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**CMS Did Not Detect
Some Inappropriate
Claims for Durable
Medical Equipment
in Nursing Facilities**

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CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities

What OIG Found

Payment edits (automated payment processes) did not detect \$18.4 million in Medicare payments in 2015 for inappropriate claims for durable medical equipment (DME) provided during stays in skilled nursing facilities (SNFs) not covered by Medicare, called “noncovered stays.” This represented 6 percent of all payments for DME during noncovered stays in SNFs.

The Centers for Medicare & Medicaid Services (CMS) uses two payment edits designed to identify and reject such claims, but neither edit rejected the claims because SNFs and DME suppliers did not submit full and accurate information required for processing.

For 72 percent of the inappropriate DME claims, DME suppliers failed to correctly code the SNF as a facility. Instead, they coded the place of service as the beneficiary’s home, thus enabling the claims to bypass the CMS edit that rejects separate payment for most DME provided at facilities. By definition, SNFs provide primarily skilled care and thus cannot be considered beneficiary homes. For 98 percent of the inappropriate DME claims, SNFs did not submit “no-payment bills,” which are administrative claims that document the dates of noncovered stays and do not result in payment. No-payment bills enable another CMS edit to identify noncovered stays and reject claims for DME provided during those timeframes.

CMS may have also allowed up to \$3.7 million in Medicare payments for inappropriate claims for DME provided during stays in Medicaid-only nursing facilities. Unlike SNFs, these facilities can be considered beneficiary homes if they provide primarily nonskilled care, permitting separate Medicare payments for DME. However, we found that CMS is unable to verify whether the facilities qualify as homes because CMS does not collect and maintain information regarding the level of care—i.e., skilled or nonskilled—that facilities provide.

What OIG Recommends and How the Agency Responded

To improve detection of inappropriate DME claims, we recommend that CMS (1) strengthen oversight of place-of-service codes by developing a process to determine whether DME claims with “home” as the place of service fit the circumstances permitting separate payment; (2) assess the costs and benefits of strengthening oversight of no-payment bills by developing a process to identify noncovered stays when SNFs do not submit no-payment bills; and (3) assess the costs and benefits of collecting and maintaining information regarding the level of care provided by Medicaid-only nursing facilities. CMS concurred with our recommendations.

Key Takeaway

By not submitting full and accurate information on claims for DME, SNFs and DME suppliers bypassed the CMS edits that were designed to detect inappropriate DME claims. As a result, CMS allowed \$18.4 million in payments for inappropriate claims for DME provided during SNF stays not covered by Medicare, and may have allowed additional inappropriate claims in Medicaid-only nursing facilities. To improve its detection of inappropriate DME claims, CMS should strengthen oversight of place-of-service codes, and assess the costs and benefits of strengthening oversight of no-payment bills and collecting information regarding Medicaid-only nursing facilities’ level of care.

Why OIG Did This Review

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directs the Office of Inspector General (OIG) to monitor the appropriateness of Medicare payments for items and services (including DME) provided during noncovered stays in SNFs. CMS requires facilities to provide DME as a standard part of nursing care, and does not permit separate Medicare payment for DME except when Medicaid-only nursing facilities serve as beneficiary homes. Previously, OIG found that CMS allowed \$41.2 million in Medicare payments for inappropriate claims for DME provided during noncovered stays in SNFs (\$30 million) and in Medicaid-only nursing facilities (\$11.2 million) in 2006. In response to OIG’s work, CMS implemented a new payment edit to reject claims for DME provided during noncovered SNF stays. However, CMS did not address stays in Medicaid-only nursing facilities. This study provides an update to OIG’s prior study, assessing Medicare claims for DME provided during noncovered stays in SNFs and Medicaid-only nursing facilities.

How OIG Did This Review

For 2015, we identified inappropriate claims for DME provided during noncovered stays in SNFs, and potentially inappropriate claims for DME provided during stays in Medicaid-only nursing facilities. We used admission and discharge dates from the Minimum Data Set and SNF claims to document facility stay dates and identify noncovered stays. We then determined whether SNFs and DME suppliers submitted information required to facilitate proper billing for DME. We also collected information about CMS’s methods to prevent processing inappropriate claims for DME in these facilities.

