Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAL SERVICES OF AMERICA DID NOT ALWAYS HAVE REQUIRED DOCUMENTATION ON FILE TO SUPPORT ITS MEDICARE CLAIMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori S. Pilcher
Regional Inspector General

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Office of Inspector General

https://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 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). CMS contracted with four durable medical equipment Medicare administrative contractors (contractors) to process and pay Medicare Part B claims for DMEPOS.

The *Medicare National Coverage Determinations Manual* defines durable medical equipment 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 requirements specified in the medical policy have been met 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, therapeutic shoes also require a certifying physician's statement be on file before billing Medicare.

Medical Services of America (MSA), incorporated in 1973, is a healthcare provider headquartered in Lexington, South Carolina that provides a variety of medical services including respiratory management and equipment, cardio diagnostics, physician management, home health, pharmacy, mail-order diabetic supplies, and hospice care. MSA has more than 200 locations across 14 states and received $4.7 million in payments for Medicare claims with dates of service between July 1, 2009 and June 30, 2010 for certain DMEPOS categories. Of the $4.7 million, $452,950 was paid to MSA for its DMEPOS supplier doing business as Medi Home Care in Columbia, South Carolina. This audit focused on the $452,950.

OBJECTIVE

Our objective was to determine whether MSA had specific required documentation on file for Medicare DMEPOS claims that it filed using the KX modifier.

SUMMARY OF FINDINGS

MSA did not always have the specific required documentation on file to support the use of the KX modifier before submitting DMEPOS claims to Medicare. MSA had the required documentation on file for 38 of the 100 sample claims; however, it did not have required documentation on file for the remaining 62 claims. Based on our sample results, we estimated that Medicare paid MSA $178,601 for unallowable claims that did not have the required documentation on file.

The table below lists the types of documentation that were missing or incomplete.

Claims With Missing or Incomplete Documentation

TYPE OF MISSING OR INCOMPLETE DOCUMENTATION	NUMBER OF CLAIMS
physician's order	45
compliant use followup statement	29
face-to-face evaluation	8
sleep test	3
proof of delivery	3

MSA was missing multiple required documents for 26 of the 62 unallowable claims. Additional details on the results of the sample are provided at Appendix C.

MSA's policies and procedures effective March 16, 2009, were not adequate to ensure that the required documentation was on file prior to billing Medicare for DMEPOS claims. MSA's Quality Assurance (QA) processes (revised February 2010) were more robust in this regard; however, MSA's QA processes were still incomplete because, although they applied to new equipment setups and routine monthly deliveries, they did not address monthly rentals or replacement supplies.

Additionally, MSA's billing software is programmed to automatically attach the KX modifier to claims that require the modifier for payment. MSA's corporate policy placed greater emphasis on the attachment of the modifier than on the assurance that the required documentation was on file.

RECOMMENDATIONS

We recommend that MSA:

- refund $178,601 to the Federal Government;
- review its claims subsequent to our audit period to determine whether it had specific required documentation on file for Medicare DMEPOS claims that it filed using the KX modifier and return any identified overpayments;
- follow its established quality assurance processes to ensure that the required documents are present prior to billing for new equipment setups;
- develop and implement a quality assurance process for monthly rental billing and replacement supplies that complies with Federal requirements; and
- remove the automatic assignment of the KX modifier from the billing software and apply the KX modifier to claims only after all of the required documentation is on file.

MEDICAL SERVICES OF AMERICA COMMENTS

MSA did not concur with the amount recommended for refund to the Federal Government and provided additional documentation with its comments. MSA concurred with our remaining recommendations. MSA's comments are included as Appendix F; however, we did not include the additional documentation that MSA provided because it was too voluminous and included personally identifiable information.

