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

Washington, D.C. 20201

April 22, 2011

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

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

SUBJECT: Review of Medicare Home Health Consolidated Billing for Calendar Years 2007 and 2008 (A-01-10-00505)

The attached final report provides the results of our review of Medicare home health consolidated billing for calendar years 2007 and 2008.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (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 contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-10-00505 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE HOME HEALTH CONSOLIDATED BILLING FOR CALENDAR YEARS 2007 AND 2008

Daniel R. Levinson
Inspector General

April 2011
A-01-10-00505

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

The Medicare home health prospective payment system requires consolidated billing of home health services. Pursuant to the consolidated billing requirement, the home health agency that establishes a beneficiary's home health plan of care has Medicare billing responsibility for services included in the prospective payment rate.

Nonroutine supplies such as surgical dressings, ostomy supplies, and catheters are included in the prospective payment to the home health agency and are subject to the consolidated billing requirement. Consequently, Medicare payments to durable medical equipment (DME) suppliers for nonroutine supplies provided during home health episodes are overpayments.

The Centers for Medicare & Medicaid Services (CMS) contracts with entities known as DME Medicare administrative contractors (DME MAC) to process and pay Medicare claims from DME suppliers. When the home health prospective payment system was established on October 1, 2000, CMS implemented edits in its Common Working File (CWF) to identify DME claims for nonroutine supplies subject to consolidated billing. The CWF postpayment edit generates a service-specific "unsolicited response." The CWF then transmits the unsolicited response to the DME MAC responsible for the DME claim for recovery of the overpayment. Before the DME MAC can initiate recovery of the overpayment, the DME claim-processing system requires that the claim be adjusted to deny payment for the services subject to consolidated billing. Such recoveries are required to be undertaken aggressively and promptly.

Our nationwide audit covered 83,865 line items of service for nonroutine supplies for which Medicare paid a total of $7,660,226 to DME suppliers for dates of service during calendar years (CY) 2007 and 2008. These nonroutine supplies were provided during home health episodes and therefore were subject to home health consolidated billing.

OBJECTIVE

The objective of our audit was to determine whether the DME MACs recovered Medicare overpayments to DME suppliers for nonroutine supplies subject to home health consolidated billing.

SUMMARY OF FINDING

The DME MACs did not recover all Medicare overpayments to DME suppliers for nonroutine supplies subject to home health consolidated billing. For the 107 sampled line items of service, the DME MACs recovered overpayments for 49 line items, and 4 line items were not associated with a home health episode and therefore were not subject to consolidated billing. For the 54 remaining line items of service, the DME MACs had not recovered overpayments totaling $24,413 as of June 10, 2010. Based on our sample results, we estimated that the DME MACs failed to recover $3,411,090 overpaid to DME suppliers for CYs 2007 and 2008.

The CWF postpayment edit consistently identified nonroutine supplies subject to home health consolidated billing. However, two of the DME MACs did not implement procedures to process and recover overpayments in a timely manner.

RECOMMENDATIONS

We recommend that CMS direct the DME MACs to:

- process and recover the $24,413 in unrecovered overpayments that we identified in our sample;

- use our data to identify, process, and recover potential unrecovered overpayments estimated at $3,386,677 for the nonsampled line items of service; and

- implement procedures to ensure prompt and aggressive action to process and recover overpayments for nonroutine supplies subject to home health consolidated billing.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendations and provided information on actions that it had taken or planned to take to address the recommendations. CMS's comments are included in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Home Health Prospective Payment System and Consolidated Billing Requirements

Section 1895 of the Social Security Act (the Act) (42 U.S.C. § 1395fff) established a Medicare prospective payment system for home health services. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, implemented the home health prospective payment system on October 1, 2000.

Pursuant to the home health consolidated billing requirement,[1] the home health agency that establishes a beneficiary's home health plan of care has Medicare billing responsibility for services included in the prospective payment rate. Pursuant to § 1842(b)(6)(F) of the Act (42 U.S.C. § 1395u(b)(6)(F)), Medicare pays the home health agency for these services, regardless of whether the services were furnished by the agency, by an outside provider under arrangement with the agency, under any other contracting or consulting arrangement with the agency, or "otherwise."

Payment for home health services is based on a national standardized 60-day episode rate that is adjusted for case mix. Payment to the home health agency for an episode is split into two amounts, with approximately half of the total payment made when the episode begins and the remainder after the episode ends and the final claim is submitted.

Nonroutine Supplies

Nonroutine supplies[2] such as surgical dressings, ostomy supplies, and catheters are included in the prospective payment to the home health agency and are subject to the consolidated billing requirement. Consequently, Medicare payments to durable medical equipment (DME) suppliers for nonroutine supplies provided during home health episodes are overpayments.