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BACKGROUND

Objective

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) permitted Medicare payments for inappropriate claims for durable medical equipment (DME) provided during noncovered stays in skilled nursing facilities (SNFs) and potentially inappropriate claims for DME provided during stays in Medicaid-only nursing facilities.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 directs the Office of Inspector General (OIG) to monitor the appropriateness of Medicare payments for items and services (including DME) furnished to residents during SNF stays not covered by Medicare, called “noncovered stays.”¹ In response to the mandate, OIG reported in 2009 that CMS had allowed \$41.2 million in Medicare payments for inappropriate claims for DME provided during noncovered stays in 2006—\$30 million for DME provided during noncovered stays in SNFs, and \$11.2 million for DME provided during stays in Medicaid-only nursing facilities.²

In 2010, CMS implemented a new payment “edit,” or automated system process, to identify and reject Medicare claims for DME provided to residents during noncovered SNF stays.³ CMS did not take action to address inappropriate claims for DME provided during stays in Medicaid-only nursing facilities. This study provides an update to OIG’s 2009 report, assessing Medicare claims for DME provided during noncovered stays in SNFs and Medicaid-only nursing facilities in 2015.

Medicare Coverage for Skilled Nursing Facility Care

Nursing facilities may provide skilled or nonskilled nursing care to residents, typically elderly and disabled individuals who are either physically or mentally unable to live independently.⁴ CMS certifies most nursing facilities that provide primarily skilled care as SNFs, meaning that they are permitted to bill Medicare for beneficiary stays. Skilled nursing care is care that is

¹ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, § 313(d).

² OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment*, OEI-06-07-00100, July 2009. The total Medicare payment amount associated with inappropriate claims (\$41.2 million) included both payments made by CMS and payments made by beneficiaries.

³ CMS, *One-Time Notification*, Pub. 100-20, Transmittal 637, Change Request 6695, February 5, 2010. See also CMS, *One-Time Notification*, Pub. 100-20, Transmittal 789, Change Request 7164, October 28, 2010, and CMS, *CMS Manual System*, Pub. 100-20, Transmittal 973, Change Request 7625, October 27, 2011.

⁴ Social Security Act (SSA), §§ 1819(a), 1919(a).

provided by licensed clinicians such as nurses and rehabilitation therapists and includes services such as intravenous injections.⁵

In 2015, CMS certified 83 percent of nursing facilities as SNFs and classified the remaining 17 percent as Medicaid-only nursing facilities.⁶ Medicaid-only nursing facilities can provide either skilled care or nonskilled care, and they receive reimbursement through State Medicaid programs.⁷ Nonskilled nursing care does not require the skills of a registered nurse or therapist and includes services such as assistance with daily activities and oral medications.⁸ In the 2009 report, OIG found that CMS did not collect and maintain information about whether Medicaid-only nursing facilities provided primarily skilled or nonskilled care. CMS only categorized the nursing facilities as SNFs or Medicaid-only nursing facilities.^{9,10}

Medicare covers SNF stays for up to 100 days for each benefit period. To reimburse SNFs for these stays, Medicare requires that (1) the beneficiary must have had a qualifying 3-day inpatient hospital stay prior to the SNF admission, and (2) the beneficiary must require and receive skilled care during the SNF stay.¹¹

Noncovered stays. When a SNF stay does not meet these Medicare coverage requirements, Medicare does not cover the stay and refers to it as a “noncovered stay.” CMS must track the dates of noncovered stays to accurately determine the beneficiary’s benefit period for Medicare-covered stays. To this end, CMS requires SNFs to submit administrative claims for

⁵ CMS, *Skilled nursing facility (SNF) care*. Accessed at <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html> on June 8, 2017. CMS, *Medicare Coverage of Skilled Nursing Facility Care*, January 2015. Accessed at <https://www.medicare.gov/Pubs/pdf/10153.pdf> on September 15, 2017.

⁶ OIG analysis of 2015 nursing facilities in the Certification and Survey Provider Enhanced Reports/Quality Improvement and Evaluation System. This figure includes facilities that are dually certified as SNFs and Medicaid providers.

⁷ SSA § 1919(a). CMS, “Special ‘Skilled Nursing Facility’ (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or ‘Spell of Illness’,” *MLN [Medicare Learning Network] Matters*, Article #SE0745, August 28, 2012. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0745.pdf> on June 7, 2017. CMS, *Medicare Coverage of Skilled Nursing Facility Care*, January 2015. Accessed at <https://www.medicare.gov/Pubs/pdf/10153.pdf> on September 15, 2017.

