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MEDICARE VULNERABILITIES: PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

OF THE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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MEDICARE VULNERABILITIES: PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

WEDNESDAY, JULY 9, 2008

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room SD–342, Dirksen Senate Office Building, Hon. Carl Levin, Chairman of the Subcommittee, presiding.

Present: Senators Levin, Carper, McCaskill, Coleman, Collins, and Coburn.

Staff Present: Kristina Ko, Legislative Assistant to Senator Levin; Mark L. Greenblatt, Staff Director and Chief Counsel to the Minority; Clifford C. Stoddard, Jr., Counsel to the Minority; Timothy R. Terry, Counsel to the Minority; Mary D. Robertson, Chief Clerk; Gina Reinhardt, Congressional Fellow; Nicholas Standiford, Intern; Donell Ries, GAO Detailee; Jonathan Ende, Intern; and John Kim, Law Clerk; Peggy Gustafson (Senator McCaskill); John Collins (Senator Carper); Priscilla Hanley (Senator Collins); and Evan Feinberg (Senator Coburn).

OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. Good morning, everybody.

Medicare is a critically important program that provides essential health care to folks across the country. But Medicare has a reputation for weak controls that waste hundreds of millions of taxpayer dollars each year. Today's hearing provides one example of those weak controls. From 2000 to 2007, we estimate that nearly half a million payments, totaling about $76 million, went to medical equipment suppliers that had submitted claims using the identification numbers of 17,000 deceased doctors, and that represents about half of the deceased doctor population.

At the request of Senator Coleman, the Subcommittee undertook this investigation to examine Medicare claim prescriptions for durable medical equipment presumably authorized by deceased doctors. This program is operated by the Centers for Medicare & Medicaid Services (CMS).

We found that doctors who had died 1, 5, even 10 years earlier, were listed on Medicare claims prescribing equipment supposedly ordered by them years after their death. Here is how the Subcommittee estimates the dollar amounts of these claims. The Subcommittee received, from the American Medical Association, a list

of physicians whose dates of death were between 1992 and 2002. We identified more than 33,000 deceased physicians who had what are called Unique Physician Identification Numbers (UPINs), and we created a random sample of 1,500 of those physicians. We then requested data from CMS about claims that had been filed from 2000 to 2007 using those physician identifiers on a prescription dated more than a year after the physician's death.

Within our sample of 1,500 doctors, we found that 734 UPINs, or about half of the sample, were used by durable medical equipment suppliers on 21,000 claims totaling over $3.4 million during that 7-year period. That is an average of almost 30 false claims filed per deceased doctor, or about $4,600 paid out per deceased doctor. Then we used those numbers to generate statistically valid estimates of the total population of erroneous payments for medical equipment using the UPINs of deceased physicians. We estimate that, from 2000 to 2007, the UPINs of more than 17,000 deceased physicians were used on close to a half a million erroneous claims for durable medical equipment that were paid over $76 million. The failure to reject these claims raises questions about who at Medicare is safeguarding taxpayer dollars, and why basic protections are not in place.

One example is a physician in Florida who died in 1999. Six to 7 years later, from November 2005 through November 2006, Medicare paid out over $544,000 worth of durable medical equipment claims supposedly ordered by this physician.

How is that possible? It seems apparent that the CMS system has failed to adequately monitor and audit the contractors who are paid to update the UPIN numbers and process the durable claims, the medical equipment claims. When a durable medical equipment claim comes in, the CMS contractor who processes the claims—called a DME Regional Carrier, (DMERC)—is supposed to verify that the claim includes a valid and active UPIN for the prescribing physician. If the UPIN does not exist or if it is assigned to a physician that is deceased, the claim should not be paid. It is supposed to be that simple.

When the $544,000 in Florida durable medical equipment claims were submitted to Medicare using the UPIN of a physician who had died up to 7 years earlier, the contractor should have determined that the claims were invalid. Instead, the contractor accepted the claims from these companies using the deceased doctor's UPIN. While those claims happened to be in Florida, contractors have been approving claims filed with deceased doctors' UPINs all over the country. We estimate that about 2,500 deceased physicians still had active UPINs as of May of this year.

What makes matters worse is that CMS was alerted to UPIN failures back in 2001 and said they took steps to correct it, but then never re-evaluated the situation to ensure that the problem was fixed. It was in November 2001, when the Inspector General of the Department of Health and Human Services, released a report finding that over $90 million had been paid for medical equipment and supply claims with invalid or inactive UPINs in 1999 alone. In 2002, CMS said that they implemented procedures to ensure that these medical equipment claims with inactive or invalid UPINs, including those belonging to deceased physicians, would be

rejected. CMS issued instructions to its contractors, including the National Heritage Insurance Company, the contractor that maintained the UPIN registry—and, by the way, these are all contractors that are for-profit. These are not nonprofit contractors. CMS instructed them to conduct a one-time cleanup to eliminate deceased physicians' UPINs. They were then paid to update their UPIN registries every 15 months. Its contractors were also required, as of April 1, 2002, to reject all claims using the UPINs of deceased physicians. Looking internally, CMS also issued a directive to reprogram its own data system to guarantee the rejection of these types of claims.

Apparently, neither CMS nor their contractors did what they were supposed to do. The UPIN registry was not kept up to date. The contractors' systems did not reject deceased physician claims. Neither did the CMS data system. And no one—CMS or the contractors—checked to see if the procedures were working. So 7 years after the IG report, we are back where we started, with CMS paying claims containing UPINs assigned to deceased doctors.

A few months ago, CMS terminated the use of the UPIN registry and replaced it with a new registry. But unless CMS and their contractors are held accountable for failures, and unless companies who wrongfully profited from improper use of deceased physicians' identification numbers are held accountable, we will be back here 7 years from now asking the same questions.

The failure to stop payment of deceased physician claims is inexcusable since dates of deaths are so readily available. This type of abuse should have been stopped long ago. It is easy to obtain deceased physicians' identification numbers and easy to use those numbers to obtain payouts through fraudulent claims. As long as millions of dollars in claims with deceased provider identification numbers are paid, fraudsters will continue to rip off the system.

To examine these issues in greater detail, we are going to hear today from some of the agencies that deal with Medicare, the Centers for Medicare & Medicaid Services—CMS—the Inspector General of the Department of Health and Human Services, and the Social Security Administration. Each of these agencies has cooperated with the Subcommittee's inquiry. We appreciate that cooperation, but we will, of course, press them as hard as we can to end the taxpayer rip-off that we have identified.

Finally, I would like to again thank the Subcommittee's Ranking Republican, Norm Coleman, who initiated this investigation, and his staff, who have worked hard to examine these issues.

Now I will call on Senator Coleman.

OPENING STATEMENT OF SENATOR COLEMAN

Senator COLEMAN. Thank you. Thank you, Senator Levin, and let me return the thanks by saying that you and your staff have been extremely supportive. Like all our investigations, this has been a tremendous bipartisan effort, and I certainly appreciate that very much.

This morning, we turn our attention to a familiar topic: Medicare fraud and abuse. And I do want to be very clear from the beginning that Medicare is an important program that provides health insur-

ance for the elderly and the disabled. It is a genuine blessing for many of America's most vulnerable citizens.

But the program has been plagued by persistent and pervasive fraud and abuse. For almost 20 years, the Government Accountability Office has consistently designated the Medicare program as "high risk" because of its vulnerability to mismanagement and improper payments. According to its own reports, Medicare made improper payments in 2004 and 2005 amounting to roughly $34 billion. That is the size of the entire Minnesota State budget general fund—wasted on improper payments.

One Harvard professor estimated that fraud and abuse could consume about 15 to 20 percent of the Medicare budget. That would be more than $70 billion in 2008 alone. Let's remember that these billions and billions are tax dollars paid by hard-working Americans.

In keeping with our long tradition of government oversight, the Subcommittee spent the past year examining the Medicare program. Our bipartisan inquiry ultimately zeroed in on abuses in payments for durable medical equipment (DME).

In short, the Subcommittee's investigation uncovered some appalling facts. The Subcommittee found that, between 2000 and 2007, Medicare paid for hundreds of thousands of DME claims in which the prescribing doctor had died years earlier. It has been estimated, as the Chairman has noted, that these payments for those claims could total over $70 million, possibly $100 million. The evidence also establishes certain links to fraudulent activity, which we will examine shortly. Clearly, we have a problem.

Although the jargon can get confusing, here is the big picture: Medicare regulations require that DME claims contain certain information in order to qualify for payment, including valid identification numbers for the patient, the DME supplier, and the prescribing doctor. As the Chairman has noted, the doctor's ID number is a UPIN.

The bottom line is that Medicare paid tens of millions of dollars on claims that contained the UPINs of doctors who died long before the claims were filed. For hundreds of thousands of claims, the doctors had passed away 5, 10, or even 15 years beforehand.

To get a sense of the problem, I just want to review a few alarming cases:

The Chairman has discussed the case of the Florida doctor who passed away in 1999 with claims to the tune of over $500,000 being processed. At least three different companies used this doctor's ID number, filing claims using his ID number 6, 7, or 8 years after the doctor died. Two of the culprits have been convicted of health care fraud, and the other companies were cited by State health agencies for violations. Altogether, the Subcommittee identified at least $350,000 paid by Medicare to these fraudulent actors for claims containing the ID number of this one doctor alone.

Another doctor passed away in 2001, and his UPIN was used in more than 3,800 claims submitted between 2002 and 2007. The total payments for these claims amounted to over $354,000.

The UPIN of another physician who died before 1999 was listed in more than 2,000 claims submitted up to 8 years after he died.

These claims resulted in Medicare payments of more than $478,000.

Now, what is alarming is that the problems are not new; that CMS had been notified of these issues several years ago; that the Inspector General of the Department of Health and Human Services reported that Medicare had paid tens of millions for claims with invalid and inactive UPINs. The IG urged CMS to make changes to ensure that the system was fixed.

CMS then did that. They then stated that claims with UPINs of deceased doctors would not be paid starting April 1, 2002. CMS attempted to fix the problems in 2002. They instituted several procedures designed to ensure that the claims with UPINs of these deceased physicians would not be used.

Unfortunately, the Subcommittee's investigation establishes that those changes did not work. For instance, even though CMS' new procedures were supposed to reject claims with UPINs of dead doctors starting on April 1, 2002, the evidence obtained by the Subcommittee reveals that an estimated 63 percent of the improper payments occurred after that date.

Similarly, CMS required that the UPIN database must be updated every 15 months and the UPINs of dead doctors must be deactivated. Yet the evidence indicates that the UPINs of thousands of physicians remained active, even though they passed away long ago. For instance, the Subcommittee estimates that the UPINs of thousands of doctors who passed away in the 1990s were still active as of this past May.

It is clear that the claims review process has not worked properly. Medicare has not made sure that dead doctors are removed from the system and that claims linked to those doctors are rejected. This is simply unacceptable. Making sure that the prescribing doctor is alive before paying a claim should be a no-brainer. These errors leave Medicare—and, therefore, American taxpayers—vulnerable to fraud. The problem must be fixed and it must be fixed now.

How do we clean up the system? The good news is that we have a unique opportunity right now to address the problem. Medicare has recently replaced the old UPINs with a new numbering system called the National Provider Identifier (NPI). So there is a golden opportunity to make sure that the problems are fixed at an early stage and make sure that the improper payments that plagued the UPINs will not recur with the NPIs.

I just have to state this. We live in a high-tech world. FedEx and UPS can track every movement of a flow of goods. Surely we should have the capacity to figure out if doctors are dead and not making payments. Information is reported. Social Security has it. The AMA has it. And to me it is somewhat incomprehensible that we do not have in government the computer capability—I should not say in government as the Chairman indicated, we have outside providers here that they do not have the computer capability to match a dead doctor's ID number with a claim that is being processed after they died.

We cannot afford $100 million loopholes, especially not now. There are too many challenges that this country is facing—energy, education, homeland security, and housing. And what is required

now is an unprecedented level of fiscal discipline and political leadership to overcome these challenges.

I will close by saying that, almost every day, my staff and I learn of a deserving Minnesota senior that is having a problem with Medicare coverage. If we want to look them in the eye and say we are trying to fix their problem, Job Number One must be attacking Medicare fraud, waste, and abuse so that precious tax dollars go to the noble use for which they were intended.

We have a special responsibility to preserve the integrity of a vital service to the Nation's elderly and disabled, and I am confident that CMS will be a productive and willing partner in that effort. I look forward to discussing with each of today's witnesses how we can work together to ensure that Medicare accomplishes its noble goals while protecting American tax dollars from fraud, waste, and abuse.

Thank you, Mr. Chairman.

Senator LEVIN. Thank you, Senator Coleman.

Let me now welcome our panel of witnesses for today's hearing: Herb Kuhn, the Deputy Administrator for the Centers for Medicare and Medicaid Services of the Department of Health and Human Services here in Washington; Robert Vito, the Regional Inspector General for the Office of Evaluations and Inspections of the Department of Health and Human Services in Philadelphia; and William Gray, the Deputy Commissioner for the Office of Systems of the Social Security Administration in Baltimore.

Gentlemen, I want to thank each of you for being here today. I want to thank you for the cooperation of your agencies. We look forward to your testimony.

Before we call on you, I understand there are other Members who may want to give brief opening statements, and we would be happy to accommodate that. So let me first call on Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thank you, Mr. Chairman. I have a statement I would like to enter for the record. Let me just briefly say, however, when you look in the dictionary and you look up a word and sometimes they have a picture beside the word? I don't know if there is any place in the dictionary where we look up "low-hanging fruit." But I think if there were, we would find this issue of making Medicare payments to doctors who have been dead in some cases for many years. If we cannot go out and make sure that we are not making those kinds of improper payments, heaven help us.

Yesterday, a reporter grabbed me. I was on my way into the LBJ Room for our weekly caucus luncheon, and they said, "I understand that the Medicare trust fund is in enormous difficulty, and it is going to go broke, and you guys are going to raise taxes." And I said, well, before we raise taxes, I think there are a couple things we need to do. One of those is to make sure that we are collecting the taxes that are owed, and there are a lot of taxes that are owed that are not being collected, including some of these for our payroll taxes.

The second thing we need to do is to stop making payments to deceased physicians who are no longer providing Medicare services.

The third thing we may want to do is to look at the monies that we spend on equipment, whether it is wheelchairs or oxygen and that sort of thing, to make sure that we are getting our value, our dollar's worth from the money that we are spending.

And another thing we might want to do, this is something that Dr. Coburn and I have been working on. We have a strong interest in addressing not just overpayments or improper payments in Medicare, but across the Federal Government. And one of the things that we have learned is there is about $55 to $60 billion in improper payments that we are aware of, and that does not cover all the agencies. But we have got a ton of it that is in Medicare. Actually, in the last 2 or 3 years, there has been a post-audit recovery operation going on with Medicare. They focused on three States: California, Florida, and New York. Last year, they recovered about $1 billion. That is real money. And I think we are just scratching the surface there.

So before we raise taxes, those are a couple things we need to do. And for God's sake, for something that would seem to be as easy to fix as this, if we cannot do this, heaven help us when it comes to going after the tough stuff.

I am delighted we are having this hearing. This is oversight at its best, putting a spotlight on something that we ought to know better than to let happen. I think by virtue of having this hearing, we are going to make sure that this does not continue to be a problem, and hopefully we will remind some other folks who have low-hanging fruit that can be snatched up in their own operations in the Federal Government, whether it is CMS or elsewhere, that they need to be more diligent in the work they do. And to the extent that there is stuff that we can do here in the Congress, in this Subcommittee or otherwise, that can help give you the tools that you need to ensure that this kind of stuff does not happen, we need to hear that as well.

We thank you for being here and look forward to your testimony.

[The prepared opening statement of Senator Carper follows:]

PREPARED OPENING STATEMENT OF SENATOR CARPER

Thank you Mr. Chairman.

I'm pleased that you and Senator Coleman have taken on this issue and are holding this hearing today.

Senator Coburn and I held a hearing at in our Financial Management subcommittee just before the 4th of July recess about the dire long-term financial crisis our nation faces. We heard testimony from the administration, from GAO, and from experts like former Comptroller General David Walker about what we need to do and what the next administration will need to do to turn things around.

The conclusions that are witnesses came to shouldn't be a surprise to any of us. We need to reform entitlement programs like Medicare and Social Security because, as the Baby Boom generation retires, these programs will eat up a bigger and bigger portion of our budget. We need to redefine our spending priorities and start focusing again on balancing our budget. We need to redefine our priorities on the revenue side as well and, along with that, do as much as we can to collect those taxes that are owed to the Treasury each year, but never paid. Finally, we need to do all we can to stop agencies from making avoidable improper payments.

Senator Coburn and I have been working on this improper payments issue for years now. According to the latest figures released by OMB—and these are based on numbers from fiscal year 2007—agencies are making an estimated $55 billion in improper payments each year. Nearly $11 billion of that total can be attributed to the Medicare fee-for-service program. Nearly $13 billion can be attributed to Medicaid. So nearly half of the improper payments—and keep in mind that these are

avoidable errors—are attributable to the programs for which Mr. Kuhn and his team at CMS are responsible.

We are wasting a tremendous amount of money year-in and year-out. But the $55 billion estimate that OMB has reported does not yet even include improper payments made in a number of large programs, including the Medicare Advantage and Medicare Prescription Drug Program.

We have our work cut out for us. I was troubled, then, to read over the materials for this hearing and learn that, as challenging as the improper payments problem is at CMS, we are not doing all we can to go after the low-hanging fruit. As I understand it, CMS knew about the payments to deceased doctors that we'll be discussing today but just didn't follow through. That is unacceptable. So I look forward to hearing from our witnesses to learn more about the path forward on this issue in particular, but also on the larger improper payments issue that has been plaguing the Medicare and Medicaid programs for a number of years now.

There may come a time in the not-so-distant future when Congress will be called upon to make some painful decisions about the future of these programs, especially Medicare. The least that we can do between now and then is eliminate the silly mistakes that have already contributed to billions in waste.

Thank you again, Mr. Chairman.

Senator CARPER. Thank you, Mr. Chairman.

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There may come a time in the not-so-distant future when Congress will be called upon to make some painful decisions about the future of these programs, especially Medicare. The least that we can do between now and then is eliminate the silly mistakes that have already contributed to billions in waste.

Thank you again, Mr. Chairman.

Senator LEVIN. Thank you, Senator Carper. Senator Collins.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

Let me thank both the Chairman and the Ranking Member for holding this hearing and conducting this investigation. I am going to put my full statement into the record and just make a few comments with the Chairman's permission.

First of all, I come to this hearing with a disturbing sense of deja-vu because the very first hearing that I chaired of this Subcommittee back in 1997 focused on fraud and abuse in the Medicare program. And during our investigation 11 years ago, we learned that the Medicare program loses more than $20 billion a year to waste, fraud, and abuse. Moreover, our investigation revealed far too many instances where Medicare and its contractors regularly wrote checks first and asked questions later.

For example, we discovered back in 1997 that Medicare had paid more than $6 million to durable medical equipment companies that had provided no goods or services whatsoever, and one of those companies listed an absurd fictitious address that, had it existed, would have been in the middle of the runway of the Miami International Airport.

I mention that particular case because just as sending checks based on claims from deceased doctors seems absurd and impossible to have occurred, sending checks to fictitious addresses also was occurring.

It is disturbing that the Subcommittee's current investigation reveals that so little has changed. Unscrupulous actors continue to take advantage of the system, wasting billions of taxpayer dollars and undermining the credibility of what, as Senator Coleman has pointed out, is an absolutely vital program to our seniors and disabled citizens.

So I am very concerned that for a decade the Medicare program has been on the GAO's high-risk list. For more than a decade, congressional investigations have time and time again shined a spotlight on egregious fraud. And yet so little seems to have changed, and that to me is very disturbing and completely unacceptable.

So it is my hope that PSI's investigation and report, the excellent bipartisan work that has been done by this Subcommittee's leaders, will finally lay the groundwork for legislative and administrative reforms to address this problem once and for all. There are many issues the Federal Government faces that are complex and difficult

to resolve, but paying fictitious claims submitted by people using the identification numbers of deceased doctors does not seem to be one of them. Our Nation's taxpayers and seniors and disabled Americans who depend on the Medicare program deserve no less.

Thank you, Mr. Chairman, and thank you, Senator Coleman, for your excellent work.

[The prepared opening statement of Senator Collins follows:]

PREPARED STATEMENT OF SENATOR SUSAN M. COLLINS

Mr. Chairman, I commend the Chair and Ranking Member for calling this morning's hearing which is based on the Subcommittee's investigation into waste, fraud and abuse in the Medicare program, with a particular focus on durable medical equipment claims.

When I first came to the Senate in 1997, I had the honor and privilege of serving as Chairman of this Subcommittee. The very first hearing that I chaired was focused on the Subcommittee's ongoing efforts to investigate and expose fraud and abuse in the Medicare program, with the twin goals of protecting the taxpayer from unscrupulous individuals who were stealing literally billions of dollars from Medicare and of protecting elderly and disabled Americans who rely upon this critically important program for their health care needs.

During the course of our investigation, we learned that the Medicare program loses more than $20 billion a year to waste, fraud and abuse. Moreover, our investigation revealed far too many instances where the then-HCFA and its contractors regularly wrote checks first and asked questions later. For example, we discovered that Medicare had paid over $6 million to durable medical equipment companies that provided no goods or services whatsoever. One of these companies even listed an absurd fictitious address, that, had it existed, would have been in the middle of the runway of the Miami International Airport.

Sadly, as the Subcommittee's current investigation reveals, little has changed. Unscrupulous actors continue to take advantage of the system, wasting billions of taxpayer dollars and undermining the credibility of the Medicare program in the process.

The Subcommittee's current investigation has found that Medicare has paid as much as $92 million over the past seven years for durable medical equipment claims containing the identification numbers of deceased prescribing physicians, many of whom had died ten years or more before the service date on the claims.

Moreover, these problems are not new. In 2001, the HHS Inspector General reported that Medicare paid $91 million in 1999 for medical equipment and supply claims with invalid or inactive numbers. In response to this report, CMS did take steps to reject claims containing the provider identification numbers of deceased physicians. These efforts, however, have evidently not been successful, since the claims are still being paid.

Mr. Chairman, it is my hope that PSI's investigation and report will help lay the groundwork for legislative and administrative reforms to address this problem once and for all. Our nation's taxpayers and the seniors and disabled Americans who depend on the Medicare program deserve no less.

Senator LEVIN. Thank you, Senator Collins. Senator McCaskill.

OPENING STATEMENT OF SENATOR MCCASKILL

Senator MCCASKILL. Thank you, Mr. Chairman. In preparing for this hearing today, I think as Senator Collins just said, the part that was most depressing is that I assumed that this was a problem that had just come to light, because this is the kind of problem when it comes to light, I think most average people think this is not a hard fix.

CMS has full access to the Social Security Administration database relating to deaths, and it is deemed to be 99.5 percent accurate. We are talking about a data match. We are talking about something that people do all the time in terms of data matches. And the idea that this was exposed as long ago as it was exposed and as of May of this year we still have 2,900 deceased physicians

still active in this database—that is enough to make you want to tear your hair out.

The sense of urgency appears to be missing, and I know that all of you have important jobs, and I know that this is a massive program. But somebody has to explain to me today why this is so hard. Why a problem that has been identified as creating an excessive amount of fraud and waste in a program that is going broke, that is so dramatically needed by the American people, is incompetence, frankly. And I do not understand it.

Now, the other thing that I am concerned about that I hope we cover today is that in June, CMS temporarily allowed the suppliers to use their own NPIs rather than the NPIs of order physicians. In auditing, there is a very important concept called "segregation of duties." Segregation of duties is, in fact, as the Inspector General—I see him nodding his head. It is the best tool we have to make sure that there is not fraud, waste, and abuse. And when you allow on a temporary basis them to use their own numbers instead of the doctor's number, you are taking away a segregation of duties. We are going the opposite direction that we should be going in terms of ensuring that we root out this important amount of fraud and waste.

So I really appreciate all those who have come to this Subcommittee before me, that have worked on this. Thank you, Mr. Chairman and the Ranking Member. And, obviously, I thank the others that exposed this problem over a decade ago. But there is somebody over there that is not mad enough, and they need to be getting mad. Thank you, Mr. Chairman.

