DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

September 9, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Jurisdiction A Medicare Payments for Selected Durable Medical Equipment Claims With the KX Modifier for Calendar Year 2007 (A-01-09-00528)

Attached, for your information, is an advance copy of our final report on Jurisdiction A Medicare payments for selected durable medical equipment claims with the KX modifier for calendar year 2007. We will issue this report to National Heritage Insurance Company, the durable medical equipment Medicare administrative contractor for Jurisdiction A, within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-09-00528 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

September 13, 2010

Report Number: A-01-09-00528

Ms. Anne Bockhoff Dalton
Vice President
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

Dear Ms. Dalton:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Jurisdiction A Medicare Payments for Selected Durable Medical Equipment Claims With the KX Modifier for Calendar Year 2007.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kimberly D. Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-09-00528 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF JURISDICTION A MEDICARE PAYMENTS FOR SELECTED DURABLE MEDICAL EQUIPMENT CLAIMS WITH THE KX MODIFIER FOR CALENDAR YEAR 2007

Daniel R. Levinson
Inspector General

September 2010
A-01-09-00528

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to sections 1832(a)(1) and 1861(n) of the Social Security Act (the Act), Medicare Part B provides for the coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Centers for Medicare & Medicaid Services (CMS) contracted with four durable medical equipment Medicare administrative contractors (DME MAC) to process and pay Medicare Part B claims for DMEPOS. These DME MACs replaced the Durable Medical Equipment Regional Carriers. Also, CMS contracts with Palmetto Government Benefits Administrators, LLC, to serve as the National Supplier Clearinghouse. The National Supplier Clearinghouse is responsible for enrolling and reenrolling DMEPOS suppliers.

Under the statutory and policy framework of the Act, the *Medicare National Coverage Determinations Manual* defines DME as equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. For certain DMEPOS, suppliers must use the KX modifier on filed claims. The KX modifier indicates that the claim meets the Medicare coverage criteria and the supplier has the required documentation on file. While suppliers must have a written physician's order and proof of delivery for all DMEPOS, suppliers must have additional documentation on file for items requiring the KX modifier. For example, respiratory assist devices also require documentation that a sleep study was performed before the date on the physician's order.

On January 6, 2006, CMS awarded the DME MAC contract for Jurisdiction A to National Heritage Insurance Company (NHIC). NHIC assumed full responsibility for administering the DME MAC work and began processing DMEPOS claims for Jurisdiction A as of July 1, 2006.

NHIC processed approximately $1.5 billion in Medicare DMEPOS claims with calendar year 2007 dates of service. This audit focused on $96,722,670 of Medicare paid claims processed by NHIC for therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2) that included the KX modifier.

OBJECTIVE

Our objective was to determine whether the KX modifier was effective in ensuring that suppliers of DMEPOS who submitted claims to NHIC had the required supporting documentation on file.

SUMMARY OF FINDINGS

The KX modifier was not effective in ensuring that suppliers of DMEPOS who submitted claims to NHIC had the required supporting documentation on file. Of the 100 sampled items, suppliers had the required documentation on file for 37 items. Suppliers did not have the required

documentation on file for the remaining 63 items. As a result, NHIC made unallowable payments totaling $5,296 for 63 of the 100 sampled items.

The types of missing documentation included:

- proof of delivery (24 of 100 items),
- physician's order (39 of 100 items),
- use or compliant use followup documentation (20 of 72 applicable items),
- sleep study (4 of 72 applicable items), and
- physician's statement (9 of 28 applicable items).

For 25 of the 63 items, suppliers were missing multiple required documents.

NHIC did not detect these errors because NHIC's electronic edits were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims. The edits could only determine whether the required KX modifier was on the claim. Based on our sample, we estimated that NHIC paid approximately $54 million to suppliers who did not have the required documentation on file to support the DMEPOS items with 2007 dates of service.

