Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CGS ADMINISTRATORS, LLC, PAID UNALLOWABLE LOWER LIMB PROSTHETICS CLAIMS

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

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Deputy Inspector General

July 2013
A-06-12-00055

Office of Inspector General

https://oig.hhs.gov

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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

CGS Administrators, LLC, paid approximately $6 million for lower limb prosthetics claims that did not meet Medicare coverage requirements for 2010 and 2011.

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews found that Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) did not ensure that lower limb prosthetic claims met the coverage requirements in local coverage determinations (LCDs). LCDs are decisions by DME MACs on whether to cover a particular service in accordance with section 1862(a)(1)(A) of the Social Security Act (the Act) and are published to provide guidance to the public and the medical community. In response to one of OIG's reviews, on March 5, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a Technical Direction Letter (TDL) directing the DME MACs to develop claim-processing edits for all requirements in LCDs for lower limb prostheses. CGS Administrators, LLC (CGS), is one of the DME MACs. This review is part of a series of reviews to determine the compliance of DME MACs with LCD requirements for lower limb prostheses.

The objective of this review was to determine whether CGS processed and paid claims for lower limb prostheses according to LCD requirements for calendar years 2010 and 2011.

BACKGROUND

Section 1862(a)(1)(A) of the Act requires that, to be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or improve the functioning of a malformed body member. Medicare Part B provides for the coverage of durable medical equipment, prostheses, orthotics, and supplies (DMEPOS).

A lower limb prosthesis is an artificial replacement for any or all parts of a leg; it provides an individual who has an amputated limb with the ability to perform functional tasks, particularly walking, that may not be possible without the device. For a lower limb prosthesis to be covered by Medicare, the patient is expected to reach or maintain a defined functional level and be motivated to ambulate.

When submitting claims to DME MACs, suppliers use Healthcare Common Procedure Coding System (HCPCS) codes. Each claim can have multiple lines of service, each of which represents a different component (e.g., foot, ankle) of the lower limb prosthesis provided by the supplier. Lines of service are billed using HCPCS codes, many of which require a modifier code to indicate such things as left or right limb and functional level. CGS published LCD L11442 for lower limb prostheses. For items and services provided during 2010 and 2011, the LCD contained coverage requirements, such as the functional levels required for certain components, socket inserts that are allowed only in certain quantities, unallowable combinations of HCPCS codes, and the DMEPOS suppliers' documentation requirements. Medicare policy instructs DME MACs to apply the LCD coverage requirements to claims on either a prepayment or postpayment basis. CGS uses claim-processing edits to apply LCD requirements for lower limb

prostheses on a prepayment basis. Prepayment edits are programming logic within a claim-processing system that are designed to evaluate claims and prevent payment for errors such as noncovered, incorrectly coded, or inappropriately billed lines of service.

WHAT WE FOUND

CGS paid $6,021,976 for 4,260 lines of service for lower limb prostheses in 2010 and 2011 that did not meet LCD requirements, consisting of:

- $5,129,019 for 2,292 lines of service that had a missing or incorrect functional level modifier,
- $709,430 for 1,730 lines of service with unallowable quantities of socket inserts, and
- $183,527 for 238 lines of service that had unallowable combinations of components.

At the time that CGS paid these lines of service, it did not have edits in place to evaluate whether they met all the LCD requirements.

WHAT WE RECOMMEND

We recommend that CGS:

- recover $6,021,976 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements in 2010 and 2011 and
- monitor the edits it developed in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

CGS ADMINISTRATORS, LLC, COMMENTS

CGS concurred with our recommendations and described corrective actions that it had taken or planned to take.

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INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews[1] found that Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) did not ensure that lower limb prosthetic claims met the coverage requirements in local coverage determinations (LCDs). LCDs are decisions by DME MACs on whether to cover a particular service in accordance with section 1862(a)(1)(A) of the Social Security Act (the Act) and are published to provide guidance to the public and the medical community. In response to one of OIG's reviews, on March 5, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a Technical Direction Letter (TDL) directing the DME MACs to develop claim-processingedits for all requirements in LCDs for lower limb prostheses. CGS Administrators, LLC (CGS), is one of the DME MACs. This review is part of a series of reviews to determine the compliance of DME MACs with LCD requirements for lower limb prostheses.

OBJECTIVE

Our objective was to determine whether CGS processed and paid claims for lower limb prostheses according to LCD requirements for calendar years 2010 and 2011.

BACKGROUND

Medicare Coverage of Lower Limb Prostheses

Under Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the Medicare program. Section 1862(a)(1)(A) of the Act requires that, to be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or improve the functioning of a malformed body member.

According to the Act, Medicare Part B provides for the coverage of durable medical equipment, prostheses, orthotics, and supplies (DMEPOS). A lower limb prosthesis is an artificial replacement for any or all parts of a leg; it provides an individual who has an amputated limb with the ability to perform functional tasks, particularly walking, that may not be possible without the device. A prosthesis joins the beneficiary's residual limb at one of several sites, such as the hip, knee, ankle, or foot.

