Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A REVIEW OF CLAIMS FOR CAPPED RENTAL DURABLE MEDICAL EQUIPMENT

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EXECUTIVE SUMMARY

OBJECTIVES

1. To determine the extent to which Medicare erroneously allowed claims for routine maintenance and servicing of beneficiary-rented and beneficiary-owned capped rental durable medical equipment (DME).
2. To determine the extent to which Medicare erroneously allowed claims for repairs of beneficiary-rented capped rental DME.
3. To determine the extent to which Medicare allowed claims for repairs of beneficiary-owned capped rental DME that failed to meet payment requirements.
4. To determine the extent to which Medicare claims for repairs of beneficiary-owned capped rental DME were questionable (i.e., were missing information or had costly repairs relative to replacement costs).
5. To describe how certain DME supplier practices adversely affected beneficiaries with high-cost repairs.

BACKGROUND

DME is medical equipment that can withstand repeated use, serves a medical purpose, is not useful in the absence of an illness or injury, and is appropriate for home use. Pursuant to statute, regulation, and CMS guidance, DME suppliers may receive payments for maintenance and servicing, including repairs, only in certain circumstances. The Deficit Reduction Act of 2005 (DRA) made changes to some of the circumstances under which suppliers may receive payments for these services. CMS contracts with Medicare Administrative Contractors (MAC) for processing and payment of Medicare claims.

This study used three separate methodologies to address the five objectives: (1) we reviewed the population of allowed routine maintenance and servicing claims and allowed claims for repairs of beneficiary-rented capped rental DME for the period 2006–2008 (objectives 1 and 2), (2) we reviewed suppliers' records for a sample of 492 allowed claims for repair of beneficiary-owned capped rental DME in 2007 (objectives 3 and 4), and (3) we conducted structured interviews with beneficiaries and reviewed supplier records for high-cost repairs (allowed repair claims in excess of $5,000) in 2007 (objective 5).

FINDINGS

From 2006 to 2008, Medicare erroneously allowed $2.2 million for routine maintenance and servicing of capped rental DME with rental periods after implementation of the DRA. Medicare erroneously allowed 31,939 maintenance and servicing claims amounting to $2.2 million. Medicare has never allowed payments for maintenance and servicing for beneficiary-rented equipment, and the DRA effectively eliminated routine maintenance and servicing for beneficiary-owned DME with rental periods that began after January 1, 2006.

From 2006 to 2008, Medicare erroneously allowed nearly $4.4 million for repairs for beneficary-rented capped rental DME. Medicare erroneously allowed 40,452 claims amounting to nearly $4.4 million for repairs of beneficiary-rented capped rental DME. Medicare has never allowed payments for repairs of beneficiary-rented capped rental DME; the costs of repairs are already included in the monthly rental payments to suppliers.

In 2007, Medicare allowed nearly $27 million for repair claims of beneficiary-owned capped rental DME that failed to meet payment requirements. Of the $90 million allowed for capped rental DME repair claims in 2007, nearly $27 million was for claims associated with payment errors. Our review of supplier records indicate that 27 percent of allowed repair claims for beneficiary-owned capped rental DME in 2007 lacked medical necessity, service, or delivery documentation or represented repairs to DME still under manufacturer or supplier warranties.

In 2007, Medicare allowed nearly $29 million for questionable repair claims for capped rental DME. Of the $90 million allowed for capped rental DME repair claims in 2007, nearly $29 million were for claims that were questionable because of missing information and high dollar allowed amounts for repairs relative to replacement costs. These claims represent 49 percent of all allowed claims for repair of capped rental DME in 2007.

Supplier practices adversely affected some beneficiaries with high-cost repairs. Beneficiaries with high-cost allowed repairs with whom we spoke reported that some suppliers failed to properly customize power mobility devices (PMD), rendering the PMDs useless to them, and that other suppliers did not offer loaner equipment when repairing PMDs, leaving some beneficiaries immobile. Some

beneficiaries reported difficulties in contacting suppliers, and record reviews indicated that suppliers charged some beneficiaries service fees for repairs of capped rental DME. Finally, other beneficiaries reported that suppliers failed to provide instructions about the proper use of their equipment and information about repair charges.

RECOMMENDATIONS

CMS should take action to reduce erroneous payments and ensure quality services for beneficiaries. To accomplish this, we recommend that CMS:

Implement an edit to deny claims for routine maintenance and servicing of capped rental DME with rental periods beginning after January 1, 2006.

Implement an edit to deny claims for repair of beneficiary-rented capped rental DME.

Improve enforcement of existing payment requirements for beneficiary-owned capped rental DME.

Consider whether to require MACs to track accumulated repair costs of capped rental DME.

Develop and implement safeguards to ensure that beneficiaries have access to the services they require.

Take appropriate action on erroneously allowed claims for maintenance and servicing, repair, and payment errors.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS agreed that maintaining strong and effective controls to ensure accurate payment of capped rental DME claims is essential. CMS responded positively to each of our six recommendations and indicated that, in general, it will work to improve its comprehensive oversight of capped rental maintenance and servicing.

In response to the first and second recommendations, CMS stated that it had implemented claim edits previously to instruct contractors to deny claims for maintenance and servicing but will conduct further systems analysis and implement additional edits, as required, to ensure these claims are denied.

In response to the third recommendation, CMS concurred and said it will communicate the policy of nonpayment of claims for repairs and maintenance for items under a manufacturer's or supplier's warranty to contractors and suppliers.

In response to the fourth recommendation, CMS agreed to consider the feasibility of requiring MACs to obtain serial numbers of repaired equipment and track accumulated repair costs.

In response to the fifth recommendation, CMS stated that it will issue guidance to DME suppliers advising them that beneficiaries should not be charged service fees above the capped rental fee unless an Advanced Beneficiary Notice is signed.

In response to the sixth recommendation, CMS concurred and said it will send information about the erroneously allowed claims to the contractors.

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5. To describe how certain DME supplier practices adversely affected beneficiaries with high-cost repairs.

BACKGROUND

DME is medical equipment that can withstand repeated use, is used primarily and customarily to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.[1, 2] Medicare coverage of DME is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury or to improve the functioning of a malformed body member.[3] Medicare guidance states that the reasonable useful lifetime of DME should be at least 5 years,[4] after which a beneficiary may elect to obtain a replacement.[5]

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[1] 42 CFR § 414.202; Centers for Medicare & Medicaid Services (CMS), *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.1. Accessed online at http://www.cms.gov on January 22, 2010.

[2] 42 CFR § 414.210(b); there are six categories of DME: (1) capped rental DME, (2) DME requiring frequent or substantial servicing, (3) prosthetics and orthotics supplies, (4) inexpensive or routinely used DME not exceeding $150, (5) customized equipment, and (6) oxygen and oxygen equipment.

[3] Social Security Act (the Act) § 1862(a).

[4] 42 CFR § 414.210(f)(1).

[5] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.C. Accessed online at http://www.cms.gov on January 22, 2010.

Capped rental DME is a category of DME for which Medicare contractors pay DME suppliers a fee schedule amount that is "capped" after a certain number of continuous months of rental to a Medicare beneficiary.[6] Examples include power mobility devices (PMD),[7] hospital beds, continuous positive airway pressure devices, commodes, and walkers. The Medicare statute governing capped rental items specifically provides for payments for the maintenance and servicing of capped rental equipment. Repairs are included within the category of maintenance and servicing.[8] During the beneficiaries' use of capped rental DME, Medicare will pay for maintenance and servicing, including repairs, depending on when the capped rental DME was first rented, who owns the DME, and what types of repairs need to be made.