Senator LEVIN. Thank you, Senator McCaskill. Senator Coburn.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. Mr. Chairman and Ranking Member Coleman, thank you for having the hearing. I have to say that I am somewhat perplexed. We are looking at $100 million worth of fraud. If you combine the CRS studies, the IG studies, and the GAO, we have $80 billion a year in waste, fraud, and abuse in the Medicare and Medicaid programs. I am not belittling the $100 million.

The Congress this week is going to pass a bill probably that eliminates $1 billion worth of savings per year in terms of DME. That is $200 million of premiums that are going to be paid by seniors that they should not be paying because we felt a little heat from competitive bidding. We already pay 30 to 40 percent too much for the DME equipment that Medicare buys.

So I am discouraged because I do not think—we are going to have a hearing here today, and the Chairman and Ranking Member are rightly so bringing this forward, and we are going to do a lot of talk, and we are going to get after CMS. But when it comes to acting responsibly, the Congress is not going to do anything except delay the competitive bidding on DME, which will get rid of a lot of the fraudulent DME companies, which is part of the problem.

We passed a farm bill that has $8 billion worth of fraud to dead farmers. We could not even get rid of that in the farm bill. We passed a farm bill that did not fix that even though we amended it in the Senate. When the compromise bill came back, we did not

fix it. So there is $8 billion worth of farm fraud that is going out to dead farmers and $100 million being paid on DME only—that is DME only that we are talking about. We are not talking about the fraudulent claims of dead doctors for other things. And yet we will not do the hard work as a Senate or as a Congress to come alongside behind you.

So my hope is, Mr. Chairman and Senator Coleman, that you start the rolling ball for us to start acting responsibly in the Congress, first by having this hearing, which I am thankful for, but, more importantly, doing the bigger things that need to be done to get rid of some of this $80 billion worth of fraud. Eighty billion means $200 billion of American taxpayer Medicare money that is being paid out, their share in Part B, $200 billion false claims to Medicare patients that they are paying for that we have not fixed.

Thank you.

Senator LEVIN. Thank you, Senator Coburn.

Now, pursuant to Rule VI, all witnesses who testify before the Subcommittee are required to be sworn, and at this time I would ask each of you to please stand and raise your right hand. Do you swear that the testimony you are about to give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. KUHN. I do.

Mr. VITO. I do.

Mr. GRAY. I do.

Senator LEVIN. Thank you. We will be using a timing system today, and about a minute before the red light comes on, you will see the lights change from green to yellow, giving you an opportunity to conclude your remarks. Your written testimony will be printed in the record in its entirety. We would ask that you limit your oral testimony to no more than 5 minutes.

Mr. Kuhn, we will have you go forward, followed by Mr. Vito, and finish up with Mr. Gray. And then after we have heard all of the testimony, we will turn to questions.

Mr. Kuhn, again, thank you for being here.

TESTIMONY OF HERB B. KUHN,[1] DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUHN. Chairman Levin, Mr. Coleman, Members of the Subcommittee, thank you for the opportunity to testify today regarding the Subcommittee's findings on Medicare payments for claims containing invalid and inactive provider identification numbers of deceased physicians. CMS appreciates the time and resources that the Subcommittee has invested in this study and is grateful for the Subcommittee's shared interest and goal in reducing waste, fraud, and abuse in the Medicare program. We are currently reviewing the findings of your report. We consider these findings very valuable for identifying areas of vulnerability in the program and accelerated our efforts to fix them.

CMS has taken several steps to implement policy changes and new procedures to ensure that invalid or inactive provider identi-

[1] The prepared statement of Mr. Kuhn appears in the Appendix on page 41.

fication numbers, or PINs, are not used by unscrupulous suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Internally, and with our claims-processing contractors, we are making changes to substantially curb and, ideally, eliminate this practice altogether.

Specifically, our conversion to the new National Provider Identifier (NPI), along with further documentation and data exchange improvements, have significantly strengthened CMS' ability to combat fraud and abuse that rely on invalid provider identifiers. All providers and suppliers intending to bill Medicare are required to apply for and secure a new NPI, and to use the NPI exclusively on all forms when billing Medicare. Before a NPI is used, CMS verifies the Social Security number with the Social Security Administration (SSA), thereby verifying the information as accurate at the time of issuance. Given this change, CMS believes the vulnerability for further fraud and abuse relying on provider identifiers and deceased physicians is substantially smaller today than before full NPI implementation.

However, as you noted in your report, we will need to guard the new NPI system, and in order to do that, CMS finalized a new information exchange agreement with the Social Security Administration, which will provide CMS with monthly updates of SSA's Death Master File and unrestricted State death data beginning in August. CMS will match this information with data contained in the National Plan and Provider Enumeration System—the central system that maintains information about the NPI—and, of course, also our provider enrollment database as well. After confirming an individual practitioner is deceased, CMS will deactivate both the NPI and the practitioner's enrollment in the Medicare program.

But we do not stop there. While our claims-processing system allows any NPI to be used for ordering and referring services to Medicare beneficiaries, we anticipate implementing changes in 2009 that will limit ordering and referring to only those individual practitioners enrolled in the Medicare program.

In addition to assuring the accuracy of the NPI, we also need to work on the other side of the ledger to make sure that we have qualified DMEPOS suppliers out there, and in this regard, we are taking the following steps to make sure that we work both sides of the ledger so that we come to the middle to have a good, secure program.

First, on July 1—and this is something Dr. Coburn referenced—we implemented DME competitive bidding in 10 metropolitan areas in the country and plan to expand to 70 more next year. This program, which ushers in new accreditation, financial and quality standards for DME suppliers, will substantially increase the quality of this program and those who are enrolled as suppliers. Furthermore, it will bring about market pricing to DME supplies. One of the vulnerabilities of the program is when you mis-price something, you bring the fraudsters into the program. This will help eliminate that.

Second, we are in the process of completing the final regulation that for the first time will require surety bonds for DMEPOS suppliers.

Third, we recently published a proposed rule requiring DMEPOS suppliers to maintain ordering and referring documentation received from a physician or other non-physician practitioner for 7 years. This change, if adopted, will strengthen our ability to identify fraudulent billing during documentation reviews.

And then, finally, through our enrollment demonstration projects initiated last summer in South Florida and Los Angeles metropolitan areas, we were able to revoke the billing privileges of nearly 1,000 DMEPOS suppliers.

Protecting Medicare's integrity, ensuring its efficient operation, and assuring safe and quality health care for all beneficiaries is our goal in all that we do. In this regard, we appreciate the Subcommittee's work on this issue and your ongoing efforts to support the Medicare program's integrity.

I look forward to answering any questions that you may have.

Senator LEVIN. Thank you, Mr. Kuhn. Mr. Vito.

TESTIMONY OF ROBERT VITO,[1] REGIONAL INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. VITO. Good morning, Mr. Chairman and Members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections at the U.S. Department of Health and Human Services' Office of Inspector General.

Because the Medicare DME benefit has proven to be particularly vulnerable to fraud, waste, and abuse, OIG has devoted substantial resources to conducting work in this area. We have performed studies on a wide array of DME-related issues; made recommendations to help CMS correct vulnerabilities; and performed targeted follow-up work to ensure that corrective action has been taken. One such issue—the use of ordering UPINs on DME claims—is the subject of my testimony today.

DME and related supplies are only covered by Medicare when ordered by a physician or a health care practitioner. To help ensure this condition is met, CMS requires DME suppliers to list the UPIN and, as of May 2008, the NPI of physicians who order the equipment on the claim form. However, as part of our DME work, we learned that Medicare's claims-processing system only verified that the UPIN met a certain format; edits were not being performed to ensure that the UPIN had been assigned or was active.

In the November 2001 report, we found that Medicare and its beneficiaries paid $32 million for DME claims with invalid UPINs in 1999. In addition, $59 million was paid for DME claims listing UPINs that were inactive on the date of service. Almost $8 million of this involved UPINs for deceased physicians. We recommended that CMS revise claims-processing edits to ensure UPINs listed on DME claims were valid and active. In response, on two occasions CMS issued instructions to its carriers to deny DME claims listing deceased physician UPINs. However, other than provider education, we know of no further action taken by CMS to address the issue of invalid and inactive UPINs. We annually highlighted this

[1] The prepared statement of Mr. Vito appears in the Appendix on page 49.

vulnerability in various publications, including our semiannual reports to Congress and our "Compendium of Unimplemented Office of Inspector General Recommendations."

To ensure effective edits for invalid and inactive UPINs, CMS needed to maintain accurate information in the UPIN Registry. However, in each of the three OIG reports issued between 1999 and 2003, we found the UPIN Registry contained inaccurate data. For example, in the 2003 report, the OIG found that 52 percent of the providers listed in the active UPIN database had inaccurate information in at least one of their practice settings. Seventeen percent of the providers no longer billed Medicare from any practice setting listed in the active UPIN file, and of that number, 14 percent were deceased, and 26 percent were retired.

Because CMS was planning to discontinue the use of UPINs once the NPI system was fully implemented, we did not perform additional studies on the UPIN for several years. In the interim, we focused on other DME issues, including payments for and coverage of power wheelchairs, pricing and utilization of inhalation drugs covered under the DME benefit, and excessive payments for home oxygen equipment.

We also significantly expanded our efforts into the area of provider enrollment. For example, in 2006 and 2007, the OIG conducted in-person site visits of more than 2,500 DME suppliers in South Florida and Los Angeles to assess compliance with Medicare supplier standards.

Now that the NPI is fully implemented, OIG is revisiting the use of physician identifiers on DME claims. Based on our preliminary analysis and discussion with CMS staff, we have concerns that valid and inactive physician numbers may be a continuing problem with the NPI. While it appears that edits will be established to verify the NPI is in the correct format, it is unclear whether there will be controls that identify NPIs that have not been assigned or correspond to inactive physicians.

In addition, according to CMS, DME suppliers are temporarily allowed to use their own NPI in place of the NPI of the ordering physician. CMS has not indicated when this policy will be discontinued. However, as long as DME suppliers are allowed to enter their own NPI rather than the physician's, a major control for preventing fraud, waste, and abuse will not be operational.

In summary, the OIG will continue to devote considerable resources to fighting fraud, waste, and abuse in the Medicare program while maintaining a particular focus on vulnerabilities related to the DME benefit. As CMS moved away from the UPINs and began requiring the use of the NPIs in their place, there was an opportunity to address vulnerabilities highlighted in our earlier findings and recommendations. However, we remain concerned that old vulnerabilities as well as new challenges may affect the integrity of the NPI system. To address these concerns, OIG expects to conduct studies related to the NPI during the 2009 fiscal year.

This concludes my statement. Thank you for the opportunity to testify today. I would be pleased to answer your questions.

Senator LEVIN. Thank you, Mr. Vito. Mr. Gray.

TESTIMONY OF WILLIAM E. GRAY,[1] DEPUTY COMMISSIONER OF SYSTEMS, SOCIAL SECURITY ADMINISTRATION

Mr. GRAY. Chairman Levin, Members of the Subcommittee, thank you for inviting me to appear before you today. You have asked us to address two questions: How can we provide death record information regarding medical providers on a timely and regular basis to the CMS? And what, if anything, do we need to facilitate the sharing of death record information with CMS? Before I explain how and when we provide death information to CMS, I would like to briefly describe who we are and what we do.

Social Security touches the lives of virtually every American. Through the Old-Age, Survivors, and Disability Insurance program, we provide benefits at critical junctures in people's lives: When they retire, when they become disabled, and when the family's wage earner dies. We also administer the Supplemental Security Income program, which provides a cash assistance safety net for aged, blind, and disabled individuals with little or no income or assets. Each year, we send benefits totaling about $650 billion to almost 60 million individuals.

In addition, we have other responsibilities that are vitally important to the Nation, but are not directly connected to our core mission, including many workloads for other programs, such as Medicare, Medicaid, E-Verify, and Food Stamps.

We collect and maintain death records which we use to determine continuing eligibility for benefits and for other program purposes. We receive approximately 2.5 million death reports each year. They come from a variety of sources, but 90 percent come from family members and from funeral homes. My written testimony describes in some detail how we gather death information and the circumstances under which it is made available to other Federal agencies and to the public. For purposes of our discussion today, I would like to summarize a few points.

Currently, there are about 85.6 million records on our Death Master File, which is commonly known as the DMF. About 4 percent of these are from State reports. The publicly available Death Master File includes all verified death information, but it does not include any State death data. However, since 2001, we have given CMS access to all of our death records, both public and State.

We provide the death information to CMS in three ways:

In 2001, we began providing the public Death Master File to CMS via direct electronic connection, and we update it weekly in the same way.

SSA also provides CMS with access to death information via the State Verification Exchange System (SVES). SVES is an overnight batch query process that matches against our records. In addition to the public data, this also gives CMS access to the State data. SSA responds each year to approximately 2 million CMS queries to SVES.

SSA also provides CMS with access to the State On-Line Query system (SOLQ). SOLQ includes the same death information as SVES, but it provides real-time online access to this information.

[1] The prepared statement of Mr. Gray appears in the Appendix on page 63.

SSA responds to approximately 1.1 million CMS requests per year through SOLQ.

Studies show that, overall, our death data is over 99.5 percent accurate, and almost 90 percent of all deaths are posted within 30 days of the date of death. Over the last 6 years, SSA and HHS have been working with the States to implement an electronic death notification process. Death information received through this Electronic Death Record (EDR) system gets to us within 5 days of an individual's death and is virtually error free. Currently, 22 States participate in EDR, and in those States, EDR replaces the more cumbersome and labor-intensive manual process of reporting death information to us. We continue to work with States who want and are able to begin using EDR.

In closing, let me say that timely and accurate death information is vital to maintaining and assuring the integrity of Federal programs and protecting taxpayer funds. However, we can do only so much. We are unable to take on any additional work without adequate resources. That said, we will keep working with CMS to make sure that it continues to be provided accurate and timely death information.

We are happy to provide the Subcommittee any additional information it would need on this issue, and I will be glad to answer any questions. Thank you.

Senator LEVIN. Thank you, Mr. Gray. Let's try an 8-minute round of questions for the first round.

As I stated in my opening statement, Mr. Kuhn, our staff found that from 1992 to 2002, there were 33,000 deceased physicians listed by the AMA, and I am sure this is similar to what we have just heard about in terms of Social Security. Our staff then took a random sample of 1,500 of those physicians. They looked at the claims that were paid by CMS as to how many of those 1,500 physicians' numbers, identification numbers, received payments. They obviously did not. They were deceased. But the numbers of these physicians were used. About half, 734 of those 1,500 deceased physicians' identification numbers were used to pay claims. Now, that is an incredible number.

Who is responsible for failure to remove those physicians' names from the approved list? Do you hire a contractor to do that?

Mr. KUHN. Yes. We use contractors to pay claims. Under the Medicare program, contractors run our enrollment systems as well. So we have contractors, but ultimately we hold the contractors responsible. So the responsibility comes to CMS, Senator.

Senator LEVIN. Ultimately you hold them accountable or you don't hold them accountable?

Mr. KUHN. We do hold them accountable, yes.

Senator LEVIN. How much money was paid to those contractors during this period of time?

Mr. KUHN. I do not have that information with me, but I would be happy to get that for the Subcommittee.

Senator LEVIN. Well, now, we identified 33—let me see if I can get you the exact number here. There were about 500,000 erroneous claims for durable medical equipment that were paid during that period by our analysis. How many of those erroneous claims paid out based on erroneous identification numbers were recovered

from our contractors who were paid to make sure that did not happen?

Mr. KUHN. I am not sure if I completely understand that question.

Senator LEVIN. Well, we pay contractors to make sure what happened did not happen.

Mr. KUHN. Correct.

Senator LEVIN. When it happens, do we recover from the contractor?

Mr. KUHN. Oh, I see your question there. We have performance metrics with the contractors, and some of those performance metrics are enhanced by bonus payments or other things that are available to the contractors. So if they were not hitting their performance metrics, then it would impact the remuneration that they receive.

Senator LEVIN. Well, I am sure there are performance metrics. There are hundreds of thousands of claims based on numbers that should not have been paid. How much recovery did we get from those contractors, for money we paid contractors to avoid that? How do we hold them accountable?

Mr. KUHN. I don't know if I have that specific information on there——

Senator LEVIN. Well, about how much have we paid to contractors for not doing their job? Give me an idea.

Mr. KUHN. I guess, the amount that we pay contractors across the board exceeds $1 billion for the Medicare program that is out there. But part of the issue——

Senator LEVIN. How much have we recovered from contractors for paying claims they should not have paid?

Mr. KUHN. Yes. And I don't have that information, but would be happy to get it for the Subcommittee.

Senator LEVIN. Well, about how much?

Mr. KUHN. I wouldn't even hazard a guess.

Senator LEVIN. Is it a common practice that we say to contractors, "You have authorized claims that should not have been authorized under your contract. We want you to pay us back for that money"? Is that a common practice?

Mr. KUHN. Yes, that would be part of the performance metrics, whether we pay them or not. In terms of whether the performance metrics of the contract require us or allow us to go back and reclaim money for erroneous claims, I would have to go back and look at the specificity of the contracts.

Senator LEVIN. Well, shouldn't they do that?

Mr. KUHN. That could be something that we could do in performance in the contracts that are out there. But, really, a lot of what the contractors——

Senator LEVIN. It could be something that we—why isn't that an automatic thing? If they are given a job to do and they do not do it, why is there not a penalty paid by our contractors?

Mr. KUHN. Part of the reason for the penalty to the contractor is really our ability to provide appropriate oversight in this area.

Senator LEVIN. It is not oversight. It is just the dates of death, which are provided easily to them.

Mr. KUHN. Well, in this issue, and I think it begs really the issue in terms of some of the questions that you and others asked in the Subcommittee. What are the resources or the tools that we as an agency need in order to fulfill our responsibility to manage this program in an effective way? And one of the areas is really the Medicare Integrity Program. It is annual appropriations that we receive from Congress. This has been capped since 2003. We have asked over the last 3 years for about $300 million more infunding for that program in order to allow us to deal with vulnerabilities like this. And so when we face situations like this—and if you look at inflation adjusted, we are probably $90 million less than we were in 2003—we have to make decisions as a program: Where are the worst vulnerabilities that we need to take on? And I will be real candid with this Subcommittee. This is an area that was not a high vulnerability compared to others in the program as we were going forward.

So one of the things—and I really appreciate the report that the Subcommittee has done and want to make sure it is clear with the Subcommittee—is that as you ask what do we need, funding for the Medicare Integrity Program would be extraordinarily helpful for us to fulfill some of these obligations.

Senator LEVIN. Some of that funding ought to come from contractors who were not doing their jobs.

Mr. KUHN. And the contractors do the jobs that we give them the information to——

Senator LEVIN. They have this information.

Mr. KUHN. Right.

Senator LEVIN. You have told them to do it. According to the Inspector General over here, his testimony, in responding to the recommendations that were made back in 2001 or 2002, "CMS indicated it had developed instructions, system changes, and edits that would reject claims listing a deceased physician's UPIN. CMS stated it planned to expand the edits to include all invalid and inactive UPINs. In November 2001 and April 2002, CMS issued instructions to its carriers stating that DME claims listing a deceased physician's UPIN would be denied."

Now, you do not even know if the contract with these carriers has a clause that penalizes the contractor for failing to do their job?

Mr. KUHN. And what we do with the contractors—and I would go back and look at the contracts and get that information for you. I don't have that information readily available to me now. But we send out, as you indicated, I think during this period from 2002 through 2006, at least five instructions in this area to deal with not only the PINs, but the UPINs in this area. And we have the change requests. We gave the instructions to the contractors to execute. Some probably were executed better than others, I think as your report shows, versus Florida, versus other areas where we show some great variation there. But we have the information in their hands. Presumably they are executing.

Where we have the difficulty——

Senator LEVIN. Presumably they are not executing.

Mr. KUHN [continuing]. Is for us to follow up to make a determination on the execution. And, again, that is where we made a choice back in 2004 in terms of program vulnerabilities. We did not

have the resources to do the follow-up here that we needed to, Senator.

Senator LEVIN. Presumably they are not executing. Look, we have a small staff. Our small staff identifies, going through these materials, huge amounts of mistakes or payments that never should have been made. Do you assume, by the way, that most of those are fraudulent or most of those are non-fraudulent?

Mr. KUHN. I would like to think some are mistakes, but I suspect, knowing what goes on in the DMEPOS area, probably a lot of those are true fraud.

Senator LEVIN. All right. So our staff, our limited staff, is able to do this in a very short amount of time, I mean, this is a huge issue here, to identify the use of the UPINs numbers of 17,000 deceased physicians. Now contractors were supposed to catch that. They did not catch it. We have got to go after our contractors. Will you?

Mr. KUHN. We are working with them on——

Senator LEVIN. Not working with them. Will you go after them to recover money that was paid that should not have been paid?

Mr. KUHN. We will go back and have conversations with them, but the other thing about the contractors——

Senator LEVIN. I don't want conversations. I want a commitment from you that you are going to seek recovery from them.

Mr. KUHN. We will go back and exercise everything we have in our contracts with them.

Senator LEVIN. If the contracts do not provide rights to get recovery from contractors who did not do their job because they paid claims that should not have been paid, will you insist that those contracts in the future have that provision?

Mr. KUHN. We will review our contracting strategy and make sure that is something we will work on.

Senator LEVIN. Well, I have to tell you, that is too wishy-washy for me. Will you let this Subcommittee know what you have done or will do?

Mr. KUHN. Absolutely.

Senator LEVIN. And will you let us know how much you have paid contractors during this period 2000 to 2007?

Mr. KUHN. Those are appropriate follow-ups, and we will get those for you.

Senator LEVIN. Thank you. Senator Coleman.

Senator COLEMAN. Thank you, Mr. Chairman.

Just if I can, one follow-up on that. Do you know whether CMS withheld any bonuses from contractors from 2000 to 2007?

Mr. KUHN. I am not sure during that period, Senator, and that is information we could get for the Subcommittee.

Senator COLEMAN. That would be another—Mr. Chairman, I would like to know whether we withheld any bonuses during that period.

And let me just say I appreciate the cooperative relationship that CMS has had with the Subcommittee on acknowledging the nature of the problem and the new system that is being put in place. But the IG, even with that new system, has raised some concerns. Let me see if I could focus on that a little bit.

First, I am not sure whether Mr. Gray or Mr. Kuhn should deal with this, but Social Security has the data, they have the information. They know who is dead. It is not that complicated. You pass it over to CMS and their contractors.

First, is there any question about the computer capability to process the Social Security data? Do we have the capacity to do that so that we have systems that are compatible today?

Mr. KUHN. We believe we do. We have actually a new interagency agreement with Social Security that was recently executed to be able to get this data feed in a format that will fit our enrollment system. So we think that is going to work out real well for us on this new system.

Senator COLEMAN. And when you say agreement, I have some information that the agreement was signed last week.

Mr. KUHN. Yes. That was wrapped up last week.

Senator COLEMAN. And somehow could I get perhaps a little more of understanding why in 2008 that we are having issues about whether CMS can use data from Social Security that—I mean, thank goodness last week we got an agreement, but why did it take so long?

Mr. GRAY. We have been sending that information to CMS since 2001 in exactly the same format that this new agreement will call for.

Senator COLEMAN. So 2001 until last week, you are sending information, but they cannot process it——

Mr. GRAY. It is the exact same format. It is not changing. So, yes, they——

Senator COLEMAN. Mr. Kuhn, I just want to make sure as we move forward that, in fact, we have a unique opportunity. You have said with the new NPI system, we are going to first—again—we are going to clean out the system—if you are dead, you cannot apply. So at least we start with that. We know we have a base. But, on the other hand, we did this in 2002, we found out that it really did not clean up the system.

First of all, I want to find out technically what we are capable of doing and see if there are shortcomings there. So all this data was coming over. What was the issue in terms of them being able to use the data that was given?

Mr. KUHN. It is interesting. We are using two different sources of data. When we were looking at the deceased physicians' files, we were collecting that data initially from the American Medical Association. We thought that was a good source document. But I think as we are all finding out, that was probably not as robust a system that we needed, and, therefore, we think the Social Security file will provide a much better data source for us.