RECOMMENDATIONS

We recommend that NHIC:

- recover the $5,296 in payments for specific DMEPOS items claimed for which the suppliers did not have the required documentation,
- review other payments for DMEPOS related to our unallowable sample items and recover any additional unallowable payments,
- notify CMS of the 24 suppliers who did not meet the supplier standard for maintaining proof of delivery so CMS can take appropriate action, and
- develop a corrective action plan to improve supplier compliance with the KX modifier and potentially save an estimated $54 million.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments to the draft report, NHIC concurred with the first three recommendations but did not concur with the fourth recommendation. We acknowledge NHIC's comments;

however, we maintain that NHIC should take additional steps to improve supplier compliance with the KX modifier. NHIC's comments are included in their entirety as Appendix D.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (the Act) in 1965 provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Pursuant to sections 1832(a)(1) and 1861(n) of the Act, Medicare Part B provides for the coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS contracted with four durable medical equipment Medicare administrative contractors (DME MAC) to process and pay Medicare Part B claims for DMEPOS. These DME MACs replaced the Durable Medical Equipment Regional Carriers (DMERC). Also, CMS contracts with Palmetto Government Benefits Administrators, LLC, to serve as the National Supplier Clearinghouse. The National Supplier Clearinghouse is responsible for enrolling and reenrolling DMEPOS suppliers. CMS will revoke a supplier's billing privileges if it finds that the supplier does not meet the supplier standards (42 CFR § 424.57(c) and (d)).[1]

Contracts for Processing Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Claims

On January 6, 2006, CMS awarded the DME MAC contract for Jurisdiction A to National Heritage Insurance Company (NHIC). NHIC assumed full responsibility for administering the DME MAC work and began processing DMEPOS claims for Jurisdiction A as of July 1, 2006. NHIC processes DMEPOS claims for Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

KX Modifier Used for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Claims Processing

National Coverage Determinations (NCD) describe the circumstances for Medicare coverage nationwide for specific medical service procedures or devices, including DMEPOS, and generally outline the conditions under which a service or device is considered covered. The *Medicare National Coverage Determinations Manual* (Pub. No. 100-03, chapter 1, section 280.1) defines DMEPOS as equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home.

Contractors develop supplier manuals, Local Coverage Determinations (LCD), and Policy Articles for covered DMEPOS items. These materials specify under what clinical circumstances the DMEPOS item is considered to be reasonable and necessary. For covered DMEPOS items

[1] Federal requirements referenced in this document are the ones that were in effect during our audit period.

(including therapeutic shoes for diabetics (therapeutic shoes), continuous positive airway pressure systems (CPAP), respiratory assist devices (RAD), and pressure reducing support surfaces (groups 1 and 2) (PRSS)),[2] the LCDs require a KX modifier be added to the claims before they can be paid. By adding the KX modifier, the supplier attests that the claim meets the Medicare coverage criteria and that the specific required documentation, which varies based on the DMEPOS item, is on file at the supplier before submitting the claim to the DME MAC. This documentation requirement includes the written physician's order and proof of delivery that are required for all DMEPOS, as well as additional documentation such as a sleep study for a RAD claim.

Through supplier manuals, LCDs, and Internet postings, the contractors instructed the suppliers to use the KX modifier only if the suppliers have the required documentation on file. However, if the KX modifier is not used with claims for DMEPOS that require it, the claims will be denied.

This audit focused on claims paid by NHIC for therapeutic shoes, CPAPs, RADs, and PRSS.

Documentation Requirements for Selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Requiring the KX Modifier

Documentation Required to be on File at Supplier	Required by	Therapeutic Shoes	CPAP	RAD	PRSS
Physician's Order (written, signed, and dated)	-*Program Integrity Manual* (PIM), Pub. No. 100-08, chapter 5 -LCDs	X	X	X	X
Proof of Delivery	-42 CFR § 424.57(c)(12) -PIM, chapter 4	X	X	X	X
Statement of Treating/Certifying Physician Before Billing	-The Act, § 1861(s)(12)(A-C) -LCDs and Policy Articles	X			X
Polysomnography (sleep study) Before Physician's Order	-NCD -LCDs		X	X	
Use or Compliant Use Followup Statement of Physician and/or Beneficiary	-LCDs		X	X	

[2] These DMEPOS are included in the Level II Healthcare Common Procedure Coding System, which is a comprehensive, standardized system that classifies similar medical products into categories for efficient claims processing. It is the standardized coding system used for describing, identifying, and preparing claims for DMEPOS.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the KX modifier was effective in ensuring that suppliers of DMEPOS who submitted claims to NHIC had the required supporting documentation on file.