The Deficit Reduction Act of 2005 and Maintenance and Servicing

The implementation of the Deficit Reduction Act of 2005 (DRA) altered Medicare coverage of routine maintenance and servicing (generally every 6 months) of capped rental equipment.

Coverage of maintenance and servicing during the rental period. Both before and after the implementation of the DRA, Medicare did not cover maintenance and servicing during the rental period, "since [suppliers] of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out …." [9]

Coverage of maintenance and servicing of beneficiary-owned equipment. Both before and after the implementation of the DRA, Medicare covered nonroutine maintenance and servicing costs of capped rental DME after the beneficiary had obtained the title to the equipment.[10] CMS has determined that under the maintenance and servicing provisions of the DRA applicable to beneficiary-owned equipment, repairs necessary to

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[6] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 30.5. Accessed online at http://www.cms.gov on January 22, 2010.

[7] PMDs include power wheelchairs and scooters.

[8] The Act § 1834(a)(7)(A)(iv). CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, §§ 110.2.A and B; CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 10.2. Accessed online at http://www.cms.gov on January 22, 2010.

[9] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2. Accessed online at http://www.cms.gov on January 22, 2010.

[10] The Act § 1834(a) (pre- and post-DRA); 42 CFR §§ 414.229(e) and (f); and CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2. Accessed online at http://www.cms.gov on January 22, 2010.

make the equipment serviceable are covered.[11] Further, "extensive maintenance which … is to be performed by authorized technicians" is covered as a repair. However, "routine periodic servicing, such as testing, cleaning, regulating, and checking … is not covered."[12] The Medicare statute has never provided for routine maintenance and servicing of beneficiary-owned equipment, yet prior to implementation of the DRA, it did allow for routine maintenance and servicing of supplier-owned equipment (an option that the DRA eliminated for capped rental DME).

Coverage of maintenance and servicing of supplier-owned equipment. Prior to the implementation of the DRA on January 1, 2006, beneficiaries had to choose at the 10th month of rental to either (1) assume ownership after 13 months of continuous rental or (2) permit the DME supplier to retain ownership. If the supplier retained ownership after 15 months of continuous rental, the supplier was required to continue providing the item to the beneficiary free of charge for the period of medical necessity.[13] In the case of power-driven wheelchairs, beneficiaries also had the option to purchase the DME on a lump-sum basis in lieu of rental.[14] The Medicare statute provided for payments every 6 months to suppliers for the cost of routine maintenance and servicing of supplier-owned equipment after the rental period.[15] These routine maintenance and servicing claims, designated with the MS modifier,[16] began 6 months after the end of the final rental

[11] 42 CFR § 414.229(e)(3) (containing the pre-DRA rule). See also CMS's implementation of the pre-DRA rule in its *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.A. Accessed online at http://www.cms.gov on January 22, 2010.

[12] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2. Accessed online at http://www.cms.gov on January 22, 2010.

[13] The Act § 1834(a)(7)(A) (pre-DRA); 42 CFR § 414.229(d) (containing the pre-DRA rule). See also CMS's implementation of the pre-DRA rule in its *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 30.5. Accessed online at http://www.cms.gov on January 22, 2010.

[14] Ibid.

[15] The Act § 1834(a)(7)(A) (pre-DRA), 42 CFR § 414.229(e) (containing the pre-DRA rule), and CMS, *Medicare Benefits Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2. Accessed online at http://www.cms.gov on January 22, 2010.

[16] Modifiers are used when the information provided by a Healthcare Common Procedure Coding System (HCPCS) code needs to be supplemented to identify specific circumstances that may apply to an item or a service.

month or after the end of the period the item was no longer covered under the supplier or manufacturer warranty, whichever was later.[17]

The Office of Inspector General (OIG) released the report *Medicare Maintenance Payments for Capped Rental Equipment* (OEI-03-00-00410) in June 2002. In that report, OIG reviewed Medicare claims from 2000 and found that DME suppliers provided actual service for only 9 percent of claims for maintenance and servicing. Medicare would have saved $98 million of the $102 million allowed for maintenance and servicing during 2000 if it instead had allowed only for repairs as needed.

Subsequently, section 5101(a) of the DRA revised the payment rules for capped rental DME to reduce Medicare expenditures and beneficiary coinsurance.[18] The DRA eliminated the option for suppliers to keep the title to capped rental DME after 15 months of continuous rental. The DRA also eliminated a supplier's ability to bill every 6 months for routine maintenance and servicing of supplier-owned equipment with new rental periods beginning January 1, 2006.[19] Consequently, the only maintenance and servicing payments with the MS modifier allowed after January 1, 2006, should be for supplier- owned capped rental DME with rental periods beginning prior to that date.[20]

Repair of Beneficiary-Owned Capped Rental DME

When ownership of the capped rental item is transferred to the beneficiary, Medicare allows for repair when necessary to make the

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[17] 42 CFR § 414.229(e)(2) (containing the pre-DRA rule); see also CMS's implementation of the pre-DRA rule in its *Medicare Benefits Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.B. Accessed online at http://www.cms.gov on January 22, 2010.

[18] CMS, *Fact Sheet: Changes to Medicare Payment for Oxygen Equipment, Oxygen Contents, and Capped Rental Durable Medical Equipment*. November 1, 2006. Accessed online at http://www.cms.gov on January 22, 2010.

[19] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, change request 5461 (February 2, 2007). Accessed online at http://www.cms.gov on January 22, 2010.

[20] CMS, *Medicare Claims Processing* (Internet Only Manual), Pub 100-04, Change Request 5461. Accessed online at http://www.cms.gov on January 22, 2010.

equipment serviceable.[21, 22] In 2007, Medicare allowed 679,000 claims amounting to $90.1 million for repairs of capped rental DME.[23]

Payment requirements. Medicare pays for repairs of capped rental DME that beneficiaries own when those repairs are necessary to make it serviceable.[24] Medicare covers repairs up to the cost of replacement for medically necessary equipment owned by the beneficiary.[25] Medicare does not allow for routine, periodic maintenance of beneficiary-owned equipment, such as testing, cleaning, and regulating of equipment.[26] Medicare also does not pay for parts and labor covered by a supplier or manufacturer warranty.[27] If the expense for repairs exceeds the estimated expense of purchasing or renting another item for the remaining period of medical need, no payment can be made for the amount of excess.[28]

Repair claims can cover the following:

- replacement of the DME;
- replacement parts for the DME (e.g., a new motor for a PMD); and/or
- labor costs associated with repairing the DME, replacing the DME, or repairing parts of the DME.[29]

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[21] The Act § 1834(a)(7)(A)(iv); 42 CFR §§ 414.210(e)(5) and 414.229(f)(3).

[22] CMS, *Medicare Benefits Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.A. Accessed online at http://www.cms.gov on January 22, 2010.

[23] Capped rental DME during rental periods were identified by one of three modifiers: KH (first rental month), KI (second rental month), and KJ (rental months 3 to 13).

[24] 42 CFR §§ 414.210(e)(1) and 414.229(f)(3); *Medicare Benefits Policy Manual*, Pub. 100-02, ch. 15, § 110.2.A; and CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 10.2. Accessed online at http://www.cms.gov on January 22, 2010.

[25] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.C. Accessed online at http://www.cms.gov on January 22, 2010.

[26] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.B. Accessed online at http://www.cms.gov on January 22, 2010.

