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Durable Medical Equipment and Supplies Activities in the OIG's 2011 Work Plan

Newsletters and Client Bulletins

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On October 1, 2010, The U.S. Department of Health and Human Services Office of the Inspector General ("OIG") released its Work Plan for 2011. The OIG releases its work plan for each year in advance of the coming year. The work plan provides stakeholders in the health care industry with a broad overview of the OIG's activities in the coming year as they relate to its enforcement priorities and issues it will review and evaluate during that fiscal year. This client alert is one in a series of alerts that will outline the OIG's activities, as discussed in the 2011 Work Plan, for a specific industry sector – suppliers of durable medical equipment and prosthetic and orthotic supplier ("DMEPOS").

The OIG's activities relating to DMEPOS suppliers for 2011 are broadly focused on issues such as medical necessity of items supplied, frequency of replacement of supplies, suppliers' documentation in support of their claims for Medicare reimbursement, the competitive bidding program, enrollment and monitoring of suppliers, and cost containment measures. The following is a summary of each of the issues and what the OIG is focusing on.

Medical Necessity and Frequency of Replacement

- **Medicare Payments for Various Categories of Durable Medical Equipment.** The OIG Office of Evaluations and Inspections ("OEI") will be conducting reviews of the medical necessity for power mobility devices (e.g., scooters), hospital beds and accessories, oxygen concentrators, and enteral/parenteral nutrition. The OIG advised that it has found significant issues with these services and supplies in the past, such as no physician orders, no delivery to beneficiaries and no medical necessity. OEI expects to finish its reviews in fiscal year ("FY") 2011.
- **Medicare Payments to Durable Medical Equipment Suppliers for Power Wheelchairs.** The OEI will review documentation for payments to DMEPOS suppliers for standard and complex rehabilitation power wheelchairs to determine whether the claims were medically necessary. Medicare Part B payment rules require that power wheelchairs be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The OEI will also determine whether suppliers have documentation in beneficiaries' medical records that supports the medical necessity of the power wheelchairs and whether this was consistent with documentation from the physicians who ordered the power wheelchairs. OEI expects to complete this review in FY 2011.
- **Frequency of Replacement Supplies for Durable Medical Equipment.** The OIG Office of Audit Services ("OAS") is going to conduct audits of randomly selected claims in order to review how DMEPOS suppliers are dealing with the frequency for replacement supplies. The certificate of medical necessity is supposed to specify the frequency. Suppliers are not supposed to dispense an automatic amount on a predetermined regular basis. OIG advised that an earlier study had identified that certain supplies for sleep apnea devices were being provided on a regular predetermined basis. OAS expects to finish its audits in FY 2011.

Suppliers' Documentation in Support of Claims

- **Medicare Payments for Durable Medical Equipment Claims With Modifiers.** The OAS will review the appropriateness of Medicare Part B payments to DMEPOS suppliers that submitted claims with modifiers. Medicare precludes payment to any service provider unless the provider has furnished the information necessary to determine the amounts due such provider. For certain items to be covered under the Medicare program, DMEPOS suppliers must use modifiers to indicate that they have the appropriate documentation on file. In addition, the suppliers are required to provide, upon request, the documentation to support their claims for payment. Reviews of suppliers conducted by several of CMS's DMEPOS Medicare Auditor Contractors ("MACs") found that suppliers had little or no documentation to support their claims, suggesting that many of the claims submitted may have been invalid and should not have been paid by Medicare. The OAS will determine whether payments to DMEPOS suppliers met Medicare requirements. The OAS expects to complete this audit in FY 2011.
- **Medicare Part B Payments for Home Blood Glucose Testing Supplies.** The OAS will review Medicare Part B payments for home blood glucose test strips and lancet supplies. Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." The local coverage determinations ("LCD") issued by the four DMEPOS MACs require that the physician's order for each item billed to Medicare include certain elements and be retained by the supplier to support billing for those services. Further, the LCDs require that the supplier add a modifier to identify when a patient is treated with insulin or not treated with insulin. The amount of supplies allowable for Medicare reimbursement differs depending on the applicable modifier. The OAS will determine the appropriateness of Medicare Part B payments to DMEPOS suppliers for home blood glucose test strips and lancet supplies. The OAS expects to complete this review in FY 2012.