Scope

NHIC processed approximately $1.5 billion in Medicare DMEPOS claims with calendar year 2007 dates of service. This audit focused on $96,722,670 of these Medicare paid claims for therapeutic shoes, CPAPs, RADs, and PRSS that included the KX modifier.

We limited our review of internal controls to gaining an understanding of the contractor's processing of selected DMEPOS claims that were submitted with the KX modifier. We did not determine whether the sample items met other Medicare coverage criteria, such as medical necessity.

From August 2009 through December 2009, we conducted fieldwork at NHIC offices in Hingham, Massachusetts, and Los Angeles, California, and at suppliers' offices in 10 States.

Methodology

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed NHIC officials concerning the manual and electronic claims processing procedures for claims for therapeutic shoes, CPAPs, RADs, and PRSS with the KX modifier and NHIC's edits in the claims processing system to ensure that claims were adjudicated;
- interviewed NHIC officials concerning the education and training specific to the KX modifier they provided to the suppliers of therapeutic shoes, CPAPs, RADs, and PRSS;
- selected a simple random sample of 100 items from four categories of DMEPOS (Appendix A);
- made unannounced visits to the 92 suppliers[3] to obtain their documentation supporting the use of the KX modifier;
- reviewed the suppliers' documentation for the sample items to determine whether it met the documentation requirements for using the KX modifier; and

[3] Eight of the ninety-two suppliers had two items in the sample.

- requested NHIC's medical review staff review the documentation provided by the suppliers for those sample items that we determined did not meet the documentation requirements for use of the KX modifier.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The KX modifier was not effective in ensuring that suppliers of DMEPOS who submitted claims to NHIC had the required supporting documentation on file. Of the 100 sampled items, suppliers had the required documentation on file for 37 items.[4] Suppliers did not have the required documentation on file for the remaining 63 items. As a result, NHIC made unallowable payments totaling $5,296 for 63 of the 100 sampled items.

The types of missing documentation included:

- proof of delivery (24 of 100 items),
- physician's order (39 of 100 items),
- use or compliant use followup documentation (20 of 72 applicable items),
- sleep study (4 of 72 applicable items), and
- physician's statement (9 of 28 applicable items).[5]

Additional details on the results of the sampled items are provided in Appendixes B and C.

NHIC did not detect these errors because NHIC's electronic edits were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims. The edits could only determine whether the required KX modifier was on the claim. Based on our sample, we estimated that NHIC paid approximately $54 million to suppliers who did not have the required documentation on file to support the DMEPOS items with 2007 dates of service.

[4] Two of these thirty-seven sampled items were from suppliers who were no longer active.

[5] For 25 of the 63 items, suppliers were missing multiple required documents.

MISSING REQUIRED DOCUMENTATION

Proof of Delivery

Pursuant to the supplier standard (42 CFR § 424.57(c)(12)), the supplier "[m]ust be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery." Also, the PIM, chapter 4, section 4.26, requires suppliers to maintain proof of delivery documentation in their files for 7 years. Section 4.26.1 outlines proof of delivery requirements for different methods of delivery. Section 4.26 also states that, for "any services, which do not have proof of delivery from the supplier, such claimed items and services shall be denied and overpayments recovered."

For 24 of the 100 items, suppliers did not have proof of delivery documentation on file to support billing for the DMEPOS. In all 24 instances, at least 1 of the following deficiencies occurred: the delivery documentation was missing, the delivery documentation was not signed and dated by the beneficiary or his or her designee, or the documentation for shipped items such as tracking numbers or the supplier's invoice was missing.

Physician's Order

The PIM, chapter 5, sections 5.2.1 and 5.2.2, state that all DMEPOS suppliers are required to keep on file a physician's order. The treating physician must sign and date the order. Section 5.2.3 states that if the supplier does not have a written order signed and dated by the treating physician before billing Medicare, the item will be denied.

For 39 of the 100 items, suppliers did not have a physician's order on file to support billing for the DMEPOS. In all 39 instances, at least 1 of the following deficiencies occurred: the order was missing, the order was not signed and dated by the physician, or the DMEPOS item was not listed on the order.