The data feeds we have been getting from the Social Security Administration, as Mr. Gray indicates, we have been using more on the beneficiary side in terms of looking at eligibility, issues like that. This will be the first time we have begun using this in terms of enrollment as well as for the NPI. And our technical staff are working on this interagency agreement to make sure that it comes in a format that is functional for us.

I know Mr. Gray has indicated that it will be coming in the same exact format. Our technical folks just want to make sure this will

work for our systems that we have because this is a different system than on the beneficiary side. And we want to make sure we do those data matches appropriately.

The nice thing about the NPI system is that it is a new system, and it is almost like the term in golf. We got a "mulligan" here. And what have we learned from the past in order to make sure that we safeguard the system as best we can? We think using the Social Security data will really help us do that.

Senator COLEMAN. This is a $100 million mulligan. That is a pretty expensive one.

Mr. KUHN. It is big, and we are as outraged as you are about it, Senator.

Senator COLEMAN. In terms of the new system, one of the issues, Mr. Vito, you talked about concerns continuing problems with NPI. One, you talked about controls. Can you give me a little more information? What type of controls do you want to see in place that you do not see right now?

Mr. VITO. When we did the work in 2001, what we looked for were edits that would prevent claims that came in that had inactive and invalid UPINs on them. Part of that would have stopped the problem for deceased physician UPINs as well. What we expect to look at in the future is to see if the NPI system will be able to have edits that would prevent that from occurring again in that they would have claims that would come in and they wouldn't be checked to see if it was a valid NPI and if it was an active NPI.

In addition to that, another important part is that the system has integrity, that the data in the system is accurate. We have found in the past that the UPIN Registry contained inaccurate data. So this is an opportunity for CMS to take the new system, rectify some of the persistent problems and make sure they have good data. When they do the edits, the data has to be good in the program for them to run properly and for it to be effective.

Senator COLEMAN. One of the issues that you raised, Mr. Vito, that has been of certain concern to the Subcommittee—and perhaps, Mr. Kuhn, you can help me understand—apparently CMS has for some period of time allowed providers to use their own NPI, their own identification number. I take it we all agree that you have three entities here: You have a patient, you have a physician, and you have a provider. And you have some measure of cross-control when we have the physician. There is a reason for the physician to sign that. They get reimbursed. We want to have an identification number.

Can you help me understand you would allow claims to be processed without the NPI from a physician?

Mr. KUHN. Yes, Senator. Because we have the new NPI system that was brought about on May 23, on June 2 we did allow and will allow for a very short period of time for the supplier of the DMEPOS products to use their own NPI if they are unable to obtain the NPI from the ordering or referring physician. Some of those physicians do not have their NPIs yet. It is a new system. And what we wanted to make sure is that there was no interruption in terms of services to Medicare beneficiaries. Had we had a hard and fast rule, we think we would have created some access issues for Medicare beneficiaries out there.

Having done that, we knew that we were creating a program with vulnerability, but when we made this decision, we told all those suppliers that are going to use their own NPI, "Do it at your own risk, because if you do, be sure that you are on our list for post-payment review." And I hope people hear this loud and clear, that we will be going to those suppliers that use their own NPI to make sure that they are candidates for post-payment review. That is the other side of the ledger to make sure that we have integrity for this short-term fix in order to assure access to beneficiaries. And that is why we did it.

Senator COLEMAN. And I understand the value of getting access to beneficiaries. In terms of being unable to obtain, other than a physician not having the new NPIs, is there any other reason why a provider would not be able to get a NPI number from a physician?

Mr. KUHN. It might be that they might not be communicating well between one another. There could be other kinds of process reasons. But we hope that this is truly the exception to the rule. But we think the fact that those that do use it will be subject to post-payment review, we think we can——

Senator COLEMAN. But here is the problem you have with that. What we have seen with DME, what we have seen with this program is that this has been a cash cow, an ATM machine for fly-by-night players. In our discussion with some of the folks who have been convicted, they talk about passing around UPIN numbers. Why do drug deals when you can get long sentences and go to a tough place, when you can simply create a DME operation, submit claims? And in this case, if you have fly-by-night suppliers, folks who are not going to worry about any post-payment review, aren't we setting ourselves up for a period of time in which folks simply want to cash in knowing that all you have to have is your own number? How do you protect against that?

Mr. KUHN. Senator, your point is well taken. It is a vulnerability to the program. But it is a balance between making sure beneficiaries have access and making sure that through the post-payment review we think that is the best check we could put in place here. We could have sided on the other side of the ledger, but then I think our goal here is to serve the beneficiaries, and we thought we were serving them well by doing that.

Senator COLEMAN. And I appreciate that. My concern is that, again, other than a physician not having the number in which you could then put in an old number, which other than that, the idea that "there is any difficulty"—I mean, part of this system requires that you can get reimbursed by the Federal Government for either something to do with durable medical equipment—and you talked about prosthetics and others, by the broader phrase there—that a physician has to say this is going to be reimbursable. And so for a provider to say they are having difficulty, it is their responsibility if they want to get paid. Why wouldn't we put the burden on them to do that?

Mr. KUHN. Well, the other part of this is that while in that particular field there would be the NPI for the referring or prescribing physician or the particular entity's NPI, it still does not—it still needs to have all the documentation there and for some that they

are going to get what is called a Certificate of Medical Necessity (CMN). There needs to be a prescription. The other documentation needs to be there as well.

So, again, that gives us the opportunity to deal with the post-payment reviews.

Senator COLEMAN. Thank you, Mr. Chairman.

Senator LEVIN. Thank you very much, Senator Coleman. Senator Carper.

Senator CARPER. Thank you.

Dr. Coburn and I held a hearing about 2 weeks ago. We invited a number of folks to come in and testify, including David Walker, who until very recently was the Comptroller General of our country. And we asked them to look way down the road at the kind of fiscal challenges, budgetary challenges that we are going to face.

I think one of our witnesses mentioned that within maybe 25 years or so, we are going to be spending about 18 percent of GDP in this country just for three programs: Social Security, Medicare, and Medicaid—18 percent of GDP. The reason why that is alarming is because historically in the last decade or two, we spent about 18 percent of GDP to run the whole Federal Government. And we are looking in our lifetime at a time when we will be spending about that much just to run those three programs—nothing for the environment, nothing for transportation, nothing for space, nothing for food programs. I mean, it is not just alarming. It is scary.

One of the reasons why we are all over this issue and other issues—and Dr. Coburn and I are going to drive people crazy before we leave here on improper payments. But we are going to make sure that improper payments come down, most of which are overpayments. And we are going to make sure to the extent that improper payments are made that we go out there and recover the money that has been mis-paid or overpaid.

One of the things that we are looking at in the legislation that he and I have co-authored to change the improper payments law is how might we penalize agencies that are not making progress in addressing their improper payments problems And I might add, Senator McCaskill has been all over this with us. She has been just a great partner in this issue. But in addition to having sticks, we want to have a couple carrots in this as well.

And you started to say, Mr. Kuhn, in response to what the Congress can do to better make sure that you all are doing your job—let's return to that for a second. What can we do? And I think you were saying something about funding for the Medicare Integrity Program. Just go back to that. What can we do to help make sure that you are doing your job so that a year from now when we have you back, and we say, well, what is different now, you have a much better story to tell us? If you do not, I would not want to be in your shoes.

Mr. KUHN. I thank you for that question. Two or three observations I would make for you on that point.

One is the Medicare Integrity Program, it has been capped since 2003. If you look at inflation growth, we are probably $90 million less than we were in 2003, and our requests have been for about $300 million over the last 3 years, which we have not seen that funding. And so when you really think about our ability to manage

these programs and deal with the integrity and the fraud and abuse, full funding in that area, I think, would be extraordinarily helpful for the agency in order to fulfill our work in this area.

Senator CARPER. Let me just interrupt for a second. I think in our legislation, we provide the opportunity for agencies to retain some of the monies that they recover and to be able to use those monies for better financial management. Would that be of help?

Mr. KUHN. That would, in fact, and we have a pilot, which I think you referenced in your opening comment, the recovery audit contractors, which we did pilots in three States and then ultimately six States, and we hope to launch nationally here very soon, which really go back to providers and look at improper payments and the recoveries. They captured in that period of time about $1 billion in those three States. We think they were good, and there might be opportunities to retain some of that funding to fund some of the program integrity area.

And then, finally, I think another important tool for us will be something that Dr. Coburn talked about earlier, DME competitive bidding. The real issue—there are two sides to this ledger, as we were talking about earlier. One is these invalid numbers, to make sure that we do things well on the front end. I think the folks in law enforcement will tell you it is kind of like health care. You want to prevent something, a disease from happening before it happens. The same thing with fraud and abuse, you want to prevent it before it occurs. So having these good quality numbers can hopefully prevent some of this stuff from happening.

But on the back side, we have to have legitimate suppliers out there to make sure that they are valid, and DME competitive bidding gives us a new set of tools to deal with that in terms of accreditation, quality standards, financial standards, plus by holding an auction, we can get pricing where it needs to be. Under the 10 demonstration areas that we are looking at right now, or the pilot areas, we brought prices down by about 26 percent across the board. That is real savings to the program, and it shows that when you mis-price something in this program, that brings the fraudsters in.

So I think competitive bidding, the issue of the recovery audit contractors, and ultimately funding for the MIP program would be very helpful to the agency.

Senator CARPER. All right. Thank you.

One of my core values in our office—and a core value when I was governor and running State administration in Delaware—was to really focus on excellence in everything we do. I used to say, "If it is not perfect, make it better." And I think we have a real opportunity to do just that with the recent switch over to the National Provider Identification for all of Medicare's providers. You have got basically a clean slate right now, and my concern is that it stays that way.

Let me just ask, what is your agency doing to take advantage of this fresh start? You spoke to this at least indirectly, but let me ask it again. What is your agency doing to take advantage of this fresh start to ensure that the registry does not face the same kind of problems that its predecessor did? How do you plan to incorporate some of the report's recommendations?

Mr. KUHN. I think the point is well taken, and I think you are right. We have this unique opportunity here that you do not really see in government too often, where we have a fresh start for a program that began on May 23, and then the value of this report that the Subcommittee has put forward, because it really puts in place, as you talked about excellence, the basic engineering model—that is, let's identify the gaps, let's address those gaps, and let's improve as part of the process.

So a couple of the real improvement areas, of course, is going to be the new data match agreement we have with the Social Security Administration to make sure that we deal with that issue effectively.

A second improvement that we are looking at, again, based on resources, is a periodic validation process in terms of all the providers that have come in with new NPIs that are out there. We estimate right now that about 25 percent of physicians have some kind of change in terms of their NPI or their enrollment process over a 5-year period, and we want to do periodic validations to keep that system as robust as we possibly can.

Another new edit we want to put in place is to make sure that the referring or ordering physician actually is an enrolled provider in the Medicare program, and we will have a cross-check that will make that happen as we go forward.

And then, finally, to make sure, at least on the DMEPOS side, we have an enrollment contractor that is doing the work there. That contract has now changed. It is a new contract that was let just a couple weeks ago, where before they mostly focused on enrollment, now they are going to be looking at enrollment and fraud. And their follow-up, their on-site inspections of these facilities out there to make sure they are legitimate businesses out there is stepped up dramatically, and I think that will help us as well.

Senator CARPER. All right. GAO has told one of our subcommittees that Dr. Coburn and I serve on—that Medicare Advantage and the Medicare Prescription Drug Benefit Program are likely committing substantial improper payments. These programs did not report their improper payment estimates for fiscal year 2007. They did not report them for 2006 or 2005 either. Nor did they provide a target date for when they would be providing that information. In fact, they were the only two programs identified by GAO who did not give a time frame—the only two in the whole Federal Government that I am aware of.

When does CMS plan on releasing this information? And does your agency have any set goals for reducing improper payments with respect to those programs?

Mr. KUHN. Senator, I am not familiar with that particular report or the timetables there, so I would like to get back to you with that information and to kind of understand behind that a little bit in terms of the improper payments because under those particular programs they are paid to an entity, and then they have separate contracts with the providers. So if it is an improper payment that we are making to the MA plan or PDP, that is one issue. If it is their contractual relationship with the providers, that is something else. And I would like to understand a little bit more, and we could get back to you in writing on that one.

Senator CARPER. Thank you. The improper payments law has been around for less than a decade. Finally, I think most of the Federal agencies are actually complying, a couple of big ones—Department of Defense, Homeland Security. A couple programs I just mentioned do not. Not only are they not out there recovering improper payments, they are not even reporting what their improper payments might be. And before we can go out and recover, we need to know, the agencies need to know, some idea of what the magnitude of the improper payments is, and then we need to go to work and recover as much of that money as we can. I will look forward to your responses.

Again, I just want to say to Senator Levin, to Senator Coleman, and to your staffs, thank you very much for your diligence and bringing us to this hearing. Thank you.

Senator LEVIN. Thank you, Senator Carper. Dr. Coburn.

Senator COBURN. Thank you, Senator Levin.

Mr. Kuhn, I want to go back to something. You did not answer Senator Levin's question, and before you leave here today, I think you—it is unbelievable that we would have contracts with Medicare service organizations that are not held responsible. And I have a very direct question for you. Will you make sure that in the future all contracts with all these service companies, these payers, have a section in there in which they are culpable and held responsible for overpayments which they should have avoided?

Mr. KUHN. Senator, I thank you for asking that question again, and here is what I will follow up and do. One, I am going to go back and sit down with our General Counsel to look at existing contracts to see if they include those provisions and did we exercise those clauses appropriately in terms of collecting improper payments. And then on a go-forward basis, we will engage with our contracting process to make sure that the Federal Acquisition Regulations out there, FAR contracting and all that, to make sure that we are properly exercising contractual arrangements; that if there are improper claims made, that we are meeting all Federal standards to go forward. So I will make sure——

Senator COBURN. I am not sure that is a yes. The fact is that any American looking at this hearing today would say Medicare is contracting with service providers, and you have not told us, yes, we will hold them accountable. And what I want is an answer, yes, we will hold them accountable.

Mr. KUHN. To the extent we can, we will. The reason I equivocate a little bit is I just do not know all the provisions of the FAR contracting rules. But if we can hold them accountable, yes, sir.

Senator COBURN. You can hold them accountable. And if you cannot, we have to change those rules. It is ridiculous. If you cannot hold a contractor accountable for doing something because of some silly regulation that we have written in contracting rules, then we need to know that and change the rules. But the fact is that we know $80 billion in waste, fraud, and abuse is in Medicare, and that $16 billion—I misspoke earlier when I said $200 billion. It is $16 billion that is coming out of the pocket of Medicare payers. Individual Medicare recipients are paying $16 billion more than they should be. So what we need is a commitment.

The second thing I would like to ask that you supply the Subcommittee with is a list of all the service contractor providers and their 10–Ks to this Subcommittee. In other words, here is the list, here are the companies, and here are their 10–Ks, and you provide that, because we are going to be wild by the time you see the profitability of the people who are your service contractors, and then we compare that to this fraud, it is a drop in the bucket to hold them accountable in terms of their profitability.

Senator LEVIN. Well, we ought to get an answer to that.

Mr. KUHN. Yes, sir. We would be happy to supply that information to the Subcommittee.

Senator COBURN. Thank you.

Did I understand your testimony that you only cross-reference this list in the past as far as dead physicians every 15 months?

Mr. KUHN. That is correct. That was the instructions.

Senator COBURN. Is that changing?

Mr. KUHN. That will change—depending on what we come up with with Social Security, whether it is now weekly, monthly, but it will—the periodic rate of that will be accelerated greatly under the new NPI system.

Senator COBURN. It ought to be every week. I mean, that is punching a button on a computer cross-checking a list.

Mr. KUHN. Right.

Senator COBURN. So why is that not just common sense that we are going to do this every time we get a list?

Mr. KUHN. That is right. Under the new interagency agreement, it is my hope it will be weekly. But weekly, monthly, biweekly, the periodic rate is going to be much quicker.

Senator COBURN. Now, one other thing you said, Mr. Kuhn, in answering questions for Senator Carper was the problem of not cross-checking whether you had—even though you had a UPIN number or a new NPI number, not knowing whether they were enrolled providers? Have we not been checking against enrolled providers all this time?

Mr. KUHN. No, we haven't. In fact——

Senator COBURN. OK. That is—just think about that for a minute. People who are not enrolled to provide for Medicare, we are paying DME suppliers for prescriptions from people who are not qualified to give those prescriptions? The question I would have is why haven't we.

Mr. KUHN. There are rare exceptions in the program, changes in the future, where there may be a physician who has elected not to participate in the Medicare program. But they are licensed in the State. They can practice in the State. But they see a Medicare beneficiary who signs an Advanced Beneficiary Notice (ABN), and says, "I am going to self-pay because I want to come to this doctor. I have been seeing him for years," and they write him a prescription. We have filled those prescriptions for that particular individual as a result of that relationship with that physician.

Senator COBURN. Fine. That is the exception to the rule.

What about the people who are off the Medicare list who have been sanctioned and still have a UPIN number and still have a NPI number? You are not cross-checking against those people for writing prescriptions for DME equipment?

Mr. KUHN. Not under the old system. Under the new one we will.

Senator COBURN. OK. Mr. Vito, on page 9 of your testimony, when you looked at the UPIN database, you found 52 percent of the providers in that database had inaccurate information in at least one category, and 17 percent of those providers no longer billed Medicare from any of the practice settings listed in the UPIN file.

Now, does that mean they were not practicing or they just were not at the location at which the UPIN file listed them?

Mr. VITO. I don't know that answer. We would have to go back and look. I think sometimes that they might not have been practicing at that location.

Senator COBURN. And of that 17 percent, 14 percent were deceased?

Mr. VITO. That is correct.

Senator COBURN. And 26 percent were retired?

Mr. VITO. That is correct. And we found that out because we asked the physicians about their info. We got the information from the UPIN directory. We asked the actual physician. We found that information because either when we asked at the practice they told us that the physician had died or a family member told us that they had died.

Senator COBURN. So what that means is at least 6 percent of the total UPIN numbers are lousy numbers because they either represent retired physicians or physicians who no longer participate in Medicare or are no longer at the practice site which they supposedly are supposed to keep updated with Medicare. Correct?

Mr. VITO. I believe there are problems with that database. There were problems with that database, and we pointed that out. But I think the point is that there was never any check at all for the UPIN other than it started with an alpha, then either had an alpha or a numeric in the next two digits, and the following three digits were just numeric.

Senator COBURN. So there was no integrity to the list in terms of the quality of the UPIN? You didn't know, even though you had a UPIN number, that may have not represented the——

Mr. VITO. What I am saying, when they processed the claims, when the claim came in, they didn't match it up to see if it was an actual——

Senator COBURN. A good number.

Mr. VITO. Yes.

Senator COBURN. OK. Mr. Kuhn, do DME equipment providers who use dead physician numbers get sanctioned by CMS?

Mr. KUHN. Yes.

Senator COBURN. Explain the sanctioning process.

Mr. KUHN. When we are aware of that, it can come about in a number of different ways. One, revocation of their ability to work with the Medicare program. They are out of the program. And then where we see cases like this, we refer them over to our law enforcement partners—IG, Department of Justice, others—for follow-up and case development if there is outright fraud there and for prosecution.

Senator COBURN. Can you give me a situation where a dead physician's prescription would not be outright fraud?

Mr. KUHN. I think there is a possibility. This is a credible hypothetical, but it is plausible, I guess, where someone wrote a prescription one day, the physician, the next day was in a car accident.

Senator COBURN. OK, so within a month, let's say. After a month, can you give me a situation in which a DME supplier could logically use a dead physician's UPIN number without trying to commit fraud?

Mr. KUHN. Without a month, 60 days, I think you are probably looking at fraud, or perhaps a mistake, but certainly more likely fraud.

Senator COBURN. So why would not all of them be completely sanctioned and banned from Medicare for that?

Mr. KUHN. They should be, and when we work up those cases, I think there should be absolutely revocation as part of that process. And what we are pleased about is that with our new contractor, our new contract in terms of those that do enrollment for DME suppliers, this is going to be one of their new charges, to make sure that we are even better policing that, because you are absolutely right, there is the one side in terms of making sure these numbers are good. But if we still have bad suppliers out there, they are going to try to find a way to commit fraud against us, and we have got to work both sides of that ledger.

Senator COBURN. Would you kindly forward to the Subcommittee the number of fraud causes that you—or the number of sanctions that have been banned from the program in the last year of DME suppliers?

Mr. KUHN. Sure, we would be happy to.

Senator COBURN. And the number that also have had dead physician prescriptions that have not been banned from the program?

Mr. KUHN. We would be happy to get that information for you.

Senator COBURN. Thank you, Mr. Chairman.

Senator LEVIN. Thank you, Dr. Coburn. Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman.

I am curious with this new system, the NPI system. Obviously, I am beyond alarmed that you have allowed these folks to make claims without a NPI number from the doctors. Could somebody explain to me why you wouldn't give the doctors NPIs before you give the providers NPIs?

Mr. KUHN. We do, and I think it is the issue in terms of us allowing how they use their own NPI in that field in terms of referral and prescription. Is that your question?

Senator MCCASKILL. Yes. I mean, as of June 2, you are allowing DME suppliers, durable medical equipment suppliers, to use their own NPIs rather than the prescribing doctor. And the issue, I was told, is that because there were some order physicians that did not have their NPIs yet.

Mr. KUHN. Right.

Senator MCCASKILL. Well, why would you give them to any providers before you give them to all the doctors?

Mr. KUHN. Here is the way that scenario works. Everybody applies for a NPI. They get their NPI. The physician or his office manager, his or her office manager, might not readily have it. They might not have applied for it yet, but they still are practicing in

the community, been there for 20, 30 years, whatever the case may be. What we were concerned about here is we know this created a vulnerability in the program. But we were also trying to balance that against access for Medicare beneficiaries to make sure that they could get the supplies and services that they needed. This is a temporary patch, but the key here, as I mentioned earlier, is that anybody that uses their own NPI in that field, any supplier, they are a very good candidate for post-payment review as a result of this scenario.

So, yes, they have the opportunity to use it if it is a true access issue. But if you do use it, beware, we are going to come and look over your shoulder.

Senator MCCASKILL. Do you get the Social Security number of the prescribing doctor if there is not a NPI for the prescribing doctor?

Mr. KUHN. We have that information in terms of the enrollment process. That is correct.

Senator MCCASKILL. OK. So for every single claim that is coming in from a provider where there is not a NPI for the doctor, are you running it through the Social Security database to make sure that the doctor is alive?

Mr. KUHN. Yes, on enrollment, yes, we do.

Senator MCCASKILL. No. I am asking on these claims. You have stopped segregating duties.

Mr. KUHN. Right.

Senator MCCASKILL. We have a program that cannot figure out for 6 years how to match the Social Security numbers of the doctors with the information you have been getting from the Social Security Administration. You have been getting the Social Security information for 6 years. You cannot figure out how to do that.

If someone is making a claim for durable medical equipment with a NPI without a doctor's NPI, you have that doctor's Social Security number; before you pay that claim, are you running it to make sure they are alive now, this minute?

Mr. KUHN. We are not right now.

Senator MCCASKILL. OK. So why not?

Mr. KUHN. We are making those systems changes. Those will be system changes that we hope will be in place by the end of this year or early next year as part of the process.

Senator MCCASKILL. OK. Clearly, the cart is before the horse here because this seems to me that at a minimum, if you are going to allow these people to use their own numbers, you have to have another safeguard in place in terms of prevention. With all due respect, Mr. Kuhn, you came to this hearing not even knowing if you have a mechanism to hold these contractors accountable. You don't even know if it is in the contract or not. That has not even gotten on your radar screen until some very pointed questions from this Subcommittee. That does not give me comfort that the priorities are in terms of looking at how we prevent fraud, waste, and abuse.

Let me ask you about this $300 million that you currently get for the Integrity Program. Who is in charge of it?

Mr. KUHN. Our Office of Financial Management and our Program Integrity Group.

Senator MCCASKILL. Who is the person in charge of the program?

Mr. KUHN. Program Integrity is run by Kimberly Brandt.

Senator MCCASKILL. Kimberly Brandt is in charge of a $300 million budget to make sure that bad guys are not ripping us off?