[27] 42 CFR §§ 414.210(e)(1) and 414.229(f)(3).

[28] CMS, *Medicare Benefit Policy Manual* (Internet Only Manual), Pub. 100-02, ch. 15, § 110.2.A. Accessed online at http://www.cms.gov on January 22, 2010.

[29] CMS, *Provider Inquiry Assistance Changes in Payment for Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and Additional Instructions Regarding Payment for Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS),* Pub. 100-20, Change Request 6297, December 23, 2008. Accessed online at http://www.cms.gov on January 22, 2010.

In 2007, repair claims for replacement parts should have used the HCPCS modifier RP (repair) in conjunction with the HCPCS code for the replacement part.[30] Repair claims for labor costs should use HCPCS code E1340. Payment allowances for the HCPCS code E1340 are based on a fee schedule (one unit of service for 15 minutes of labor) and are adjusted to reflect local wages.[31]

When suppliers (including DME suppliers) accept Medicare assignment, they accept Medicare reimbursement as payment in full and should not collect more than the deductible and coinsurance from beneficiaries.[32] They should not bill beneficiaries for service fees to repair capped rental DME.[33] Suppliers receive additional reimbursement when they loan DME to beneficiaries while their original DME is being repaired.[34]

Documentation requirements. DME suppliers are required to keep physician prescriptions on file and must have orders from treating physicians before dispensing DME.[35] A new order is required when there is a change in the order for the accessory, when an item is renewed, when an item is replaced, and when there is a change in the supplier.[36] This documentation provides evidence of medical necessity of the capped rental DME. When claims for repair are submitted, the supporting documentation should include the HCPCS code of the capped rental DME being repaired and must indicate that the capped rental DME is beneficiary owned.[37]

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[30] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, Change Request 5461, February 2, 2007. During the period of our review, the RP modifier was used for repairs or replacement while the MS modifier was used for routine maintenance and servicing. Subsequent to the period of our claims, CMS instituted separate modifiers for replacement and repair, RA and RB, respectively. CMS, *Changes in Payment for Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and Additional Instructions Regarding Payment for DMEPOS*, Pub. 100-20, Change Request 6297, December 23, 2008. Accessed online at http://www.cms.gov on January 22, 2010.

[31] American Medical Association, *Medicare's National Level II Codes*, 2007.

[32] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 1, § 30.3.2. Accessed online at http://www.cms.gov on January 22, 2010.

[33] 42 CFR § 424.57(c)(14).

[34] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 40.1. Accessed online at http://www.cms.gov on January 22, 2010.

[35] CMS, *Medicare Program Integrity Manual* (Internet Only Manual), Pub. 100-08, ch. 5, § 5.2.1. Accessed online at http://www.cms.gov on January 22, 2010.

[36] CMS, *Medicare Program Integrity Manual* (Internet Only Manual), Pub. 100-08, ch. 5, § 5.2.4. Accessed online at http://www.cms.gov on January 22, 2010.

[37] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 10.2.B. Accessed online at http://www.cms.gov on January 22, 2010.

When suppliers deliver DME to beneficiaries, Medicare requires documentation of delivery and recommends that the documentation include: (1) beneficiary's name, (2) quantity delivered, (3) detailed description of the replacement parts or repaired DME being delivered, (4) brand name, and (5) serial number.[38] The beneficiary's (or designee's) signature should be included on the delivery slip or proof of delivery.[39] Suppliers must also provide beneficiaries with necessary information and instructions (e.g., owner's manual and warranty information) on how to use their capped rental DME safely and effectively.[40]

Additional matters considered. Medicare provides guidance to Medicare Administrative Contractors (MAC)[41] for consideration when reimbursing for repairs. For example, MACs may consider whether accumulated repair costs for capped rental DME exceed 60 percent of the cost for a replacement item when they determine whether to replace equipment that does not function during the reasonable useful lifetime.[42]

In addition, if MACs determine that the capped rental DME will not last its reasonable useful lifetime, they may hold suppliers responsible for furnishing replacement capped rental DME at no cost to beneficiaries or the Medicare program.[43]

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[38] 42 CFR § 424.57(c)(12); CMS, *Medicare Program Integrity Manual* (Internet Only Manual), Pub. 100-08, ch. 4, § 4.26.1. Accessed online at http://www.cms.gov on January 22, 2010.

[39] CMS, *Medicare Program Integrity Manual* (Internet Only Manual), Pub. 100-08, ch. 4, § 4.26.1. Accessed online at http://www.cms.gov on January 22, 2010.

[40] 42 CFR § 424.57(c)(12).

[41] MACs serve as the primary points of contact for provider enrollment, Medicare coverage and billing requirements, and processing and payment of Medicare fee-for-service claims.

[42] 71 Fed. Reg., No. 217 (Nov. 9, 2006), p. 65921. This was originally proposed by CMS as a requirement, but included in the Final Rule as a matter for the MACs' consideration. CMS does not pay repair costs for prosthetics that exceed 60 percent of the cost for a replacement item.

[43] 42 CFR § 414.210(e)(5).

METHODOLOGY

This study used three separate methodologies to address our five study objectives.

Objectives 1 and 2

To determine the extent to which Medicare erroneously allowed (1) claims for routine maintenance and servicing of beneficiary-rented and beneficiary-owned capped rental DME and (2) claims for repairs of beneficiary-rented capped rental DME.

Population identification. Using the 2005, 2006, 2007, and 2008 DME Standard Analytical Files from the National Claims History file, we identified claims for capped rental DME with rental periods beginning on or after implementation of the DRA on January 1, 2006.

Identification of maintenance and servicing claims. We analyzed capped rental DME claims for rental periods beginning on or after implementation of the DRA to identify erroneously allowed routine maintenance and servicing claims for the period 2006 through 2008. We identified maintenance and servicing claims with the MS modifier for those capped rental months.

To identify beneficiary-rented capped rental DME, we identified claims with a KH, KI, or KJ modifier designating a specific rental month.[44] We determined whether routine maintenance and servicing claims for capped rental DME were allowed during rental periods. To identify beneficiary-owned capped rental DME, we identified claims with a BP modifier (i.e., beneficiary purchased). For rentals beginning after implementation of the DRA, we identified capped rental DME as transitioning from beneficiary-rented to beneficiary-owned when the rental month modifiers were no longer attached to the claim. Separate payments for routine maintenance and servicing for capped rental DME during the rental period or after ownership has transitioned to the beneficiary have never been allowed.

Identification of repair claims for beneficiary-rented capped rental DME. Although the DRA did not change how Medicare should pay repair claims for capped rental DME, we sought to determine whether repair claims volume and/or payment amounts increased after implementation

[44] Capped rental DME during rental periods were identified by one of three modifiers: KH (first rental month), KI (second rental month), and KJ (rental months 3 to 13).

of the DRA to potentially offset the loss of the routine maintenance and servicing payments. We analyzed repair claims for beneficiary-rented capped rental DME for rental periods beginning on or after January 1, 2006, to identify erroneously allowed repair claims from 2006 to 2008.

We defined the rental period as the period beginning with the first use of the KH modifier and terminating up to 12 months thereafter, depending on the presence of KI or KJ modifiers; thus, we did not include any rental periods that may have begun prior to the DRA.

For the claims during the rental period that we identified above, we determined whether an RP modifier was present, indicating a repair claim. Separately itemized charges for repair of capped rental DME equipment are not allowed during the rental period.