⁸ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 30, § 70.4.5; CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 8 § 30.5.

⁹ CMS also acknowledges facilities that are dually certified as SNFs and Medicaid providers and acknowledges that some nursing facilities have “distinct parts,” a term referring to portions of nursing facilities that are certified differently than the rest of those facilities. 42 CFR § 483.5.

¹⁰ OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment*, OEI-06-07-00100, July 2009.

¹¹ SSA, §§ 1812(a)(2)(A), 1861(a); 42 CFR § 409.30; CMS, *Medicare Benefit Policy Manual*, ch. 8 §§ 20, 30. CMS, *Skilled nursing facility (SNF) care*. Accessed at <https://www.medicare.gov/coverage/skilled-nursing-facility-care.html> on June 8, 2017.

noncovered stays. These administrative claims document the dates when residents received care in SNFs outside of Medicare coverage.¹²

Depending on the circumstances, SNFs are required to submit one of two types of administrative claims for noncovered stays: (1) “no-payment bills,” which a SNF submits when a beneficiary who resides in a SNF no longer requires a skilled level of care, and (2) “benefits exhaust bills,” which a SNF submits when a beneficiary exhausts the 100 days of SNF benefits.^{13, 14} Because both types of claims identify noncovered stays, we combined “no-payment bills” and “benefits exhaust bills” for our analysis and refer to them collectively as “no-payment bills.” CMS does not require Medicaid-only nursing facilities to submit no-payment bills because stays in these facilities are never covered by Medicare.

Medicare Coverage for Durable Medical Equipment

DME is reusable medical equipment that serves a primarily medical purpose and is appropriate for use in a beneficiary’s home, such as a wheelchair, walker, or hospital bed.¹⁵ Medicare-enrolled DME suppliers provide DME to beneficiaries for use in their homes, and these suppliers submit claims to Medicare payment contractors for reimbursement. If the payment contractor determines that the DME claim is allowable, Medicare pays the approved amount, minus copayments and deductibles that are either paid by the beneficiary or reimbursed from other insurance providers.^{16, 17}

CMS considers most DME to be a standard part of care provided by SNFs and Medicaid-only nursing facilities, and generally does not permit separate Medicare payment for DME provided during covered or noncovered

¹² CMS, *Medicare Claims Processing Manual*, ch. 6, § 40.8.

¹³ Neither no-payment bills nor benefits exhaust bills are required for beneficiaries who are initially admitted to SNFs for nonskilled care because these services are not covered by Medicare.

¹⁴ CMS, *Medicare Claims Processing Manual*, ch. 6, § 40.8.

¹⁵ CMS, *Medicare Benefit Policy Manual*, ch. 15, § 110.1.

¹⁶ CMS, *Medicare Claims Processing Manual*, ch. 20, § 190A.

¹⁷ DME claims dated on or after April 1, 2013, incur a 2-percent reduction in payment in accordance with the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 (i.e., sequestration). For further explanation, see <https://www.cms.gov/Outreach-and-Education/Outreach/FFSPProvPartProg/Downloads/2013-03-08-standalone.pdf>.

stays.^{18, 19} However, CMS permits separate Medicare payment for DME when Medicaid-only nursing facilities serve as beneficiary homes. To qualify as a home, the facility must provide primarily nonskilled care.²⁰ (SNFs never qualify as beneficiary homes because, by definition, they provide primarily skilled care.) To receive the separate Medicare payment for facilities that qualify as homes, DME suppliers identify “home” as the place of service on the Medicare claim.

There are two circumstances under which CMS permits separate Medicare payment for DME when the facility—a SNF or a Medicaid-only nursing facility—does *not* serve as the beneficiary’s home: (1) when the beneficiary rented DME for the month during which he/she was admitted to the facility and (2) when the beneficiary received DME in anticipation of discharge for use in his or her home.^{21, 22} To receive the separate Medicare payment under these circumstances, CMS instructs DME suppliers to identify “home” as the place of service on the Medicare claim.

Ensuring Accurate Medicare Claims

To ensure that Medicare reimburses only appropriate claims, CMS instructs payment contractors to identify and reject certain claims that should not be paid. These instructions are programmed within the payment processing system as “edits” that trigger the system to automatically reject the claim during processing.²³

¹⁸ SSA, § 1861(h)(5). CMS, “Special ‘Skilled Nursing Facility’ (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or ‘Spell of Illness,’” *MLN [Medicare Learning Network] Matters*, Article #SE0745, August 28, 2012. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0745.pdf> on June 7, 2017. See also The Henry J. Kaiser Family Foundation, *Medicaid Benefits: Medical Equipment and Supplies*, 2012. Accessed at <http://www.kff.org/medicaid/state-indicator/medical-equipment-and-supplies/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> on July 6, 2017.

¹⁹ There are a few exceptions for specific categories of DME; for example, CMS permits separate Medicare payment for surgical dressings and prosthetic devices. CMS, *Medicare Claims Processing Manual*, ch. 7, § 10.1.

²⁰ CMS, *Medicare Benefit Policy Manual*, ch. 15, § 110.1(D). See also CMS, “Special ‘Skilled Nursing Facility’ (SNF) Definition Used in Determining Durable Medical Equipment (DME) Coverage, and in Ending a Benefit Period or ‘Spell of Illness,’” *MLN [Medicare Learning Network] Matters*, Article #SE0745, August 28, 2012. (For URL, see footnote 18 above.)

²¹ CMS permits payment for the entire rental month that overlaps the nursing facility admission. *Ibid.*

²² CMS permits payment for DME claims if the DME is delivered to a beneficiary in the SNF up to 2 days prior to discharge to home. In these situations, CMS instructs DME suppliers to use the date of discharge as the date of service on the claim. CMS, *Medicare Benefit Policy Manual*, ch. 15, § 110.5.

²³ CMS/Medicare Learning Network, *Medicare Claim Review Programs*, September 2016. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf on June 19, 2017. CMS, *Annual Report to Congress on the Medicare and Medicaid Integrity Programs*, Fiscal Year 2015, § 2.2. Accessed at <https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf> on January 30, 2018.

For DME, CMS has two payment edits that are designed to identify and reject these claims:

Edit that uses place-of-service codes. One CMS edit rejects claims for DME that is provided in institutional settings, including SNFs and Medicaid-only nursing facilities. This edit identifies and rejects Medicare claims for DME that do not have the place of service coded as “home” or another appropriate setting that would permit separate payment for DME.²⁴ As previously mentioned, DME suppliers can appropriately code Medicaid-only nursing facilities as beneficiary homes if the facility provides primarily nonskilled care or if one of several other exceptions apply.

Prior OIG studies found that place-of-service codes can be inaccurate. In the 2009 report that identified Medicare payments for inappropriate claims for DME provided during noncovered SNF stays, OIG found that 98 percent of inappropriate DME claims were incorrectly coded with “home” as the place of service.²⁵ In 2015, OIG found that Medicare potentially overpaid physicians approximately \$33.4 million for incorrectly coding nonfacility places of service on claims.²⁶

Edit that uses no-payment bills. In response to OIG’s prior finding of inappropriate claims, CMS implemented another edit that identifies and rejects inappropriate claims for DME provided during noncovered SNF stays. The new edit uses no-payment bills submitted by SNFs to document the dates of noncovered stays and rejects DME claims during those timeframes for a list of DME codes specified by CMS.^{27, 28} If SNFs do not submit no-payment bills, either because they fail to submit them or because they are not required to submit them, this edit does not have the information it needs to identify the noncovered stays and reject inappropriate claims.

²⁴ Noridian Healthcare Solutions, *Place of Service*, June 30, 2017. Accessed at <https://med.noridianmedicare.com/web/jadme/claims-appeals/claim-submission/pos> on July 12, 2017. Noridian Healthcare Solutions, *Place of Service*, June 15, 2017. Accessed at <https://med.noridianmedicare.com/web/jddme/search-result/-/view/2230703/place-of-service> on November 21, 2017. CGS, *DME MAC Jurisdiction B Supplier Manual*, Summer 2017. Accessed at https://cgsmedicare.com/jb/pubs/pdf/jb_supplier_manual_summer2017.pdf on November 21, 2017. CGS, *DME MAC Jurisdiction C Supplier Manual*, October 2, 2017. Accessed at <https://www.cgsmedicare.com/jc/pubs/pdf/chpt6.pdf> on November 21, 2017.

²⁵ OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment*, OEI-06-07-00100, July 2009.

²⁶ OIG, *Incorrect Place-of-Service Claims Resulted in Potential Medicare Overpayments Costing Millions*, May 2015, A-01-13-00506.

²⁷ Select categories of DME, such as surgical dressings and prosthetic devices, are permitted.

²⁸ CMS, *One-Time Notification*, Pub. 100-20, Transmittal 637, Change Request 6695, February 5, 2010. See also CMS, *One-Time Notification*, Pub. 100-20, Transmittal 789, Change Request 7164, October 28, 2010. See also *CMS Manual System*, Pub. 100-20, Transmittal 973, Change Request 7625, October 27, 2011.

Methodology

For this study, we identified inappropriately allowed claims for DME provided during noncovered stays in SNFs and potentially inappropriate claims for DME provided during stays in Medicaid-only nursing facilities for calendar year 2015. We identified noncovered stays by combining data from several databases to document the timeframes for facility stays.

Data Sources

We used facility admission and discharge dates from the Minimum Data Set (MDS), a component of the Resident Assessment Instrument, to document the dates when residents stayed in the facilities. To document the residents' health and general well-being, CMS requires facilities to complete and electronically submit MDS assessments for all residents at the time facilities admit and discharge them.²⁹

We identified residents who received any type of MDS assessment during 2015 and extracted their Social Security numbers; assessment dates; and facility admission and discharge dates. We combined the MDS data with SNF claims from the National Claims History (NCH) to document the dates of the covered and noncovered periods of the SNF stays. We then determined whether SNFs submitted no-payment bills for the noncovered stays. We also extracted facility names and facility types (i.e., SNF or Medicaid-only nursing facility) from the Certification and Survey Provider Enhanced Reports/Quality Improvement and Evaluation System.

Using the facility admission and discharge dates in MDS, we identified 3,030,178 DME claims that occurred during noncovered stays; these claims totaled \$350,774,111.^{30, 31} We also collected information from CMS regarding its methods to prevent the processing of inappropriate claims for DME provided during noncovered stays.

Analysis

Inappropriate Claims. To identify inappropriate claims, we used the list of DME codes that CMS specified in its edit for noncovered stays. We totaled the allowed amounts of inappropriate claims for DME provided during noncovered stays both in SNFs and in Medicaid-only nursing facilities. The Medicare payment amounts associated with inappropriate claims include payments both by CMS and by beneficiaries. We also grouped DME into broad categories and described the types of DME associated with such inappropriate claims.

²⁹ CMS, *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, Version 1.14, ch. 5, §5, October 2016. Accessed at <https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf> on March 16, 2017.

³⁰ We used assessment dates when admission or discharge dates were missing.

³¹ The total number of DME claims (3 million) and associated Medicare payments (\$351 million) included claims and payments from both SNFs (2,525,198 claims, \$287,560,924) and Medicaid-only nursing facilities (504,980 claims, \$63,213,188).

Place of Service. For DME provided in SNFs and in Medicaid-only nursing facilities, we determined whether DME suppliers had coded the place of service as “home.” For DME provided in SNFs, we considered all claims with place-of-service codes of “home” as inappropriate unless one of these two circumstances was applicable: (1) the beneficiary rented DME for the month during which he/she was admitted to the facility or (2) the beneficiary received DME in anticipation of discharge to use in his or her home. To assess the exception for rented DME, we determined whether the service dates were within the same month as the admission. To assess the exception for DME received in anticipation of a beneficiary’s discharge, we determined whether the DME was provided within 3 days of discharge (expanding beyond CMS’s permitted 2 days, to account for possible time discrepancies).³² For DME provided in Medicaid-only nursing facilities, we also determined whether the claims fit one of the two previously mentioned circumstances that permit separate Medicare payment for DME.

No-Payment Bills. We determined whether SNFs submitted no-payment bills for their residents on whose behalf DME suppliers inappropriately submitted claims. We identified “no-payment bills” for beneficiaries who no longer required a skilled level of care and “benefits exhaust bills” for beneficiaries who had fully exhausted their 100 days of SNF benefits. As previously stated, both types of bills are required only for beneficiaries admitted to SNFs for skilled nursing care. In our analysis, we included admissions both for skilled and nonskilled care and did not assess whether submission of no-payments bills or benefits exhaust bills was required. We counted benefits exhaust bills that included both Medicare-covered and noncovered days as though they were Medicare-covered stays in their entirety, which had a negligible impact on our analysis. We combined no-payment bills and benefits exhaust bills, and we refer to them collectively as no-payment bills in the findings and recommendations.

Limitation

We did not determine whether the DME provided to SNF and Medicaid-only nursing facility residents was medically necessary.

Standards

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

³² To determine whether the DME was provided within 3 days of discharge, we compared the DME claims’ dates of service to the beneficiaries’ dates of discharge. (CMS instructs DME suppliers to use the date of discharge as the date of service on the claim.)

FINDINGS

CMS's edits did not detect \$18.4 million in Medicare payments for inappropriate claims for DME provided during noncovered SNF stays

In 2015, CMS allowed \$18,350,191 in Medicare payments across 292,848 inappropriate claims for DME provided during noncovered stays in SNFs.³³ This total dollar amount includes both payments made by CMS (\$14,000,204) and payments made by beneficiaries (\$4,349,987). These payments represented 6 percent of all payments for DME provided during noncovered stays in SNFs in 2015 (\$287,560,924).³⁴ Oxygen and wheelchair equipment were the largest categories of DME among these inappropriate claims, accounting for 67 percent of the total payments for inappropriate claims for DME provided during noncovered stays in SNFs. (See Appendix A for a list of all inappropriately allowed DME by category.) CMS permitted these inappropriate DME claims despite using two payment edits intended to identify and reject them.

For many of these inappropriate claims, DME suppliers incorrectly coded the SNF as "home," thus bypassing a CMS edit

For 72 percent (212,132) of the inappropriately allowed DME claims, DME suppliers incorrectly coded the SNFs with "home" as the place of service.³⁵ As previously mentioned, SNFs cannot serve as beneficiary homes and should not be coded as "home" except under two circumstances, and none of the 292,848 DME claims met these circumstances.³⁶ Therefore, DME suppliers' coding the SNFs as "home" bypassed the CMS edit designed to reject claims for DME provided in institutional settings, such as SNFs and Medicaid-only nursing facilities not serving as homes.

For nearly all of these inappropriate claims, SNFs did not submit no-payment bills, thus bypassing another CMS edit

For 98 percent (288,011) of the inappropriately allowed DME claims, SNFs did not submit no-payment bills covering the time periods when the DME was provided. Although CMS requires submission of no-payment bills for beneficiary admissions for skilled care, SNFs have little incentive to submit these administrative claims given that they do not receive compensation. CMS does not have a process to ensure that SNFs submit them.³⁷

³³ This figure includes facilities that are dually certified as SNFs and Medicaid providers.

³⁴ The majority of the \$288 million was for DME that CMS permits during noncovered stays, such as orthotics, prosthetics, and enteral nutrition.

³⁵ OIG review using dates of care provided by MDS determined that the remaining 28 percent of DME claims were also inappropriate, but suppliers did not code "home" as the place of service.

³⁶ These claims did not include modifiers indicating the equipment was rented in the first month of care, and the beneficiary had not been discharged within 3 days of receiving DME.

³⁷ One incentive for SNFs to submit no-payment bills is to obtain a Medicare denial notice, which may be required for coverage by another insurer. CMS, *Medicare Claims Processing Manual*, ch. 6, § 40.8 2a.

CMS may have allowed additional Medicare payments for inappropriate claims for DME provided during stays in Medicaid-only nursing facilities

In addition, CMS does not require submission of no-payment bills if the initial admission is for unskilled care and accordingly is not covered by Medicare.

CMS's edit relies on no-payment bills to document the dates of noncovered stays—when residents received care outside of Medicare coverage. When CMS did not receive no-payment bills, the edit was unable to identify the noncovered stays and reject the inappropriate claims. CMS does not use additional data sources beyond the no-payment bills, such as MDS, which documents dates for noncovered stays via resident assessments.

For the remaining 2 percent (4,837) of inappropriately allowed DME claims, SNFs submitted no-payment bills that provided the dates of the noncovered stays, making it feasible to identify the inappropriate DME claims. Yet CMS allowed these inappropriate claims and made payments of \$156,996.³⁸ It is unclear why the edit did not reject these claims.