Mr. KUHN. No, let me correct the numbers here. Right now we get $720 million for Program Integrity. That number has been frozen since 2003. Over the last 3 years, we have requested additional funding to the tune of $300 million in that area. Overall, that program is run by our Office of Financial Management. That is run by a gentleman by the name of Tim Hill. And then a particular group within the Office of Financial Management is the Program Integrity Group. They run many of the program integrity issues, but those dollars are also used in terms of audit function, different organizations within the Office of Financial Management.

Senator MCCASKILL. Well, so now what you are telling me is we are spending $720 million—and you want $1 billion—to make sure people are not stealing from us.

Mr. KUHN. That is correct.

Senator MCCASKILL. OK. That gives me a headache. That means that we are spending $1 billion on top of all the people who work there, on top of the IG and the GAO, we are spending $1 billion—you want us to spend $1 billion. We are spending $720 million.

Mr. Chairman, I think it would be a really good idea to have a hearing and talk to these integrity people. I would love to know what they are doing. I would love to see an org. chart. Could you provide to the Subcommittee an org. chart of how the $720 million is being spent?

Mr. KUHN. Happy to.

Senator MCCASKILL. And I would like to know how many people it is paying for. I would love to know how many contractors we are buying with that money. And what are they doing? The idea that you would be spending $720 million a year and for 6 years nobody has checked the death database at Social Security for doctors? Talk about needing to fire some people.

Mr. KUHN. I think that is a fair question. But I think as I tried to share with the Subcommittee earlier, we face on a regular basis a number of vulnerabilities in the program. In 2004, when we were going to do the follow-up checks in terms of this issue of the deceased physician files that were out there, here is what we were looking at in 2004: We had a major scandal going on in this country with the issue of powered mobility devices or powered wheelchairs in certain parts of the country, to the tune of about $1 billion being ripped off from the Medicare program. With law enforcement, we launched a major initiative called Operation Wheeler Dealer. We threw resources in that direction.

We had the new enrollment program, the PECOS system that came up. We moved resources in that direction. We had, on the heels of the Medicare Modernization Act, the new Part D program, and we wanted to make sure that was secure and up and running before it got out of the gate.

So we make tough choices in terms of areas of vulnerability. This is an important area, but at that time when we were making these decisions, there were things that were much higher for us to put resources on. These are tough choices, but these are the decisions we made.

Senator MCCASKILL. Well, all of the money that you are throwing to these various programs is addressing fraud that has occurred as opposed to investing that money, integrating this money into prevention. And this hearing today is a drop in the bucket. I realize that. But it is a symbolic drop in the bucket in terms of, we are chasing the cow after it gets out of the barn rather than doing some pretty simple checking on that lock on the barn. And, if there are $720 million worth of people at Medicare that are supposed to be fixing the lock on the barn, then the very basic would be some of the things that clearly have not been done.

I am curious that the Integrity Section, how they felt about you guys using NPI numbers for people providing the equipment as opposed to the doctors that were prescribing it. Did anybody over there scream? They should have. That should be something they should be reviewing. Everything should be going on at the front end, not at the back end.

Of all the dead doctors we have found who prescribed DME after they had been dead a month, how many of those have been referred for prosecution? How many of those providers have gone to jail?

Mr. KUHN. We are hoping to get the information from the Subcommittee in terms of the report. In the report, I think they identify one DME supplier. I did not see that they identified any physicians by name, but we hope to follow up with the Subcommittee to get their files, their identification. And I have asked staff, once we get that, to pursue active investigations in these areas and recoveries where we can.

Senator MCCASKILL. What I would certainly like to see is if you all can do this without us passing a law demanding you do it. Is there any reason that every time you find a prescription that has been filled for a doctor who has been dead for more than 30 days that you cannot send a letter to the Attorney General in that State saying, "We have evidence of fraud. Go for it?"

Mr. KUHN. That might be a nice improvement to have as part of this process. I like that suggestion. I will take that back.

Senator MCCASKILL. Yes, and the $720 million worth of staff over at the integrity place, I would be curious why they have not demanded that you be doing that. You have 50 Attorneys General out there that are staffed and ready to handle these cases, and I know that it is a big deal in my State, and local prosecutors, too. Everybody wants to go after people that are preying upon sick people and undermining the Medicare program.

I know my time is up. Thank you, Mr. Chairman.

Senator LEVIN. Thank you, Senator McCaskill.

We have asked you for a number of reports. Can you assure us we will have those reports in 30 days?

Mr. KUHN. We will do our level best to get it to you in 30 days. If we are unable to, we will inform you accordingly and give you a time certain when we think we can deliver the information.

Senator LEVIN. Fine. Now, let's just take maybe 3 minutes each because we have some roll call votes coming on the Senate floor.

You indicated, Mr. Kuhn, that CMS had a problem in terms of the data that was coming in. You apparently suggested that the AMA data was faulty. Now, the data that our staff looked at were

your files. In your files, the prescription dates came after the dates of death.

Mr. KUHN. I think the issue is not that it was faulty, but it was not as robust as——

Senator LEVIN. Forget robust. That is, 734 out of the 1,500 cases were in your files.

Mr. KUHN. Right.

Senator LEVIN. It does not take much. Look, I am not a high-tech guy, but it does not seem to me it is very complicated for software to be written that says if there is a date of death in your file, you do not pay claims.

Mr. KUHN. Oh, I do not dispute——

Senator LEVIN. What is complicated about that?

Mr. KUHN. I do not dispute that the matches weren't made as good or——

Senator LEVIN. Not "as good." The claims should not have been paid.

Mr. KUHN. But, again, a lot of it is the thing that we have got to have good data sources. I know when we talked to the staff——

Senator LEVIN. No. I am sorry. I have to interrupt you. I have only 3 minutes. This is not good data. So this is your data. This investigation by our staff looked at your files. In your files, the date of death was present. For the 1,500 we looked at, that random sample, in half of those deceased physicians there were payments made. Those 1,500 cases had dates of death in CMS files. It is not a matter of getting information from Social Security or from AMA. Your files had the date of death. How complicated is it for someone to write a program that says in your files where there is a date of death, you hold off paying any claims? Why is that complicated?

Mr. KUHN. I cannot imagine why that should be so complicated, and I do not understand why that one was not corrected. I will look into that one personally.

Senator LEVIN. Why does that take $300 million to do?

Mr. KUHN. It was an issue of priorities at the time, what we were——

Senator LEVIN. But there is no dollar priority. That is a software issue. That is just writing a simple software program that says do not pay a claim where there is a date of death in CMS' files for a physician.

Mr. KUHN. Senator, it is tough calls. If someone is stealing a billion dollars here, someone——

Senator LEVIN. Go after the billion dollars.

Mr. KUHN. We are going to go after the billion dollars.

Senator LEVIN. I am with you, but could you get $1,000 for someone to write a program?

Mr. KUHN. We will see what we can do to chase the others.

Senator LEVIN. No. It is not chase the others. It is to write a program in your own file which says if there is a date of death in your file, you do not pay claims. That is not a complicated, expensive deal. So I do not think it is good enough for you to say, well, you have asked for $300 million more above the $700 million that you have not gotten when that is a simple software cure.

Mr. KUHN. The only thing I can answer, Senator, is that we have to make choices with limited resources. We made some choices on

vulnerabilities here. I understand that this sounds simple, but we made some choices in 2004, and this is the choices we made.

Senator LEVIN. You mean you looked at this possibility and decided not to do it?

Mr. KUHN. We looked at where we had program vulnerabilities, and as I said, $1 billion, chasing those that were stealing on power wheelchairs, the new PECOS system, the new Part D program is where we put our resources.

Senator LEVIN. I would agree with that decision to put resources there. What I am telling you is this is not a complicated thing. This is writing software, a program, which is not complicated. This is not a matter of making sure the data that comes in from Social Security or AMA is accurate and up to date. This is where your file has that record in there that there is a physician that has died and where you have not automatically then said no payments based on that identification number.

Mr. KUHN. And I appreciate that distinction.

Senator LEVIN. I have to tell you, I just do not find your testimony credible in this regard. To talk about other needs that you have to go after—the wheelchair frauds—I agree with you, if it is a matter of either/or, you do it. But this is a very simple fix, and I do not get how you can defend not doing it and how you do not know whether or not the contract that you signed with contractors who are supposed to implement this program contains a provision that holds them accountable for failures to do their job. On all those items you mentioned, looking forward, you have to have accountability in there. And that is what has been missing, and it is still missing. There is no accountability for failure to do people's jobs. That to me is a huge gap, and it is a gap in too many programs, too many government programs, where people, including our contractors, are not held accountable for not doing their job.

I would add that to your program as the No. 1 item that you ought to have in any new program.

Senator Coleman.

Senator COLEMAN. Thank you, Mr. Chairman.

First, just to go back to the issue of the DME providers providing a number and not the physicians. Again, I stress the concern with the fly-by-night folks, that a post-payment review is not going to be of help for those folks who are doing this to rip off the system. We know that they are out there. Then we have contractors that do the review. That costs money.

My strong suggestion is that as you go back, you look at putting a guard at the front door. It goes back to the issue the Chairman raised and I raised in my opening statement. I talked about things that UPS does and FedEx does. It is the ability with computer capability today to be able to check things. You would think that there would be some kind of automated system at the front door. So I would urge you to go back because I do not want to be back here in another year looking at what happened in that period where we did not require the new NPI from physicians.

Second, it would appear that if we have dead physicians, there was obviously no system in place to check against treatment visits. In other words, CMS has information from treatment visits. Physicians are being reimbursed for that. So, again, where we are today,

we have to look back and you see all these years of payments with this—it was then a UPIN, but I would presume that there would be a big blank for many years about any treatment visit because there is no physician. Why doesn't CMS cross-check claims with DME for doctor visits?

Mr. Vito, I would turn to you. Would that be another piece of the way in which we ensure greater integrity by doing—again, at the press of a button. I have to believe that you can press a button, and it may be more expensive than $1,000. It probably costs money to do this. But we are paying contractors to do it. This is not the government's limitation. We have lots of money in the private sector. What am I missing in having a cross-check of treatment visits to physicians in looking at DME payments, claims?

Mr. VITO. Well, there are two different systems at CMS. There is the DMERC, the DME system, and also the Part B system. And sometimes they are not housed together. But when we do reviews and when we look at billing patterns for aberrations involving UPINs, we look at the beneficiaries. Then we also look to see if there were any Part B bills indicating that they had an office visit at the time that they were supposed to have gotten an order for this equipment.

Senator COLEMAN. But that is my point. I would presume that is what you do, and in this day and age, where we have such capability electronically, it shouldn't matter where you are housed. It shouldn't matter. That is of no relevance today. It is a question of whether we want to ensure that the right hand knows what the left hand is doing. And so it all goes to this issue of what kind of capability do we have today to be able to provide—not waiting for you to come in after the fact, Mr. Vito. And I appreciate it—I do not want to put you out of a job. But it would be nice if you would have less to look at because you are doing what I believe could be done up front.

Mr. VITO. Right. The only issue here is that they are not even editing for the most basic format. CMS did not edit for the most basic edit of just seeing if the UPIN was active. You are talking about even doing more, which would be even more computer capabilities and requirements because you would then have to match it up onto the Part B system. What I am saying is we could start by taking first steps and build upon those first steps to make it so that we would have a system that certainly has more integrity and does more checks. We will be glad to work with CMS and you to make sure that happens.

Senator COLEMAN. I appreciate that, Mr. Vito. Thank you, Mr. Chairman.

Senator LEVIN. Thank you. Dr. Coburn.

Senator COBURN. Thank you. I am starting to get a little worried that CMS' computer systems are like the Pentagon's, and it is scaring me to death. Am I hearing you right that there is no cross-reference capability between Medicare Part D, CME, Part B, and Part A to talk to one another?

Mr. KUHN. Probably 5 years ago there was not, but there is now.

Senator COBURN. All four of those, you can run cross-checks all the way across—eligibility, UPIN numbers, date of birth, certifi-

cation, enrolled doctors, certified suppliers—all that can be cross-referenced?

Mr. KUHN. My understanding is that with the changes—let me even back up, a little more history here. Part of the Medicare Modernization Act gave us authority to do contractor payment reform, something that the agency has wanted to do for 20 years of this whole legacy system that we had out there. And so we got rid of the fiscal intermediaries; we got rid of the carriers; we got rid of the DMERCs. All those folks are gone now, and basically we are creating what we now call Medicare Administrative Contractors (MACs), which for the first time brings Medicare A and B together. Those systems now talk to one another. They work together.

Senator COBURN. But do they talk to Medicare Part D?

Mr. KUHN. And we are working on making sure that they can now talk to the DMACs. I don't know if that system is actually put in place yet, but ultimately that is the goal so that the whole system is synched up across the way. And that is part of the reform effort to get at the very issues Mr. Coleman was raising.

Senator COBURN. Mr. Chairman, I would just say Medicaid is designed to be defrauded. I mean, we have designed it. You look at DME. We set artificial prices. We inflated the prices based on inflation. It had nothing to do with the real cost of goods. We set it up, and we created the system and said here is a real lucrative area, let's go take some of it. And what we really have to do is we have to go back and look at Medicare and change it. And I have proposed this to CMS before, if we are not going to do everything up front like we should be doing—which we should be holding contractors accountable. If you were in the private sector and you did not have this cross-referencing available and you did not think about doing it beforehand, not after the fact, I mean, why wasn't this part of the program 10 years ago of talking? We had a very accurate computer. But the answer to this is undercover patients. The fact is people do not like going to jail. And all you have to do is throw about 50 doctors in jail and about 100 DME suppliers and 100 hospice suppliers, and you know what? This fraud would go from $80 billion a year down to about $5 billion. But nobody wants to do the hard work of the true undercover to get rid of the fraud. And we will not do the hard work of changing the system where it is not fraud—it is not a pro-fraud environment.

I would like to know from Mr. Kuhn and Mr. Vito, how would you have us change the Medicare program so that it is not so enticing for fraud?

Mr. KUHN. Boy, that is a very good question. I think part of the issues you talked about in terms of are there better ways that we can do it in terms of active surveillance or areas that we are looking at. For example, one of the initiatives we launched with the Justice Department, the IG, and others was about 2 years ago called Operation Accidental Tourist, where we went through the Miami area looking at DME suppliers. And as a result, that resulted in a revocation of close to 500 suppliers out there that were nothing more than storefronts, folks that were clearly trying to defraud the program.

There is a new Medicare task force operated by the Department of Justice that is having some real success, and my understanding,

within the last year to 18 months, is that has led to around 55 prosecutions and convictions out there right now.

So I think getting tougher on the fraud side of the ledger is going to make a big difference. But you are right at the outset. It really is how you pay and what you pay for. When you have mis-priced procedures, when you pay too much for something, as we do in DME and other areas, it does bring the fraudsters into the program.

When you have systems that do not adequately work with one another and talk, as has been the subject of this hearing, it leaves opportunities for people to kind of encroach on the program that is out there.

But I think at the end of the day, where it really makes a difference is that we have good, legitimate suppliers out there, people we can count on and trust and try to drive integrity in every step of the process that we have there, and to make sure that the payment systems are as fair and as honest as they can be. I think we have a fair payment and legitimate suppliers out there. Those are the areas that I think are going to give us the biggest bang for our buck.

Senator COBURN. Mr. Vito.

Mr. VITO. Well, it is very important that the controls that are established be utilized in the manner that is most effective. Largely, the program is relying on honest providers to file claims properly, and that is the way the system was designed. So it is a lot of trust that is involved in the provider billing process. But I think there needs to be more verification with the trust and more checks up front to ensure that things are done properly.

We have worked with CMS, the Department of Justice, and others, for example, in South Florida, and we have really made a dent into the problem of the DME suppliers down there. I think it is a concerted effort of identifying vulnerabilities, correcting those vulnerabilities, making sure that they do not exist, and then engaging in collaborative activities that best utilize our investigators and the Department of Justice resources simultaneously. So largely what it is, is all of us working together to get the best results and by doing it with all the tools that are available to us, such as eliminating the vulnerabilities that we identify and then taking actions to prosecute the people who committed the crimes and make sure that is known by other people who would do likewise. We need to make sure that we continue to stay on the task until it is resolved.

Senator COBURN. Mr. Chairman, I have one further request, and I don't know if I asked you this. And I think I did, but I wanted to confirm it with Mr. Kuhn. The list of people who have been filing claims for DME equipment under the pretense of a deceased physician and the sanctions applied, you will give that to the Subcommittee?

Mr. KUHN. You did ask for that, and we will supply that to the Subcommittee.

Senator COBURN. Thank you, Mr. Chairman.

Senator LEVIN. Thank you, Dr. Coburn.

Just one thing that I want to pursue and then see if colleagues have any additional questions. There is supposed to be a vote any minute.

When we talked before about the deceased date information coming to the agency, what you said, Mr. Gray, is that the same information is going to be going under the new system as is going under the old system. That is not going to change.

Mr. GRAY. Let me be clear, Senator. It is the same file format.

Senator LEVIN. All right. And then the question was raised: How often would somebody press a button, I guess, at CMS to put a hold on any payment to somebody, a doctor, who is deceased, a payment to a provider based on that identification number? And I think Dr. Coburn asked the question about—well, you said every month, and Dr. Coburn I think said why not do it every week, and you said, well, we could do it every week.

Why can't that be done automatically? Why couldn't it be done when the information comes over from Social Security that somebody is deceased, automatically there is a hold on that file? Why does someone have to press a button even? Why can't we have software saying it is automatic?

Mr. KUHN. I think there are two different issues here at play. One is trying to update the files to make sure that we have the batches that we get from Social Security in order to get the deceased physicians, and that is one issue, to make sure that our files are accurate. That presumably would be done on a weekly basis.

I think the question you are asking is that when our claims system detects that there is a deceased——

Senator LEVIN. No.

Mr. KUHN. OK. I am sorry.

Senator LEVIN. I go to the first question. Why is that not done automatically? Why isn't there a hold placed automatically when that information comes electronically to you?

Mr. KUHN. Oh, well, it depends when we process the batches.

Senator LEVIN. Is that electronic processing?

Mr. KUHN. Yes, and presumably—and again, our data folks would be the ones that could speak to this better. But presumably they have to reserve data-processing time. These probably would be files that would be run at night, on weekends, things like that.

Senator LEVIN. It would just be inputted by hand?

Mr. KUHN. I do not think so. I am sure it is all electronic.

Senator LEVIN. Well, then, why do we have to wait a week? Why isn't it an automatic hold on that file electronically when that information comes in?

Mr. KUHN. Well, I think, as you may know, Senator, there is real competition for computer time when you run large files like this, and I think it is just a matter of whenever they can schedule that. If we can do it even more rapidly than every week, I think that would be preferable.

Senator LEVIN. Well, I am just wondering why it is not an automatic deal. If you could check——

Mr. KUHN. Sure, with the data folks.

Senator LEVIN. Just find out whether that could be done automatically as the information comes in, bingo, it is done electronically as it comes in, just the way we get e-mail automatically, which triggers a bell in my wife's head somewhere.

Senator COLEMAN. I have nothing further now. We have a lot of information coming back to us, Mr. Chairman, that we will need

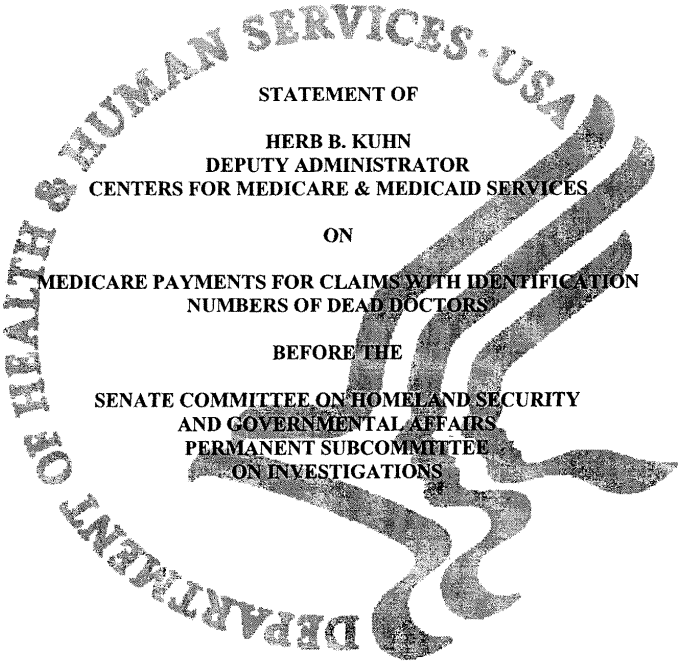
to take a look at and see whether we need to schedule another hearing.

Senator LEVIN. We want to thank our witnesses. Again, thank you, Senator Coleman, and your staff for your initiative here, and we thank all of our staff. They work together very well, as you pointed out. We are grateful for that.

We will stand adjourned.

[Whereupon, at 11:54 a.m., the Subcommittee was adjourned.]

APPENDIX



STATEMENT OF

HERB B. KUHN
DEPUTY ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE PAYMENTS FOR CLAIMS WITH IDENTIFICATION NUMBERS OF DEAD DOCTORS

BEFORE THE

SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

July 9, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services
On
Medicare Payments for Claims with Identification Numbers of Dead Doctors
Before the
Senate Committee on Homeland Security and Governmental Affairs
Permanent Subcommittee on Investigations

July 9, 2008

Chairman Levin, Ranking Member Coleman, thank you for the opportunity to testify today regarding the Subcommittee's findings on Medicare payments for claims containing invalid or inactive provider identification numbers (PINs) of deceased physicians. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources that the Subcommittee has invested in this study; we have carefully considered the preliminary findings shared verbally with us by Subcommittee staff, and we too are concerned. We look forward to an opportunity to review the complete findings and the Subcommittee's report.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding CMS programs are greater than ever. Fraud, waste, and abuse schemes have become increasingly complex, and are quick to adapt and stump even the latest oversight strategies of Congress, CMS, and our law enforcement partners. With CMS' expansive role in the U.S. health care system comes a tremendous responsibility to protect our programs' integrity, promote efficient operations, and ensure safe and quality health care for all beneficiaries.

Responsible and efficient stewardship of taxpayer dollars is a critical goal of this Administration, as evidenced by a government-wide effort to improve financial management by way of the President's Management Agenda (PMA). Under the PMA, Federal agencies are mobilizing people, resources, and technology to identify improper

payments in high-risk programs; establish aggressive improvement targets; and implement corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse, and to improve quality of care.

As part of a sound financial management strategy, CMS has a long history of using improper payment calculations as a tool to monitor the fiscal integrity of Medicare. Improper payment calculations help identify the amount of money that has been inappropriately paid; the causes of the inappropriate payments; and strategies for strengthening internal controls to stop improper payments from continuing.

CMS has made great strides in significantly reducing the Medicare fee-for-service (FFS) error rate in recent years by educating providers about appropriate medical record documentation and methods to improve their accuracy and completeness. For example, in FY 2005, we strove for a Medicare FFS error rate of 7.9 percent and the actual error rate was 5.2 percent. For FY 2006, the goal was 5.1 percent and the actual error rate was 4.4 percent. The goal for FY 2007 was 4.3 percent and the actual error rate released in November 2007 was 3.9 percent, again improving upon the target. Paying claims right the first time ensures the proper expenditure of the Medicare trust funds and saves resources required to recover improper payments.

Durable Medical Equipment Fraud

CMS appreciates the Subcommittee's shared interest and goal of reducing waste, fraud, and abuse in the Medicare program, such as the apparent, continuing inappropriate use of PINs at issue today. As discussed in further detail below, CMS already has taken steps to implement policy changes and new procedures so that invalid or inactive PINs are not used by unscrupulous suppliers of Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) or any other unscrupulous provider to bill Medicare in the future.

As you know, the topic of fraud and abuse in the context of Medicare-covered DMEPOS has been a focal point of CMS program integrity initiatives in recent years. The activity highlighted by the Subcommittee's recent findings is one troubling example of DMEPOS fraud and abuse, but in truth, the variations in this area are manifold.

Within the last 18 months, CMS and our law enforcement partners at the Department of Health & Human Services Office of Inspector General (OIG), the Department of Justice, and the Federal Bureau of Investigation have identified and documented significant fraudulent activity by DMEPOS suppliers in Miami and the Los Angeles metropolitan areas. While both regions of the country have high numbers of Medicare beneficiaries, there has been a tremendous spike in the number of suppliers and utilization: the number of DMEPOS suppliers in these areas has almost doubled and billing from the suppliers remains disproportionately high.