Objectives 3 and 4

To determine the extent to which Medicare (3) allowed claims for repairs of beneficiary-owned capped rental DME that failed to meet payment requirements and (4) allowed claims for repairs of beneficiary-owned capped rental DME that were questionable.

Population and sample identification. We reviewed 2007 Medicare-allowed capped rental DME repair claims to determine whether claims were correctly allowed based on payment and documentation requirements and whether claims were questionable. These objectives were limited to 2007 data only because of the type of methodology used (record review), whereas the two previous objectives relied on a review of claims data alone. We did not include claims for oxygen equipment and related supplies because those DME are capped after 36 months of continuous rental.

Using the 2007 DME Standard Analytical File from the National Claims History file, we identified allowed repair claims for beneficiary-owned capped rental DME. We excluded 9,957 claims under $1 from this population as these claims represented 1 percent of the expenditures and 2 percent of capped rental DME claims for 2007 billed with the RP modifier. Many of these claims represented replacement batteries for glucose monitors.

We selected a stratified random sample of 499 allowed repair claims[45] with HCPCS codes with the RP modifier or HCPCS code E1340 from

[45] Typically, a repair claim will have individual line items for the replacement part(s) and the associated labor costs.

four strata as shown in Table 1. For each sampled claim, we requested repair records from suppliers to determine whether the capped rental DME repair claims met payment and documentation requirements.

Table 1: Sample Stratification of Allowed Capped Rental DME Repair Claims

Stratum	Definition	Population	Sample Size	Adjusted Sample Size	Responses
1	Allowed claims from $1.00 to $100.00	440,661	95	93	91
2	Allowed claims from $100.01 to $500.00	191,658	191	187	184
3	Allowed claims from $500.01 to $5,000.00	36,779	159	159	155
4	Allowed claims over $5,000.00	54	54	53	52
Total		**669,152**	**499**	**492**	**482**

Source: OIG analysis of claims data, 2010.

We removed three sampled claims because they involved open OIG investigations and four sampled claims because they did not match the study criteria upon review of the documentation, creating an adjusted sample size of 492 repair claims. The four claims not matching the study criteria appeared as repairs for capped rental DME according to claims data, but upon review of the record, we determined that each claim was not a repair for capped rental DME. We received responses from suppliers for 482 of our sampled claims for a response rate of 98 percent. Of the 10 sampled claims we were unable to review, 7 were from suppliers that were out of business and 3 were from suppliers that we were unable to locate and that we could not confirm remained in business.

Since the RP modifier used at the time of our review indicated both repair and replacement, we could not differentiate between claims for repair or replacement without reviewing the records. Based on a review of the records associated with the 482 claims, we determined that 335 were for repair of capped rental DME.[46] We used these claims to determine the extent to which repair claims met Medicare payment requirements. The remaining 147 claims were generally for

[46] Eighty-seven percent of the sampled claims were for PMDs.

replacement of capped rental DME when it was determined that the original DME no longer met the beneficiaries' needs.

Interviews with DME suppliers. Prior to our record review, we interviewed DME suppliers to ascertain their practices and better develop our data collection instruments. We asked suppliers questions about volume of repairs, nature and location of repairs, followup with beneficiaries, methods for accessing policy guidance, documentation used to support claims, warranty coverage, and accumulated repair costs.

Review of repair records. We reviewed repair records provided by suppliers for sampled claims to determine whether each repair met Medicare requirements or whether supplier practices created vulnerabilities in claims payment. Specifically, we reviewed the extent to which records for repairs to capped rental DME indicated that:

Requirements:

- a prescription existed documenting DME medical necessity, [47, 48]
- service was documented,[49]
- delivery was documented,[50]
- the DME was under warranty, [51] and
- service fees were charged to beneficiaries.[52]

Additional matters considered:

- a valid serial number was provided, and
- repair costs exceeded 60 percent of the new purchase price.

Objective 5

To describe how certain DME supplier practices adversely affected beneficiaries.

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[47] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 20, § 10.2. Accessed online at http://www.cms.gov on January 22, 2010.

[48] CMS, *Program Integrity Manual* (Internet Only Manual), Pub. 100-08, ch. 5, § 5.2.1. Accessed online at http://www.cms.gov on January 22, 2010.

[49] The Act § 1833(e).

[50] 42 CFR § 424.57(c)(12).

[51] 42 CFR §§ 414.229(f)(3) and 414. 210(e)(1).

[52] CMS, *Medicare Claims Processing Manual* (Internet Only Manual), Pub. 100-04, ch. 1, § 30.3.2. Accessed online at http://www.cms.gov on January 22, 2010.

Beneficiary interviews. In addition to conducting a record review, we conducted structured interviews with beneficiaries who received repairs for their capped rental DME in excess of $5,000 in 2007.

We conducted structured interviews with beneficiaries representing 34 of the 53 sampled claims in stratum four. At the time of our review, eight beneficiaries were deceased. Eleven beneficiaries were unreachable by U.S. Postal Service mail or telephone. We requested that beneficiaries confirm whether repairs billed for capped rental DME were actually rendered. We also asked the beneficiaries to describe the services they received and any problems they encountered with suppliers that may have adversely affected their ability to use the capped rental DME.

Overall limitations. During our review period, we were unable to determine from claims data alone the difference between a repair and a replacement of DME using the RP modifier. We were able to make definitive determinations based upon review of the records. This reduced the number of sampled units we could review for payment errors.

Standards. This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

From 2006 to 2008, Medicare erroneously allowed $2.2 million for routine maintenance and servicing of capped rental DME with rental periods after implementation of the DRA

For the period 2006 to 2008, Medicare erroneously allowed 31,939 routine maintenance and servicing claims totaling $2,211,106 for capped rental DME with rental periods that began after implementation of the DRA.[53]

Medicare has never allowed claims for maintenance and servicing during the rental period; therefore, MACs should not have had to make changes to their payment systems to prevent these payments after implementation of the DRA. Additionally, MACs should not have allowed maintenance and servicing after 13 months of continuous rental for beneficiary-owned capped rental DME (see Table 2).

Table 2: Erroneous Maintenance and Servicing Claims

Year	During Rental Period (Allowed Claims)	During Rental Period (Allowed Amount)	Beneficiary-Owned (Allowed Claims)	Beneficiary-Owned (Allowed Amount)
2006*	1,303	$88,643	119	$19,928
2007	10,508	$731,702	6,471	$519,463
2008	10,488	$575,768	3,050	$275,602
Total	**22,299**	**$1,396,113**	**9,640**	**$814,993**

*Beneficiary-owned results from 2006 are not comparable to those for other years because section 5101(a) of the DRA became effective January 1, 2006. Aside from beneficiary-purchased DME, title to capped rental DME that was under a rental agreement did not begin to be transferred to beneficiaries until February 1, 2007 (13 months after implementation).

Source: OIG analysis of claims data, 2010.

Erroneous routine maintenance and servicing claims occurred for several categories of capped rental DME. The erroneous claims most commonly included nebulizers (14,420), continuous positive airway pressure devices (5,378), hospital beds (3,540), standard wheelchairs (2,111), and elevating leg rests for wheelchairs (1,377). These five categories represented 84 percent of erroneous claims.

[53] Medicare allowed 6,344,684 claims for routine maintenance and servicing of all capped rental DME, totaling $456,328,500. Most of these allowed claims were for maintenance and servicing of capped rental DME with rental periods beginning prior to implementation of the DRA.