OFFICE OF INSPECTOR GENERAL RESPONSE

We reviewed the additional documentation that MSA provided with its comments. We determined that the additional documentation adequately supported 3 of the 65 claims that we previously determined to be unallowable. We updated the numbers accordingly throughout the report. The documentation that MSA provided for the remaining 62 claims did not adequately support the claims. MSA had previously provided us with most of the additional documentation, and both the Medicare administrative contractor and we had already reviewed it and determined the claims to be unallowable.

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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).

KX Modifier

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 durable medical equipment 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.

CMS contracted with four durable medical equipment Medicare administrative contractors (contractors) to process and pay Medicare Part B claims for DMEPOS. The contractors developed Local Coverage Determinations (LCD) and Policy Articles (PA) for some covered DMEPOS items. LCDs and PAs specify under what clinical circumstances the DMEPOS item is considered to be reasonable and necessary. For covered DMEPOS items,[1] the LCDs require the addition of a KX modifier to submitted claims before Medicare will pay them. By adding the KX modifier, the supplier is attesting that it meets certain requirements in the medical policies and that it has on file the specific required documentation, which varies based on the DMEPOS item, before submitting the claim to the contractors. This documentation requirement includes the written physician's order and proof of delivery that are required for all DMEPOS, in addition to specific documentation required for certain DMEPOS, such as a certifying physician's statement for a therapeutic shoe claim.

Through the LCDs, the contractors instructed suppliers to use the KX modifier only if the suppliers had the required documentation on file. However, if suppliers did not use the KX modifier on claims for DMEPOS on which it was required, the claims would be denied. See Appendix A for a table detailing the documentation required by Medicare for each of the four DMEPOS categories in our review.

[1] Covered DMEPOS items for this audit include therapeutic shoes for persons with diabetes (therapeutic shoes), positive airway pressure devices (PAP), respiratory assist devices (RAD), and pressure reducing support surfaces (groups 1 and 2) (PRSS). These DMEPOS are included in the Level II Healthcare Common Procedure Coding System (HCPCS), 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.

Medical Services of America

Medical Services of America (MSA), incorporated in 1973, is a healthcare provider headquartered in Lexington, South Carolina, that provides a variety of medical services including respiratory management and equipment, cardio diagnostics, physician management, home health, pharmacy, mail-order diabetic supplies, and hospice care. MSA has more than 200 locations across 14 States.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether MSA had specific required documentation on file for Medicare DMEPOS claims that it filed using the KX modifier.

Scope

Medicare paid approximately $4.7 million to MSA for claims for therapeutic shoes, PAPs, RADs, and PRSS using the KX modifier for dates of service between July 1, 2009, and June 30, 2010. Of the $4.7 million, Medicare paid $452,950 to MSA for its DMEPOS supplier doing business as Medi Home Care in Columbia, South Carolina. This audit focused on the $452,950.

We limited our review of internal controls to gaining an understanding of MSA's processing of selected DMEPOS claims that were submitted to Medicare for payment using the KX modifier for our dates of service.

We conducted fieldwork at the MSA corporate office in Lexington, South Carolina, the MSA office in Columbia, South Carolina, where it does business as Medi Home Care, and the CIGNA Government Services office in Nashville, Tennessee.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, as well as MSA policies and procedures;

- interviewed MSA officials concerning the education and training, specific to the KX modifier, provided to its employees who handled Medicare beneficiary orders for therapeutic shoes, PAPs, RADs, and PRSS;

- selected a random sample of 100 claims totaling $11,503 from 4 categories of DMEPOS (Appendix D);

- reviewed documentation for the sample claims to determine whether they met the documentation requirements for using the KX modifier;

- discussed the sample claims that were missing documentation with MSA officials; and

- requested the contractor's medical staff review all documentation provided by MSA for sampled claims that we determined did not meet the 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

MSA did not always have the specific required documentation on file to support the use of the KX modifier before submitting DMEPOS claims to Medicare. MSA had the required documentation on file for 38 of the 100 sample claims; however, it did not have required documentation on file for the remaining 62 claims. Based on our sample results, we estimated that Medicare paid MSA $178,601 for unallowable claims that did not have the required documentation on file.