For a lower limb prosthesis to be covered by Medicare, the patient is expected to reach or maintain a defined functional level and be motivated to ambulate. Functional levels range from level 0 to level 4 and are indicated on prosthetic claims by modifiers K0 to K4. A K0 functional level modifier identifies a beneficiary who does not have the ability or potential to ambulate or

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[1] *Lower Limb Prosthetics Claims Paid to Premier Prosthetics and Orthotics Were Not Always Supported by Adequate Documentation* (A-07-12-05026), issued December 2012, and *Questionable Billing by Suppliers of Lower Limb Prostheses* (OEI-02-10-00170), issued August 2011.

transfer safely with or without assistance, and a prosthesis does not enhance his or her quality of life or mobility. In contrast, a K4 functional level modifier is for a beneficiary who has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills; this level is typical of the prosthetic demands of the child, active adult, or athlete.

Durable Medical Equipment Medicare Administrative Contractors

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required, among other things, the use of MACs to process Medicare claims. CMS contracted with four DME MACs to process and pay DMEPOS claims. Each DME MAC processes claims for one of four jurisdictions, known as Jurisdictions A, B, C, and D. CGS is the DME MAC for Jurisdiction C; it processes DMEPOS claims in 15 States, Puerto Rico, and the U.S. Virgin Islands.[2]

When submitting claims to DME MACs, suppliers use Healthcare Common Procedure Coding System (HCPCS) codes.[3] Each claim can have multiple lines of service, each of which represents a different component (e.g., foot, ankle) of the lower limb prosthesis provided by the supplier. Lines of service are billed using HCPCS codes, many of which require a modifier code[4] to indicate such things as left or right limb and functional level.

Local Coverage Determinations and Claim-Processing Edits

According to chapter 13, section 13.1.3, of the *Medicare Program Integrity Manual*, Pub. No. 100-08, LCDs are decisions by DME MACs on whether to cover a particular service in accordance with section 1862(a)(1)(A) of the Act. Section 13.1.3 also states: "The LCDs specify under what clinical circumstances a service is considered to be reasonable and necessary. They are administrative and educational tools to assist providers in submitting correct claims for payment. Contractors publish LCDs to provide guidance to the public and medical community within their jurisdictions."

CGS published LCD L11442 for lower limb prostheses. For items and services provided during 2010 and 2011, the LCD contained coverage requirements, such as the required functional levels for certain components, restrictions on the quantities of socket inserts,[5] unallowable combinations of HCPCS codes, and the DMEPOS suppliers' documentation requirements.

Additionally, chapter 13, section13.10, of the *Medicare Program Integrity Manual* states that DME MACs should apply the coverage requirements documented in LCDs to claims on either a

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[2] Jurisdiction C States are Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

[3] HCPCS is a medical code set used throughout the health care industry as a standardized system for describing and identifying health care procedures, equipment, and supplies in health care transactions.

[4] A modifier is a two-position code reported with a HCPCS code and is designed to give Medicare and commercial payers additional information needed to process a claim.

[5] A socket insert is used in the socket of the prosthesis to protect the beneficiary's limb and to allow for modifications to the fit of the prosthesis because of fluctuations in the size of the limb.

prepayment or postpayment basis. CGS uses claim-processing edits to apply the LCD requirements for lower limb prostheses on a prepayment basis. Prepayment edits are programming logic within a claim-processing system that are designed to evaluate claims and prevent payment for such errors as noncovered, incorrectly coded, or inappropriately billed lines of service.

CMS issued its March 5, 2012, TDL to all DME MACs in response to OIG's report issued in August 2011. CMS's TDL directed DME MACs to work collaboratively to develop a uniform set of edits based on all of the LCD requirements and to implement these edits in the local claim-processing system at each DME MAC no later than July 1, 2012.

HOW WE CONDUCTED THIS REVIEW

CGS paid approximately $500 million for 676,044 lines of service (135,339 claims) for lower limb prostheses for 2010 and 2011. We developed programming logic to analyze these lines of service to determine whether they met LCD requirements. Our analyses focused on the requirements that could be tested through data analytics without the need to obtain additional documentation from suppliers. We did not conduct a medical review to determine whether the claims were medically necessary.

We assessed the reliability of the data from CMS's National Claims History file by electronically testing required data elements and by checking the basic reasonableness of the data against another source. We determined that these data are sufficiently reliable for the purposes of this report.

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 objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

CGS paid $6,021,976 for 4,260 lines of service for lower limb prostheses in 2010 and 2011 that did not meet LCD requirements, consisting of:

- $5,129,019 for 2,292 lines of service that had a missing or incorrect functional level modifier,
- $709,430 for 1,730 lines of service with unallowable quantities of socket inserts, and
- $183,527 for 238 lines of service that had unallowable combinations of components.