From 2006 to 2008, Medicare erroneously allowed nearly $4.4 million for repairs for capped rental DME during rental periods

Medicare erroneously allowed 40,452 claims totaling nearly $4.4 million for repairs of beneficiary-rented capped rental DME. These payments have never been permitted, before or after the DRA. These repair claims were erroneous because costs for repair of rented capped rental DME are included in the monthly rental payment to suppliers. Over the 3-year period after implementation of the DRA, erroneously allowed claims almost doubled and erroneously allowed payments increased by nearly $1.8 million (see Table 3).

Table 3: Erroneous Rental Repair Claims

Year	Allowed Claims	Allowed Amount
2006	7,478	$493,178
2007	13,507	$1,631,757
2008	19,467	$2,257,190
Total	**40,452**	**$4,382,125**

Source: OIG analysis of claims data, 2010.

Erroneous repair claims occurred for several different categories of capped rental DME. The erroneous claims most commonly included continuous positive airway pressure devices (12,215), nebulizers (11,489), infusion pumps (5,531), standard wheelchairs (3,770), and hospital beds (2,573). These five categories represented 88 percent of erroneous claims.

In 2007, Medicare allowed nearly $27 million for repair claims for beneficiary-owned capped rental DME that failed to meet payment requirements

Of the $90 million allowed for capped rental DME repair claims in 2007, nearly $27 million was for claims associated with payment errors. These claims represent 27 percent of all allowed claims for repair of capped rental DME meeting the parameters of the methodology, which involved reviewing documentation for allowed claims. See Appendix A for point estimates and confidence intervals. See Appendix B for case examples of additional allowed claims failing to meet payment requirements.

Medicare claims that did not meet payment requirements (claim and payment errors) are summarized in Table 4.

Medicare-allowed claims that did not meet payment requirements

Payment errors included (1) lack of documentation of medical necessity, (2) lack of documentation of service, (3) lack of documentation of delivery, and (4) repairs for capped rental while under warranty. Additionally, we identified suppliers that violated Medicare assignment policy by charging service fees to beneficiaries.

Table 4: Payment Errors

Type of Error	Sample Size	Claims in Error (Percentage)	Payments in Error
Repair or replacement			
Lack of documentation of medical necessity	482	20.4	$20,772,891
Lack of documentation of service	482	4.8	$4,624,264
Lack of documentation of delivery	482	1.8	$1,234,534
Total repair or replacement errors	**482**	**27.1***	**$26,631,689**
Repair only			
Repairs while under warranty	335	2.6	$1,912,669
Total errors (gross)	**482**	**29.4***	**$28,738,808***
(Overlapping errors)	482	(2.3)	($1,943,653)
Total errors (net)	**482**	**27.1**	**$26,795,154**

*Totals may not sum exactly because of rounding and the effect of having denominators of 335 and 482 for different statistics. Overlapping errors are subtracted from gross errors to derive the net errors.

Source: OIG analysis of claims data, 2010.

Lack of documentation of medical necessity. Twenty percent of claims were associated with supplier-provided records that did not include prescriptions to document medical necessity of the capped rental DME.[54] Without such documentation, determination factors were unknown, such as the anticipated timeframe that the capped rental DME would be needed, expected therapeutic benefit, the physician's

[54] We counted an initial prescription or a prescription for the repair as documentation of medical necessity for the claim.

involvement in supervising the use of the prescribed capped rental DME, and the detailed description of the beneficiary's clinical and functional status.

Lack of documentation of service or delivery. Five percent of claims lacked sufficient information to indicate the service provided. An additional 2 percent of claims had no evidence of delivery or evidence that the beneficiary actually received the capped rental DME replacement parts or repaired DME as required under supplier standards.

Repairs while under warranty. Three percent of repair claims were for repairs that should have been covered under warranty. Separately, we also identified an instance in which the documented date of service would have been under warranty, but the claim form submitted by the supplier indicated a date of service much later than noted in other documentation. This new date was outside of the warranty period, and Medicare allowed the claim.

The percentage of claims that did not comply with this policy might have been greater because certain suppliers provided invalid serial numbers or did not provide serial numbers. Without correct serial numbers, we were unable to check warranty coverage. Additionally, we found that larger PMD manufacturers have systems that suppliers can query to determine warranty coverage. However, some of the manufacturers remove serial numbers from these systems for items that were manufactured more than 5 years ago, which prevented determination of warranty coverage.

Service fees charged for repairs. Suppliers that have accepted Medicare assignment of benefits may not charge beneficiaries additional fees for Medicare-covered services. Record reviews indicated that suppliers that accepted assignment charged beneficiaries service fees ranging from $25 to $100 for 2 percent of claims.[55] These fees were in addition to the normal copays and deductibles. For example, one supplier charged a $20 travel service fee when it picked up a beneficiary's PMD for repair work and a $40 travel service fee when it returned the chair to her home. Another record indicated that a beneficiary paid $5 in cash and an additional $20 with a personal check. Because the suppliers did not

[55] Based on a lack of information in claims data, we were unable to determine whether sampled repair claims were for rented or purchased capped rental DME.

submit separate line item claims for these service fees, the extent of the problem is unknown.

In 2007, Medicare allowed nearly $29 million for questionable repair claims for beneficiary-owned capped rental DME

Of the $90 million allowed for capped rental DME repair claims in 2007, nearly $29 million were questionable (i.e., suppliers did not provide serial numbers, suppliers provided invalid serial numbers, and repair costs claims on sampled dates of service exceeded 60 percent of the purchase price of new capped rental DME). These claims represent 49 percent of all allowed claims for repair of capped rental DME. The net result of either erroneous claims (the prior finding) or claims that were questionable was 62 percent, or nearly $39 million. Medicare claims that were questionable are summarized in Table 5. See Appendix A for point estimates and confidence intervals for claims that were questionable. See Appendix C for statistics on net results of payment errors and claims that were questionable.

Table 5: Questionable Claims for Beneficiary-Owned Capped Rental DME

Questionable Practice	Sample Size	Claims (Percentage)	Allowed Amounts
Supplier did not provide serial number	335	24.8	$10,943,415
Supplier provided invalid serial number	335	23.2	$13,921,304
Repair costs on the date of service exceeded 60 percent of the new purchase price	335	2.9	$6,687,925
Total (gross)	**335**	**50.9**	**$31,552,644**
(Overlapping)	335	(1.6)	($2,697,105)
Total (net)	**335**	**49.3**	**$28,855,539**

Overlapping amounts are subtracted from gross amounts to derive the net amounts.

Source: OIG analysis of claims data, 2010.

Suppliers did not provide serial numbers or provided invalid serial numbers. Suppliers did not provide serial numbers for 25 percent of repairs and provided invalid serial numbers for 23 percent of repairs, which prevented us from determining the models and therefore the purchase prices of new capped rental DME. Overall, 48 percent of claims had insufficient information for us to identify the manufacturers, makes, and models of capped rental DME. This prevented us from determining the replacement cost of some capped rental DME, as discussed below.

Repairs exceeded 60 percent of replacement cost. The costs of repairs associated with the dates of service for 3 percent of sampled claims exceeded 60 percent of the purchase prices for new capped rental DME. If total accumulated repair costs exceed 60 percent of the replacement cost for capped rental DME and the items have been in use for less than 5 years, the MAC may choose to hold suppliers responsible for replacement.[56] Since our analysis included only a single date of service, our estimate of the number of items for which repairs exceeded 60 percent of the replacement cost is an underestimate. Accumulated repair claims would likely have been greater over the lifetime of the item. Because of missing and invalid serial numbers, we could not calculate the replacement cost for 48 percent of new capped rental DME; thus our estimate of vulnerable payments is conservative. Because tracking repair costs is not a CMS requirement, CMS staff indicated to us that they have not provided guidance to MACs on how to track accumulated repair costs.

