Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DURABLE MEDICAL EQUIPMENT CLAIMS PAID BY NATIONAL HERITAGE INSURANCE COMPANY, INC., DID NOT ALWAYS MEET THE REQUIREMENTS OF THE LOCAL COVERAGE DETERMINATION FOR LOWER LIMB PROSTHESES

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

Patrick J. Cogley
Regional Inspector General

August 2013
A-07-13-05040

Office of Inspector General

https://oig.hhs.gov/

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

National Heritage Insurance Company, Inc., paid approximately $450,000 for lower limb prosthetics claims that did not meet Medicare coverage requirements for the period January 1, 2009, through September 30, 2012.

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. National Heritage Insurance Company, Inc. (NHIC), 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 NHIC processed and paid claims for lower limb prostheses according to LCD requirements for the period January 1, 2009, through September 30, 2012.

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, prosthetics, 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. NHIC published LCD L11464 for lower limb prostheses. 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. NHIC 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

NHIC paid $450,157 for 651 lines of service for lower limb prostheses from January 1, 2009, through September 30, 2012, that did not meet LCD requirements, consisting of:

- $374,492 for 593 lines of service that had unallowable combinations of components,
- $63,583 for 43 lines of service that had missing or incorrect functional level modifiers,
- $9,026 for 7 lines of service with unallowable HCPCS codes, and
- $3,056 for 8 lines of service with unallowable quantities of test socket inserts.

At the time that NHIC paid these lines of service, it did not have edits in place to evaluate whether they met all the LCD requirements. In response to CMS's March 2012 TDL, NHIC implemented and improved edits to address the LCD requirements. Of the 651 lines of service we identified that did not meet LCD requirements, 66 lines of service occurred after the implementation of the new and revised edits. NHIC did not reprocess previous claims to ensure that they were in accordance with the LCD.

WHAT WE RECOMMEND

We recommend that NHIC:

- recover $450,157 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements and
- monitor the edits it developed and updated in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

AUDITEE COMMENTS

In written comments on our draft report, NHIC concurred with both of 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 (see Appendix A) 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. National Heritage Insurance Company, Inc. (NHIC), 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 NHIC processed and paid claims for lower limb prostheses according to LCD requirements for the period January 1, 2009, through September 30, 2012.

BACKGROUND

Medicare Coverage of Lower Limb Prostheses

Under Title XVIII of 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, prosthetics, 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 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. NHIC is the DME MAC for Jurisdiction A; it processes DMEPOS claims in 11 States and the District of Columbia.[1]

When submitting claims to DME MACs, suppliers use Healthcare Common Procedure Coding System (HCPCS) codes.[2] 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[3] 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."

On January 1 of each year of our audit period, NHIC published LCD L11464 for lower limb prostheses. The LCD contained coverage requirements, such as the required functional levels for certain components, restrictions on the quantities of socket inserts,[4] unallowable combinations of HCPCS codes, and the DMEPOS suppliers' documentation requirements.

Additionally, chapter 13, section 13.10, 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. NHIC uses claim-processing edits to apply the LCD

[1] Jurisdiction A States are Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

[2] 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.

[3] 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.

[4] 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 due to fluctuation in the size of the limb.

requirements for lower limb prostheses on a prepayment basis. Prepayment edits are programming logic within a claim-processing system that is 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 (see Appendix A). 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

NHIC paid approximately $327.5 million for 539,295 lines of service (116,631 claims) for lower limb prostheses from January 1, 2009, through September 30, 2012. 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 services 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 with NHIC. 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 contains the details of our audit scope and methodology.

FINDINGS

NHIC paid $450,157 for 651 lines of service for lower limb prostheses from January 1, 2009, through September 30, 2012, that did not meet LCD requirements, consisting of:

- $374,492 for 593 lines of service that had unallowable combinations of components,
- $63,583 for 43 lines of service that had missing or incorrect functional level modifiers,
- $9,026 for 7 lines of service with unallowable HCPCS codes, and
- $3,056 for 8 lines of service with unallowable quantities of test socket inserts.

Chapter 13, section 13.10, 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 NHIC paid the claims for these lines of service, it did not have claim-processing edits in place to evaluate whether they met all the LCD requirements. In response to CMS's March 2012 TDL, NHIC implemented and improved edits to address the LCD requirements. Of the 651 lines of service we identified that did not meet LCD requirements, 66 lines of service occurred after the implementation of the new and revised edits. NHIC did not reprocess previous claims to ensure that they were in accordance with the LCD.

UNALLOWABLE COMBINATIONS OF COMPONENTS

LCD L11464 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 NHIC processed and paid for both L5500 and L5629 lines of service. In total, NHIC paid $374,492 for 593 lines of service that had unallowable combinations of components.

