Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL GOVERNMENT SERVICES, INC., 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

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A-07-13-05039

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 Government Services, Inc., paid approximately $1.5 million 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 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 our 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 Government Services, Inc. (NGS), 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 NGS 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. NGS published LCD L27013 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. NGS 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

NGS paid $1,461,464 for 770 lines of service for lower limb prostheses from January 1, 2009, through September 30, 2012, that did not meet LCD requirements, consisting of:

- $1,418,407 for 682 lines of service that had missing or incorrect functional level modifiers and

- $43,057 for 88 lines of service that had unallowable combinations of components.

When NGS 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. NGS implemented and improved edits throughout our audit period, and in response to CMS's TDL, to address the LCD requirements. Of the 770 lines of service we identified that did not meet LCD requirements, NGS paid for 29 lines of service after implementation of its latest updated edits.

WHAT WE RECOMMEND

We recommend that NGS:

- recover $1,461,464 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements and

- continue to 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, NGS stated that it had addressed our recommendations. Specifically, NGS said that it had issued overpayment requests for all of the claim lines we had identified and that it had to date recouped $1,365,822 of the $1,461,464 in identified overpayments. NGS also described corrective actions that it had taken with respect to implementing and improving its claim-processing edits and added that, as part of its standard practices, it would review existing edits to determine their effectiveness within the claim-processing system.

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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 our 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 Government Services, Inc. (NGS), 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 (see Appendix A).

OBJECTIVE

Our objective was to determine whether NGS 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. NGS is the DME MAC for Jurisdiction B; it processes DMEPOS claims in seven States.[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."

Throughout each year of our audit period, NGS had an LCD in effect for lower limb prostheses, LCD L27013. 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. NGS uses claim-processing edits to apply the LCD requirements for lower limb prostheses on a prepayment basis. Prepayment edits are

[1] Jurisdiction B States are Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

[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.

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

NGS paid approximately $322.8 million for 529,351 lines of service (124,154 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 NGS. We determined that these data were 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

NGS paid $1,461,464 for 770 lines of service for lower limb prostheses from January 1, 2009, through September 30, 2012, that did not meet LCD requirements, consisting of:

- $1,418,407 for 682 lines of service that had missing or incorrect functional level modifiers and

- $43,057 for 88 lines of service that had unallowable combinations of components.

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. When NGS 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. NGS implemented and improved edits throughout our audit period, and in response to CMS's TDL, to address the LCD requirements. Of the 770 lines of service we identified that did not meet LCD

requirements, NGS paid for 29 lines of service after implementation of its latest updated edits. NGS did not reprocess the 29 claims made prior to the implemented and improved edits to ensure that they were in accordance with the LCD.

MISSING OR INCORRECT FUNCTIONAL LEVEL MODIFIERS

LCD L27013 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 NGS 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, NGS paid $1,418,407 for 682 lines of service that had a missing or incorrect functional level modifier code. Of the 682 lines of service, 514 lines had an incorrect functional level modifier (K3-K0), and 168 lines were missing a functional level modifier.

UNALLOWABLE COMBINATIONS OF COMPONENTS

LCD L27013 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 NGS processed and paid for both L5500 and L5629 lines of service. In total, NGS paid $43,057 for 88 lines of service that had unallowable combinations of components.

RECOMMENDATIONS

We recommend that NGS:

- recover $1,461,464 in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements and

- continue to 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, NGS stated that it had addressed our recommendations. Specifically, NGS said that it had issued overpayment requests for all of the claim lines we had identified and that it had to date recouped $1,365,822 of the $1,461,464 in identified overpayments. NGS also described corrective actions that it had taken with respect to implementing and improving its claim-processing edits and added that, as part of its standard practices, it would review existing edits to determine their effectiveness within the claim-processing system. NGS'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
CGS Administrators, LLC, Paid Unallowable Lower Limb Prosthetics Claims	A-06-12-00055	7/2013
Durable Medical Equipment Claims Paid by Noridian Healthcare Solutions, LLC, Did Not Always Meet the Requirements of the Local Coverage Determination for Lower Limb Prostheses	A-07-12-05035	8/2013
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	A-07-13-05040	8/2013

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

NGS paid $322,841,681 for 529,351 lines of service (124,154 claims) for lower limb prostheses for the period January 1, 2009, through September 30, 2012. Our review focused on whether NGS 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 NGS in Indianapolis, Indiana, from January through March 2013.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and DME MAC guidance;
- interviewed staff at NGS 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 NGS 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 NGS officials on May 10, 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 NGS. We determined that these data were 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

MEDICARE

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September 3, 2013

Report Number: A-07-13-05039

Patrick Cogley
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

National Government Services (NGS) appreciates the opportunity to review and comment on the above referenced draft audit report. Responses to the recommendations made by the Office of Inspector General are included below.

1. Recommendation:
   Recover $1,461,464 in identified overpayments for lines of service for lower limb prostheses that did not meet the LCD requirements.

   NGS Response: During the audit period of January 1, 2009 through September 30, 2012, NGS paid associated services for Lower Limb Prosthetics in the amount of $322,841,681. The audit identified services with a corresponding payment amount of $1,461,464 (0.5%) that did not meet the LCD requirements. Prior to the publication of this report, NGS had issued overpayment requests for all of the identified claim lines. To date, NGS has recouped $1,365,822 on receivables associated with the claim lines in question.

2. Recommendation:
   Continue to monitor the edits developed and updated in response to CMS's March 2012 TDL to ensure that the edits are functioning correctly.

   NGS Response: As noted in the report, NGS implemented and improved edits throughout the audit period to address the LCD requirements to the extent afforded by the claims processing system. As part of our standard practice we will review existing edits to determine the effectiveness of the edits within the claims processing system.

In conclusion, the Jurisdiction B DME MAC has addressed all of the recommendations outlined in the OIG report. We will continue edit evaluation practices to help ensure lines of service for lower limb prostheses are processed in accordance with CMS's March 2012 TDL and compliant with guidelines

National Government Services

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outlined in the associated Local Coverage Determination to the extent possible afforded by the DME claims processing system.

Sincerely,

David Barnett
Jurisdiction B DME MAC Program Manger

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