[56] See 71 Fed. Reg., No. 217 (Nov. 9, 2006) p. 65921.

Supplier practices adversely affected some beneficiaries with high-cost repairs

Our interviews with beneficiaires representing 34 of the 53 high-cost claims revealed that some supplier practices adversely affected beneficiaries' quality of life and activities of daily living. Certain suppliers failed to properly customize PMDs, rendering them useless to beneficiaries. Even though Medicare will pay for loaner DME when capped rental DME is being repaired, some suppliers did not offer this service when repairing PMDs, leaving some beneficiaries immobile. Some beneficiaries reported difficulty in contacting suppliers. Finally, beneficiaries reported that some suppliers failed to provide information and instruction, as required.

Some suppliers billing for high-cost repairs failed to properly customize Medicare-allowed capped rental DME. PMDs are medically necessary for beneficiaries who cannot effectively perform mobility-related activities of daily living using other mobility-assistive equipment, such as a cane, walker, or manual wheelchair.[57] PMDs for beneficiaries with severe mobility limitations can be upgraded with power options and other electronic features to accommodate beneficiaries' specific mobility needs. In some cases, beneficiaries did not receive the proper customization to meet their needs. Below are a few examples:

- A beneficiary reported multiple repairs to his chair. He stated that nothing on his current PMD is original aside from the frame. The computer system for his chair had been repaired 11 times and still did not meet his needs because it did not function properly. Further, the supplier repaired his $16,000 power tilt and recline seating system twice, but the repairs did not meet his needs for daily activities. The last attempt to properly fit the seating system included an inappropriately sized foam pad placed in the back of the chair; this failed to work.
- A beneficiary reported that he was provided a PMD that he was unable to use because he would slide out of the chair. The supplier indicated to him that it would fashion a pole for the chair that would keep him from sliding out. The beneficiary reported that the supplier never fashioned the pole; he keeps the PMD in a closet because he cannot use it.

[57] CMS's Medicare Learning Network, *Medicare Coverage of Power Mobility Devices: Power Wheelchairs and Power Operated Vehicles*. Accessed at http://www.cms.gov on January 22, 2010.

- One record for a beneficiary noted that she received an evaluation for a new PMD after only 3 months of using her current PMD. The beneficiary was given a new PMD, but she was unable to operate its controls because of her paralysis.

Some suppliers did not provide loaner DME. Although suppliers are not required to loan DME, suppliers receive additional Medicare reimbursement when loaning DME to beneficiaries while their original items are being repaired. Claims information indicated that beneficiaries received loaner DME for only 22 of our sampled claims. Without loaner DME, beneficiaries may not have the ability to maintain their daily functioning. For example:

- A beneficiary reported that although his supplier is located minutes away from the PMD manufacturer, replacement parts took weeks to arrive because they had to be mailed. The supplier provided a loaner only when the supplier initially ordered his new chair. Although the PMD had been repaired frequently since then, the supplier never again provided a loaner PMD. The beneficiary, who has quadriplegia, reported that he was completely immobile until his PMD was repaired.

Some beneficiaries reported difficulty in reaching their suppliers for high-cost repairs. Medicare requires that suppliers answer questions and respond to complaints beneficiaries have about Medicare-covered items that they have sold or rented. Four of the beneficiaries interviewed reported difficulty in reaching their suppliers. Specifically:

- One beneficiary reported that a supplier often would not answer the telephone or return calls. The beneficiary had to call repeatedly to finally reach a customer service representative. Because of such poor service by this supplier and problems with the PMD, the beneficiary purchased a backup manual wheelchair from eBay for $300 and planned to buy a $1,200 PMD from a private owner as a backup.
- Two beneficiaries reported that their PMDs needed repairs and/or modifications, but because their suppliers had gone out of business without notification, they had to locate new suppliers that were willing to repair and/or modify their PMDs.

Not all suppliers provided beneficiaries with instructions about the proper use of their high-cost capped rental DME, as required. Suppliers must provide beneficiaries with necessary information on how to use the equipment safely and effectively. If beneficiaries are provided with information regarding the general maintenance of their capped rental DME, unnecessary repairs or replacements to items may be less likely. Without this information, beneficiaries may not know how to maintain their capped rental DME. Collectively:

- Eight beneficiaries reported that the suppliers that provided their items did not provide any information about the items' warranties, common problems, or general maintenance.

From 2006 to 2008, Medicare erroneously allowed $2.2 million for routine maintenance and servicing of capped rental DME with rental periods after implementation of the DRA and $4.4 million for repairs of capped rental DME during rental periods. In 2007, $27 million (27 percent) of Medicare claims for repairs of beneficiary-owned capped rental DME did not meet payment requirements. In addition, 49 percent ($29 million) of claims during 2007 were questionable. A net 62 percent ($39 million) of claims were either erroneously allowed or were questionable. Further, our beneficiary interviews revealed that certain supplier practices adversely affected those beneficiaries.

CMS should take action to reduce erroneous payments and ensure quality services for beneficiaries. To accomplish this, we recommend that CMS:

Implement an edit to deny claims for routine maintenance and servicing of capped rental DME with rental periods beginning after January 1, 2006

CMS should ensure that routine maintenance and servicing claims are denied for capped rental DME with rental periods beginning after January 1, 2006.

Implement an edit to deny claims for repairs of beneficiary-rented capped rental DME

CMS should ensure that claims for repairs during the rental period are never allowed.

Improve enforcement of existing payment requirements for beneficiary-owned capped rental DME

CMS should ensure that claims for repairs of capped rental DME include documentation of medical necessity (for the initial prescription of the item), service, and delivery (if applicable). CMS should also ensure that claims for repairs are not allowed for capped rental DME under warranty and enforce Medicare assignment policy (i.e., when DME suppliers charge beneficiaries service fees).

Consider whether to require MACs to track accumulated repair costs of capped rental DME

CMS should consider requiring MACs to obtain serial numbers of repaired equipment and track accumulated repair costs of capped rental DME in the same way it tracks repair costs of prosthetics. This would allow MACs to identify and prevent payment for repairs that exceed 100 percent of the purchase price for replacement capped rental DME, which is not allowed. This same technique could be used to identify claims for accumulated repairs that exceed 60 percent of the purchase price for replacement capped rental DME.

Develop and implement safeguards to ensure that beneficiaries have access to the services they require

CMS could update the supplier standards and guidance to increase protections for beneficiary-purchased DME with respect to not charging extra service fees, such as prohibiting service fees for purchased capped rental DME. CMS could promote access to suppliers through resources such as a listing of capped rental DME suppliers that provide high-quality services integrated with a listing of suppliers that routinely accept assignment.

Take appropriate action on erroneously allowed claims for maintenance and servicing, repair, and payment errors

We will forward information on erroneously allowed claims identified in our review to CMS in a separate memorandum.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS agreed that maintaining strong and effective controls to ensure accurate payment of capped rental DME claims is essential. CMS responded positively to each of our six recommendations and indicated that, in general, it will work to improve its comprehensive oversight of capped rental maintenance and servicing.