Medicare Contractors

CMS contracts with four entities known as DME Medicare administrative contractors (DME MAC) to process and pay Medicare claims from DME suppliers. Each DME MAC is responsible for processing claims submitted by DME suppliers within a designated region of the United States and its territories.

Similarly, during our audit period, CMS contracted with three regional home health intermediaries (RHHI) and one home health and hospice Medicare administrative contractor

[1] See §§ 1862(a)(21) and 1861(m) of the Act (42 U.S.C. §§ 1395y(a)(21) and 1395x(m)).

[2] See CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 50.4.1.3.

(HH/H MAC), each responsible for a designated region, to process and pay Medicare claims from home health agencies.[3]

System Edits and Overpayment Recovery

When the home health prospective payment system was established, CMS implemented edits in its Common Working File (CWF) to identify DME claims for nonroutine supplies subject to home health consolidated billing. If the CWF processes and pays a home health agency final claim before processing a related DME claim, a prepayment edit is intended to deny payment for the nonroutine supplies subject to consolidated billing.

If the CWF processes and pays a DME claim before processing a corresponding home health agency final claim, a postpayment edit generates a service-specific "unsolicited response." The CWF then electronically transmits the unsolicited response to the DME MAC responsible for the DME claim for recovery of the overpayment. Before the DME MAC can initiate recovery of the overpayment, the DME claim-processing system requires that the claim be adjusted to deny payment for the services subject to consolidated billing.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether the DME MACs recovered Medicare overpayments to DME suppliers for nonroutine supplies subject to home health consolidated billing.

Scope

Our nationwide audit covered 83,865 line items of service for nonroutine supplies for which Medicare paid a total of $7,660,226 to DME suppliers for dates of service during calendar years (CY) 2007 and 2008. These nonroutine supplies were provided during home health episodes and therefore were subject to home health consolidated billing.

The objective of our audit did not require an understanding or assessment of the overall internal control structure at the DME MACs, RHHIs, the HH/H MAC, or CMS. Therefore, we limited our internal control review to obtaining a general understanding of the controls related to the recovery of overpayments to DME suppliers for nonroutine supplies subject to home health consolidated billing. We conducted our fieldwork at the DME MACs in Hingham, Massachusetts; Fargo, North Dakota; and Indianapolis, Indiana, during June 2010.

[3] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, requires CMS to transfer the functions of RHHIs, among other contractors, to MACs between October 2005 and October 2011.

Methodology

To accomplish our objective, we:

- reviewed Federal laws and regulations and CMS guidance concerning home health consolidated billing,

- interviewed CMS officials to gain an understanding of home health consolidated billing policies and the operation of the CWF postpayment edit,

- used data from the National Claims History file to match final claims for home health episodes to DME claims for nonroutine supplies that were subject to consolidated billing and provided in the beneficiaries' homes,

- identified from our data match 83,865 paid line items of service for nonroutine supplies that were furnished during home health episodes and that totaled $7,660,226,

- selected a stratified random sample of 107 line items of service for nonroutine supplies from the sampling frame of 83,865 line items of service that were potentially unrecovered overpayments (Appendix A),

- reviewed available claim data from the CWF to determine whether the postpayment edit generated unsolicited responses for the sampled line items of service,

- contacted the appropriate RHHIs and HH/H MAC to validate service dates and payment for the home health episode claims corresponding to the sampled line items of service,

- contacted the DME MACs to obtain an understanding of their procedures for processing overpayments identified in unsolicited responses,

- reviewed documentation from the DME MACs to determine whether each sampled line item of service had been adjusted and whether the corresponding overpayment had been recovered,

- estimated the total value of overpayments not recovered based on our sample results (Appendix B), and

- discussed the results of our review with CMS officials.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The DME MACs did not recover all Medicare overpayments to DME suppliers for nonroutine supplies subject to home health consolidated billing. For the 107 sampled line items of service, the DME MACs recovered overpayments for 49 line items, and 4 line items were not associated with a home health episode and therefore were not subject to consolidated billing. For the 54 remaining line items of service, the DME MACs had not recovered overpayments totaling $24,413 as of June 10, 2010. Based on our sample results, we estimated that the DME MACs failed to recover $3,411,090 overpaid to DME suppliers for CYs 2007 and 2008.

The CWF postpayment edit consistently identified nonroutine supplies subject to home health consolidated billing. However, two of the four DME MACs did not implement procedures to process and recover overpayments in a timely manner.