MISSING OR INCORRECT FUNCTIONAL LEVEL MODIFIERS

LCD L11464 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 NHIC processed and paid for L5930 lines of service that did not have a modifier code or that had a modifier code other than K4 (indicating a lower functional level). In total, NHIC paid $63,583 for 43 lines of service that had a missing or incorrect functional level modifier code.

UNALLOWABLE HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODES

LCD L11464 states that certain lower limb prostheses are never allowable for Medicare reimbursement. The LCD states that reimbursement for HCPCS code L5990, a user-adjustable heel height feature, must be denied as not reasonable and necessary. However, we identified instances in which NHIC paid for lines of service that had HCPCS code L5990. In total, NHIC paid $9,026 for 7 lines of service with the unallowable HCPCS code L5990.

UNALLOWABLE QUANTITIES OF TEST SOCKET INSERTS

LCD L11464 states that no more than two test socket inserts are allowed for an individual lower limb prosthesis. NHIC processed and paid for more than two test socket inserts for individual prosthetics, totaling $3,056 for eight lines of service.

RECOMMENDATIONS

We recommend that NHIC:

- recover $450,157 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements and

- monitor the edits it developed and updated in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

AUDITEE COMMENTS

In written comments on our draft report, NHIC concurred with both of our recommendations and described corrective actions that it had taken or planned to take. Specifically, NHIC stated that it would initiate recovery of the overpayments that we identified within limits as specified in CMS program guidance and application regulations. NHIC added that it had ongoing edit monitoring, including the monitoring of an ongoing widespread prepayment complex review for lower limb prostheses HCPCS codes billed with a K3 functional level modifier.

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

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Questionable Billing by Suppliers of Lower Limb Prostheses	OEI-02-10-00170	8/2011
Lower Limb Prosthetics Claims Paid to Premier Prosthetics and Orthotics Were Not Always Supported by Adequate Documentation	A-07-12-05026	12/2012
Lower Limb Prosthetics Claims Paid to Ozark Prosthetics and Orthotics Were Not Always Supported by Adequate Documentation	A-07-12-05029	4/2013

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

NHIC paid $327,515,019 for 539,295 lines of service (116,631 claims) for lower limb prostheses for the period January 1, 2009, through September 30, 2012. Our review focused on whether NHIC 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 did not conduct a medical review to determine whether the services were medically necessary. We limited our review of internal controls to those related to our audit objective.

We conducted our audit work, which included contacting NHIC in Hingham, Massachusetts, from January through March 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and DME MAC guidance;
- interviewed staff at NHIC to gain an understanding of its procedures for the processing and payment of DMEPOS claims for lower limb prostheses;
- used CMS's National Claims History file to identify all DMEPOS claims processed and paid by NHIC during the period January 1, 2009, through September 30, 2012;
- 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 and provided detailed data on our findings to NHIC officials on May 8, 2013.

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 with NHIC. 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 C: AUDITEE COMMENTS

Durable Medical Equipment
Medicare Administrative Contractor
Phone: (781) 741-3029

July 22, 2013

Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region V11
601 E 12th St, Room 0429
Kansas City, MO 64106

Attention: Patrick J. Cogley
Regional Inspector General for Audit Services

Subject: OIG Draft Audit Report A-07-13-05040 "Durable Medical Equipment Claims Paid by National Heritage Insurance Company, LLC, Did Not Always Meet the Requirements of the Local Coverage Determination for Lower Limb Prostheses"

Dear Mr. Cogley:

NHIC appreciates the opportunity to work with the Office of Inspector General on this important issue facing NHIC in our oversight of DME MAC Juridiction A. Please find on the following page our response to the recommendations in the draft audit report cited above. If you have any questions about NHIC's response, please contact Jennifer Otten, Manager of Audit & Controls, in Chico, California at 530-332-1169 (or at jennifer.otten@hp.com).

Sincerely,

s/Andrew Conn
NHIC DME MAC A Program Director

cc: Jennifer Otten, NHIC, Corp.
Karen Grasso, NHIC, Corp.
Ed Knapp, RN, NHIC, Corp.
Paul Hughes, MD, NHIC, Corp.
Debbie Bach, RN, NHIC, Corp.

OIG Draft A-07-13-05040—NHIC JA Response

NHIC's response to each of the OIG Recommendations:

1. **Recommendation**
   Recover $450,157 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements

   NHIC Response
   NHIC concurs with this recommendation and will initiate recovery of the payments specified above within limits as specified in CMS program guidance and application regulations.

2. **Recommendation**
   Monitor the edits it developed and updated in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

   NHIC Response
   NHIC concurs with this recommendation and has ongpoing edit monitoring, including the monitoring of an ongoing widespread prepayment complex review for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier.