we found that the items supplied by Medassist were off-the-shelf hand splints used to treat or prevent contractures. In conjunction with your staff, we determined that these items were not custom fabricated and should have been billed using a miscellaneous code.

The upcoded L3805 claims were profitable to Medassist. For example, on September 25, 1996, Medassist submitted a claim to Medicare for two hand splints using procedure code L3805 and received reimbursement totaling $446. However, if Medassist had submitted the claim using procedure code L3999, they would have received reimbursement totaling $189. Therefore, by billing the wrong code Medassist received excess reimbursement totaling $257 for this claim.

Similar price variances were found in the other 22 errors identified in our sample involving L3805 claims. Therefore, we determined that all 23 claims in our sample for procedure code L3805 were improper and should have been billed using miscellaneous procedure code L3999.

c. Upcoded L3730 Claims

In addition, Medassist submitted 17 claims in our sample for procedure code L3730. The DMERC Supplier Manual and the IGOP both describe this procedure code as an "elbow orthosis, double upright with forearm/arm cuffs, and extension/flexion assistance." According to the IGOP, this custom fabricated orthosis made from tracings, should be designed primarily to provide medial-lateral support of the elbow and contain a spring-loaded elbow joint to assist raising or lowering the forearm. This procedure code required the item to be a custom fabricated elbow orthosis. However, we found that the items supplied by Medassist were off-the-shelf elbow splints used to treat or prevent contractures and did not appear to have a mechanism to assist in the raising or lowering of the forearm.

For example, on February 28, 1996, Medassist submitted a claim to Medicare for an elbow splint using procedure code L3730 and received reimbursement totaling $618. However, if Medassist had submitted the claim using procedure code L3999, they would have received reimbursement totaling $94. Therefore, by billing the wrong code Medassist received excess reimbursement totaling $524 for this claim.

Similar price variances were found on the other 16 error claims involving procedure code L3730. After discussions with your staff, we determined that all 17 claims in our sample for procedure code L3730 were improper and should have been billed using miscellaneous procedure code L3999.

d. Upcoded L3720 Claims

Further, Medassist submitted three claims in our sample for procedure code L3720. The DMERC Supplier Manual and the IGOP both describe this procedure code as an "elbow orthosis, double upright with forearm/arm cuffs, free motion." According to the IGOP, this custom-fabricated orthosis made from tracings should be designed primarily to provide medial-lateral support of the elbow. This procedure code required the item to be a custom fabricated elbow orthosis. However, we found that the items supplied by Medassist were off-the-shelf elbow splints used to treat or prevent contractures. After discussions with your staff, we determined that all three claims in our sample for procedure code L3720 were improper and should have been billed using miscellaneous procedure code L3999.

For example, on September 27, 1996, Medassist submitted a claim to Medicare for an elbow splint using procedure code L3720 and received reimbursement totaling $458. However, if Medassist had submitted the claim using procedure code L3999, they would have received reimbursement totaling $94. Therefore, by billing the wrong code Medassist received excess reimbursement totaling $364 for this claim. Similar price variances were found in the other two error claims involving procedure code L3720.

e. Upcoded L1832 Claims

Moreover, Medassist submitted six claims in our sample for procedure code L1832. The IGOP describes this procedure code as a "knee orthosis, adjustable knee joints, positional orthosis, rigid support, custom-fitted." In addition, the DMERC Supplier Manual describes this procedure code as a "knee orthosis, adjustable knee joints, positional orthosis, rigid support." According to DMERC personnel, the L1832 product, should be used following injury for rehabilitative purposes. However, we found that the items supplied by Medassist were off-the-shelf knee splints used to treat or prevent contractures. After consulting with your staff, we determined that all six claims in our sample for procedure code L1832 were improper and should have been billed using miscellaneous procedure code L2999.

For example, on September 11, 1996, Medassist submitted a claim to Medicare for two knee splints using procedure code L1832 and received reimbursement totaling $871. However, if Medassist had submitted the claim using procedure code L2999, they would have received reimbursement totaling $205. Therefore, by billing the wrong code Medassist received excess reimbursement totaling $666 for this claim. Similar price variances were found in the other five claims for procedure code L1832.

With respect to upcoding, our determinations that the products supplied by Medassist did not meet the definitions of the procedure codes billed were only made after consultation with and agreement by your staff. We periodically met with you and your staff to discuss the results of our review. During the meetings, it was agreed that the products supplied by Medassist did not meet the procedure codes billed to Medicare. Specifically, your staff indicated that when "L" procedure codes are assigned by HCFA to products they have been developed around a prototype. When products are reviewed for coding guidance, the product under consideration is evaluated against the prototype. Attention is given, not just to the product's description, but also to the prototype and the history of the particular "L" procedure code. The "L" procedure codes are designed and priced to describe products that are individually manufactured by the orthotics industry, and not mass produced as is the case with Medassist's products. The developed price includes materials and professional fees related to the evaluation, fitting, and follow-up. Further, Medassist's products are designed to brace contractures to keep them from getting worse, but they are not rehabilitative products. After discussions with your staff, we determined that all 79 upcoded claims in our sample should have been billed using either miscellaneous procedure code L2999 or L3999.