In 2015, CMS allowed up to \$3,720,401 in Medicare payments during noncovered stays in Medicaid-only nursing facilities.^{39, 40} Of these 59,949 claims, DME suppliers coded 81 percent (48,615 claims) with “home” as the place of service, thus bypassing the CMS edit and enabling separate payments for DME.⁴¹ These designations may have been correct, given that Medicaid-only nursing facilities can serve as beneficiary homes if the facility provides primarily nonskilled care. However, CMS is unable to verify whether the Medicaid-only nursing facilities associated with these claims provide primarily nonskilled care and therefore can qualify as beneficiary homes. CMS does not collect and maintain information regarding whether Medicaid-only nursing facilities provide primarily nonskilled care; as a result, it cannot confirm the accuracy of the place-of-service codes. Given the high rate of inaccurate place-of-service codes found in claims for DME provided during noncovered SNF stays, and given similar findings in prior OIG reports, some of the 81 percent of DME claims for Medicaid-only nursing facilities coded as “home” may also be inaccurate.⁴²

³⁸ The CMS payment was \$120,608 and the beneficiary payment was \$36,388.

³⁹ This figure includes distinct parts of nursing facilities. None of the claims that we reviewed fit the circumstances under which CMS permits separate payment for DME in facilities that are not serving as beneficiary homes.

⁴⁰ The CMS payment was \$2,837,650 and the beneficiary payment was \$882,751.

⁴¹ We did not assess the place-of-service codes for the remaining 19 percent of allowed claims for DME provided during Medicaid-only nursing facility stays. The claims were coded with a range of places of service, such as assisted living facilities and custodial care facilities.

⁴² OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment*, OEI-06-07-00100, July 2009. OIG, *Incorrect Place-of-Service Claims Resulted in Potential Medicare Overpayments Costing Millions, May 2015*, A-01-13-00506.

CONCLUSION AND RECOMMENDATIONS

CMS requires SNFs and Medicaid-only nursing facilities to provide DME as a standard part of care and does not permit separate Medicare payment for DME unless the facility serves as the beneficiary's home. Our findings demonstrate that CMS did not detect some inappropriate claims for DME provided during noncovered stays in SNFs, despite using two payment processing edits intended to identify and reject such claims.

We also note that CMS is unable to assess the appropriateness of claims for DME provided in Medicaid-only nursing facilities when DME suppliers code these facilities as the beneficiary's home, because CMS does not collect and maintain information about the level of care provided in these facilities. We recommend that CMS:

Improve oversight of place-of-service codes submitted by DME suppliers for DME provided during noncovered SNF stays

To strengthen oversight of place-of-service codes submitted by DME suppliers for DME provided during noncovered SNF stays, CMS should (1) develop a process to determine whether claims for DME provided during noncovered SNF stays with "home" as the place of service fit one of the two circumstances that permit separate Medicare payment for DME and recover any inappropriate reimbursements associated with these claims; and (2) provide targeted education to DME suppliers who frequently submit inaccurate place-of-service codes.

Assess the costs and benefits of improving oversight of no-payment bills submitted by SNFs

To strengthen oversight of no-payment bills submitted by SNFs, CMS should assess whether it would be cost-effective to (1) develop a process—such as the one that OIG used for this review—to identify noncovered stays for which SNFs did not submit no-payment bills and recover any inappropriate reimbursements associated with these claims; and (2) provide targeted education regarding submission of no-payment bills to SNFs found to have high numbers of missing bills.

Assess the costs and benefits of collecting and maintaining information regarding the level of care provided by Medicaid-only nursing facilities

To strengthen oversight of place-of-service codes submitted by DME suppliers on claims for DME provided during Medicaid-only nursing facility stays, CMS should assess whether it would be cost-effective to collect and maintain information regarding whether facilities provide primarily nonskilled care and can serve as beneficiary homes. This information may enable CMS to develop and implement a process to confirm the accuracy of place-of-service codes.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendations and described several ongoing efforts to prevent improper DME claims. These efforts include claims processing edits (automated payment processes); prepayment and postpayment reviews; and provider education regarding proper DME billing through various channels such as the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

In response to our recommendations, CMS stated that it will do the following:

- Instruct Medicare Contractors to review place-of-service codes on claims submitted by DME suppliers for DME provided during noncovered SNF stays. CMS will also recover inappropriate reimbursements associated with these claims and provide targeted education to suppliers that frequently submit inaccurate codes.
- Assess whether it would be cost-effective to implement a process—similar to the one that OIG used for this review—to identify noncovered stays for which SNFs did not submit the required no-payment bills. CMS will also consider providing targeted education to SNFs found to have high numbers of missing no-payment bills.
- Evaluate ways to improve oversight of place-of-service codes on claims submitted by DME suppliers for DME provided during stays in Medicaid-only nursing facilities.

