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OIG WORK PLAN 2012:
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

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On October 5, 2011, the U.S. Department of Health and Human Services Office of Inspector General ("OIG") released its Work Plan for the fiscal year 2012. The Work Plan describes the OIG's new and ongoing initiatives for the upcoming fiscal year. Typically, these initiatives focus on areas that have been recent problem areas for the OIG. Several of the OIG's new and ongoing initiatives are of particular interest to Durable Medical Equipment, Prosthetics, Orthotics and Supplies ("DMEPOS") suppliers.

New Initiatives

The OIG identified four new initiatives with respect to DMEPOS for fiscal year 2012. First, the OIG will review Medicare claims for diabetic testing supplies to verify questionable billing and other characteristics indicative of fraud, waste, and abuse. DMEPOS suppliers should ensure that they maintain documentation supporting that all claims for diabetic testing supply claims and other DMEPOS meet all coverage, coding and medical necessity requirements.

Second, the OIG will review how well the DME Medicare Administrative Contractors' claim processing controls prevent payments to multiple suppliers of home blood glucose testing supplies. These controls should monitor suppliers' compliance with the published guidelines for refilling blood glucose testing supplies. The OIG has been conducting a similar review of claims for other frequently replaced DME supplies.

The requirements for glucose testing supplies and other frequently replaced DME supplies are set forth in the Medicare Claims Processing Manual (Ch. 20, Section 200), the Medicare Program Integrity Manually (Ch. 4, Section 4.26.1), and local coverage decisions. A supplier may not refill frequently replaced DME supplies without first contacting the beneficiary to verify that a refill is necessary and to obtain the beneficiary's or caregiver's request for a refill. Furthermore, a supplier may not obtain advanced authorizations from beneficiaries for routine dispensing of refills. Instead, a supplier should contact a beneficiary no sooner than seven days prior to shipping the refills.

However, the OIG previously determined that payments had been made to multiple suppliers for supplies dispensed to the same beneficiary with overlapping service dates. A DMEPOS supplier, therefore, should implement safeguards to determine whether a beneficiary has exhausted any supplies furnished not only by the supplier, but any other DMEPOS supplier, before furnishing a beneficiary refills for frequently replaced DME supplies.

Third, the OIG will compare the DMEPOS suppliers' acquisition costs for support surfaces to Medicare's payment rates for these items. This review is in addition to the OIG's ongoing initiatives comparing acquisition costs to Medicare's payment rates for pre-fabricated lumbar supports (HCPCS L6031) and parenteral nutrition. OIG's lumbar support investigation has revealed that supplier's acquisition cost for lumbar supports and the online retail price for similar items are significantly lower than Medicare's payment rates for lumbar supports. Similarly, the OIG preliminary investigation of the various payor's reimbursement rates for parenteral nutrition has revealed that Medicare's reimbursement rate was an average higher than other payors, including Medicaid (45% higher) and Medicare managed care plans (78% higher).

If the OIG concludes that the difference between the acquisition cost and payment rate for an item is excessive, then the Medicare payment rates for the item may be reduced by the Centers for Medicare and Medicaid Services (CMS). Although the payment rates for any item may be reduced at anytime, DMEPOS suppliers should pay particular attention to items with Medicare payment rates that are significantly higher than the supplier's acquisition cost or amounts paid by other governmental or private

payors when conducting long term financial planning because such items will be subject to a higher level of scrutiny.

Finally, the OIG will start a new initiative to review the use of surety bonds to recover overpayments. Most DMEPOS suppliers are required to obtain and maintain a surety bond in an amount of no less than $50,000. The surety bond was meant to not only ensure the recoupment of at least a portion of any overpayment to a supplier, but also help make sure that only legitimate suppliers are enrolled in Medicare because "illegitimate" suppliers are less likely to qualify financially to obtain a surety bond. The OIG will determine the amount of overpayments recouped through collection of surety bonds and identify any barriers to collecting surety bonds. If an insignificant amount has been recouped through surety bonds or there are significant barriers to collecting the surety bonds, then this initiative may serve as a basis to amending or repealing a requirement viewed by many DMEPOS suppliers as an unnecessary expense.

Ongoing Initiatives

The OIG will continue several ongoing initiatives involving the competitive bidding program, enrollment and qualifications of DMEPOS suppliers, and payments by Medicare.

First, the OIG is currently conducting two congressionally mandated initiatives regarding the DMEPOS competitive bidding program. The statutory mandate to review the program was due to the well-documented issues that occurred during the first time Round 1 of the program was bid in 2009 and which resulted in Round 1 being delayed and then opened for rebidding by Congress. The OIG is required to review the procedures by which CMS conducted the competitive bidding and pricing determinations during the first round and second round (which has yet to take place). Additionally, the OIG will interview prescribing physicians to assess whether suppliers awarded contracts under the program solicit physicians to prescribe more profitable brands or modes of delivery and investigate changes in billing patterns arising from implementation of the program. The results of the OIG review will be of great interest to opponents of the program and suppliers that were not awarded a contract under the program.

Second, the OIG also has two long-standing initiatives aimed at ensuring that DMEPOS suppliers are properly enrolled and qualified as DMEPOS suppliers. The OIG has been reviewing and assessing Medicare contractors enrollment-screening mechanisms and post-enrollment monitoring to determine how well the contractors identify enrollees who pose fraud risks or omitted information on their enrollment applications. As with all submissions to CMS, it is imperative that DMEPOS suppliers completely and accurately fill out their enrollment applications.

In a related initiative, the OIG is reviewing the qualifications of certain providers submitting claims for custom-fabricated orthotic or prosthetic devices. The OIG will determine to what extent CMS oversees credentialing of orthotists and prosthetists or has provided guidance to State licensing boards and the industry regarding what is a "qualified practitioner" of orthotics and prosthetics. Orthotists and prosthetists should review State licensure requirements to verify that they are in compliance with the requirements in their state and that they are in fact a qualified practitioner of orthotics or prosthetics.

Finally, the OIG will continue reviewing the appropriateness of Medicare payments for various categories of durable medical equipment, payment of frequently replaced DME supplies, and payment of claims submitted with modifiers. The OIG will be identifying suppliers in select geographic areas that have high-volume claims and reimbursement for specified items, including power mobility devices, hospital beds, oxygen concentrators and nutrition. As in the past, the focus of the review will be on durable medical equipment and supplies that were not ordered by physicians, not delivered to the beneficiaries, or were not needed by the beneficiary. Lastly, the OIG will review select claims submitted with modifiers indicating that the supplier has the documentation to support their claims for required for payment on file to verify that the supplier do in fact have the documentation on file that supports their claims. A supplier should not submit a claim requiring a modifier unless the required documentation is on file.

Additional Information

The Benesch Health Care Practice Group regularly counsels clients on compliance with Medicare supplier standards, coverage and reimbursement requirements, and enrollment. If you have any questions regarding the issues presented in this article or if the Benesch Health Care Practice Group could otherwise be of assistance, please contact:

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As a reminder, this Advisory is being sent to draw your attention to issues and is not to replace legal counseling.

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