Competitive Bidding Program

- **Competitive Bidding Program: Supplier Influence on Physician Prescribing.** The OEI will review DMEPOS claims to determine the extent to which suppliers participating in the competitive bidding program are soliciting physicians to prescribe certain brands or modes of delivery of covered items that are more profitable to suppliers. Pursuant to the Social Security Act, CMS is required to establish a competitive bidding process for the purchase of selected DMEPOS items, which Congress delayed until 2011. The Social Security Act requires that OIG conduct reviews (including this evaluation) to examine the competitive bidding process. The OEI will also examine billing patterns to identify changes resulting from competitive bidding. The OEI expects to conduct these reviews in FY 2012.
- **Competitive Bidding Process for Medical Equipment and Supplies.** The OAS will review the process CMS used to conduct competitive bidding and subsequent pricing determinations for certain DMEPOS items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program. The Medicare Improvements for Patients and Providers Act ("MIPPA") requires OIG to conduct postaward audits to assess the process used by CMS for competitive bidding and subsequent pricing determinations under rounds 1 and 2 of the competitive bidding program. The OAS expects to complete this review in FY 2011.

- **Medicare Market Shares of Mail-Order Diabetic Testing Strips.** The OEI will determine the brands and models of diabetic testing strips reimbursed by Medicare. The Social Security Act requires OIG to complete a study of diabetic testing strip products and submit it to the Secretary before January 1, 2011. CMS may use the results of this study in future rounds of competitive bidding for mail-order diabetic testing strips to ensure that suppliers that submit winning bids are able to provide beneficiaries' preferred types of testing strips. The OEI will also determine the market shares of diabetic testing strips that Medicare beneficiaries receive by mail order. The OEI expects to complete this review in FY 2011.

Enrollment and Monitoring of DMEPOS Suppliers

- **Medicare Enrollment and Monitoring of DMEPOS Suppliers.** The OEI will review Medicare contractors' processes for enrolling and monitoring suppliers of DMEPOS. Pursuant to CMS's Medicare Program Integrity Manual, Medicare contractors must conduct prescreening, verification, validation, and final processing of Medicare provider enrollment applications. A recent OIG study found that suppliers omitted or provided inaccurate information on enrollment applications, which resulted in improper enrollment. The OEI will also assess Medicare contractors' use of enrollment screening mechanisms and post-enrollment monitoring activities to identify applicants that pose fraud risks to Medicare and the extent to which applicants omitted ownership information on enrollment applications. The OEI expects to complete this review in FY 2011.
- **Medicare Qualifications of Orthotists and Prosthetists.** The OEI will review the extent to which Medicare claims for orthotics and prosthetics were paid to unqualified practitioners in 2009. The OEI will also assess whether CMS provided guidance to State licensing boards and industry on how to define a "qualified practitioner" of orthotics and prosthetics. Pursuant to the Social Security Act, no payment may be made for such items unless provided by a "qualified practitioner" as defined in the statute. Previous OIG work found that miscoded orthotics represented $33 million in inappropriate Medicare payments in 1998 because the device did not meet the specifications billed, the device was not custom-fabricated, or the part billed was already included in the base code for a larger device. OIG concluded that the qualifications of orthotic suppliers varied, with noncertified suppliers most likely to provide inappropriate devices and services. The OEI will review the credentials of a sample of providers submitting orthotic and prosthetic claims and determine the extent to which CMS provides oversight of credentialing of orthotists and prosthetists. The OEI expects to complete this review in FY 2011.

Cost Containment Considerations

- **Medicare Pricing for Parenteral Nutrition.** The OEI will review Medicare's fee schedule for parenteral nutrition, compared with fees paid by other sources of reimbursement. Parenteral nutrition is the practice of feeding a person intravenously to replace the function of a permanently inoperative or malfunctioning internal body organ and is covered under the prosthetic device benefit of the Social Security Act. In 2009, Medicare paid more than $137 million for parenteral nutrition supplies. Previous OIG work found that Medicare allowances for major parenteral nutrition codes averaged 45% higher than Medicaid prices, 78% higher than prices available to Medicare risk-contract health maintenance organizations ("HMOs"), and 11 times higher than some manufacturers' contract prices. The OEI will also identify reimbursement amounts paid by public and private payers for parenteral nutrition services. The OEI expects to complete this review in FY 2012.
- **Medicare Part B Payments for Lower Limb Prostheses in 2009.** The OEI will review Medicare payments for lower-limb prostheses in 2009. In 2009, Medicare paid about $655 million for lower-limb prostheses, which represented 82% of Medicare Part B payments for all prostheses. Over the last five years, payments for lower-limb prostheses increased by 27%. The OEI will also assess the policies and practices that Medicare contractors have in place for lower-limb prosthetic claims to prevent fraud, waste, and abuse. The OEI expects to complete this review in FY 2011.

Each of the above areas of inquiry in the OIG's 2011 Work Plan represent issues that DMEPOS suppliers should be tuned into. OIG Work Plan priorities often result in additional enforcement action, significant change in CMS policy or both.

For more information on the OIG's Work Plan for 2011, its priorities, Medicare and Medicaid program integrity initiatives in general or assistance with responding to an OIG or OEI inquiry relating to any issue, please contact a member of Benesch's Health Care Department:

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