During FY 2006, the National Supplier Clearinghouse (NSC), the national enrollment contractor for DMEPOS suppliers, conducted 1,472 inspections of Miami DMEPOS suppliers. As of October 2006, the billing numbers of 634 DMEPOS suppliers had been revoked, including 143 suppliers that had been enrolled within the previous 12 months. This effort, which is still ongoing, resulted in a projected savings to the Medicare program of $317 million. The NSC spent approximately $3 million on all enrollment efforts in Miami, resulting in a return on investment of greater than 100:1 ($100 in savings for each dollar spent to conduct the project). A similar initiative was conducted in the Los Angeles area last year.

The types of fraud committed by the DMEPOS suppliers in Miami and the Los Angeles metropolitan areas included: (1) billing for services not rendered, which involved claims for power wheelchairs, scooters, nutritional products (e.g., Ensure), orthotics, prosthetics, hospital beds, etc.; and, (2) billing for services not medically necessary. CMS and its contractors have identified thousands of Medicare beneficiaries living in California and Florida who are receiving DMEPOS items that they did not require based upon their medical history and/or are receiving Medicare Summary Notices (MSNs) for items that

are not only unnecessary, but never ordered by their physician and never received by the beneficiary. CMS staff in Los Angeles and Miami have interviewed multiple physicians who have provided attestations that they never saw the patients for which DMEPOS was ordered and correspondingly never ordered the suspect DMEPOS items.

Fraud and Abuse Activities Involving Invalid Provider Identification Numbers
CMS shares the Subcommittee's concern with inappropriate use of invalid or inactive PINs on Medicare claims. We have taken steps internally and with our claims processing contractors to substantially curb and ideally eliminate this practice.

CMS processes claims and makes payments for FFS Medicare benefits through contracts with private companies called fiscal intermediaries (FIs), carriers, and Medicare Administrative Contractors (MACs). For 2008, CMS estimates that these claims administration contractors will process well over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers. The contractors review claims submitted by providers to ensure payment is made only for Medicare-covered items and services that are reasonable and necessary and furnished to eligible individuals.

CMS issues more than 600 instructions annually to claims administration contractors and the process for reviewing and implementing those instructions is well documented by the Agency. After a detailed review and comment process, where implementing instructions are fine-tuned by CMS with its contractors, claims administration contractors are required to certify that they have implemented each final instruction and report back to CMS on a quarterly basis. CMS conducts regular oversight of each Medicare claims administration contractor and "spot checks" the implementation of new processing instructions. In addition, CMS conducts formal performance evaluations on an annual basis to assess individual contractor compliance with Agency requirements for implementation of Agency directives.

When concerns with use of invalid or inactive physician identification numbers were first brought to CMS' attention by the OIG in 2001, we concurred with their recommendations and took steps, working with our contractors, to ensure that identification numbers used on DMEPOS claims were valid and active. For example, contractors were instructed to research, update, correct and where necessary, deactivate PINs with invalid addresses and/or no claims activity for one year. In addition, the contractor responsible for maintaining our physician identification number registry subcontracted with the American Medical Association (AMA) to obtain provider data extract files containing physicians' dates of death on a bi-weekly basis. On a monthly basis, CMS' claims payment contractors were sent a deceased physician notification list and notified to update their physician records. This was intended to ensure that Medicare does not pay claims in both the circumstance where the physician (or other Medicare-recognized practitioner) is the rendering practitioner as well as where the physician or practitioner is the ordering or referring entity (as is usually the case with DMEPOS) and the date of the physician's death precedes the date of service. Notwithstanding the completion of these initiatives, CMS looks forward to the opportunity to review the Subcommittee's recent findings to determine what additional measures we might implement to further reduce improper payments of this nature.

Beginning in October 2006, CMS initiated a systematic deactivation of PINs where there has been no claims activity for 12 consecutive months. If any claim is received after the deactivation date, the Medicare contractor would reject the claim submission and require the physician or supplier to update their Medicare enrollment prior to receiving payment. To date, CMS has deactivated approximately 1.5 million PINs.

Fortunately, the recent conversion to the new National Provider Identifier (NPI), along with further documentation and data exchange improvements, significantly strengthen CMS' ability to combat fraud and abuse that rely on invalid provider identifiers. The Health Insurance Portability and Accountability Act of 1996 required the establishment of new, unique national identifiers to improve the efficiency and effectiveness of electronic transmission of health care administrative transactions. CMS achieved

compliance with this requirement on May 23, 2008, from which point all Medicare claims submitted by physicians and other practitioners, laboratories, ambulance suppliers, DMEPOS suppliers, and others who bill Medicare, are required to include only the new NPI in such transactions. Further, all providers and suppliers intending to bill Medicare are required to apply for and secure a new NPI – and to use the NPI exclusively on all forms, and in all electronic formats, when billing Medicare. Moreover, for all claims where a physician or other practitioner has ordered or referred the service or item (as in the case of DMEPOS), the billing entity must furnish the NPI of the ordering or referring physician or practitioner. Medicare program safeguard system edits, which had previously referenced PINs, now reference NPIs.

The mandate to use the NPI exclusively for all provider or supplier identifications in Medicare billing has the added benefit of eliminating invalid or inactive legacy PINs, which previously might have been used for illegitimate purposes such as those highlighted by the Subcommittee. As a result, CMS believes the vulnerability for further fraud and abuse relying on provider identifiers of deceased physicians is substantially smaller today than before full NPI implementation. To date, CMS has assigned approximately two million NPIs to individual practitioners such as physicians and non-physician practitioners.

Further, on January 25, 2008, CMS published in the Federal Register a proposed rule titled, "Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards" (CMS-6036-P). CMS proposed requiring DMEPOS suppliers to maintain ordering and referring documentation received from a physician or other non-physician practitioner (e.g., nurse practitioner, physician assistant, etc.) for seven years. We believe that this change, if adopted, will strengthen our ability to identify fraudulent billing during documentation reviews. We believe that requiring DMEPOS suppliers to maintain documentation from the ordering physician or non-physician practitioner will allow CMS to expand its efforts to identify and detect DMEPOS suppliers who are submitting claims that are not supported by the appropriate verifiable documentation.

CMS currently is reviewing public comments received on the proposed rule. On June 30, 2008, we proposed a similar requirement for physicians and non-physician practitioners when ordering or referring services for Medicare patients in the CY 2009 Medicare Physician Fee Schedule.

In addition, CMS finalized a new information exchange agreement with the Social Security Administration (SSA) on July 1, 2008 which will provide CMS with monthly updates of the SSA's Death Master file and unrestricted State death data beginning in August. CMS will then be able to match this information with information contained in the National Plan and Provider Enumeration System – the central system that maintains information about NPI – and our provider enrollment database, the Provider Enrollment, Chain and Ownership System. After confirming an individual practitioner is deceased, CMS will deactivate both the NPI and the practitioner's enrollment in the Medicare program.

Finally, while our current claims processing system allows any NPI to be used for the purpose of ordering and referring services to Medicare beneficiaries, we anticipate implementing changes in 2009 that will limit ordering and referring to individual practitioners enrolled in the Medicare program.

Conclusion

Thank you again for the opportunity to testify today. CMS appreciates the Subcommittee's ongoing efforts in support of fiscal and program integrity. We believe the initiatives described above will address many of the issues surrounding improper payments for claims relying on invalid or inactive provider identification numbers. We are continually considering initiatives to improve program integrity within Medicare and look forward to continued work with the Subcommittee and our partners represented here today to further strengthen our stewardship of the Medicare trust funds.

Testimony before the

Permanent Subcommittee on Investigations
Committee on Homeland Security & Governmental Affairs
U.S. Senate

"Medicare Payments for Claims with Identification Numbers of Dead Doctors"

Testimony of

Robert Vito
Regional Inspector General for Evaluation and Inspections

Office of Inspector General
Department of Health and Human Services

July 9, 2008
10:30 A.M.
342 Dirksen Senate Office Building

Daniel R. Levinson,
Inspector General
Department of Health and Human Services

Testimony of:
Robert A. Vito
Regional Inspector General for Evaluation and Inspections
Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Mr. Chairman and Members of the Subcommittee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia at the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG). Consistent with its statutory mandate, OIG has devoted considerable resources toward fighting fraud, waste, and abuse involving Medicare coverage and payment for durable medical equipment (DME), prosthetics, orthotics, and related supplies. OIG has performed evaluations, investigations, and audits on an array of DME-related issues; made recommendations to the Centers for Medicare & Medicaid Services (CMS) to help correct vulnerabilities that make the DME area so susceptible to fraud, waste, and abuse; and performed targeted follow-up work to ensure that corrective actions have been taken to eliminate or minimize these vulnerabilities.

One issue—the Medicare requirement that a supplier include on a DME claim the unique physician identification number (UPIN) of the physician who ordered the DME—is the subject of my testimony today. OIG has found that the lack of edits or other reviews that validate the UPIN listed on DME claims presents a vulnerability that has allowed millions of dollars in questionable claims to be paid. OIG studies have uncovered: (1) the use of UPINs that were invalid or inactive, (2) the use of UPINs that belonged to physicians who had died prior to the dates of service, (3) the improper use of surrogate UPINs, and (4) the use of legitimate UPINs that were associated with an unusually large number of claims.

It should be noted that effective May 23, 2008, CMS began requiring the use of national provider identifiers (NPIs) rather than UPINs on supplier claims, as mandated by the Health Insurance Portability and Accountability Act of 1996. However, OIG remains concerned that the vulnerabilities identified in our UPIN studies, as well as other NPI-specific challenges, may affect the integrity of the new system.

My testimony today provides a brief overview of OIG and our work related to DME.. It then specifically focuses on studies involving the use of UPINs on DME claims. Finally, I will discuss issues to be considered by CMS now that the NPI requirement has been implemented, as well as OIG's future plans to provide oversight on this important issue.

Role and Responsibilities of HHS OIG

HHS OIG was created in 1976 and was the first statutory OIG in the Federal Government. Two years later, the Inspector General Act of 1978 (IG Act) established OIGs at other Cabinet-level departments of the Federal Government, as well as at some independent Government agencies.

Congress created OIGs to be independent and objective units within Federal departments and agencies for the purpose of: (1) conducting audits and investigations of programs and operations; (2) coordinating and recommending policies to promote economy, efficiency, and effectiveness in the administration of programs; (3) preventing and detecting fraud and abuse; and (4) keeping the Department Secretary or Agency Administrator and Congress informed about the necessity for corrective action.

To achieve these objectives, our office reviews departmental programs to identify systemic vulnerabilities and makes recommendations to improve their efficiency and effectiveness; investigates specific instances of fraud, waste, or abuse and takes appropriate enforcement actions; audits specific payments, providers, and programs to identify and recover overpayments; and promotes voluntary compliance by issuing guidance to health care providers and the health care industry.

Although the Medicare program relies on providers to submit accurate and appropriate claims for payment, and the vast majority of providers are honest and trustworthy, provider efforts alone are not sufficient to ensure the integrity of the program. OIG plays a key role in protecting public funds and the health and welfare of beneficiaries. Our effectiveness relies heavily on coordination and cooperation with our law enforcement partners, including the Department of Justice's (DOJ) Civil, Criminal, and Civil Rights Divisions, U.S. Attorneys' Offices, and the Federal Bureau of Investigation (FBI). As the administrator of Medicare, CMS is also a key partner and plays an important role in our efforts to protect the program and its beneficiaries.

Our staff expertise, national presence, organizational structure, and collaboration with law enforcement partners enable OIG to leverage scarce resources to achieve maximum return for the oversight dollars invested. In the 6-month period from October 1, 2007, to March 31, 2008, OIG conducted audits and investigations that resulted in anticipated recoveries of $2.2 billion; exclusions of 1,291 individuals and entities from participation in Federal health care programs; 293 criminal prosecutions for crimes against HHS programs; and 142 civil or administrative monetary recoveries pursuant to False Claims Act cases, unjust enrichment suits, civil money penalty cases and administrative recoveries related to provider self disclosure matters. For fiscal years 2004–2006, our average return on investment was nearly $13 for every $1 in funding.

Each year, to help ensure that we achieve maximum effectiveness and impact, OIG develops a work plan to guide our activities.[1] Although resource constraints preclude us from annually reviewing all 300-plus programs administered by the Department, OIG engages in this comprehensive work-planning process to identify the most important and timely issues for the upcoming fiscal year and to direct our resources accordingly. Among the things that OIG considers in setting its work priorities are findings from previous OIG and external reviews, the size of the program (e.g., expenditures, number of beneficiaries served), specific requests for work from Congress and the Department, the need to revisit program areas with identified vulnerabilities, and the need to review new and emerging issues.

[1] Available online at http://www.oig.hhs.gov/publications/workplan.html.

In addition to our work-planning process, and consistent with the requirements of the IG Act, OIG reports to Congress semiannually on our activities. OIG's semiannual report provides a 6-month summary of OIG's completed work during the reporting period and covers the spectrum of OIG audit, evaluation, and enforcement accomplishments. Each semiannual report identifies significant recommendations described in previous semiannual reports for which corrective action has not been completed. Appendixes to each semiannual report list significant unimplemented recommendations.

Because of the abbreviated nature of the appendixes to the semiannual reports, OIG also issues a "Compendium of Unimplemented Office of Inspector General Recommendations."[2] This document serves as a useful tool for Congress, the Administration, and the Department in their respective efforts to identify ways to contain costs, maximize the effectiveness of programs and services, and improve the efficiency of departmental programs. Implementation of the recommendations in this document could result in substantial savings and increased effectiveness in the operation of the Medicare program.

OIG Work Related to DME

OIG work related to UPINs was undertaken within the broader context of our oversight efforts involving Medicare coverage and payment for DME. Because Medicare's DME benefit has proven to be particularly susceptible to fraud, waste, and abuse, it has been a focal point of a number of OIG activities, initiatives, and recommendations. Medicare Part B expenditures for DME and related supplies totaled more than $10 billion in 2007, of which beneficiaries paid more than $2 billion in the form of copayments and deductibles. OIG evaluations, audits, and investigations have demonstrated that: (1) Medicare pays too much for certain DME and supplies; (2) Medicare pays for some DME claims that do not meet coverage requirements; and (3) a number of DME suppliers have been able to circumvent the existing controls and defraud the program, costing Medicare millions of dollars a year. I will discuss each of these in turn.

Pricing of DME and Related Supplies

OIG's evaluations involving power wheelchairs, hospital beds, diabetic supplies, home oxygen equipment, and inhalation drugs used with nebulizers, among other items, have consistently found that Medicare pays too much for certain pieces of DME and related supplies. In many cases, we have performed additional studies on a subject in an attempt to ensure that our recommendations were implemented and outstanding issues were resolved.

For example, OIG issued its first report on excessive Medicare payments for home oxygen equipment in 1987.[3] We released a second report on the issue in 1991, again

[2] Available online at http://www.oig.hhs.gov/publications/compendium.html.
[3] "Medicare Reimbursement for At-Home Oxygen Care" (OAI-04-87-00017). December 1987.

finding that Medicare paid substantially more than other payers.[4] We revisited the subject of oxygen reimbursement in a 2005 report, which found that Medicare allowances for home oxygen equipment were substantially higher than the Federal Employee Health Benefit program rates.[5] Information from our report was used to reduce Medicare payment rates by an average of 8.6 percent for stationary oxygen equipment and 8.1 percent for portable oxygen equipment. To assess the impact of these changes, in December 2006, OIG released another report, which found that Medicare payment levels for oxygen concentrators were still several times higher than their actual cost.[6]

In addition, OIG issued eight reports between 1996 and 2004 that focused on Medicare payments for inhalation drugs used with nebulizers (e.g., albuterol, ipratropium bromide) that are covered under the DME benefit.[7] We repeatedly found that Medicare reimbursement amounts for these drugs greatly exceeded other pricing points (i.e., Medicaid, supplier acquisition costs, and retail prices), and made numerous recommendations calling for Medicare payments to be lowered. These recommendations were implemented by the new drug reimbursement methodology established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

DME Coverage Requirements

OIG has also performed numerous reviews to determine whether the DME claims paid under Medicare conformed to coverage requirements. For example, in a 2004 evaluation, we sought to determine whether power wheelchair claims met Medicare's coverage and documentation requirements.[8] We found that most of the reviewed claims did not meet Medicare's coverage criteria for the wheelchair that was provided; however, some claims may have met coverage criteria for a less expensive mobility device. For over half of the claims we reviewed, required documentation was missing, incomplete, or dated after the date of service listed on the claim. We recommended that CMS improve compliance with Medicare's coverage criteria for power wheelchairs and suggested several specific steps to help accomplish that goal.

CMS implemented many of OIG's recommendations through its power wheelchair workgroup, which was established to develop a plan of action to ensure that Medicare payments are only made for power wheelchairs that are reasonable and necessary. We recently started another study on power wheelchairs that will determine the effect of CMS's actions.

OIG has also investigated cases in which DME suppliers billed for services not rendered or medically unnecessary services. For example, OIG, in coordination with its partners at

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[4] "Oxygen Concentrator Reimbursement: Medicare and the Department of Veterans Affairs" (OEI-03-91-00711). August 1991.
[5] "Medicare Payment Rates for Home Oxygen Equipment" (OEI-09-03-00160). March 2005.
[6] "Home Oxygen Equipment: Cost and Servicing" (OEI-09-04-00420). December 2006.
[7] For example, see "Update: Excessive Medicare Reimbursement for Albuterol" (OEI-03-03-00510). January 2004, and "Update: Excessive Medicare Reimbursement for Ipratropium Bromide" (OEI-03-03-00520). January 2004.
[8] "Medicare Payments for Power Wheelchairs" (OEI-03-02-00600). April 2004.

the Texas Medicaid Fraud Control Unit and FBI, recently completed an investigation involving inappropriate DME claims submitted by The Scooter Store, Inc. The Government alleged that the company submitted false claims to Medicare and Medicaid for power wheelchairs that beneficiaries did not want, did not need, or could not use; submitted claims for used power wheelchairs, scooters, and accessories as though the equipment were new; submitted claims for power wheelchair accessories that were not ordered by a physician; and improperly induced beneficiaries by promising free mobility equipment. In 2007, The Scooter Store entered into a settlement agreement with the Government to resolve its False Claims Act liability. The Scooter Store agreed to pay $4 million and relinquish its right to approximately $13 million in claims initially denied for payment by CMS. The Scooter Store and its individual owner also agreed to enter into a 5-year corporate integrity agreement.

Controls To Ensure Appropriate DME Payment

OIG has also focused on DME suppliers and, in some cases, ordering physicians, who circumvent existing controls in order to defraud the program. Many of these efforts addressed the three basic controls employed by Medicare to ensure that claims are legitimate. These three controls validate that: (1) the beneficiary is enrolled in the Medicare program; (2) the DME supplier meets the Medicare standards and has received a Medicare billing number; and (3) the DME or supplies have been ordered by a physician or other approved health care practitioner. I will address each of these in more detail below.

OIG Work on Beneficiary and Supplier Controls

Beneficiaries

As part of many DME-related studies, OIG has contacted beneficiaries to gather their experiences with certain pieces of equipment or particular suppliers. We have also analyzed claims data to identify payments made to suppliers for ineligible beneficiaries.

For example, as part of a study published in 2000, we found that Medicare paid $9.2 million in 1997 for DME and related supplies provided after the beneficiary was deceased.[9] We recommended that CMS conduct prepayment edits and postpayment reviews to ensure that payments are not made for these types of claims. In response, CMS created a prepayment edit to deny payments when the beneficiary is deceased. In addition, CMS instructed its contractors to conduct annual postpayment reviews to identify and recover payments for items and services furnished and claimed after a beneficiary's date of death.

Suppliers

DME suppliers must enroll in the Medicare program to sell or rent items to Medicare beneficiaries and, in turn, submit claims to Medicare for reimbursement. Currently,

[9] "Medicare Payments for Services After the Date of Death" (OEI-03-99-00200). March 2000.

DME suppliers must comply with 24 supplier standards to receive and maintain a Medicare billing number. For more than 10 years, OIG has reported on weaknesses in CMS's oversight of DME suppliers' compliance with Medicare's enrollment standards.

In a 1997 report, OIG recommended that CMS conduct site visits of DME suppliers specifically at the time of enrollment in the Medicare program.[10] Subsequently, CMS incorporated initial site visits into the supplier enrollment process. In a second report issued in 2001, we recommended that CMS institute random, unannounced site visits of suppliers in addition to the initial enrollment and reenrollment visits.[11] In response, CMS stated that it would increase site visits to suppliers that did not pass inspection.

We have recently expanded efforts to identify suppliers who were not in compliance with Medicare enrollment standards. In 2005, we conducted out-of-cycle site visits to 169 DME suppliers to determine whether they met the Medicare requirements of maintaining a physical facility and being open to conduct business during posted hours.[12] We found that 10 of these suppliers were not in operation at their business address, yet still billed Medicare almost $393,000 in the 2 months after we had determined they did not maintain facilities at their address of record.

Further, based on evidence of concentrated problems with supplier enrollment in certain areas of the country, we conducted unannounced site visits to 1,581 DME suppliers in South Florida in late 2006.[13] We found that 31 percent of these DME suppliers did not maintain physical facilities or were not open and staffed during their posted business hours. Another 14 percent of suppliers were open and staffed but did not meet additional requirements we reviewed. We recommended several steps that CMS could take to address the concerns highlighted in these reports, including conducting random unannounced site visits, strengthening the provider enrollment process, and limiting the ability of fraudulent suppliers to obtain Medicare billing numbers. In response, CMS implemented a 2-year demonstration project involving the enrollment of DME suppliers into Medicare.[14]

In 2007, OIG expanded its review of supplier enrollment by conducting unannounced site visits to 905 suppliers in Los Angeles County.[15] We found that 13 percent of suppliers did not maintain a physical facility or were not open when we visited, and an additional 9 percent did not meet additional standards we reviewed. We again recommended that CMS strengthen the supplier enrollment process and ensure that suppliers meet Medicare

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[10] "Medical Equipment Suppliers: Assuring Legitimacy" (OEI-04-96-00240). December 1997.
[11] "Medical Equipment Suppliers: Compliance with Medicare Standards" (OEI-04-99-00670). August 2001.
[12] "Medical Equipment Suppliers: Compliance With Medicare Enrollment Requirements" (OEI-04-05-00380). March 2007.
[13] "South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits" (OEI-03-07-00150). March 2007.
[14] Available online at http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/DME%20Fact%20Sheet.pdf.
[15] "Los Angeles County Suppliers' Compliance With Medicare Standards: Results from Unannounced Site Visits" (OEI-09-07-00550). February 2008.

supplier standards. In response to our recommendations, CMS stated that, among other actions, it had increased the frequency of unannounced site visits, begun targeted background checks of suppliers in high-fraud areas, and announced a mandatory accreditation process for DME suppliers.

Recent investigations by OIG, DOJ, and other law enforcement agencies have also identified and pursued enforcement actions against fraudulent DME suppliers. In March 2007, OIG and DOJ formed a Medicare Fraud Strike Force composed of Federal, State, and local investigators to combat the fraudulent activities of medical equipment suppliers in South Florida through the analysis of Medicare billing data. During a 3-month period in 2007, 56 individuals were charged in South Florida with fraudulently billing Medicare more than $258 million. As of March 2008, the Strike Force had brought charges against 120 defendants, resulting in 101 convictions. Our investigation included one case in which a Medicare DME company billed Medicare over $14 million (and paid more than $1 million) for wound care, enteral nutrition products, and wheelchairs that were neither prescribed nor delivered. In this case, certain claims listed two prescribing physicians who were deceased prior to the incorporation of the company.

OIG Work on UPINs and Physician Controls

OIG has conducted evaluations, audits, investigations, and additional data analysis focusing on the ordering physicians listed on DME claims. The Consolidated Omnibus Budget Reconciliation Act of 1985 required CMS to establish UPINs for all physicians who provide services to Medicare beneficiaries. Information on UPINs is stored in a national database known as the UPIN Registry.

Prior to the recent implementation of the NPI, Medicare regulations required DME suppliers to provide the UPIN of the physician who ordered the equipment on the claim form. Medicare relies on physicians and other health care practitioners to act as gatekeepers to ensure that only medically necessary equipment and supplies are ordered. When a DME supplier puts a UPIN (or NPI) in the appropriate field on the claim form, the supplier is indicating that a physician has verified the need for the equipment. In addition, the presence of the UPIN or NPI enables CMS to determine who prescribed the equipment and/or supplies as part of any postpayment reviews.