CONSOLIDATED BILLING OVERPAYMENT RECOVERY

Federal Requirements

Pursuant to CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 27, § 100.1, when a DME MAC receives an unsolicited response, it must (1) initiate an adjustment to deny the original payment for nonroutine supplies subject to consolidated billing and (2) recover the overpayment resulting from the denial. Pursuant to 31 CFR § 901.1(a), recovery procedures require aggressive, prompt collection of all debts.

Results of Sample

Contrary to Federal requirements, the DME MACs often did not act promptly, or at all, to recover overpayments for nonroutine supplies subject to home health consolidated billing. Specifically, the DME MACs did not recover $24,413 in overpayments for 54 of the 107 sampled line items of service.[4]

Example of Overpayment Not Recovered

A DME MAC paid a DME supplier $55 for ostomy supplies. Our analysis showed that the supplies were provided during a home health episode and subject to consolidated billing. After the DME claim was processed, the corresponding home health agency final claim was processed, and the CWF postpayment edit identified the $55 as an overpayment and generated an unsolicited response. However, the DME MAC neither adjusted nor recovered the $55 overpayment.

[4] We counted as errors only the sampled line items of service provided during home health episodes for which no part of the overpayment subject to home health consolidated billing had been recovered as of June 10, 2010.

Estimate of Overpayments Not Recovered

Based on our sample results, we estimated that DME MACs did not recover $3,411,090 in overpayments to DME suppliers for nonroutine supplies provided during home health episodes for CYs 2007 and 2008 (Appendix B).

Internal Control Weakness in Overpayment Recovery

Each of the four DME MACs experienced a backlog of home health consolidated billing unsolicited responses for CYs 2007 and 2008. Two of the four DME MACs implemented procedures to process the backlog of unsolicited responses and recover overpayments. The two remaining DME MACs did not implement procedures to deal with the backlog and recover overpayments in a timely manner.

RECOMMENDATIONS

We recommend that CMS direct the DME MACs to:

- process and recover the $24,413 in unrecovered overpayments that we identified in our sample;

- use our data to identify, process, and recover potential unrecovered overpayments estimated at $3,386,677 for the nonsampled line items of service; and

- implement procedures to ensure prompt and aggressive action to process and recover overpayments for nonroutine supplies subject to home health consolidated billing.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on our draft report, CMS agreed with our recommendations and provided information on actions that it had taken or planned to take to address the recommendations.

Regarding the first recommendation, CMS stated that it planned to recover the overpayments identified consistent with the agency's policies and procedures. Regarding the second recommendation, CMS stated that actions have been taken to address unrecovered overpayments and that it will complete an independent sample of the Office of Inspector General nonsampled cases to confirm resolution.

Regarding the third recommendation, CMS agreed that internal control vulnerabilities existed during the period of review of the DME MACs. CMS has taken steps to ensure contractors are aware of their ongoing responsibility to process and recover overpayments for nonroutine supplies subject to home health consolidated billing. CMS has also assigned a workgroup to examine the end-to-end process for unsolicited responses, including reviewing contractor data and making recommendations to monitor and improve the timeliness and efficiency of processing these transactions.

We will provide CMS with the information requested in its reply to our first and second recommendations.

CMS's comments are included in their entirety as Appendix C.

OTHER MATTER

Officials of two DME MACs brought to our attention a potential limitation of the DME claim-processing system. A DME MAC cannot pay a claim until a specified number of calendar days after it receives the claim.[5] During that time, the claim is said to be "on the payment floor."[6]

These officials stated that the DME claim-processing system prevents the DME MAC from taking any action on claims on the payment floor. As a result, when the DME MAC receives an unsolicited response for a claim on the payment floor, the DME MAC cannot adjust the claim to deny payment for services subject to consolidated billing. Instead, the DME MAC must make the scheduled payment even though it has already been notified that an overpayment will occur.

[5] See § 1842(c)(3) of the Act (42 U.S.C. § 1395u(c)(3)).

[6] CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1, § 80.2.1.2, defines the term "payment floor."

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of nationwide Medicare paid claims for services furnished by durable medical equipment (DME) suppliers on behalf of beneficiaries in home health episodes during calendar years (CY) 2007 and 2008.

SAMPLING FRAME

The sampling frame was an Access database containing the payment amounts for 83,865 line items of service for nonroutine supplies furnished by DME suppliers on behalf of beneficiaries in home health episodes during CYs 2007 and 2008.

SAMPLE UNIT

The sample unit was a line item of service for nonroutine supplies furnished by a DME supplier on behalf of a beneficiary during a home health episode.

SAMPLE DESIGN

We used a stratified random sample with three strata:

- line items of service with provider payments of at least $10[1] and less than $160,
- line items of service with provider payments of at least $160 and less than $4,610, and
- line items of service with provider payments of $4,610 or greater.

SAMPLE SIZE

The sample consisted of 107 line items of service: 50 each from strata 1 and 2 and all 7 from stratum 3.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OIG/OAS), random number generator to generate the random numbers.

METHOD OF SELECTING SAMPLED ITEMS

We consecutively numbered the sample units in each stratum. After generating 50 random numbers for each of strata 1 and 2, we selected the corresponding frame items. We selected all seven frame items from stratum 3.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the potential unrecovered overpayments.

[1] Pursuant to CMS's *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 4, § 90.2, overpayments less than $10 are not required to be recovered.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Stratum: Range of Provider Payments	Frame Size	Frame Value	Sample Size	Value of Sample	Number of Overpayments Not Recovered	Value of Overpayments Not Recovered
$10.00 to $159.99	73,448	$3,627,348	50[1]	$1,950	18	$608
$160.00 to $4,609.99	10,410	3,990,576	50	17,380	34	12,035
$4,610.00 or greater	7	42,302	7	42,302	2	11,770
Total	**83,865**	**$7,660,226**	**107**	**$61,632**	**54**	**$24,413**

Estimated Overpayments Not Recovered
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$3,411,090
Lower limit	2,575,645
Upper limit	4,246,535

[1] Four line items of service in stratum 1 were not associated with a home health episode. We did not count any of the four sampled line items as errors.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 1 1 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick M.D.
Administrator

SUBJECT: Office of the Inspector General Draft Report: Review of Medicare Home Health Consolidated Billing for Calendar Years 2007 and 2008 (A-01-10-00505)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and respond to the Office of Inspector General's (OIG) Draft Report titled "Review of Medicare Home Health Consolidated Billing for Calendar Years (CYs) 2007 and 2008" (A-01-10-00505).

In the Summer of 2009, and prior to the OIG review (A-01-10-00505) CMS discovered issues with the Common Working File (CWF) Informational Unsolicited Response (IUR) processes and the handling of these IURs by the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC). Part of the discovery was the identification of a backlog of unprocessed IURs as self-disclosed by National Government Services (NGS) DME Jurisdiction B. Upon this discovery, CMS directed NGS to stage its overpayment recovery actions and begin with the 2006 backlog. It is expected that the overpayments included in OIG's sample were part of this backlog previously disclosed to CMS by NGS and which have now been collected.

OIG Recommendation:

The OIG recommends that CMS process and recover the $24,413 in unrecovered overpayments that were identified in the sample.

CMS Response:

CMS concurs with this recommendation. CMS agrees that the $24,413 in overpayments should be recovered. We plan to recover the overpayments identified consistent with the agency's policies and procedures. We request that OIG furnish for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor-specific data should be written to separate cd-roms or separate

hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation:

Use OIG data to identify, process, and recover potential unrecovered overpayments estimated at $3,386,677 for the non-sampled line items of service.

CMS Response:

CMS concurs with this recommendation to take action on potential unrecovered overpayments. As previously stated, actions have been taken to address this area. In order to confirm resolution, CMS will complete an independent sample of the OIG non-sampled cases. To assist in completing its review, CMS requests that the OIG furnish the data used in its sampling effort. Medicare contractor-specific data should be written to separate cd-roms or separate hardcopy worksheets.

OIG Recommendation:

CMS should implement procedures to ensure prompt and aggressive action to process and recover overpayments for non-routine supplies subject to home health consolidated billing.

CMS Response:

CMS concurs with this recommendation. CMS agrees that internal control vulnerabilities existed during the period of review of the DME MACs. Prior to OIG's publication of its draft report, CMS had already taken steps to ensure contractors are aware of their on-going responsibility to process and recover overpayments for non-routine supplies subject to home health consolidated billing and other IUR situations.

A workgroup has since examined the end-to-end process for IURs generated by the CWF. The workgroup included participation from CMS and all Medicare claims administration contractors to review the volume of these responses and to ascertain current processes and procedures in place to identify and manage this workload. All contractors responded that they have processed all backlogged IURs and their current workload is manageable.

CMS collected feedback from the contractors for enhancements to the systems they use to review these responses to improve the efficiency of reviewing and processing these transactions in the future. This workgroup is currently reviewing the contractor data and will make recommendations for implementing monthly contractor reporting and possible contractor timeliness metrics for processing unsolicited responses which would allow CMS to more closely monitor contractors in the future.

We thank the OIG for presenting its findings and appreciate their perspective on these issues.