Appendix B contains the full text of CMS's comments.

APPENDIX A: Inappropriate Claims and Payments for Durable Medical Equipment (DME) Provided During Noncovered Stays in Skilled Nursing Facilities

Category	Payments	Number of Claims
Oxygen and respiratory supplies and related equipment	\$6,157,499	63,545
Wheelchairs and accessories	\$6,047,178	85,025
Seat/patient lifts	\$1,264,175	3,787
Hospital beds and accessories	\$1,088,213	14,708
Transcutaneous and/or neuromuscular electrical nerve stimulators	\$793,977	485
IV poles	\$791,997	73,147
Blood glucose monitoring equipment	\$709,053	43,053
Wound care	\$311,392	407
Decubitus care equipment	\$234,971	2,173
Pneumatic compressor and appliances	\$194,513	286
Infusion pump supplies and equipment	\$168,032	1,194
Hearing and communication DME	\$157,298	148
Pacemakers and related equipment	\$150,939	61
Walkers, canes, crutches, and attachments	\$90,417	1,673
Sitz baths and commodes	\$73,392	1,513
Temporary replacement for patient-owned equipment being repaired	\$68,254	166
Traction equipment	\$25,910	1,244
Range-of-motion devices	\$20,833	171
Other	\$2,148	62
Total	\$18,350,191	292,848

Source: OIG analysis of 2015 DME claims.

APPENDIX B: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY - 3 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma *SV*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities (OEI-06-16-00380)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews.

As OIG notes, CMS has two payment edits relevant to durable medical equipment and skilled nursing facilities that are designed to identify and reject claims that should not be paid. Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for durable medical equipment. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS improve oversight of place-of-service codes submitted by DME suppliers for noncovered SNF stays by (1) developing a process to determine whether claims for DME provided during noncovered SNF stays with "home" as the place of service met one of the two circumstances that allow for separate Medicare payment for DME and recover any inappropriate reimbursements associated with these claims; and (2) providing targeted education to DME suppliers who frequently submit inaccurate place-of-service codes.

CMS Response

CMS concurs with this recommendation. CMS will instruct the Medicare Contractors to review place-of-service codes submitted by durable medical equipment suppliers during noncovered skilled nursing facility stays. CMS will recover any inappropriate reimbursements associated with these

claims consistent with agency policy and procedures and will provide targeted education to durable medical equipment suppliers that are found to be frequently submitting inaccurate place of service codes.

OIG Recommendation

The OIG recommends that CMS assess the costs and benefits of improving oversight of no-payment bills submitted by SNFs by assessing whether it would be cost-effective to (1) develop a process such as the one that OIG used for this review, to identify noncovered stays for which SNFs did not submit no-payment bills and recover any inappropriate reimbursements associated with these claims; and (2) provide targeted education regarding submission of no-payment bills to SNFs found to have high numbers of missing bills.

CMS Response

CMS concurs with this recommendation. CMS will evaluate ways to improve oversight of no-payment bills submitted by skilled nursing facilities including assessing whether it would be cost effective to implement a process similar to the one that OIG used for this review to identify noncovered stays for which skilled nursing facilities did not submit the required no-payment bills and provide targeted education regarding submission of no-payment bills to skilled nursing facilities found to have high numbers of missing bills.

OIG Recommendation

The OIG recommends that CMS assess the costs and benefits of collecting and maintaining information regarding the level of care provided by Medicaid-only nursing facilities by determining whether it would be cost-effective to collect and maintain information regarding whether facilities provide nonskilled care and can serve as beneficiary homes to enable CMS to implement a new edit or other process to confirm the accuracy of place-of-service codes.

CMS Response

CMS concurs with this recommendation. CMS will evaluate ways to improve oversight of place-of service codes submitted by durable medical equipment suppliers for Medicaid-only nursing facility stays.

ACKNOWLEDGMENTS

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This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Amy Ashcraft and Petra Nealy, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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