Use or Compliant Use Followup Documentation

The LCDs for the CPAP effective March 1, 2006, June 1, 2007, and July 1, 2007, and the LCDs for the RAD effective April 1, 2006, June 1, 2007, and July 1, 2007, state that, for an E0601 (CPAP) and an E0470 (RAD) to be covered beyond the first 3 months of therapy, the supplier must ascertain no sooner than the 61st day after initiating therapy that the CPAP is being used and that the RAD is being compliantly used. For the CPAP, either the beneficiary or the treating physician must confirm that the beneficiary is continuing to use the CPAP, and the supplier must maintain documentation that the requirement has been met. For the RAD, the supplier must obtain signed statements from both the treating physician and the beneficiary stating that the RAD is being compliantly used.[6] The LCDs state that continued coverage of the device will be denied if the requirements are not met.

[6] The LCD defines "compliantly used" for a RAD as an average usage of 4 hours out of 24 hours.

For 20 of the 72 applicable items in our sample, suppliers did not have the use or compliant use followup documentation on file to support billing for the DMEPOS. In all 20 instances, at least 1 of the following deficiencies occurred: the use or compliant use followup documentation was missing, the use or compliant use followup was done within 60 days after initiating therapy, the statement(s) required to be completed by the treating physician and/or the beneficiary were missing for the RAD, or the item was billed after the first 3 months but before the supplier obtained use or compliant use followup documentation.

Sleep Study

The LCDs for the CPAP (E0601), effective March 1, 2006, June 1, 2007, and July 1, 2007, and the RAD (E0470) effective April 1, 2006, June 1, 2007, and July 1, 2007, require that the beneficiary have a documented polysomnographic study. Additionally, polysomnographic studies must not be performed by a DMEPOS supplier.

For 4 of the 72 applicable items, suppliers did not have sleep study documentation on file to support billing for the DMEPOS. In all four instances, the sleep study documentation was missing.

Physician's Statement

Pursuant to the Act, § 1861(s)(12)(A), the physician must certify that the patient meets specific criteria for therapeutic shoes. The LCDs and Policy Articles for therapeutic shoes and PRSS, groups 1 and 2, state that DMEPOS items are covered if the supplier obtains a signed and dated statement from the certifying or treating physician[7] saying the patient meets specific criteria.[8] The physician's statement must be signed and dated some time during the year before the date of service for therapeutic shoes, and the Policy Articles state that the items will be denied if the requirements are not met.

For 9 of the 28 applicable items in our sample requiring a physician's statement, suppliers did not have the physicians' statements on file to support billing for the DMEPOS. In all nine instances, at least one of the following deficiencies occurred: the physician's statement of medical need was missing, was incomplete, or was not timely.

KX MODIFIER SYSTEM EDITS

The LCDs require DMEPOS suppliers to include the KX modifier on claims submitted for therapeutic shoes, CPAPs, RADs, and PRSS when the "specific required documentation is on file." Use of the KX modifier constitutes a statement that the suppliers have the documentation on file that the policy requires for the particular item or service.

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[7] The certifying or treating physician is the physician who treats the underlying condition that requires the use of the DMEPOS.

[8] For therapeutic shoes, LCDs were effective March 1, 2006, June 1, 2007, and July 1, 2007, and Policy Articles were effective January 1, 2006, June 1, 2007, and July 1, 2007. For PRSS (group 1 only), LCDs were effective January 1, 2007, and June 1, 2007, and a Policy Article was effective January 1, 2007. For PRSS (group 2 only), LCDs were effective March 1, 2006, and July 1, 2007, and a Policy Article was effective March 1, 2006.

NHIC established electronic edits to evaluate the claims submitted by the DMEPOS suppliers. These edits could only determine whether the required KX modifier was on the claim and were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims.

EFFECT OF UNALLOWABLE PAYMENTS

For 63 of the 100 items in our sample, suppliers who did not have the required documentation on file to support their use of the KX modifier received $5,296 in payments. Based on our sample, we estimated that NHIC paid approximately $54 million in unallowable Medicare payments to DMEPOS suppliers with 2007 dates of service.

RECOMMENDATIONS

We recommend that NHIC:

- recover the $5,296 in payments for specific DMEPOS items claimed for which the suppliers did not have the required documentation,

- review other payments for DMEPOS related to our unallowable sample items and recover any additional unallowable payments,

- notify CMS of the 24 suppliers who did not meet the supplier standard for maintaining proof of delivery so CMS can take appropriate action, and

- develop a corrective action plan to improve supplier compliance with the KX modifier and potentially save an estimated $54 million.

AUDITEE COMMENTS

In written comments to the draft report, NHIC concurred with our first three recommendations and listed the actions it intends to take. NHIC did not concur with the fourth recommendation to "develop a corrective action plan to improve supplier compliance with the KX modifier and potentially save an estimated $54 million," and cited examples of educational and error rate reduction efforts it has undertaken. NHIC also stated that the KX modifier is intended as a self-certification mechanism rather than an editing tool to determine the veracity and appropriateness of medical records documentation. NHIC's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge NHIC's response regarding the intention of the KX modifier and the electronic edits. We recognize the education and error rate reduction efforts that NHIC has undertaken. However, the error categories that are the focus of NHIC's error rate reduction efforts do not include the types of DMEPOS addressed in this review, and we maintain that NHIC should take additional steps to improve supplier compliance with the KX modifier.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items for the year ending December 31, 2007, that DMEPOS suppliers claimed for payment using the KX modifier under Medicare Part B.

SAMPLE FRAME

The sampling frame consisted of 1,020,402 line items totaling $96,722,670 for the year ending December 31, 2007. These items were for specific categories of DMEPOS (therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2)) claimed for payment using the KX modifier under Medicare Part B.

SAMPLE UNIT

The sample unit was a line item.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of the Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the amount of potentially unallowable payments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Frame Value	Sample Size	Value of Sample	Number of Unallowable Payments	Value of Unallowable Payments
1,020,402	$96,722,670	100	$10,373	63	$5,296

ESTIMATES OF UNALLOWABLE PAYMENTS
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$54,040,694
Lower limit	42,702,383
Upper limit	65,379,005

APPENDIX C: ERROR DETAILS

TYPES OF MISSING DOCUMENTATION	DMEPOS Required For	Total In Sample	Number of Errors					Line Items with Only One Error
			Total	CPAP	TS *	RAD	PRSS	
Proof of Delivery	All	100	24	15	5	4	0	5
Physician's Prescription/Order	All	100	39	26	6	7	0	18
Use or Compliant Use Follow-up Documentation	CPAP, RAD	72	20	14	0	6	0	10
Sleep Study	CPAP, RAD	72	4	2	0	2	0	1
Physician's Certifying Statement	TS, PRSS	28	9	0	8	0	1	4
Total Errors (Duplicated Count)			**96**	**57**	**19**	**19**	**1**	**38**

CATEGORIES OF DME	Dollars Tested	Items Tested	Items Allowed †	Items Errors	Dollars in Error	1 Error	2 Errors	3 Errors	4 Errors	Multiple Errors ‡
Continuous Positive Airway Pressure Systems	$3,720.14	56	19	37	$2,342.95	22	11	3	1	15
Therapeutic Shoes for Diabetics	2,701.41	24	11	13	1,168.06	7	6	0	0	6
Respiratory Assist Devices	2,168.44	16	4	12	1,362.93	8	2	1	1	4
Pressure Reducing Support Surfaces (groups 1 and 2)	1,782.63	4	3	1	422.08	1	0	0	0	0
Totals	**$10,372.62**	**100**	**37**	**63**	**$5,296.02**	**38**	**19**	**4**	**2**	**25**

* Therapeutic shoes are a one-time purchase.

† Two of these thirty-seven sampled items were for suppliers who were no longer active and were considered non-errors.

‡ Twenty-five of the sixty-three unallowable sampled items had multiple errors.

DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies

CPAP = continuous positive airway pressure systems

TS = therapeutic shoes for diabetics

RAD = respiratory assist devices

PRSS = pressure reducing support surfaces (groups 1 and 2)

Durable Medical Equipment
Medicare Administrative Contractor
Phone: (781) 741-3029

June 22, 2010

Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region 1
John F Kennedy Federal Building
Boston, MA 02203

Attention: Michael J. Armstrong
Regional Inspector General for Audit Services

Subject: OIG Draft Audit Report A-01-09-00528, "Review Of Jurisdiction A Medicare Payments For Selected Durable Medical Equipment Claims With The KX Modifier For Calendar Year 2007"

Dear Mr. Armstrong:

NHIC appreciates the opportunity to work with the Office of Inspector General on this important issue facing DME contractors. Please find on the following pages our response to the recommendations in the draft audit report cited above. If you have any questions about NHIC's response, please contact Jennifer Otten, Manager of Audit & Controls, in Chico, California at 530-332-1169 (or at jennifer.otten@hp.com).

Sincerely,

s/Andrew Conn
NHIC DME MAC Program Director

cc: Jennifer Otten, NHIC, Corp.
Karen Grasso, NHIC, Corp.
Amy A. Capece, NHIC, Corp.
Paul Hughes, MD, NHIC, Corp.
Travis Moore, NHIC, Corp.
Debbie Bach, NHIC, Corp.
Martin Furman, CMS

Summary of OIG's recommendations and NHIC's response to each:

1. **Recommendation**
   Recover the $5,296 in payments for specific DMEPOS items claimed for which the suppliers did not have the required documentation.

   NHIC Response
   NHIC concurs with this recommendation and will initiate recovery of the payments specified above.

2. **Recommendation**
   Review other payments for DMEPOS related to our unallowable sample items and recover any additional unallowable payments.

   NHIC Response
   NHIC concurs with this recommendation and will investigate other claims from the sample group and recover any unallowable payments.

3. **Recommendation**
   Notify CMS of the 24 suppliers who did not meet the supplier standard for maintaining proof of delivery so CMS can take appropriate action.

   NHIC Response
   NHIC concurs with this recommendation and will make the necessary referrals to the National Supplier Clearinghouse for the suppliers who did not meet the supplier standard of maintaining proof of delivery.

4. **Recommendation**
   Develop a corrective action plan to improve supplier compliance with the KX modifier and potentially save an estimated $54 million.

   NHIC Response
   NHIC does not concur with this recommendation.

   In the report's Summary of Findings it indicates that, *"These errors occurred because NHIC's electronic edits in place were not effective for determining whether suppliers had the required documentation on file when they used the KX modifier on claims."*

   This statement misrepresents what the KX modifier is intended to do. Absent performing a complex medical review of every claim submitted with a KX modifier, there is NO electronic edit (or any other automated tool) that can assure that a supplier actually is in possession of all required documents at the time a claim is submitted.
   The KX modifier is intended as a self-certification mechanism for the supplier and not an editing tool to determine the veracity and appropriateness of medical records documentation.

There are two benefits in the use of the KX modifier:

(1) When used correctly by suppliers **it allows for automated determinations**, and correct coverage determinations can be made. This is demonstrated by the 37% of reviewed claims that were correctly paid.

(2) When not used correctly, as identified in this report, **it provides evidence that supports the position that a claim was falsely submitted,** thereby making it easier to take appropriate action such as an administrative recovery or to prove a fraud/abuse allegation, etc.

NHIC's supplier education on the appropriate use of the KX modifier is extensive, timely and embedded throughout our many educational offerings such as our:

- Jurisdiction A supplier manual
- Local Coverage Determinations
- DME MAC Jurisdiction A *Resource*
- Medical Review articles
- Website *Frequently Asked Questions*, Tutorials, and
- Seminars and Outreach events

As part of our ongoing educational efforts and activities on the proper use of the KX modifier and the necessity for appropriate documentation on file to support it, we may publish or make reference to the final report as a reminder to our community of the seriousness of the problem and of the Inspector General's concerns regarding the abuse and/or neglect of the modifier's intended use.

The proper use of the KX modifier and the review of supporting documentation to determine if the KX modifier was appropriately submitted is an integral component of our clinical staff's procedures when conducting complex medical review of claims.

Finally, to further support error rate reduction, NHIC developed a RAC Work Plan. The RAC Work Plan recommended Jurisdiction A CERT error categories to be addressed through post-pay complex reviews:

- Glucose Testing Supplies (A4253 and A4259)
- Nebulizer w/ Compressor (E0570),
- Oxygen Concentrators Portable Gaseous equipment (E1390 and E0431), and
- Power Wheelchair (K0823).

Two of these error categories (glucose supplies and power wheelchairs) have a KX modifier component. NHIC supports collaboration among contractors to reduce the claims payment error rate. By providing this recommendation to the RAC for Jurisdiction A, NHIC shares important information about those

categories of DMEPOS that contribute most to the overall claims payment error rate. Post payment review performed by the RAC, in conjunction with DME MAC MR complex medical reviews, serves to educate the supplier on the need for proper supporting documentation and prevent and recover improper payments.