In response to the first and second recommendations, CMS stated that it implemented claim edits in Transmittal 1177 (Change Request 5461) in February 2007 to instruct contractors to deny claims for maintenance and servicing of capped rental items and pay claims only for beneficiary-owned capped rental items. In view of our findings, CMS will conduct further systems analysis and implement additional edits, as required, to ensure these claims are denied.

In response to the third recommendation, CMS concurred and said it will communicate the policy of nonpayment for repairs and maintenance for items under a manufacturer's or supplier's warranty to contractors and suppliers. CMS will also issue a Medicare Learning Network article to the provider and supplier community to emphasize that documentation requirements will be enforced.

In response to the fourth recommendation, CMS agreed to consider the feasibility of requiring MACs to obtain serial numbers of repaired equipment and track accumulated repair costs.

In response to the fifth recommendation, CMS stated that it will issue guidance to DME suppliers advising them that beneficiaries should not be charged service fees above the capped rental fee unless an Advanced Beneficiary Notice is signed by the beneficiary.

In response to the sixth recommendation, CMS concurred and said it will take the appropriate action and send information about the erroneously allowed claims to the contractors.

The full text of CMS's comments can be found in Appendix D.

APPENDIX ~ A

Table A-1: Point Estimates and Confidence Intervals

Description	Sample Size (n)	Point Estimate	95% Confidence Interval
Statistics from Table 4			
Percentage of claims that lacked documentation of medical necessity	482	20.4	14.8–26.0
Allowed amount of claims that lacked documentation of medical necessity	482	$20,772,891	$16,707,498–$24,838,284
Percentage of claims that lacked documentation of service	482	4.8	1.6–8.0
Allowed amount of claims that lacked documentation of service	482	$4,624,264	$2,263,479–$6,958,049
Percentage of claims that lacked documentation of delivery	482	1.8	0.6–5.5*
Allowed amount of claims that lacked documentation of delivery	482	$1,234,534	$120,026–$2,349,042
Percentage of claims that lacked documentation of medical necessity, service, or delivery (gross)	482	27.1	20.2–34.0
Allowed amount of claims that lacked documentation of medical necessity, service, or delivery (gross)	482	$26,631,689	$21,805,711–$31,457,666
Percentage of claims for repairs while under warranty	335	2.6	1.0–6.4*
Allowed amount of claims for repairs while under warranty	335	$1,912,669	$438,549–$3,386,789
Percentage of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (gross)	482	29.4	22.3–36.5
Allowed amount of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (gross)	482	$28,738,808	$23,573,956–$33,903,659
Percentage of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (overlapping)	482	2.3	0.9–5.7*
Allowed amount of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (overlapping)	482	$1,943,653	$480,217–$3,407,090
Percentage of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (net)	482	27.1	20.8–33.4
Allowed amount of claims that lacked documentation of medical necessity, service, or delivery or were under warranty (net)	482	$26,795,154	$22,202,772–$31,387,536
Statistics from Table 5			
Percentage of repair claims for which the suppliers did not provide the serial numbers	335	24.8	17.9–31.7
Allowed amount for repair claims for which the suppliers did not provide the serial numbers	335	$10,943,415	$7,711,195–$14,175,636
Percentage of repair claims with invalid serial numbers	335	23.2	16.5–29.8
Allowed amount of repair claims with invalid serial numbers	335	$13,921,304	$10,509,611–$17,333,007

continued on next page

Table A-1: Point Estimates and Confidence Intervals, Continued

Description	Sample Size (n)	Point Estimate	95% Confidence Interval
Percentage of allowed claims for repair costs on the date of service that exceeded 60 percent of the new purchase price	335	2.9	1.0–4.8
Allowed amount of repair costs on the date of service that exceeded 60 percent of the new purchase price	335	$6,687,925	$4,095,793–$9,280,057
Percentage of repairs that had invalid serial numbers or no serial numbers provided or whose repair costs on the date of service exceeded 60 percent of the new purchase price	335	50.9	42.9–58.9
Allowed amount of repairs that had invalid serial numbers or no serial numbers provided, or whose repair costs on the date of service exceeded 60 percent of the new purchase price	335	$31,522,644	$26,271,998–$36,833,290
Percentage of repairs that had invalid serial numbers or no serial numbers provided or whose repair costs on the date of service exceeded 60 percent of the new purchase price (overlapping)	335	1.6	0.1–2.6*
Allowed amount of claims for repairs that had invalid serial numbers or no serial numbers provided or whose repair costs on the date of service exceeded 60 percent of the new purchase price (overlapping)	335	$2,697,105	$936,258–$4,457,952
Percentage of repairs that had invalid serial numbers or no serial numbers provided or whose repair costs on the date of service exceeded 60 percent of the new purchase price (net)	335	49.3	41.7–57.0
Allowed amount of claims for repairs that had invalid serial numbers or no serial numbers provided or whose repair costs on the date of service exceeded 60 percent of the new purchase price (net)	335	$28,855,539	$24,340,724–$33,370,354
Other statistics			
Percentage of repair claims without serial numbers and without valid serial numbers	335	48.0	40.3–55.6
Statistics from Appendix C not earlier provided			
Percentage of erroneous claims and claims that were questionable (gross)	482	76.7	66.2–87.1
Allowed amount of erroneous claims and claims that were questionable (gross)	482	$51,102,079	$43,921,779–$58,282,379
Percentage of erroneous claims and claims that were questionable (overlapping)	482	14.9	9.4–20.5
Allowed amount of erroneous claims and claims that were questionable (overlapping)	482	$12,413,575	$8,899,211–$15,927,939
Percentage of erroneous claims and claims that were questionable (net)	482	61.8	54.4–69.1
Allowed amount of erroneous claims and claims that were questionable (net)	482	$38,688,504	$33,967,207–$43,409,801

* Confidence intervals were calculated using the logit transformation because of poor coverage properties of the standard approximation method when a small number of sample elements possessed the characteristic of interest.

Source: Office of Inspector General analysis of claims data, 2010.

APPENDIX ~ B

Case Examples of Allowed Claims That Failed To Meet Payment Requirements

The following are included for illustrative purposes only and are not included in our error projections for this finding.

Billing for more labor time than was provided. Allowed labor units often did not match documentation provided by suppliers. For the 59 sampled E1340 claim line items, 6 line items did not have documentation supporting the number of units billed. In the extreme, a supplier billed 571 15-minute units (nearly 143 hours) for a single date of service. The supplier identified the overpayment and submitted a voluntary statement and refund indicating that only 291 15-minute units were provided. The 291 units were allowed without further scrutiny by the DME MAC even though the claim represented nearly 73 hours, or the equivalent of 3 days, of labor for a single date of service. On April 1, 2009, MACs implemented standardized labor times allowed for common repairs, which may reduce the potential for labor billing abuse.

Billing for repairs that exceed the purchase price. Repairs for five claims on our sampled date of service exceeded the purchase price of replacement capped rental DME. In total, Medicare allowed $21,206 for these five claims, $6,105 of which exceeded the purchase price of replacement DME. Additional repair costs prior to the sampled date of service may have also been reimbursed, which would increase the amount Medicare paid in excess of the price of replacement DME for these five claims.

High-dollar claim allowed in error. One supplier provided a beneficiary a replacement electronic wiring harness costing $141.91. The supplier submitted a claim for 100 times that amount, or $14,191. Medicare allowed $9,990 for the claim. We confirmed with the DME MAC responsible for processing the claim that a $9,990 payment was made to the supplier for the $141.91 part.