The table below lists the types of documentation that were missing or incomplete.

Claims With Missing or Incomplete Documentation

TYPE OF MISSING OR INCOMPLETE DOCUMENTATION	NUMBER OF CLAIMS
physician's order	45
compliant use[2] followup statement	29
face-to-face evaluation	8
sleep test	3
proof of delivery	3

MSA was missing multiple required documents for 26 of the 62 unallowable claims. Additional details on the results of the sample are provided at Appendix C.

MSA's policies and procedures effective March 16, 2009, were not adequate to ensure that the required documentation was on file prior to billing Medicare for DMEPOS claims. MSA's Quality Assurance (QA) processes (revised February 2010) were more robust in this regard; however, MSA's QA processes were still incomplete because, although they applied to new equipment setups and routine monthly deliveries, they did not address monthly rentals or replacement supplies.

[2] "Compliant use" means that the patient is using the DMEPOS item in accordance with the applicable policy.

Additionally, MSA's billing software is programmed to automatically attach the KX modifier to claims that require the modifier for payment. MSA's corporate policy placed greater emphasis on the attachment of the modifier than on the assurance that the required documentation was on file.

MISSING OR INCOMPLETE REQUIRED DOCUMENTATION

Physician's Order

The Program Integrity Manual (PIM) (chapter 5, sections 5.2.1 and 5.2.2) states that all DMEPOS suppliers are required to keep a physician's order on file. Medicare will deny a DMEPOS claim for which a supplier does not have a written order signed and dated by the treating physician (section 5.2.3).

For 45 of the 100 sampled claims, MSA did not have a complete physician's order on file to support billing for the DMEPOS. In all 45 instances, at least one of the following deficiencies occurred: the order was missing, the order was not signed or dated by the physician, the order was dated after delivery for PRSS items, the DMEPOS item was not listed on the order, the DMEPOS item did not contain a quantity or frequency, or the verbal order was not followed by a written order.

Compliant Use Followup

The LCDs for Continuous Positive Airway Pressure Systems (CPAPs),[3] PAPs, and RADs include specific compliant use followup criteria. These criteria vary based on type of equipment and initial date of service, but all require documentation to verify that the patient is compliantly using the equipment and is benefitting from its use. (See Appendix B for compliant use followup documentation requirements.)

For 29 of the 100 sampled claims, MSA did not have the compliant use followup documentation on file to support billing for the DMEPOS items. Of the 29 claims, 25 related to PAPs. In all 25 instances, at least one of the following deficiencies occurred: the 30-day download was missing or not timely, the compliant use followup documentation was missing, was incomplete, or was not timely.

The remaining 4 claims related to RADs. In all 4 instances, at least one of the following deficiencies occurred: the statement(s) required to be completed by the physician or the beneficiary was missing or the statement indicated noncompliance. (See Appendix C.)

[3] Effective March 13, 2008, LCD titles began using the term "PAP" in place of CPAP to reflect the addition of coverage for RADs.

Face-to-Face Evaluation

The LCDs for PAPs[4] (E0470 or E0601), effective January 1, 2009, September 1, 2009, January 1, 2010, and April 1, 2010, require the beneficiary to have a face-to-face clinical evaluation performed by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

For 8 of the 100 sampled claims, MSA did not have documentation of a face-to-face evaluation on file to support billing for the DMEPOS claims. (See Appendix C.)

Sleep Test

The LCDs for the CPAP, effective January 1, 2008, for PAPs (E0601[5] or E0470), effective March 13, 2008, January 1, 2009, September 1, 2009, January 1, 2010, and April 1, 2010, and for RADs (E0470 or E0471), effective March 13, 2008, September 1, 2009, and February 1, 2010, require that the beneficiary have a Medicare-covered sleep test. Additionally, the sleep test must not be performed by a DMEPOS supplier.

For 3 of the 100 sampled claims, MSA did not have documentation of a sleep test on file to support billing for the DMEPOS claims. In all 3 instances, at least one of the following deficiencies occurred: sleep test documentation was missing, incomplete, or not timely. (See Appendix C.)

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 and 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." Section 4.26.1 outlines proof of delivery requirements for different methods of delivery.

For 3 of the 100 sampled claims, MSA did not have proof of delivery documentation on file to support billing for the DMEPOS. (See Appendix C.)

INADEQUATE INTERNAL CONTROLS

The policies and procedures in place at MSA as of March 16, 2009, were not adequate to ensure that the required documentation was on file prior to billing Medicare for DMEPOS claims. MSA's Quality Assurance (QA) processes (revised February 2010) were more robust in this regard; however, MSA's QA processes were still incomplete because, although they applied to

[4] The LCDs for RADs do not include a requirement of an initial face-to-face evaluation.

[5] E0601, E0470, and E0471 are codes from the HCPCS. An E0601 is a CPAP, E0470 is a RAD without backup rate feature, and E0471 is a RAD with backup rate feature.

new equipment setups and routine monthly deliveries, they did not address monthly rentals or replacement supplies.

Additionally, MSA's billing software is programmed to automatically attach the KX modifier to claims that require the modifier for payment. MSA's corporate policy placed greater emphasis on the attachment of the modifier than on the assurance that the required documentation was on file. For example, if an MSA staff member noticed an item was missing a required KX modifier during the order entry process, the policy instructed the staff member to immediately alert MSA's MedAmerica division[6] to add the KX modifier to that item in its special price file. The MedAmerica division maintains the special price file, which contains pricing information that is used for billing.

Based on our sample results, we estimated that MSA was paid $189,459 for unallowable Medicare claims that were not supported by the required documentation.

RECOMMENDATIONS

We recommend that MSA:

- refund $178,601 to the Federal Government;
- review its claims subsequent to our audit period to determine whether it had specific required documentation on file for Medicare DMEPOS claims that it filed using the KX modifier and return any identified overpayments;
- follow its established quality assurance processes to ensure that the required documents are present prior to billing for new equipment setups;
- develop and implement a quality assurance process for monthly rental billing and replacement supplies that complies with Federal requirements; and
- remove the automatic assignment of the KX modifier from the billing software and apply the KX modifier to claims only after all of the required documentation is on file.

MEDICAL SERVICES OF AMERICA COMMENTS

MSA did not concur with the amount recommended for refund to the Federal Government and provided additional documentation with its comments. MSA concurred with our remaining recommendations. MSA's comments are included as Appendix F; however, we did not include the additional documentation that MSA provided because it was too voluminous and contained personally identifiable information.

[6] The MedAmerica division researches and corrects contractual reimbursement issues related to billings, claim payments, provider numbers, and special price files.

OFFICE OF INSPECTOR GENERAL RESPONSE

We reviewed the additional documentation that MSA provided with its comments. We determined that the additional documentation adequately supported 3 of the 65 claims that we previously determined to be unallowable. We updated the numbers accordingly throughout the report. The documentation that MSA provided for the remaining 62 claims did not adequately support the claim. MSA had previously provided us with most of the additional documentation, and both the Medicare administrative contractor and we had already reviewed it and determined the claims to be unallowable.