Misrepresentation of Services

We believe that Medassist misrepresented its services when they submitted claims for their basic hand splints and improperly billed them as two separate procedure codes. Every time Medassist provided a hand splint, they would submit a claim for procedure code L3805 and an additional claim for either procedure code L3810 or L3860. The DMERC Supplier Manual and the IGOP both describe procedure code L3810 as a wrist-hand-finger orthosis, addition to short and long

opponens, thumb abduction "C" bar. The "C" bar is used to hold the thumb in a functional position. In addition, L3860 is described as a "wrist-hand-finger orthosis, addition to the short and long opponens, adjustable metacarpal phalangeal flexion control and interphalangeal." This addition should be used to assist the hand and fingers with flexion control.

Of the 113 claims in our review, Medassist submitted six and 21 claims for procedure codes L3810 and L3860, respectively. A detailed analysis of each of these 27 claims determined that Medassist provided a basic off-the-shelf hand splint. After consulting with your staff, we jointly concluded that the product supplied by Medassist and billed as procedure code L3810 did not hold the thumb in a functional position. Further, the product supplied by Medassist and billed as procedure code L3860 did not provide any assistance for flexion control.

For example, in 1996 Medassist submitted a claim for procedure code L3805 and received reimbursement totaling $223. At the same time, Medassist submitted another claim for procedure code L3860 causing them to receive additional reimbursement of $84, making the combined reimbursement $307 for the hand splint. Further, we were informed by DMERC officials that the hand splints supplied by Medassist did not contain either of the additions as claimed. Therefore, we believe that Medassist was misrepresenting its services by submitting claims for their basic hand splints by billing two separate procedure codes when only one product was received by the beneficiary.

Medassist officials contend that when they bill procedure codes L3810 and L3860 they are submitting a claim for either a styrofoam insert (roll with a cover) or a plastic air bladder that attaches to their hand splint. However, officials from your office stated that the rolls and the air bladders are part of the basic hand splint and are not special attachments. Your officials also assert that neither the rolls nor air bladder billed by Medassist as procedure codes L3810 and L3860 provide the necessary flexion control assistance. Moreover, your staff stated that procedure codes L3810 and L3860 are designed to be additions or attachments to legitimate procedure code L3805 orthotic items and not the products supplied and billed by Medassist as L3805.

Therefore, we determined that all six L3810 and 21 L3860 procedure code claims in our review were improper.

DME in Nursing Home Setting

Contrary to Medicare regulations, Medassist was providing DME to beneficiaries residing in a nursing home and improperly billing Medicare. Medassist submitted four claims in our sample to Medicare for procedure code L3968 and received reimbursement totaling $2,747. The IGOP and DMERC Supplier Manual both describe procedure code L3968 as, "a shoulder-elbow-wrist-hand orthosis, mobile arm support attached to a wheelchair, balanced and fitted to patient, friction arm support (friction dampening to proximal and distal joints)." According to your staff, procedure code L3968 can only be used on wheelchairs, and therefore is considered DME.

Medicare regulations prohibit the claiming of DME for residents of nursing homes. Specifically, 42 CFR section 410.38 stipulates that Medicare Part B pays for the rental or purchase of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home. This same regulation also stipulates that an institution that is used as a home may not be a skilled nursing facility or nursing home. Nonetheless, during our site visits we found all four of these devices attached to wheelchairs and that three of the four L3968 claims in our sample were for beneficiaries residing in nursing homes. We also found that Medassist incorrectly reported the place of service for each of these three beneficiaries as a private residence, and not a nursing home.

Therefore, we determined that Medassist improperly received Medicare reimbursement totaling $2,059 for three L3968 procedure code claims.

Least Costly Alternative

Medassist submitted three claims in our sample for procedure code L4310. The IGOP and the DMERC Supplier Manual describe procedure code L4310 as a "multi-podus or equal orthotic preparatory management system for lower extremities." Regulations found in the DMERC Supplier Manual at Section 16.2-3 stipulate, "If a multi-podus type splint (L4310) is provided and all the criteria for Code K0129 are met, payment is based on the allowance for the least costly alternative."

Although the product supplied by Medassist meets the definition of procedure code L4310, we determined that it also meets the description of procedure code K0129. The DMERC Supplier Manual describes procedure code K0129 as an ankle contracture splint. In our opinion, the item supplied by Medassist meets the description of an ankle contracture splint. Also, this issue was discussed with your staff and it was agreed that Medassist should have been reimbursed for this item under procedure code K0129.