Chapter 13, section13.10, of the *Medicare Program Integrity Manual* states that DME MACs should apply the coverage requirements documented in LCDs to claims on either a prepayment

or postpayment basis. At the time that CGS paid the claims for these lower limb prosthetic lines of service, it did not have claim-processing edits in place to evaluate whether they met all the LCD requirements. However, CGS officials told us that in response to the TDL that CMS issued on March 5, 2012, CGS developed claim-processing edits to address the LCD requirements.

MISSING OR INCORRECT FUNCTIONAL LEVEL MODIFIERS

LCD L11442 states that to receive certain lower limb prostheses, individuals should attain a certain functional level, and the functional level modifier code must be included on the line of service. For example, HCPCS code L5930 is for a high-activity knee frame. A beneficiary who receives this knee frame must be able to attain a functional level of 4, and Medicare claims with a line of service for L5930 must include the K4 modifier code. We identified instances in which CGS processed and paid for L5930 lines of service that did not have a modifier code or that had a modifier code other than K4. In total, CGS paid $5,129,019 for 2,292 lines of service that had a missing or incorrect functional level modifier code.

UNALLOWABLE QUANITITES OF SOCKET INSERTS

LCD L11442 states that no more than two of the same socket inserts are allowed for an individual lower limb prosthesis at the same time. CGS processed and paid for more than 2 of the same socket inserts for individual prostheses, totaling $709,430 for 1,730 lines of service.

UNALLOWABLE COMBINATIONS OF COMPONENTS

LCD L11442 identifies certain combinations of components that are not allowed on lower limb prostheses. For example, HCPCS code L5500 is for an initial below-the-knee prosthesis. When this prosthesis is provided to a beneficiary, certain prosthetic additions, such as HCPCS code L5629 (below-the-knee acrylic socket) are not allowable. We identified instances in which CGS processed and paid for both L5500 and L5629 lines of service. In total, CGS paid $183,527 for 238 lines of service that had unallowable combinations of components.

RECOMMENDATIONS

We recommend that CGS:

- recover $6,021,976 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements in 2010 and 2011 and
- monitor the edits it developed in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

CGS ADMINISTRATORS, LLC, COMMENTS

CGS concurred with our recommendations and described corrective actions that it had taken or planned to take. CGS's comments appear in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CGS paid approximately $500 million for 676,044 lines of service (135,339 claims) for lower limb prosthetics for 2010 and 2011. Our review focused on whether CGS met Medicare requirements by paying only those lines of service for lower limb prosthetics that were in accordance with its LCD on lower limb prostheses. We excluded claims that were flagged for review by the Medicare Recovery Audit Contractor. We did not conduct a medical review to determine whether the services were medically necessary. We did not review CGS's overall internal control structure, but limited our review of internal controls to those related to our audit objective.

We conducted our audit from August 2012 to March 2013 and performed our fieldwork at CGS's headquarters in Nashville, Tennessee.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and DME MAC guidance;

- interviewed staff at CGS to gain an understanding of processing and payment of DMEPOS claims for lower limb prostheses;

- used CMS's National Claims History file to identify Medicare Part B DMEPOS claims with dates of service from January 1, 2010, through December 31, 2011;

- developed programming logic to analyze the lines of service, focusing on the LCD requirements that could be tested through data analytics without the need to obtain additional documentation from suppliers; and

- discussed the results of our review with CGS officials.

We assessed the reliability of the data from CMS's National Claims History file by electronically testing required data elements and by checking the basic reasonableness of the data against another source. We determined that these data are sufficiently reliable for the purposes of this report.

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 objectives.

APPENDIX B: CGS ADMINISTRATORS, LLC, COMMENTS

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June 14, 2013

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
1100 Commerce Street, Room 632
Dallas, TX 75242

RE: CGS Response to Draft OIG Report entitled *CGS Administrators, LLC Paid Unallowable Lower Limb Prosthetics Claims* (A-06-12-00055)

Dear Ms. Wheeler,

CGS Administrators, LLC, the Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction C, appreciates the opportunity to comment on the Office of Inspector General's draft report entitled *CGS Administrators, LLC Paid Unallowable Lower Limb Prosthetics Claims.* In addition to requesting comments on the report, you ask that CGS state concurrence or non-concurrence with each of the recommendations in the report.

The OIG makes two (2) recommendations in its report. Those recommendations are:

1. Recover the overpayment identified in the report as $6,021,976.00.
2. Monitor the edits it developed in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

CGS concurs with both recommendations in the report. CGS will recoup the overpayment identified and will use the information from the audit in its supplier educational activities. CGS has ongoing edit monitoring and has noted no issues with the edits implemented as the result of CMS's March 2012 TDL. In addition, CGS Technical Staff demonstrated the functionality of the edits to the OIG staff during their on-site review.

In summary, CGS Administrators, LLC appreciates the opportunity to respond to the recommendations outlined in draft report A-06-12-00055 and, as demonstrated above, has taken steps to address those vulnerabilities. Should you have any additional questions, please contact Larry Kennedy at 615.782.4607 or Larry.Kennedy@cgsadmin.com.

Sincerely,

John Kimball

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