APPENDIXES

APPENDIX A: DOCUMENTATION REQUIREMENTS

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	PAP	RAD	PRSS
Physician's Order					
Physician's Order, (written, signed and dated)	Program Integrity Manual (PIM), Pub. No. 100-08, ch. 5 LCDs	X X	X X	X X	X X
Physician's Written Order, Prior to Delivery	PIM, ch. 5				X
Compliant Use Followup					
Face-to-Face Compliant Use	LCDs		X		
Statement of Physician and/or Beneficiary Compliant Use	LCDs			X	
PAP Download of Use Reviewed by Physician	LCDs		X		
Face to Face Evaluation					
Face-to-Face Prior to Sleep Test	LCDs		X		
Sleep Test					
Sleep Test Before Physician's Order	NCD LCDs		X X		
Proof of Delivery					
Proof of Delivery	42 CFR § 424.57(c)(12) *PIM*, ch. 4	X X	X X	X X	X X

APPENDIX B: COMPLIANT USE FOLLOWUP DOCUMENTATION REQUIREMENTS

The LCD for the CPAP, effective January 1, 2008, states that continued coverage of an E0601 device beyond the first 3 months of therapy requires that, no sooner than the 61st day after initiating therapy, the supplier ascertain from either the beneficiary or the treating physician that the beneficiary is continuing to use the CPAP device. The supplier must maintain documentation that this requirement has been met.

For initial dates of service prior to November 1, 2008, the LCDs for PAP devices (CPAP and RAD), effective March 13, 2008, stated that continued coverage of a PAP device (E0470 or E0601) beyond the first 3 months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For initial dates of service on or after November 1, 2008, the LCDs for PAP devices, effective January 1, 2009, September 1, 2009, January 1, 2010, and April 1, 2010, state that continued coverage beyond the first 3 months of therapy requires documentation, no sooner than the 31st day and no later than the 91st day after initiating therapy, of a face-to-face clinical re-evaluation by the physician with the beneficiary stating that the beneficiary is continuing to compliantly use the PAP device and is benefiting from its use. Compliant use must be documented over a consecutive 30-day period within the first 3 months of use and supported by a report printed from the PAP or a report supporting the read out of data from the PAP for the consecutive 30-day period. The treating physician must review this objective evidence of compliant use of the PAP device.

The LCDs for RAD devices, effective March 13, 2008, September 1, 2009, and February 1, 2010, require re-evaluation. The re-evaluation must occur no sooner than the 61st day after initiating therapy by the treating physician. Medicare will not continue coverage for the fourth and succeeding months of therapy until this re-evaluation has been completed.

There must be documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond 3 months: 1) a signed and dated statement completed by the treating physician, no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24 hour period) and that the patient is benefiting from its use and 2) a Medicare beneficiary statement[1] completed by the patient no sooner than 61 days after initiating use of the device. The LCDs state that continued coverage of the device will be denied if these requirements are not met.

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[1] The requirement for a beneficiary statement was removed as of February 1, 2010.

APPENDIX C: ERROR DETAILS

TYPES OF MISSING DOCUMENTATION	DMEPOS Required for	Number of Errors						Total Number of Errors	Number of Duplicative Errors	Total Net Errors
		PAP	PAP Supplies*	RAD	RAD Supplies*	PRSS	TS			
Physician's order missing	ALL	0	30	1	6	0	0	37		
DMEPOS item(s) missing from physican's order	ALL	3	3	0	0	0	0	6		
Physician's order not signed/dated	ALL	0	0	1	0	1	0	2		
No written physician's order after verbal order	ALL	1	0	0	0	0	0	1		
Total Physician's Order Errors (Duplicated Count)		**4**	**33**	**2**	**6**	**1**	**0**	**46**	1	**45**
Compliant use followup missing	PAP/RAD	16	0	0	0	0	0	16		
Compliant use followup incomplete	PAP/RAD	5	0	0	0	0	0	5		
RAD beneficiary/physician statement missing	RAD	0	0	4	0	0	0	4		
30-day download not timely	PAP	3	0	0	0	0	0	3		
Compliant use followup not timely	PAP/RAD	3	0	0	0	0	0	3		
30-day download missing	PAP	2	0	0	0	0	0	2		
RAD beneficiary/physician statement indicates non-compliance	RAD	0	0	1	0	0	0	1		
Total Compliant Use Followup Errors (Duplicated Count)		**29**	**0**	**5**	**0**	**0**	**0**	**34**	5	**29**
Face-to-face evaluation prior to sleep test missing	PAP	8	0	0	0	0	0	8	0	**8**
Sleep test missing	PAP/RAD	2	0	1	0	0	0	3	0	**3**
Proof of delivery missing	ALL	3	0	0	0	0	0	3	0	**3**
Total Errors (Duplicated Count)		**46**	**33**	**8**	**6**	**1**	**0**	**94**		