Payments for DME Claims With Invalid and Inactive UPINs

In conducting our DME-related work, we learned that Medicare claims-processing systems verified only that the UPIN listed on a claim met certain format requirements. Computer system edits were not performed to ensure that the UPIN listed on a claim had been assigned or was active. To assess the impact of this vulnerability, OIG determined the prevalence of invalid and inactive UPINs listed on Medicare claims in 1999, and released a report on the issue in 2001.[16]

[16] "Medical Equipment and Supply Claims With Invalid or Inactive Physician Numbers" (OEI-03-01-00110). November 2001.

We compared the UPINs listed on Medicare DME claims in 1999 to information contained in the UPIN Registry. We then identified Medicare payments for claims for which the listed UPIN was either invalid or inactive on the date of service. An invalid UPIN is one that has never been assigned; an inactive UPIN has been assigned but all the practice settings associated with the UPIN have been deactivated.

We found that Medicare and its beneficiaries paid $32 million for DME claims with invalid UPINs in 1999. One-quarter of the invalid UPINs began with a letter for which no UPINs had ever been issued, meaning that the UPIN could easily be identified as one which was never assigned. Approximately 100 of the invalid UPINs were each associated with more than $50,000 in Medicare DME payments. A single invalid UPIN was listed as the ordering physician by seven different suppliers on $1.1 million in paid Medicare DME claims.

Furthermore, Medicare and its beneficiaries paid an additional $59 million in 1999 for DME claims listing UPINs that were inactive on the date of service. Almost $8 million of this amount involved UPINs for physicians who were deceased prior to the dates of service entered on the claims. Over 30 percent of the inactive UPINs listed on the claims had been inactive for at least 3 years.

Finally, we found that a small number of suppliers accounted for a significant share of the $91 million in Medicare payments for DME claims with invalid or inactive UPINs. One hundred suppliers were reimbursed for $17 million of that total. One supplier was responsible for $1.2 million in Medicare claims, using over 1,700 different invalid or inactive UPINs on medical equipment and supply claims that year. Another supplier had 62 percent of its Medicare reimbursement associated with one invalid UPIN.

To address the issues identified by this report, OIG recommended that CMS: (1) revise claims-processing edits to ensure that UPINs listed on DME claims are valid and active and (2) emphasize to suppliers the importance of using accurate UPINs when submitting claims to Medicare. In responding to our recommendations, CMS indicated that it had developed instructions, system changes, and edits which would reject claims listing a deceased physician's UPIN. CMS also stated that it planned to expand the edits to include all invalid and inactive UPINs. In November 2001 and April 2002, CMS issued instructions to its carriers stating that DME claims listing a deceased physician's UPIN would be denied.[17] We are unaware of any further CMS action taken to address the presence of invalid and inactive UPINs on DME claims. Therefore, we continued to promote our recommendations addressing the invalid and inactive UPIN issue by including them through 2007 in our annual publications listing unimplemented OIG recommendations.[18]

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[17] Available online at http://www.cms.hhs.gov/transmittals/downloads/B0173.pdf and http://www.cms.hhs.gov/Transmittals/downloads/B02024.pdf

[18] "Compendium of Unimplemented Office of Inspector General Recommendations" May 2007, page 21.

Accuracy of the UPIN Registry

To ensure effective edits that prevent payments for DME claims with invalid and inactive UPINs, CMS needs to maintain accurate information in the UPIN Registry. However, in a 1999 report, we found that although CMS had taken steps to enhance the accuracy of UPIN data, some problems still persisted.[19] These problems included UPINs with no recent claim activity still being listed as active, inaccurate physician information in UPIN Registry fields, and format-related issues. Further, in 2002, we issued a report to CMS that noted issues with the physician addresses listed in the UPIN registry that we identified during a study involving Medicare mental health services.[20]

In 2003, OIG issued another report on the accuracy of CMS's UPIN data.[21] For this study, we contacted providers and asked them to verify information contained in the UPIN database for each of their active practice settings. We also reviewed the universe of active UPIN registry records to identify inconsistent, missing, and questionable information.

OIG found that 52 percent of providers listed in the active UPIN database had inaccurate information in at least one of their practice setting records. Seventeen percent of providers no longer billed Medicare from any of the practice settings listed in the active UPIN file. Of that number, 14 percent were deceased, and 26 percent indicated they had retired. Another 9 percent of providers could not be contacted by mail at the addresses listed in the UPIN Registry.

We noted that when information housed in the UPIN Registry is unreliable, CMS's ability to conduct effective oversight is jeopardized. For instance, inaccurate UPIN data limits CMS's ability to identify unusual billing activity, both in the performance of services and the ordering of services, and also inhibits CMS from verifying that sanctions are correctly imposed.

Therefore, OIG recommended that CMS: (1) correct inaccurate and incomplete information in the UPIN Registry and deactivate practice settings that have never been or are no longer used by Medicare providers; (2) review data contained in the UPIN Registry to ensure that they are complete, accurate, and consistent; (3) conduct a review of providers who billed Medicare for Part B services in 2000 but could not be contacted by mail; and (4) review and revise existing UPIN Registry data entry guidelines. CMS concurred with our recommendations and indicated that it was taking steps to correct the issues.

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[19] "Accuracy of Unique Physician Identification Number Data" (OEI-07-98-00410). October 1999.
[20] "Inaccuracies in the Unique Physician Identification Number Registry: Incorrect Addresses for Mental Health Service Providers" (OEI-03-99-00131). May 2002.
[21] "Accuracy of Unique Physician/Practitioner Identification Number Registry Data" (OEI-03-01-00380). May 2002.

Use of Surrogate UPINs

In 2002, OIG issued a report examining the use of surrogate UPINs on DME claims.[22] Under Medicare guidelines, surrogate UPINs are temporary UPINs that may be used until an individual UPIN has been assigned. If the ordering physician for a DME item does not have a permanent UPIN, the supplier must use a surrogate UPIN when submitting the claim. At the time of our review, CMS had established four specific surrogate UPINs, as well as guidelines for their use.

We selected a sample of DME claims from 1999 that listed surrogate UPINs. We found that 61 percent of reviewed claims should have listed a permanent UPIN rather than a surrogate, because the ordering physician had a permanent UPIN at the time the service was provided. Furthermore, nearly half of the DME ordered with a surrogate UPIN (45 percent) had either: (1) no written order or certificate of medical necessity to support the service or (2) a written order or certificate of medical necessity with one or more items missing. Medicare paid an estimated $61 million for these services that year.

We noted that the use of surrogate UPINs on medical equipment claims enables them to be processed automatically whether the equipment has been ordered by a physician or not. If the inappropriate use of surrogate UPINs by suppliers goes unchecked, the Medicare program becomes vulnerable to fraudulent billings and inappropriate payments. Therefore, OIG recommended that CMS: (1) perform targeted reviews of claims for DME ordered with surrogate UPINs and (2) continue to educate suppliers and physicians that accurate UPINs must be used on claims. CMS concurred with OIG's recommendations.

Additional Work on UPINs

OIG has also identified numerous UPINs that were used to order unusually high dollar amounts of DME. For example, in 2006, through the coordinated effort of OIG, DOJ, and others, a South Florida physician pleaded guilty to violating the anti-kickback and false claims statutes. According to the press release issued by the U.S. Attorney's Office for the Southern District of Florida,

> Beginning in approximately April 1999, [the physician] established referral relationships with the owners of numerous medical equipment companies. The owners would bring "patients" to [the physician's] office and specify which types of equipment and medications they wanted her to prescribe. Defendant would conduct a cursory examination of the patients

[22] "Durable Medical Equipment Ordered with Surrogate Physician Identification Numbers" (OEI-03-01-00270). September 2002.

> and then sign the requested prescriptions, regardless of whether they were medically necessary.[23]

The UPIN belonging to this physician was used on almost $8 million in DME claims in 1999. This dollar amount equates to the physician ordering more than $20,000 in DME each day of the year.

In other cases, it is likely that the physician did not know his or her UPIN was being used to order the DME. Our audits of DME suppliers identified several situations in which the physicians whose UPINs were listed on Medicare claims said that they had not ordered the equipment or supplies. In most cases, the physicians had no medical records for these beneficiaries, and/or stated that the beneficiaries were not their patients. The suppliers identified in these audits were then forwarded to OIG's Office of Investigations for further review.

More recently, we have identified additional UPINs that are associated with questionable billing levels in South Florida for inhalation drugs used with DME. According to CMS, its local Miami office has begun to actively monitor UPIN usage and is now working with the physicians, most of whom did not know about the billings, to limit fraudulent claims.

These cases illustrate that using UPINs (or NPIs) as a control to prevent fraud is more complicated than simply performing edits to ensure that the identifier is valid and active. Because UPINs and NPIs are readily available to the public, fraudulent suppliers can easily obtain a valid number from their geographic area and use that number on their DME claims.

National Provider Identifier

The Health Insurance Portability and Accountability Act of 1996 requires issuance of an NPI to each physician, supplier, and other provider of health care. To comply with this requirement, CMS began to accept applications for NPIs on May 23, 2005. Beginning May 23, 2008, the NPI must be used in lieu of legacy provider identifiers, such as supplier numbers and UPINs.

To determine whether CMS addressed the problems identified with invalid and inactive UPINs in the months directly prior to the full implementation of the NPI, we are in the process of analyzing DME claims from 2007. Based on our preliminary analysis and discussions with CMS staff, we have found evidence that issues with invalid and inactive UPINs still existed in 2007, and may be a continuing problem with the NPI. According to CMS documents, edits will be established to verify that the NPI is in the correct format.[24] However, it is unclear whether there will be any edits to identify NPIs that have not been assigned or that correspond to inactive physicians.

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[23] Available online at http://149.101.1.32/usao/fls/PressReleases/060825-03.html.
[24] Available online at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf.

Furthermore, according to a CMS communication published on its Web site and dated June 2, 2008, CMS is temporarily allowing DME suppliers to use their own NPIs rather than the NPIs of the ordering physicians:

> To assist those billing providers, which, after reasonable effort, are still unable to obtain NPIs for secondary providers, Medicare has instituted a temporary measure that allows billing providers to use their own NPI in secondary identifier fields.[25]

The communication does not indicate the date when this policy will be discontinued. However, as long as DME suppliers are allowed to enter their own NPIs rather than the NPIs of the ordering physicians, a major control for preventing fraud, waste, and abuse will not exist.

Because of our concerns with various aspects of the NPI, OIG is planning additional studies on the subject. Therefore, we expect to conduct several evaluations on the NPI during fiscal year 2009.

Conclusion

OIG has devoted considerable resources to identifying fraud, waste, and abuse involving DME claims. From large-scale reviews involving supplier site visits to data analysis involving the UPINs listed on DME claims, OIG has worked to safeguard taxpayer dollars and protect Medicare and its beneficiaries. OIG will continue to focus its attention on the integrity of Medicare payments for DME, make recommendations to resolve potential vulnerabilities, and conduct targeted follow-up work as warranted.

One of the best ways to combat fraud, waste, and abuse is to ensure that the safeguards put in place to protect the program are operating effectively. One such safeguard, the requirement that an identifier for the physician ordering the equipment be listed on the claim, can be bolstered through the appropriate use of prepayment edits. However, despite our earlier recommendations, CMS never implemented edits that would ensure that the UPINs listed on DME claims were valid and active. As a result, we remain concerned that the vulnerabilities highlighted by our earlier work, as well as new challenges, may affect the integrity of the NPI system.

Unfortunately, edits like those we previously recommended will not completely prevent fraud, waste, and abuse. As our work has shown, some suppliers will use valid identifiers (often without the physicians' knowledge) when submitting their claims. In those cases, CMS must work to identify cases when there are spikes in the use of a particular NPI, when the NPI is consistently associated with an aberrant number of claims, or when the NPI used on claims is not in the geographic vicinity of the beneficiary. These postpayment reviews would require not only data analysis, but also outreach to the physicians whose NPIs are being abused. To that end, OIG is available to assist CMS in

[25] Available online at http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp.

monitoring the use of NPIs on DME claims as well as developing effective methods for increasing the awareness of NPI-related issues among the supplier and physician community.

This concludes my statement. Thank you for the opportunity to testify today. I would be pleased to answer your questions.

Statement of Bill Gray, Deputy Commissioner of Systems
Social Security Administration

Testimony before
the Permanent Subcommittee on Investigations of the
Senate Committee on Homeland Security and Governmental Affairs
on
Medicare Payments for Claims with Identification Numbers of
Dead Doctors

July 9, 2008

Chairman Levin and Members of the Subcommittee:

Thank you for inviting me to appear before you today to discuss the Social Security Administration's (SSA) collection, maintenance, and distribution of death information. You have asked us to address two questions: 1) How can we provide death records information regarding medical providers on a timely and regular basis to the Centers for Medicare and Medicaid Services (CMS); and, 2) What, if anything, do we need to facilitate the sharing of death records information with CMS?

However, before I explain what, how, and when we provide death information to CMS, I would like to briefly describe who we are and what we do.

Mission and Work of SSA

We administer the Nation's social insurance program and one of the Nation's largest means-tested income maintenance programs. Each year we send benefits totaling about $650 billion to almost 60 million individuals.

Through the Old-Age, Survivors, and Disability Insurance program, we provide benefits to workers and their dependents and survivors at critical junctures in their lives: when they retire, when they become disabled, and when the family's wage-earner dies.

We also administer the Supplemental Security Income (SSI) program, which assists the most vulnerable in our society. These payments are a safety net for those persons with little or no income or resources. The elderly, the blind, and the disabled, including children, rely upon SSI to meet their basic needs.

In addition, we have a number of other responsibilities that are vitally important to the Nation, but are not directly connected to our core mission, including many workloads for other agencies' programs, such as Medicare, Medicaid, E-Verify, Black Lung, Railroad Retirement, and Food Stamps. We participate in many data exchanges, including transmission of death information, with other Federal and State agencies as allowed by law. We recognize that providing this data is useful and important; however, performing these additional services directly affects our ability to carry out our core mission and responsibilities to the American people.

Death Information Collection

Now, I would like to provide background information on the death information that we collect and maintain in our records. We use death information to determine continuing eligibility for benefits, as a lead to develop possible entitlement to benefits, and for other program and integrity purposes.

We receive approximately 2.5 million death reports each year from many sources. We receive 90 percent of the reports from family members and funeral homes, with the remainder coming from States and other Federal agencies through data exchanges and reports from postal authorities and financial institutions. Almost 90 percent of deaths are reported and posted to our records within 30 days of death. We match these death reports against our payment records to stop the benefits of those who are deceased and as a lead to develop possible entitlement to benefits for surviving family members. We annotate the reported death on our master Social Security and SSI payment records for beneficiaries. We also enter the information on the Social Security Number (SSN) record file, known as the NUMIDENT, for both beneficiaries and non-beneficiaries.

Because of the proven accuracy of reports from family members and funeral homes, we do not have to verify these reports, but take immediate action to terminate benefits. However, in most instances, we verify all other reports, such as those reports received from financial institutions, postal authorities and other data exchanges, before we post beneficiaries' deaths to our payment records and terminate their benefits. We verify death reports by contacting another source—usually someone in the beneficiary's home, a representative payee, a nursing home, a doctor, or hospital—to confirm that the person is deceased and, if the date of death is an issue, to corroborate the reported date of death.

We do not verify death reports of persons not receiving Social Security or SSI; however, we do annotate the death information on our NUMIDENT. It would be difficult for us to verify these records since we do not have address or other identifying information for these individuals in our records.

The death data that we maintain is 99.5 percent accurate overall. As with any process, there are occasional errors, but to the best of our knowledge, no case of fraud or abuse has occurred as a result of errors in the Death Master File.

Electronic Death Registration

We are working with States who want, and are able, to build a streamlined death registration process, known as Electronic Death Registration (EDR). The EDR will replace the States' more cumbersome and labor-intensive process through which we currently receive death information. This streamlined electronic process allows States to transmit to us more accurate and timely death reports. Through this system, we receive verified death reports within 5 days of the individual's death and within 24 hours after the State receives it. We can take immediate action to terminate benefits on these cases. EDR transactions are virtually error free, and our systems automatically stop benefits without employee intervention.

EDR has slowly expanded on a state-by-state basis over the past 4 years, and currently 22 States, the City of New York, and the District of Columbia participate in this initiative. If all States participated in EDR, future death reporting would be virtually error free. The Nationwide roll-out of EDR is contingent on congressional funding of the Department of Health and Human Services so that it can fund the state grants.

Death Master File (DMF)

In addition to annotating an individual's death on our records, we also maintain a national file of death information, known as the Death Master File or DMF. This file is an extract of the death information from our NUMIDENT.

We create different versions of the DMF because the States have the authority to limit SSA's redisclosure of their death records. Twenty-seven States, the District of Columbia, and the City of New York restrict redisclosure of their death data. However, once we verify death reports

received from the States, the State data then becomes our data, and we can redisclose it regardless of the originating State's redisclosure policy.

As of June 2008, the full DMF, which includes the public death data as well as the restricted and unrestricted State death data, contained approximately 85.6 million records. The full DMF includes both the verified and unverified reports of death for Social Security beneficiaries and non-beneficiaries. If available in our records, the DMF contains the deceased individual's SSN, first name, middle name, surname, date of death, date of birth, state, county, and zip code of the last address on our records.

Many Federal agencies, State and local governments, and the private sector use the DMF to prevent fraud, waste, and abuse. Some entities may have access to only the public death data, whereas others may have access to all death data, including the restricted and unrestricted State death data. Generally, we are reimbursed for the cost of providing this information.

As I noted, our death data is over 99.5 percent accurate. While there are occasional errors, we are not aware of any cases of fraud or abuse that have occurred as a result of errors in the DMF. We will continue to release the DMF to facilitate private and public organizations' ability to prevent fraud, abuse, and billions of dollars in erroneous payments.

Death Information in SSA Electronic Data Exchanges

In addition to the DMF, we have an electronic data exchange, known as the State Verification and Exchange System (SVES), with all States and a large number of Federal agencies, including CMS. The SVES is an overnight batch query process that matches against our NUMIDENT and beneficiary records. Using the SVES, requesters may ensure, among other things, that Federal benefits are not paid to deceased individuals. We also offer an online version of SVES, known as State On-Line Query (SOLQ). SOLQ allows authorized agencies real-time access to the SSN verification service and, if permitted, access to certain beneficiary data.

While SVES is a batch system that processes multiple requests overnight, SOLQ is a direct query process that allows an authorized user to submit an individual request and provides an immediate response to the user.

Sharing SSA Death Data with CMS

Now that I have explained how SSA collects and uses death information and the ways in which SSA shares death information with other entities, I would like to summarize the three different methods we use for sharing death information with CMS:

- We provide the "public version" of the DMF to CMS via a direct electronic connection. As noted above, this version includes SSA death data, but does not include any State death data. We first provided this version to CMS in its entirety in 2001, and we now provide weekly updates. In total, this version currently contains approximately 82.4 million records.

- CMS uses our SVES. We have provided this access on a daily basis since 2000. Through SVES, we provide CMS not only the information contained in the "public" DMF, but also the unrestricted State death data, which includes the date of death, and an indicator for restricted State death data. This means that CMS has access to all 85.6 million death records. Annually, we respond to approximately 2 million requests from CMS through SVES.

- CMS also has access to our SOLQ. We have provided this access on a daily basis since the early 2000s. Through SOLQ, we currently provide real-time online access to the same information and number of death records as provided under SVES. Annually, we respond to approximately 1.1 million requests from CMS through SOLQ.

You have also asked what we might need to facilitate the sharing of our death records with CMS. As I have described, we have the authority to provide CMS with the information it needs in a timely way. And, as I also mentioned earlier, generally, SSA must be reimbursed for the expense we incur in sharing death data. In addition, the efficiency and accuracy of death data we are able to provide would be improved if every State had the necessary funding to implement the EDR initiative.

Conclusion

Thank you for the opportunity to discuss how we collect and distribute death information for our own and other programs' purposes. This data is vital to maintaining and assuring the integrity of Federal programs and protecting taxpayer funds. We have described how we assist these efforts to combat fraud against the people of the United States. As with our

existing data sharing agreements, we would require reimbursement to SSA for these workloads. That said, we are certainly willing to work with this Subcommittee and to keep working with CMS to make sure that it continues to be provided accurate and timely death information.

I will be glad to answer any questions.

Follow-Up to the July 9, 2008 Hearing
"Medicare Payments for Claims with Identification Numbers of Dead Doctors"
Before the Senate Homeland Security and Governmental Affairs Committee
Permanent Subcommittee on Investigations

August 19, 2008

Thank you for giving the Centers for Medicare & Medicaid Services (CMS) the opportunity to testify before the Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations regarding "Medicare Payments for Claims with Identification Numbers of Dead Doctors" on July 9, 2008.

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding CMS programs are greater than ever. We are continually considering initiatives to improve program integrity within Medicare and look forward to continued work with the Subcommittee to further strengthen our stewardship of the Medicare trust funds. With that in mind, as follow-up to the hearing, we are providing below additional information regarding (1) Medicare claims processing and fee-for-service (FFS) administrative contracting; as well as (2) CMS efforts to combating fraud and reduce improper payments in Medicare.

I. Medicare Claims Processing and Contracting

Claims Processing
CMS is among the most efficient FFS health insurance administrators. Through Medicare FFS claims administration contractors, CMS processes and pays over 1.1 billion Medicare claims a year at a cost of less than a dollar per claim. In addition, over 99 percent of CMS claims are paid within 30 days, well above the legislatively-mandated standard of 95 percent. The Medicare FFS error rate is under 4 percent. The volume and unit costs from 2000-2007 are as follows:

	FY 2000 Actual	FY 2001 Actual	FY 2002 Actual	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual
Claims Volumes (in millions)								
Part A	150.8	158.6	166.9	170.6	179.2	185.6	185.9	185.7
Part B	740.2	772.0	836.7	881.9	949.7	979.9	991.5	959.4
								1145.1
Unit Costs								
Part A	0.86	0.86	0.86	0.90	0.93	0.96	0.96	0.93
Part B	0.63	0.61	0.60	0.61	0.63	0.64	0.64	0.51

The recent Subcommittee analysis focused on claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These claims are reimbursed under Medicare Part B, and typically account for about 5-6 percent of the annual Part B claims volume. CMS is eager to review the Subcommittee's analysis and results to respond more directly to the Subcommittee's findings, though we have not yet received this information.

Permanent Subcommittee on Investigations
EXHIBIT #1

Medicare Contracting Reform
CMS has long sought additional contracting authorities to help improve performance accountability in our claims administration contractors. The original 1965 Medicare legislation placed limitations on the types of entities who could perform Medicare claims administration activities, which Congress amended through the enactment of Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which began to be utilized in Medicare contracting in 2006. Once fully implemented, the provisions in this section of the MMA will bring these critical Medicare claims processing contracts into alignment with provisions in the Federal Acquisition Regulations (FAR) that guide federal contracting practices related to full and open competition and performance management.

Medicare Contracting Reform (Section 911 of the MMA) allows CMS to utilize full and open competition to select claims administration contractors, as well as provide the opportunity for successful and high-performing contractors to earn a modest profit. Competition helps ensure that the Government is getting the best value in its contracting, balancing price and performance. Congress ensured that the competitive spirit would remain as an incentive for companies to perform well at a good price by requiring CMS to compete the FFS contracts every five years. The profit these contractors, known as Medicare Administrative Contractors (MACs), can earn is negotiated and divided between a base fee (profit awarded for meeting contract requirements) and award fee (profit that is earned, based on criteria for excellent performance and innovation).

CMS is in the midst of implementing contracting reform. CMS awarded and implemented the first of the new contracts during 2006. At present, CMS has awarded about one-half of its Medicare FFS workload to MACs and expects to award the remainder to MACs by the end of 2008; following a transition period, the new contracts will be fully implemented before the end of 2010.