APPENDIX ~ C

Table C-1: Net Payment Errors and Questionable Claims

Type of Concern	Claims of Concern (Percentage)	Allowed Amount (Total)
Payment errors (net)	27.1	$26,795,154
Questionable claims (net)	49.3	$28,855,539
Gross concerns	76.7*	$51,102,079*
Overlapping concerns	(14.9)	($12,413,575)
Net concerns	**61.8**	**$38,688,504**

*Totals may not sum exactly because of rounding and the effect of having denominators of 335 and 482 for different statistics.

Source: Office of Inspector General analysis of claims data, 2010.

APPENDIX ~ D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY 1 1 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report: "Capped Rental DME: A Review of Repair Claims" (OEI-07-08-00550)

Thank you for the opportunity to review and comment on the Office of Inspector General's draft report, "Capped Rental DME: A Review of Repair Claims." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which Medicare improperly paid claims for routine maintenance and servicing of capped rental durable medical equipment (DME).

The DME items covered by Medicare are medical equipment that often requires maintenance and repairs and Medicare pays DME suppliers for maintenance and repairs in certain circumstances. Capped rental DME is a specific category of DME for which Medicare pays a fee schedule amount that is capped after 13 continuous months of rental to a beneficiary. The Deficit Reduction Act of 2005 (DRA) revised the payment rules for capped rental DME so that ownership of the equipment would transfer to the beneficiaries after 13 continuous months of rental.

During this audit, the OIG reviewed approximately 500 claims and conducted 34 beneficiary interviews and concluded claims for repairs of beneficiary-owned capped rental DME were improperly paid. The OIG's recommendations address strategies to reduce improper payments and strengthen program integrity.

The CMS appreciates the OIG's efforts and insight on this report. As described in our detailed responses, CMS agrees that maintaining strong and effective controls to ensure accurate payment of capped rental DME claims is essential. In fact, CMS has already taken action to strengthen Medicare claims processing edits to ensure proper payments in this vulnerable area. We agree to pursue additional analyses to validate the effectiveness of our claims processing and enforcement requirements and, as necessary, implement improvements to ensure all systems and requirements achieve our goal of accurate payments. In general, the CMS will work to improve our comprehensive oversight of capped DME rental maintenance and servicing. The CMS looks forward to continually working with the OIG on issues related to waste, fraud and abuse in the Medicare program.

The OIG made the following recommendations.

OIG Recommendation 1

Implement an edit to deny claims for routine maintenance and servicing of capped rental DME with rental periods beginning after January 1, 2006. CMS should ensure that routine maintenance and servicing claims are denied for capped rental DME with rental periods beginning after January 1, 2006.

CMS Response

The CMS accepts the recommendation and has already implemented the recommended claim edit. On February 2, 2007, CMS issued Transmittal 1177 (Change Request 5461) to instruct the claims processing contractors and shared system maintainers to deny claims for maintenance and servicing for capped rental items. Nevertheless, CMS will conduct further systems analysis in view of the OIG's findings and will implement additional system edits as may be required to ensure that the system denies claims for routine maintenance and servicing of capped rental DME during a rental period. The target date for implementing any additional system edits that may be indicated would be scheduled for the January or April 2011 quarterly system release.

OIG Recommendation 2

Implement an edit to deny claims for repairs of beneficiary-rented capped rental DME. CMS should ensure that repairs during the rental period are never allowed.

CMS Response

The CMS accepts the recommendation and has already implemented the recommended claim edit. On February 2, 2007, CMS issued Transmittal 1177 (Change Request 5461) to instruct the claims processing contractors and shared system maintainers to pay for reasonable and necessary repairs and servicing of capped rental items once the beneficiary owns the equipment. CMS will conduct further systems analysis in view of the OIG's findings and will implement additional system edits as may be required to ensure that the system denies claims for repairs of beneficiary-rented capped rental DME during a rental period. The target date for implementing any additional system edits that may be indicated would be scheduled for the January or April 2011 quarterly system release.

OIG Recommendation 3

Improve enforcement of existing payment requirements for beneficiary-owned capped rental DME. CMS should ensure that claims for repairs of capped rental DME include documentation of medical necessity (for the initial prescription of the item), service, and delivery (if applicable). CMS should also ensure that repairs are not allowed for capped rental DME under warranty and enforce Medicare assignment policy (i.e., when DME suppliers charge beneficiaries service fees).

CMS Response

The CMS concurs. Medicare payment for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty. CMS will communicate this policy to contractors and suppliers through the issuance of program instructions and Medicare Learning Network (MLN) articles.

The CMS will also issue an MLN article to the provider and supplier community to emphasize documentation requirements will be enforced.

OIG Recommendation 4

Consider whether to require MACs to track accumulated repair costs of capped rental DME. CMS should consider requiring MACs to obtain serial numbers of repaired equipment and track accumulated repair costs of capped rental DME in the same way it tracks repair costs of prosthetics. This would allow MACs to identify and prevent payment for repairs that exceed 100 percent of the purchase price for replacement capped rental DME, which is not allowed. This same technique could be used to identify claims for accumulated repairs that exceed 60 percent of the purchase price for replacement capped rental DME.

CMS Response

As part of our ongoing efforts to enhance oversight of DME suppliers, CMS will consider the feasibility of requiring MACs to obtain serial numbers of repaired equipment and track accumulated repair costs of capped rental DME. While the OIG report noted that CMS tracks repair costs for prosthetics, there is no CMS requirement to do this. CMS would have to consider the cost of collecting and tracking the serial numbers of repaired equipment with the potential savings if the equipment were to be replaced rather than repaired.

OIG Recommendation 5

Develop and implement safeguards to ensure that beneficiaries have access to the services they require. CMS could update the supplier standards and guidance to increase protections for beneficiary-purchased DME with respect to not charging extra service fees, such as prohibiting service fees for purchased capped rental DME. CMS could promote access to suppliers through resources such as a listing of capped rental DME suppliers that provide high-quality services integrated with a listing of suppliers that routinely accept assignment.

CMS Response

CMS cannot require DME suppliers to accept assignment. However, we will issue guidance to DME suppliers advising them that beneficiaries should not be charged service fees above the capped rental fee. If a DME supplier chooses to charge a Medicare beneficiary above the capped rental fee, the DME supplier must get the beneficiary to sign an Advanced Beneficiary Notice to confirm that the beneficiary agrees to be responsible for the additional fees.

As of October 1, 2009, all DME suppliers were required to meet the Medicare DME accreditation standards, and these new standards that became effective October 1, 2009 help to ensure that Medicare beneficiaries receive medical items and services from only qualified suppliers. Medicare beneficiaries can access the CMS website to obtain a current list of DME suppliers, including those that have accepted Medicare assignment.

CMS is also exploring implementation of a process that would provide beneficiaries, caregivers, and others information about suppliers' assignment rates for various items of DME.

OIG Recommendation 6

Take appropriate action on erroneously allowed claims for maintenance and servicing and repair, and on payment errors. We will forward information on erroneously allowed claims identified in our review to CMS in a separate memorandum.

CMS Response

The CMS concurs. CMS will take appropriate action and send the OIG identified erroneously allowed claims to the appropriate contractors. The CMS requests the OIG furnish the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.). In addition, CMS requests that Medicare contractor-specific data be written to separate CD-ROMs or separate hardcopy worksheets to better facilitate the transfer of information to the appropriate contractors.

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Brian T. Whitley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Julie Dusold, LCDR Mike Garner, and Rae Hutchison; central office staff who contributed include Scott Manley and Megan Ruhnke.

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