CATEGORIES OF DME	Dollars Tested	Items Tested	Items Allowed	Item Errors	Dollars in Error	1 Error	2 Errors	3 Errors	4 Errors	Multiple Errors‡
Positive Airway Pressure Systems	$8,455.04	83	31	52	$4,588.12	30	18	3	1	22
Respiratory Assist Devices	2,556.44	14	5	9	1,487.71	5	3	1	0	4
Therapeutic Shoes for Diabetics	475.14	2	2	0	0.00	0	0	0	0	0
Pressure Reducing Support Surfaces (groups 1 and 2)	16.42	1	0	1	16.42	1	0	0	0	0
Totals	**$11,503.04**	**100**	**38**	**62**	**$6,092.25**	**36**	**21**	**4**	**1**	**26**
Rounded	**$11,503**				**$6,092**					

* A total of 39 (33 + 6) claims included errors related to supplies.
‡ Twenty-six of the 62 unallowable claims had multiple errors.

CPAP = continuous positive airway pressure systems
DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies
PAP = positive airway pressure
PRSS = pressure reducing support surfaces (groups 1 and 2)
RAD = respiratory assist devices
TS = therapeutic shoes for diabetics

APPENDIX D: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare Part B claims for specific categories of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) - therapeutic shoes for persons with diabetes, positive airway pressure devices, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2) - that DMEPOS suppliers submitted with dates of service between July 1, 2009, and June 30, 2010, using the KX modifier under Medicare Part B.

SAMPLE FRAME

The sampling frame consisted of 3,689 DMEPOS claims totaling approximately $452,950 for dates of service between July 1, 2009, and June 30, 2010.

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 claims.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE CLAIMS

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

ESTIMATION METHODOLOGY

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

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Unallowable Payments	Value of Unallowable Payments
3,689	$452,950	100	$11,503	62	$6,092

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

Point estimate	$224,743
Lower limit	$178,601
Upper limit	$270,885

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September 21, 2012

Lori S. Pilcher
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RE: A-04-11-04010

Dear Ms. Pilcher:

On behalf of my client, Medical Services of America, Inc., ("MSA") I am writing in reply to your draft report dated August 28, 2012, written to John Keim, Vice President & Chief Financial Officer entitled *MEDICAL SERVICES OF AMERICA DID NOT ALWAYS HAVE REQUIRED DOCUMENTATION ON FILE TO SUPPORT ITS MEDICARE CLAIMS*. Enclosed herein are MSA's written comments in reference to said draft report concerning the sampled 100 "patient claims" (patient claims shall mean all claims associated with a particular patient) that were billed with the KX modifier which states MSA has specific documentation on file for Medicare DMEPOS items.

The draft report stated MSA only had the required documentation for 35 of the 100 sample patient claims and did not have the required documentation for 65 claims. On February 9, 2012, the OIG provided MSA with a spreadsheet containing the 65 patient claims and an error key that explained what documentation was missing for each claim. MSA was asked to provide the additional missing documentation, if possible. Please note, a significant portion of the missing documentation was located and presented by MSA to the OIG during the February 9, 2012, meeting. However, it does not appear that said documentation was incorporated into the draft final report. I have enclosed copies of said documentation, as well as, additional documentation located after the February 9, 2012, meeting in this response.