Contractor Accountability
There are many ways CMS holds its claims administration contractors – carriers and fiscal intermediaries (contractors under the old contracting authority) as well as MACs – accountable for performance, including accurate claim payments. Carriers and fiscal intermediaries are reviewed annually by CMS through the application of a variety of evaluation protocols, including onsite visits and evaluations, SAS-70 reviews, and OMB Circular A-123 reviews. In addition, claims administration contractors are scored under the Contractor Error Rate Testing (CERT) program, wherein claims are sampled by an independent entity which assesses the accuracy of the payment through reviews of medical documentation. Additional performance monitoring occurs throughout the year by agency staff. When necessary, CMS can require that the contractor submit a corrective action plan (CAP) for any areas where their performance has been lacking, and subsequently, CMS monitors the contractors' adherence to and success of the CAP. CMS issues an annual Report of Contractor Performance for all contractors, which CMS uses as a critical record of past performance that is taken into consideration when CMS selects winning bidders for new MAC contracts.

Prior to mid-2006, the DME Regional Carriers (DMERCs) processed and paid all DMEPOS claims. However, CMS chose to compete DMEPOS claims administration contracts as the first

under the new contracting authority contained in MMA Section 911, ultimately awarding four new DME MACs that are now fully operational. As mentioned above, the MMA gave CMS additional ways to hold MACs accountable and provide incentives for good performance, including:

- CMS requires all MACs to create a Quality Control Plan, which documents the contractor's processes to ensure not only that they implement "quality processes," but also monitor themselves to ensure they are meeting contract requirements. CMS approves this individualized Plan and conducts onsite audits at the MACs to ensure they are adhering to their approved Plan.
- CMS evaluates key performance requirements annually for every MAC. Many of these evaluations occur onsite.
- CMS manages a rigorous award fee plan program, rewarding contractors for exceeding contract requirements. For implemented MAC contracts, CMS has seen marked improvement in criteria from one award fee period to another, demonstrating that the award fee plan program is an effective way to focus contractors on excellence.
- CMS and HHS, working with the Office of Management and Budget (OMB), are piloting the use of the Medicare claims payment error rate as one key determinant of the award fee for which a contractor may qualify. This metric is currently in the A/B MAC Jurisdiction 3 award fee plan, covering the states of North Dakota, South Dakota, Utah, Arizona, Montana and Wyoming, and providing increasing rewards for lower and lower scored error rates. The first evaluation and potential award will occur with the official November 2008 error rate report.

CMS is committed not only to ensuring acceptable contract performance, but providing incentives for superior performance from our contractors.

Contract Types and Authorities

Before CMS began implementing Medicare Contracting Reform in the middle of 2006, special provisions in Title XVIII of the Social Security Act governed CMS contracting with Medicare FFS claims administration contractors. All of the contracts were "pure" cost-reimbursement contracts, meaning that contractors were reimbursed only for their costs of performing work on the government's behalf; the contractors did not earn profit or bonuses. These contractors include carriers, fiscal intermediaries, and DMERCs. Since CMS is in the midst of fully implementing Contracting Reform, some of these contractors still provide some claims processing services under the old cost-reimbursement structure.

Accordingly, to the extent that the apparent mis-payments of concern to the Subcommittee in this recent investigation occurred prior to mid-2006, the DMERCs that processed these claims were under the old contracting authority and received no profit margin for their claims processing work.

Under Medicare Contracting Reform, CMS is now able to award contracts governed by FAR. With careful examination of the type of work and the circumstances under which it is performed (e.g., operating in an ever-changing environment, with quick implementations brought about by legislative changes in the structure and provisions of the Medicare benefit), CMS' contracting

office has determined that the appropriate MAC contract type under the FAR is Cost-Plus-Award-Fee. This type of contract also reimburses the contractor for all costs, but allows the contractor to earn a small profit (generally no more than 5 percent of the value of the contract). Further, some of this profit can only be earned for exceptional performance, based on criteria CMS establishes. CMS fully intends to consider contractor payment errors in making contractor award fee determinations.

Performance Penalties
The Subcommittee has asked whether CMS would recover penalties (or the cost of the overpayment) from contractors who pay fraudulent claims associated with dead physicians. The Subcommittee has also asked whether CMS's future contracts will deny payment to contractors who process claims associated with deceased physicians.

The Medicare claims processing environment is very complex because the health care delivery system is very complex. As an example, all claims or even a majority of claims involving services referred or ordered by deceased physicians are not automatically invalid – there are many legitimate scenarios whereby a claim could show a deceased physician's number in the ordering or referring field for a period of time (see Technical Note Section below). Given that the Medicare claims processing environment is so complex, from the inception of the program and continuing even into the new MAC contracting environment, the Congress has determined that Medicare claims processing contractors cannot be held liable for individual claims processing errors. Under the former contracting authority that was in place prior to enactment of the MMA, some federal courts even held that Medicare contractors had statutory immunity for their claims processing activities. Post-MMA, in accordance with Section 1874A (d) of the Social Security Act, the MACs cannot be held liable for their claims processing activities unless their payment conduct meets the legal standard for "reckless disregard" or fraud. While very few situations meet this test, CMS pursues overpayment recoveries from the provider or DMEPOS supplier involved when appropriate.

As mentioned above, current Contracting Reform initiatives allow CMS to establish performance standards for accurate claims payment based on achieving Government Performance and Results Act goals established for the CERT program, and CMS is beginning to provide parts of eligible payments to contractors (award fee) for superior error rate achievement.

CMS is also able to ensure poor performers are held accountable: not only does MMA Section 911 require that CMS re-compete claims processing contracts every five years, CMS may non-renew any contract year to year. This means that every contractor must ensure it remains the best value to the government (good performance, lowest cost) or it will lose its business with Medicare.

Technical Notes
As mentioned above, CMS is eager to review the Subcommittee's analysis and results in detail regarding the asserted inappropriate DMEPOS claims payments. Payment for equipment that was ordered by a legitimate, living physician for a Medicare beneficiary would likely be appropriate, even if the physician died before the equipment was delivered or before the equipment is no longer needed. In the Medicare program, many types of DMEPOS are paid

through monthly rental payments. Rental payments, payments for maintenance, service, and repair of equipment may occur for many months after the initial order. Even if a physician died after ordering this equipment, in many cases it would continue to be appropriate for Medicare to pay for claims related to the approved item for the beneficiary.

It should also be noted that this issue – that a physician dies shortly after making a referral or ordering a laboratory service – could apply to many different types of ordered Medicare services – not just DMEPOS –without automatically invalidating the underlying claims. Approximately 10 percent of Americans die between the ages of 30 and 60, which is the age range for most practicing physicians. As the physician community numbers several hundred thousand, presumably it would not be uncommon for physicians to make valid referrals or issue valid prescriptions shortly before an unanticipated death.

The Medicare claims processing contractors, including the contractors that process DMEPOS claims, utilize standard systems furnished by CMS. These systems include robust claims editing capabilities, but of course, the systems do not and cannot address all potential claims processing situations. Moreover, the proper computer systems edits cannot be stronger or more effective than the program databases against which they edit. In regard to the Subcommittee's issue, at this time CMS provides data to the contractors on deceased physicians based on a file received from the American Medical Association (AMA), although that process will change with the new inter-agency agreement that CMS has entered into with the Social Security Administration. As is the case with all files, the data on deceased physicians is not automatically captured on a real-time basis. Clearly, CMS cannot hold contractors accountable in situations where the contractor's activities were constrained by the capabilities of CMS's systems or limitations in the AMA data that are passed through to them by CMS. CMS desires to conduct an analysis of whether any of these issues played a role in the apparent mis-payments identified by the Subcommittee, so that the true level of contractor-sourced errors may be determined. In order to do so, CMS has requested the Subcommittee's underlying analysis and results regarding the asserted inappropriate DMEPOS payments.

Provider & Supplier Accountability

The Subcommittee (in particular, Senator Coburn) asked for information about sanctions imposed on providers and suppliers who submitted claims to CMS associated with dead physician NPI or UPIN identifiers. As noted previously, CMS is eager to review the Subcommittee's analysis and results in detail regarding the asserted inappropriate DMEPOS claims payments. Payment for equipment that was ordered by a legitimate, living physician may continue to be appropriate, even if the physician died before the equipment was delivered to the Medicare beneficiary or before the equipment is no longer needed by the Medicare beneficiary.

CMS has not specifically focused on the underlying reasons why suppliers or physicians may have been sanctioned and will need more information on specific claims that the Subcommittee considered in order to respond to this particular question. However, the following information is available on suppliers and physicians whose participation in the Medicare program has ended in recent years.

	Deactivations	Revocations
FY 2003:	18,067	585
FY 2004:	16,071	1,403
FY 2005:	12,989	711
FY 2006:	12,292	1,037
FY 2007:	17,623	1,297
FY 2008:	11,614	1,259 (thru May 2008)

CMS shares the Subcommittee's interest in establishing a payment environment that stops fraud before it occurs, however, it is a challenge to "put an automatic hold on claims with fraudulent data," as suggested by Subcommittee members, because in many cases there is no way of knowing that the data a provider submits is fraudulent. CMS contractors use system edits that are programmed to catch potential claim submission errors and fraudulent activities, but these systems are not foolproof. However, other edits in place have accounted for a significant savings to the Medicare Trust Funds. (see below)

II. Combating Fraud and Reducing Improper Payments in Medicare

CMS Efforts to Combat Fraud and Related Convictions
As we carry out our obligations, we have undertaken several effective efforts to combat waste, fraud and abuse in this $430 billion program. Our efforts have saved Medicare – and the American taxpayers – more than $22 billion in just the last two years. CMS, the Agency within HHS that is the department's first line of defense against Medicare abuse, has implemented a number of programs over the past 3 years that have achieved remarkable success. For example we:

- Decreased the number of fraudulent DME suppliers by 50 percent over the past year, with over 1,000 of the revocations occurring in fraud hot spots of South Florida and Los Angeles.

- Implemented a new overpayment recovery program, which during a three state pilot over the past three years returned nearly $1 billion to the Medicare program.

- Worked with local authorities in California to indict 12 fraudulent Medicare providers who were also state tax cheats with returns to the state and Medicare program of over $20 million. There are an addition 50 providers identified as part of this program and the projected savings are in excess of $100 million. This program was so successful that other local jurisdictions are partnering with Medicare to root out these wrong-doers.

- In high risk areas like Florida, where steps have been taken to control fraudulent infusion therapy activities, corrective actions have resulted in denial of fraudulent and medically unnecessary Medicare infusion claims in excess of $1.8 billion in 2005 and 2006.

- Working with local authorities, we shut down a particularly abuse Medicare Advantage plan, which was providing clinically insufficient services and defrauding Medicare.

- Collaborative efforts between the Miami Field Office and CMS' program safeguard contractor to put in place auto-denials for preferred providers for claims submitted by specific DME suppliers or high ordering physicians have resulted in year to date savings of nearly $120 million thus far in 2008.

- Data analysis by a CMS program safeguard contractor helped identify aberrant billing by an Oklahoma provider and resulted in that provider being indicted by a federal grand jury on 51 counts of illegally dispensing controlled dangerous prescription drugs, one count of health care fraud and one count of falsifying patient records. The indictment alleges that the provider, during 2006 and 2007, illegally dispensed more than 4,500 tablets, including narcotics, stimulants and tranquilizers, "outside the usual course of his medical practice and without legitimate medical purposes" to four individuals, one of whom was an undercover investigator with the Oklahoma State Board of Medical Licensure.

- A joint initiative between the Los Angeles Field Office and CMS' program safeguard contractor has resulted in 850 investigations pertaining to suspected fraud involving

DME suppliers in Southern California which have resulted in administration actions such as revocations, suspensions, overpayments or pre-payment edit. Others have been referred to law enforcement for potential prosecution as part of the law enforcement strike force formed in March 2008. These cases consist of suspected blatant fraud, and dollar losses to the Medicare program exceeded $500 million. The aggressive administrative actions taken as a result of this initiative have resulted in savings to the Medicare program in excess of $1 billion.

- CMS is working collaboratively with the U.S. Department of Health & Human Services, Office of the Inspector General (OIG), and the Department of Justice through Strike Forces and CMS Field Offices in Miami and in Los Angeles to crack down on fraudulent and criminal activities in the Medicare program. These partnership efforts have resulted in several criminal cases, convictions, and plea bargain agreements.

  At the August 20, 2007, joint HHS/DOJ press conference announcing the Infusion Demonstration program, the US Attorney's Office, Southern District of FL announced the filing of 20 criminal cases against 42 defendants:

  (1) United States vs. Frantz Achille, No. 06-20496-CR
  (2) United States vs. Onelio Baez, et al., No. 05-20849-CR
  (3) United States vs. Gregory Delatour, No. 06-20029-CR
  (4) United States vs. Pedro Diaz, et al., No. 05-20869-CR
  (5) United States vs. Luis Manuel Fernandez, et al., No. 06-20322-CR
  (6) United States vs. Magda Lavin, No. 05-20814-CR
  (7) United States vs. Thaiz Parra, et al., No. 06-60167-CR
  (8) United States vs. Isaac Nosovsky, et al., No. 06-20178-CR
  (9) United States vs. Rafael Walled, No. 06-20030-CR
  (10) United States vs. Rosa Walled, No. 06-20031-CR
  (11) United States vs. Cesar Romero, No. 06-20740-CR
  (12) United States vs. Arnold Garcia, et al., No. 07-20057-CR
  (13) United States vs. Luis G. Henriquez Delgado, No. 07-20180-CR
  (14) United States vs. Jose Prieto, et al., No. 07-20177-CR
  (15) United States vs. Leider Alexis Munoz, No. 07-20225-CR
  (16) United States vs. Jorge Luis Mocega, et al., No. 07-20419-CR
  (17) United States vs. Orestes Alvarez-Jacinto, MD, No. 07-20420-CR
  (18) United States vs. Lester Miranda, et al., No. 07-20612-CR
  (19) United States vs. Rupert Francis, No. 07-20631-CR
  (20) United States vs. Rita Campos Ramirez, No 07-20633-CR (1)

- The Medicare Fraud Strike Force, a multi-agency group begun in March 2007 in Miami, has brought 120 criminal and civil cases against more than 200 defendants. The total fraud involved in the South Florida cases amounts to over $638 million.

Improper Payments reporting and future goals for reducing Improper Payments
CMS is firmly committed to ensuring the highest measures of financial accountability to the American people and our improper payment activities have helped focus our efforts to strengthen CMS' stewardship over taxpayer dollars. With the size and scope of CMS programs and the limited resources available to combat fraud, we know that it is critical to prioritize and be aggressive in our activities to identify and take action to reduce improper payments.
As required under the Improper Payments Information Act of 2002 (IPIA) (P.L. 107-300) and related guidance issued by OMB, CMS implemented methodologies to estimate improper payments for our programs: Medicare, Medicaid and SCHIP.

As part of HHS' FY 2007 Agency Financial Report, CMS reported a Medicare fee-for-service program error rate of 3.9 percent, a significant decrease from the 5.2 percent reported in 2005, and a reduction of greater than 50 percent from the 10.1 percent rate reported in FY 2004. This is a cumulative savings to Medicare and the taxpayers of over $10 billion. With continued monitoring and error reducing efforts our goal is to achieve an error rate of 3.8 percent in 2008 and 3.7 percent by 2009.

In addition to the Medicare FFS program, CMS initiated programs to measure and report on improper payments in the Medicare Advantage or the Medicare Prescription Drug Benefit Programs (also referred to as Medicare Part C and Medicare Part D, respectively). In FY 2007, the CMS prepared a Part C Risk Assessment and a Part D Risk Assessment. CMS also measured a component rate for Medicare Advantage and the Medicare Prescription Drug Benefit programs. CMS provided an estimate of the payment system calculation discrepancy rate. Each of these programs reported less than a one percent component rate. CMS is expanding its payment error rate component reporting for Medicare Advantage and the Medicare Prescription Drug programs in the FY 2008 Performance & Accountability Report (PAR) or its equivalent. Once a baseline error rate is established CMS will report targets and continue to implement an Improper Payments Information Act compliant program.

Our Medicaid error rate program is also underway. From FY 2002 – FY 2005, CMS conducted Medicaid payment error measurement pilot projects and collaborated with States to determine a systematic means of measuring payment error rates at the State and national levels. In FY 2007, CMS measured and reported a preliminary national Medicaid FFS error rate for FY 2006 claims in 17 states based on medical review and data processing reviews. CMS is in the process of completing the error rate measure for the FY 2006 claims and will report the full-year Medicaid FFS rate in the FY 2008 PAR or its equivalent. In addition, CMS expects to report a comprehensive error rate for both the Medicaid and the SCHIP programs based on FY 2007 data. The comprehensive measurement will include measuring the FFS, managed care, and eligibility components for both the Medicaid program and SCHIP.

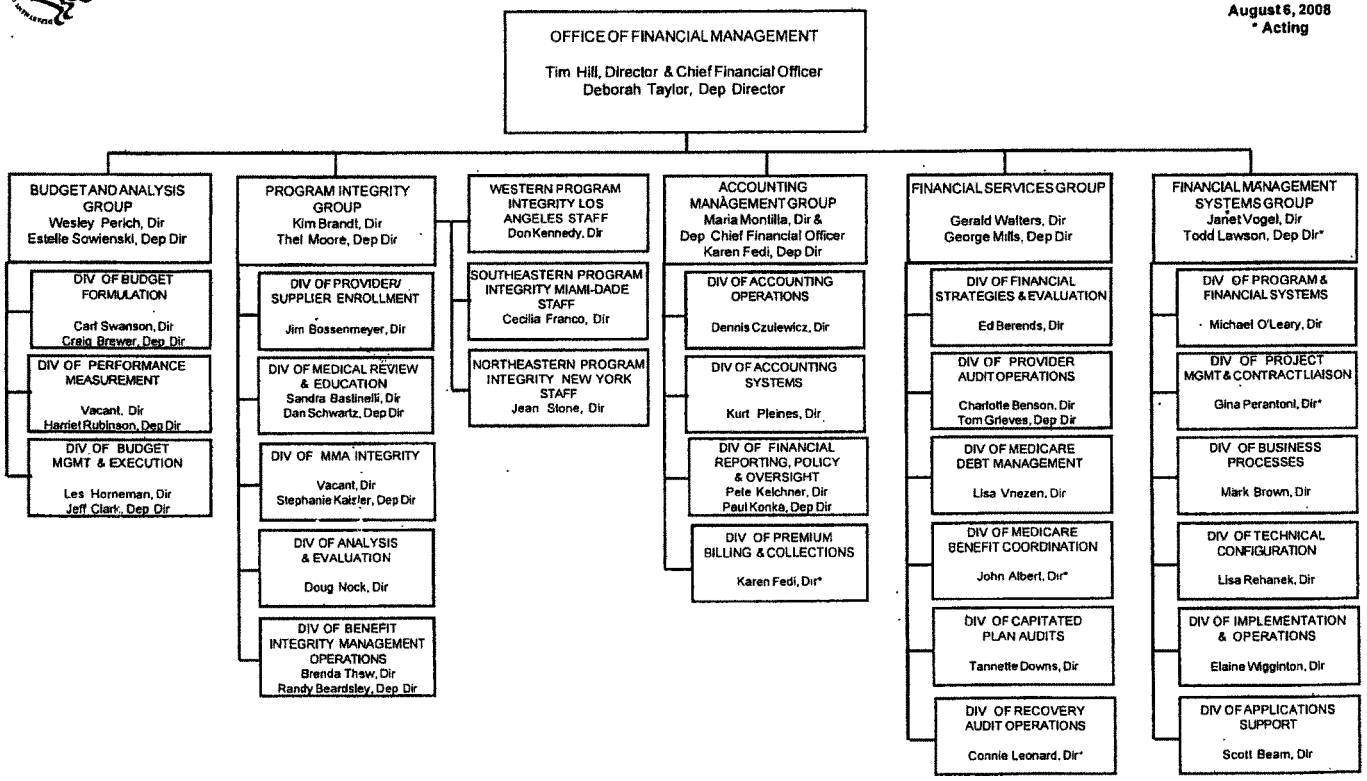
Under the President's Management Agenda improper payments initiative, Federal agencies are mobilizing people, resources, and technology to identify improper payments in high risk programs, establishing aggressive improvement targets, and implementing corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is firmly committed to ensuring the highest measure of accountability within our programs. Unfortunately, since

funding for these activities was capped in 2003, CMS has sustained an approximately $90 million inflationary loss to our purchasing power that has seriously degraded the Agency's ability to meet ongoing challenges. Thus, to preserve CMS' commitment to program integrity, the President's FY 2009 budget requests $198 million in discretionary Health Care Fraud & Abuse Control funding to build upon programs with a proven record for accountability. We believe that without these additional resources to keep pace with inflation, CMS will be unable to devote needed payment error prevention and anti-fraud efforts to an ever expanding program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP

As of August 6, 2008
*** Acting**



United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Homeland Security and Governmental Affairs
Carl Levin, Chairman
Norm Coleman, Ranking Minority Member

MEDICARE VULNERABILITIES: PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

STAFF REPORT

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

RELEASED IN CONJUNCTION WITH THE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
JULY 9, 2008 HEARING

Permanent Subcommittee on Investigations
EXHIBIT #2

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PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
STAFF REPORT
MEDICARE VULNERABILITIES:
PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

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MEDICARE VULNERABILITIES: PAYMENTS FOR CLAIMS TIED TO DECEASED DOCTORS

July 9, 2008

I. INTRODUCTION

The Medicare program was created to provide health insurance for the elderly and the disabled. In 2007, Medicare paid more than $400 billion to cover more than 43 million beneficiaries.[1] Despite its noble intentions, the Medicare program has faced a pervasive and persistent problem with fraud and abuse. In its fiscal year 2005 performance and accountability report, the Department of Health and Human Services (HHS) reported that Medicare paid an estimated $12.1 billion in improper payments for claims in 2005 and an estimated $21.7 billion in 2004. Since 1990, the Government Accountability Office (GAO) has consistently designated the Medicare program as high risk for fraud, waste, and abuse, because of its size, complexity, and vulnerability to mismanagement and improper payments.[2]

Abuses particularly plague the Medicare Part B program, which pays for certain medical equipment and supplies – commonly called durable medical equipment (DME) or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – for eligible beneficiaries. According to the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Medicare program, abuses related to DME claims cost billions of dollars each year.[3] On March 8, 2007, the Chief Financial Officer of CMS testified before a Congressional committee that "[t]he fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics and supplies suppliers continue to cost the Medicare program billions of dollars."[4] In 2007, GAO reported that CMS estimated that Medicare made improper payments based on mistakes, abuse, or fraud totaling approximately $700 million for DME supplies in one year alone.

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[1] 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at page 2.

[2] GAO-07-310, High-Risk Series: An Update, January 2007.

[3] Testimony of CMS Chief Financial Officer Timothy B. Hill before the House Ways and Means Subcommittees on Health and Oversight, March 8, 2007. The Centers for Medicare and Medicaid Services was formerly called the Health Care Financing Administration (HCFA). The name was changed in 2001.

[4] *Id.*

According to GAO, these types of payments represented approximately 7.5 percent of total payments made for DME items.[5]

In light of reports of abuses in the Medicare program, the U.S. Senate Permanent Subcommittee on Investigations (the Subcommittee) initiated an investigation into fraud, waste, and abuse in Medicare, with a particular focus on DME claims. The Subcommittee's inquiry is also examining the efficacy of efforts to identify and prevent such abuses by CMS and its contractors. The Subcommittee's investigation has included a detailed examination of data concerning millions of DME claims submitted between 1995 and 2007. The Subcommittee has also interviewed numerous officials from CMS, Medicare contractors, the Department of Justice Fraud Section, the Department of Health and Human Services Office of the Inspector General (HHS/OIG), as well as physicians, representatives of DME suppliers, Medicare beneficiaries, and DME suppliers who have been convicted of Medicare fraud. This Report presents the findings and recommendations of the Subcommittee staff on one aspect of the problem, the payment of Medicare DME claims referencing a prescribing physician who is deceased.

II. EXECUTIVE SUMMARY

Medicare regulations require that DME claims contain certain information in order to qualify for payment.[6] For instance, claims must include valid identification numbers for the beneficiary and the DME supplier. Another essential element is the identification number for the prescribing medical provider – the Unique Physician Identification Number, commonly called the UPIN.