The Medicare reimbursement for procedure code L4310 was $317 for 1994 and 1995 and $335 for 1996. Whereas, the Medicare reimbursement for procedure code K0129 in 1994 and 1995 was $91.32 and $94.06 in 1996. Therefore, consistent with the DMERC's policy, we down-coded all three claims in our sample from procedure code L4310 to procedure code K0129.

CONCLUSIONS AND RECOMMENDATIONS

We found that Medassist was improperly upcoding the procedure codes, misrepresenting its services, providing DME in nursing home settings, and receiving reimbursement in contrast to the least costly alternative when they submitted their claims to Medicare. All these billing practices by Medassist enabled them to receive excess reimbursement totaling at least $1,616,222. These findings are consistent with observations made by New York State officials,

the SADMERC and your staff. Therefore, we believe that this provider warrants close scrutiny.

We recommend that the Region A DMERC:

- recover the estimated overpayment of $1,616,222; and
- more closely monitor the claims submitted by Medassist and conduct periodic, in-depth reviews of its claims.

DMERC's Comments and OIG Response

In comments dated October 20, 1999, the DMERC fully concurred with our findings and recommendations. The DMERC also indicated in its response that DMERC officials had previously commented to us informally about changes in wording in the report regarding unbundling (the OIG should use the word misrepresenting instead of unbundling) and changes in the verbiage in a certain HCPCS definition. The complete text of the DMERC's comments is presented as APPENDIX C.

We are pleased that the DMERC fully concurred with our findings and recommendations. Regarding the DMERC's comments about wording changes involving unbundling and a certain HCPCS definition, we agree and have incorporated these two suggestions into our final report.

Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

Please refer to Common Identification Number A-02-97-01039 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management, HCFA, Region II
US Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

APPENDICES
A, B, C

APPENDIX A

STATISTICAL SAMPLING METHODOLOGY

Objective:	To determine the propriety of orthotic "L" procedure code claims paid to Medassist by Medicare Part B for beneficiaries residing in New York or New Jersey.
Population:	The universe consisted of claims totaling $2,265,645 for orthotic items provided to residents of New York or New Jersey during the period January 1, 1994 through December 31, 1996.
Sampling Unit:	Orthotic "L" procedure code claim for a Medicare beneficiary.
Sampling Design:	A stratified random sample was used.
Sample Size:	A sample size of 113 sample items (50 items in stratum 1, 50 items in stratum 2, 13 items in stratum 3).
Source of Random Numbers	Department of Health and Human Services, Office of Inspector General, Office of Audit Services Random Number Generator.
Estimation Methodology:	We used the Department of Health and Human Services, Office of Inspector General, Office of Audit Services variables appraisal program to appraise the sample results, and used the lower limit at the 90 percent confidence level to estimate the overpayment.
Method of Selecting Sample Items:	The sample items in the computer file containing the sampling frame were sorted in ascending order by beneficiary number, orthotic "L" procedure code, and service date. For each of the three strata, the claims were consecutively numbered.

APPENDIX B

DETAILS OF SAMPLE REVIEW					
Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	6,681	50	$ 977,745.74	50	$ 4,963.49
2	2,297	50	1,274,701.85	49	22,201.58
3	13	13	13,197.36	13	10,647.46
Total	8,991	113	$2,265,644.95	112	$37,812.53

HCFA
Health Care Financing Administration

A-02-97-01039

MEDICARE
REGION A DME-CARRIER

570-735-9619

October 20, 1999

Jim Cox
Office of Inspector General
14 Computer Drive West
Albany, NY. 12205-1607

Dear Mr. Cox,

This is follow-up correspondence related to the Medassist report issues to the Region A DMERC in August 1999. As discussed in previous telephone conversations, the Region A DMERC does concur with the Medassist report that was disseminated to the carrier in August. As per your request, we did comment with some personal comments related to the Medassist report that was forwarded to you in September. In discussion with Dr. Hughes, we do concur with the Medassist report and your findings pertaining to the orthotic study. As we did discuss those two areas for comments pertaining to the unbundling and the verbiage in the HCPCS Codes definition, those changes should be made throughout your report. The Region A DMERC does also recommend that this report be provided to HCFA for any additional comments. Thank you for this opportunity to review the report and providing you assistance in this matter. If there are any questions related to this commentary, please contact me at 570-735-9619.

Sincerely,

Tina M McCarthy, RN, BSN
Manager, Medical Review
Region A DMERC

cc: Dr. Paul Hughes
Medical Director
Region A DMERC

Jeanne Mariani
Site Director
Region A DMERC

TM/LT