The spreadsheet that was provided to MSA by the OIG in February 2012 is enclosed and has been color coded in order to properly address the incorporation of the additional

documentation. As you will see, the spreadsheet is now color coded according to the below key:

Pink- Could Not Locate Requested Documentation
Green- Submitted All Requested Documentation
Yellow- Some Additional Documentation Was Located But File Still Not Complete
Orange- Documentation Requested Not Required At Initial Setup Date

With the addition of the aforementioned documentation, MSA has determined the following:

- An additional thirty-two (32) claims ((or sixty-seven (67) in all)) now have **all** required documentation as prescribed by the KX modifier which are color coded Green.

- MSA has identified six (6) claims that are color coded Orange that did **not** need the required documentation requested per Medicare guidelines at the time of initial setup. For clarity, a brief explanation as to why the documentation is **not** required is included beside each of the six (6) instances.

- Eleven (11) are color coded Yellow to indicate that some additional information was found and is enclosed but other information is still missing, but being searched for.

- The remaining sixteen (16) claims are color coded Pink which indicates no additional information could be located at this time.

Each additional document referenced is included below and organized by patient by an alleged error code. To date, MSA is still searching for the missing documents in its hard copy files.

You have requested that MSA include a statement of concurrence or nonoccurrence regarding each recommendation present. Below I have listed the OIG recommendations (in bold type) and MSA's comments regarding each recommendation.

OIG RECOMMENDATIONS

- **Refund $189,459 to Federal Government.**

    - MSA Does **Not** Concur - MSA was able to locate and provide required documentation for thirty-two (32) additional claims, and further, six (6) claims should **not** have been included in the repayment calculation as the documentation was **not** required. In summary, MSA has all documentation for sixty-seven (67) claims out of the ninety-four (94) claims properly

included in the audit sample or **71.27%**. Accordingly, the proposed refund amount needs to be recalculated based upon this information.

- **Review claims subsequent to our Audit period to determine whether it had specific required documentation on file for Medicare DMEPOS claims that it filed using the KX modifier and return any unidentified overpayments.**

    - Concur - MSA will continue auditing its charts to ensure it has the required documentation on file for all claims subsequent to this audit period requiring the KX modifier.

- **Follow its established quality assurance processes to ensure that the required documents are present prior to billing for new equipment setups.**

    - Concur - MSA has implemented a Quality Assurance Order Checklist to further ensure compliance is met and MSA will obtain the required documentation prior to billing.

- **Develop and implement a quality assurance process for monthly rental billing and replacement supplies that complies with the Federal requirements.**

    - Concur - In addition to the Quality Assurance Order Checklist referenced above, MSA is re-implementing its Corporate Quality Assurance Department which will not only address new equipment setups and routine monthly deliveries but also monthly rentals and replacement supplies.

- **Remove the automatic assignment of the KX modifier from the billing software and apply the KX modifier to claims only after all of the required documentation is on file.**

    - Concur - MSA has converted to new billing software called Brightree so that it has the capabilities and transparency to ensure billing compliance. When MSA converted to its new software, it implemented a more robust Documentation Quality Assurance process before claims are transmitted to the insurance carrier. Before the KX modifier is attached to claims, MSA's Corporate Certificate of Medical Necessity ("CMN") department ensures that all required documentation is accounted for. Post conversion, MSA's Corporate CMN department now logs the information into its billing software and thereafter the claim is released to the particular insurance carrier with the KX modifier, when appropriate (i.e. all documentation on file). If MSA does not have all the required documentation on file, it will request and receive said documentation, from its field locations before releasing the claims to the carrier. MSA's

Corporate Quality Assurance Department will monitor this process for quality assurance.

Once you have had an opportunity to review this information, I am confident that a new, substantially reduced, refund amount will be calculated based on the enclosed information. Should you have any additional questions, I will be happy to schedule a time to meet with you. Thank you for your time and attention concerning this matter.

Sincerely,

Timothy W. Stewart
General Counsel