Over the course of its investigation into fraud, waste, and abuse in Medicare, the Subcommittee has uncovered a substantial volume of paid DME claims that contained UPINs for deceased physicians. Specifically, the Subcommittee staff estimates that, from 2000 through 2007, Medicare paid for approximately 478,500 claims that contained the UPINs of deceased doctors, and the number of claims paid could be as high as 570,000. The Subcommittee staff also estimates that the amount of money paid for these claims is well over $76.6 million, and it is possible that the number actually exceeds $92 million.[7] The

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[5] GAO-07-59, Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies, January 31, 2007.

[6] Medicare Claims Processing Manual, Chapter 1, Section 80.3.1 through 80.3.2.

[7] All estimates presented here are based on a 95-percent confidence level, as discussed in greater detail in Footnote 44 below. For the number of claims submitted to Medicare with deceased physician UPINs, the 95-percent confidence interval ranges from a low of 384,730 claims to a high of 572,268 claims. For the Medicare expenditures on claims containing

Subcommittee's analysis indicates that these Medicare claims contained the UPINs of between 16,500 and 18,200 deceased physicians. Sixteen percent of the estimated 478,500 claims, amounting to 51,534 claims valued at roughly $4 million, contained UPINs of doctors who died 10 or more years before the service date on the claims.[8] The Subcommittee also found that an estimated 2,000 to 2,900 deceased physicians still had active UPINs as of May 2008.[9]

Because of the high number of Medicare claims and reports of fraud, waste, and abuse in Florida, the Subcommittee also examined claims using deceased physician UPINs in that State. The Subcommittee's investigation uncovered alarming case studies that included one UPIN that was used in 484 claims, totaling more than $544,000, that were paid more than six years after the death of the prescribing physician. Similarly, the Subcommittee discovered that the UPIN assigned to one doctor who died in 2001 was used in more than 3,800 claims submitted between 2002 and 2007, resulting in Medicare payments of more than $354,000. In another instance, the Subcommittee found that the UPIN of a physician who died before 1999 was used on more than 1,600 claims submitted after April 2002, resulting in Medicare payments of more than $478,000.

These problems are not new. In November 2001, HHS/OIG reported that Medicare paid $91 million in 1999 for medical equipment and supply claims with invalid or inactive UPINs. HHS/OIG recommended that CMS: (1) revise its claims process to ensure that UPINs listed on medical equipment and supply claims are valid and active; and (2) emphasize to suppliers the importance of using accurate UPINs when submitting claims to Medicare. CMS agreed with HHS/OIG's recommendations and, in its written comments to the report, stated that on April 1, 2002, it would provide instructions and implement changes to its automated claims processing system to reject medical equipment and supply claims using deceased physician UPINs.[10]

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deceased physician UPINs, the 95-percent confidence interval ranges from a low of $60,317,099.12 to a high of $92,819,900.74.

8 The 95-percent confidence interval for the claims tied to doctors who died at least 10 years before the listed service date ranges from 26,915 to 76,154. The 95-percent confidence interval for the amount of money paid for those claims ranges from a low of $2,000,595.81 to a high of $5,793,331.90.

9 The estimate for the number of deceased doctors with active UPINs as of May 2008 was generated by calculating the proportion of doctors within the sample that had active UPINs as of May 2008, and estimating the population proportion and confidence interval using the equation: $= 1.96\left(\sqrt{\frac{p(1-p)}{n}}\right)$.

10 HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

After the issuance of the HHS/OIG report, CMS took several steps to reject claims containing UPINs assigned to deceased physicians. For example, CMS instructed its claims processing contractors to perform a one-time review of its UPIN registry and in-house provider files to deactivate UPINs for doctors who were deceased or did not file any claims from their practices for 12 months.[11] CMS further directed its claims processing contractors, beginning on April 1, 2002, to reject claims using invalid or inactive UPINs. CMS also announced that it would make changes to its payment systems to ensure that claims using invalid or inactive UPINs would be automatically rejected.

Despite these actions, the Subcommittee investigation found that claims with deceased physician UPINs were still not automatically rejected. To the contrary, payment data supplied by CMS showed that Medicare paid claims containing UPINs from physicians who had died more than 12 months prior to the dates of service on the claims. In fact, 63 percent of the claims identified by the Subcommittee as using deceased physician UPINs were paid with dates of service after April 1, 2002, the date after which Medicare was supposed to reject such claims.

Apparently, neither CMS, the HHS/OIG, nor the claims processing contractors performed the reviews or audits needed to ensure that the steps taken in 2002 were effective in stopping the payment of Medicare claims using deceased physician UPINs. This oversight failure resulted in tens of millions of dollars in improper payments.

A. Report Findings

Based upon its investigation, the Subcommittee staff makes the following findings of fact.

1. **Tens of Millions Paid for Medicare Claims With Deceased Physician UPINs.** From 2000 to 2007, Medicare paid an estimated $60 million to $92 million for hundreds of thousands of DME claims that contained identification numbers assigned to an estimated 16,500 to 18,200 deceased physicians.
2. **CMS Actions Taken in 2002 to Stop Deceased Physician Claims Failed.** In 2002, CMS implemented procedures to ensure that DME claims with UPINs of deceased physicians would be rejected, but those procedures were ineffective in resolving the problem, and HHS and CMS personnel failed to perform the reviews or audits needed to ensure the procedures were working. As a result, CMS has paid claims containing

[11] *Id.* at pg. 2.

UPINs assigned to deceased doctors years after their death.

3. **Medicare Remains Unprotected from Deceased Physician Claims.** As of May 2008, the UPINs of an estimated 2,000 to 2,900 deceased physicians remained active, until replaced by the National Provider Identifier number (NPI). The continuing inability of CMS's payment systems to reject claims containing deceased physician identification numbers renders Medicare vulnerable on a continuing basis to millions of dollars in improper claims each year.

B. Report Recommendations

After being informed of the Subcommittee's investigative findings, CMS did not dispute them, but told the Subcommittee that CMS is currently undergoing substantial changes in the way Medicare claims are processed, including recent changes to physician and DME supplier identification numbers.[12] Specifically, over the past year, CMS has terminated the UPIN registry and replaced UPINs with a new National Provider Identifier (NPI) numbering system for all Medicare service providers.[13] Beginning in May 2008, NPIs are required to be submitted for all Medicare claims.

Based upon the Subcommittee's investigative findings and the ongoing reform of the Medicare claims review processes, the Subcommittee staff makes the following recommendations.

1. **Strengthen Procedures to Deactivate NPIs after Physician Death.** CMS should examine its procedures for identifying deceased physicians to ensure timely receipt of deceased physician data, automatic deactivation of relevant NPI numbers, and continual update of the NPI registry. CMS should develop a quality control program to ensure NPIs are deactivated within a specified period of time after receiving notice of a physician's death, such as 90 days.

2. **Initiate Regular NPI Registry and Claim Audits.** CMS should initiate periodic audits of its NPI registry to test whether NPI numbers assigned to deceased physicians have been deactivated within the specified timeframe and to test Medicare payment records to determine whether claims containing deceased physician NPIs were rejected.

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[12] CMS's responses are produced in Appendices II and III below.

[13] 45 CFR Part 162, Federal Register, Vol. 69, No. 15, January 23, 2004, at pg. 3434.

3. **Consider Additional Procedures and Audits to Strengthen NPI Registry.** CMS should consider instituting additional procedures and audits to ensure the prompt deactivation of NPIs assigned to Medicare service providers who have stopped providing services due to licensure revocation, retirement, or other reasons, including automatic deactivation of any NPI that has not been used in a Medicare claim within a specified time period, such as 12 months. Consideration should also be given to developing procedures to allow deactivated NPIs to be reinstated upon proper application.

III. BACKGROUND

A. Overview of Medicare and Durable Medical Equipment Claims

1. Medicare and DME in General

Title XVIII of the Social Security Act (SSA), entitled "Health Insurance for the Aged and Disabled," established the Medicare program in 1965.[14] Medicare was created to provide health insurance for the aged, disabled, and persons with end-stage renal disease. The program is administered by HHS through CMS.

Medicare is comprised of four parts. Part A, the Hospital Insurance Program, covers hospital services, post-hospital services, and hospice services. Part B, the Supplementary Medical Insurance Program, covers medical services including physician, laboratory, outpatient services, and DME. Part C covers managed care options for beneficiaries enrolled in Part A and Part B. Part D, created by the Medicare Prescription Drug Improvement and Modernization Act of 2003, covers outpatient prescription drug benefits as of January 1, 2006.[15] For the purposes of this Report, the Subcommittee will focus on Medicare Part B.

Under Part B, the Medicare program will pay for certain DME for eligible Medicare beneficiaries under the DMEPOS benefit.[16] The term DME refers to medical equipment and supplies that are used in the patient's home (including an institution such as a nursing home in which the patient resides).[17] Medicare regulations define DME as:

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[14] Title XVIII appears in the United States Code at 42 U.S.C. §§ 1395-1395(ccc).

[15] Prior to this date, many prescription drugs were covered under Medicare Part B.

[16] SSA Section 1833(a)(1)(I).

[17] SSA Section 1861(n).

> [E]quipment furnished by a supplier or a home health agency that:
>
> (1) Can withstand repeated use;
> (2) Is primarily and customarily used to serve a medical purpose;
> (3) Generally is not useful to an individual in the absence of an illness or injury; and
> (4) Is appropriate for use in the home.[18]

Examples of DME include wheelchairs, oxygen condensers, nebulizers, canes, hospital beds, prosthetics, diabetic equipment and supplies such as blood glucose test strips, and some prescription medications.

2. DME Claims and Suppliers

The Medicare claims process for DME typically involves three parties: (1) the Medicare beneficiary who is prescribed certain medical supplies or equipment; (2) the medical practitioner, such as a physician, nurse practitioner, or physician assistant who is treating the beneficiary and prescribing the equipment; and (3) the DME supplier, a private entity authorized by CMS to provide DME items to Medicare beneficiaries and bill Medicare directly. The process of a DME claim generally starts with the Medicare beneficiary receiving treatment from a medical practitioner. If the physician writes an order or prescription for DME, the beneficiary can take the prescription to a DME supplier of his or her choosing and the DME supplier sells or rents the prescribed item to the beneficiary.[19]

In most circumstances, the DME supplier submits a claim for payment to an entity authorized by CMS to receive, review, and process Medicare claims, such as a Durable Medical Equipment Regional Carrier (DMERC) or other Medicare carrier. DMERCs were established to standardize the coverage and payment of DME claims and were designed to be the experts in the Medicare DME claims process. Their primary role was to accept and process Medicare Part B DME claims. In doing so, DMERCs were also expected to consolidate and focus efforts to combat fraud, waste, and abuse in the DME benefit program.[20]

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[18] 42 CFR 414.202.

[19] For certain DME, including equipment that is expensive and prone to fraudulent activity, CMS regulations require the physician to provide a Certificate of Medical Necessity (CMN) in addition to a prescription. For instance, Medicare requires a CMN for oxygen or infusion pumps. A CMN is a form required to help document the medical necessity and other coverage criteria for selected DMEPOS. Medicare Claims Processing Manual, Chapter 20, Section 100.2.

[20] Section 911 of the Medicare Modernization Act of 2003, known as the Medicare Contracting Reform provision, required CMS to compete all currently held contracts for administration of

Physicians generally file Medicare claims that deal with treatment, office visits, and other medical procedures, while DME claims are typically submitted by suppliers. As noted above, DME suppliers are entities that are authorized by the Medicare program to sell or rent DME to eligible beneficiaries and submit claims for payment directly to Medicare. DME suppliers typically include pharmacies or companies that specialize in DME such as wheelchairs, oxygen supplies, diabetic supplies and other supplies and equipment that are provided to Medicare beneficiaries, as well as other medical patients.

B. Unique Physician Identification Numbers

The Omnibus Budget Reconciliation Act of 1985 required CMS to establish UPINs for all physicians who provide services to Medicare beneficiaries.[21] Under the UPIN system, each physician was assigned one unique number that never changed. CMS contracted with one company, National Heritage Insurance Company Corporation (NHIC), to manage the UPIN registry, a database containing detailed information about each physician approved to submit Medicare claims, including the practice settings of each physician assigned a UPIN.[22] The database included an Internet component, available to the public, that could be used to verify a physician's UPIN or other data such as name or practice location.[23]

In addition, since 1992, Medicare regulations have required DME suppliers to provide the UPIN of the physician who ordered the DME

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the fee-for service Medicare program. The new contractors selected through these competitions are called Medicare Administrative Contractors (MACs). DME MACs are the new contractors for DME services.

[21] UPINs were phased out of the Medicare program on May 23, 2008, in favor of a new numbering system involving NPIs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the development of the NPIs to be used by all entities who file claims with Medicare. As a result, no new UPINs have been issued since June 2007, and all Medicare claims are now required to have NPIs.

[22] According to the definition provided on the NHIC website, "a practice setting is defined as a specific location at which a physician, medical group, or non-physician practitioner renders service. It is physically separate from any other location in which he or she renders service." *See* http://www.upinregistry.com/faq.asp#6.

[23] The UPIN online registry was terminated on May 23, 2008. According to the CMS website at http://www.cms.hhs.gov/nationalprovidentstand:

> The NPI will be Required for all HIPAA Standard Transactions on May 23rd. This means:
>
> > For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions . . . [and] paper claims . . . .
>
> The reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.
>
> A similar website has been established for the NPI system, which is managed by Fox Systems, Inc. under contract with CMS.

items on all claims submitted to Medicare for payment. The regulations state that claims without a valid UPIN must be denied.[24] In its response to Subcommittee questions, CMS summarized these regulations as follows:

> The effective date for requiring the UPIN of the ordering/referring physician for all services was January 1, 1992. As required by section 1833(q) of the Social Security Act, all claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, diagnostic laboratory services, diagnostic radiology services, consultative services, and durable medical equipment. Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN. All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the Medicare carrier. ... If durable medical equipment, prosthetics and orthotics are ordered, the name and UPIN of the ordering physician must be on Form CMS-1500 in items 17 and 17a.

C. 2001 HHS Inspector General Report

In 2001, the HHS/OIG published a report analyzing the payment of Medicare claims containing invalid or inactive UPINs.[25] The study found that, in 1999, Medicare paid $32 million for medical equipment and supply claims with invalid UPINs and an additional $59 million for claims with inactive UPINs. The HHS/OIG recommended that CMS revise the claims processing procedure to ensure: (1) that claims are paid only if they contain valid and active UPINs; and (2) that CMS emphasize to suppliers the importance of using valid UPINs when submitting claims. The HHS/OIG reported that, according to CMS, the then-existing Medicare claims processing system only verified that UPINs on claims met certain format requirements and did not reject UPINs that were invalid or inactive.

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[24] Medicare Claims Processing Manual, Chapter 1, Section 80.3.2.1.2. This same restriction also applies to NPIs.

[25] HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

CMS reviewed the HHS/OIG report prior to its release and concurred with its recommendations. In commenting on the report, the then-CMS Administrator stated:

> Since the OIG study, CMS has developed instructions, system changes, and edits which will reject medical equipment and supply claims using a deceased physician's UPIN. The implementation date for this initiative is April 1, 2002. After this initiative is implemented, CMS will expand it to include inactive and invalid UPINs.

CMS also concurred with the HHS/OIG's recommendation to educate Medicare service providers on the importance of submitting accurate UPINs on Medicare claims. In November 2001, the HHS/OIG acknowledged CMS actions taken to resolve the problem of deceased physician claims identified in the 2001 report, but also urged CMS to perform post-payment reviews in order to detect the use of invalid or inactive UPINs on claims after the new initiative's implementation.[26]

D. CMS Efforts to Ensure Rejection of Deceased Physician Claims

Following the 2001 HHS/OIG report, CMS took a number of steps to ensure Medicare claims containing deceased physician UPINs were not paid. In the latter half of 2001, CMS told the HHS/OIG that it had developed a new claims review process that would reject claims containing UPINs of deceased physicians. CMS indicated that this new process was to be implemented on April 1, 2002.[27] CMS also stated that, in addition to resolving the deceased physician problem, it would put mechanisms in place to ensure that all claims with invalid or inactive UPINs were not accepted. CMS stated that it would advise its carriers to deactivate all UPINs for which there had been no claim activity from the practice setting during the previous 12 months.[28]

On November 9, 2001, CMS issued a program memorandum to the DMERCs, instructing them to conduct a one-time review of deceased physician UPINs being used on DME claims.[29] The purpose of this one-time review was to identify UPINs belonging to deceased physicians, verify the remaining UPINs being used on DME claims, and update the DMERCs' provider files and the UPIN Registry with the verified information.

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[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] HHS/CMS, Program Memorandum Carriers, Reviewing Deceased Physicians' Unique Physician Identification Numbers (UPINs) on DMERC Claims, Transmittal B-01-73, Change Request 1735, November 9, 2001.

To implement the program memorandum, the DMERCs and other Medicare carriers were required to reconcile a UPIN file of deceased physicians that was attached to the program memorandum against their in-house provider files. Additionally, carriers were instructed to deactivate UPINs that had no claim activity for 12 months and include this information in their update of their in-house provider files and the UPIN registry. Carriers were instructed to provide a monthly progress report of their completed work on this project to CMS beginning January 4, 2002. The goal of this one-time effort was to ensure that the Medicare claims processors would be working with an updated and validated UPIN registry by April 2002.

In addition to establishing procedures for updating the UPIN registry, the November 2001 program memorandum stated that, effective April 1, 2002, the Medicare Common Working File (CWF)[30] was required to reject DMERC claims with UPINs whose date of service came after the physician's date of death.[31] CMS told the Subcommittee that, as of April 2002, the CWF began rejecting DMEPOS claims with deceased physicians' UPINs when the date of service came after the date of death.[32] CMS also indicated that if a UPIN was missing on a claim form or an entry was not in the proper format, the contractors would reject the claim and return it as unprocessable to the provider or supplier for correction.

CMS told the Subcommittee that the file containing deceased physicians' UPINs were supposed to be updated with deceased physician data every 15 months.[33] To ensure accurate data, CMS told the Subcommittee that the UPIN registry contractor set up a system with the American Medical Association (AMA) to obtain biweekly data specifying the date of death for deceased physicians across the country. The UPIN registry contractor then compared the AMA data to the data in the registry, identified registered physicians who had died, and issued

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[30] The Common Working File is the master record of all Medicare beneficiary information and claim transactions, including both Medicare Part A, Part B and DME data. The claims processing systems interface with the CWF to verify the beneficiary's entitlement to Medicare, deductible status and available benefits. The CWF also reviews claims history to check for duplicate services, inpatient or Skilled Nursing Facility (SNF) stays, and other insurance that may pay primary to Medicare, secondary to Medicare or should pay in place of Medicare. As a final step in processing, most claims are sent to the CWF for review and validation of claim data.

[31] CMS letter to the Subcommittee, June 4, 2008, answers to Questions 1 and 4, reprinted in Appendix II of this Report. CMS issued a subsequent program memorandum on April 12, 2002, that stated that for a claim to be properly adjudicated, the physician's date of death would need to be included in the information provided by the carriers. The effective and implementation date for this program memorandum was October 1, 2002. HHS/CMS, Program Memorandum Carriers, Deceased Physician UPIN Information – (Transmittal B-01-73), Transmittal B-02-024, Change Request 2042, April 12, 2002.

[32] *Id.*, answers to Questions 1, 4, and 5.

[33] *Id.*, answer to Question 5.

a monthly report identifying the deceased registry physicians to Medicare's claims processing contractors that were supposed to update their in-house physician lists.[34]

To further ensure that appropriate UPINs were being deactivated, CMS told the Subcommittee that, in September 2002, it sent a program memorandum instructing its contractors to educate and train Medicare service providers about their responsibility to ensure that accurate UPINs are used on claims.[35]

CMS told the Subcommittee that the actions described in the November 2001 and September 2002 program memoranda were, in fact, carried out.[36] Additionally, in CMS's response to the OIG report of November 2001, CMS indicated they would also implement changes to the claims process that would reject claims using invalid and inactive UPINs, other than those assigned to deceased physicians.[37] In its fiscal year 2004 semiannual report to Congress, however, the HHS/OIG stated that CMS had decided against implementing changes to its automated claims processing system and the CWF to block the payment of Medicare claims containing inactive or invalid UPINs, opting instead to rely on provider-education efforts and its two program memorandums to stop service providers from submitting claims with deceased physician UPINs.[38]

IV. MEDICARE CLAIMS PROCESS ALLOWED PAYMENTS FOR DECEASED PHYSICIAN CLAIMS

Problems in the Medicare program have been long-standing and well-documented. Oversight bodies such as HHS/OIG and GAO have reported program integrity issues in the Medicare program for many years. In HHS's fiscal year 2007 agency financial report, HHS/OIG reported integrity of Medicare payments as one of the agency's top management and performance challenges.[39] In its 2007 High-Risk Series, GAO reported that further action was needed to address program integrity weaknesses.[40] Moreover, the HHS/OIG and GAO continue to find program weaknesses, specifically in the area of DME. In HHS's

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[34] *Id.*, answers to Questions 2 and 5.

[35] CMS stated that the instructions were reported in program memorandum AB-02-1 and had an effective date of October 1, 2002.

[36] *Id.*, answers to Questions 1 and 2.

[37] HHS/OIG, Medical Equipment and Supply Claims with Invalid or Inactive Physician Numbers, November 2001.

[38] HHS/OIG Semiannual Report to Congress, April 1, 2004 – September 30, 2004.

[39] Department of Health and Human Services, Fiscal Year 2007 Agency Financial Report, November 15, 2007.

[40] GAO-07-310, High-Risk Series: An Update, January 2007.

fiscal year 2007 agency financial report, HHS/OIG reported that it has consistently found that the Medicare DMEPOS benefit is vulnerable to fraud and abuse. To illustrate the point that action is needed to enhance Medicare program integrity, GAO pointed out that, while Medicare's fiscal year 2006 improper payment error rate was the lowest since 1996, certain providers – such as suppliers of DME – continued to receive improper payments at a higher rate.

In the case of deceased physician claims, the Subcommittee's investigation has found that, despite the 2001 HHS/OIG report that found CMS paid millions of dollars for claims with invalid or inactive UPINs and the actions taken by CMS to address the problem, CMS has failed to ensure claims containing only valid UPINs are paid. Since the UPIN is one of the key pieces of data required on claims, the failure of Medicare claims processing contractors to automatically reject claims with an invalid UPIN rendered the program susceptible to tens of millions of dollars in fraud, waste, and abuse. Further, the failure of the Medicare system to routinely deactivate UPINs belonging to deceased physicians created a program vulnerability that allowed DME suppliers to be paid for improper claims. When the Subcommittee presented to CMS its own payment data showing that, from 2000 to 2007, millions of dollars had been paid on Medicare claims containing deceased physician UPINs, CMS did not challenge either the payment data or the Subcommittee's interpretation of that data.[41]

A. From 2000 to 2007, Medicare Paid Between $60 Million and $92 Million for Hundreds of Thousands of DME Claims Containing Deceased Physician UPINs

The Subcommittee obtained comprehensive data concerning more than 33,000 deceased physicians from the AMA and selected a statistically random sample of 1,500 deceased physicians for further analysis. The Subcommittee obtained the UPINs belonging to the deceased physicians in the sample and obtained DME claims data from Medicare related to those 1,500 UPINs.[42]

Of the 1,500 UPINs for deceased physicians that the Subcommittee examined, 734 (48.9 percent) had been used on claims with dates of service between January 1, 2000, and December 31, 2007. For these 734 UPINs, 21,458 claims were submitted for payment. The total amount paid for these claims was $3.4 million.[43] In addition, more than

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[41] *See* CMS responses reprinted in Appendices II and III; Subcommittee interview of CMS officials, June 5, 2008.

[42] *See* Appendix I for more information about the scope and methodology of the Subcommittee's analysis.

[43] The Subcommittee reviewed only claims that contained services dates that occurred more than 12 months after the physicians' deaths. Had the Subcommittee considered all claims

55 percent of the total claims were for dates of service at least five years after the physicians had died. The Subcommittee also found that 1,618 claims totaling more than $234,000 contained the UPINs of physicians who had died at least 10 years before the date of service on the claim. Further, the Subcommittee noted that 110 of the 1,500 deceased physicians (roughly 7 percent) had active UPINs as of May 21, 2008.

Based on the results of the random sample, the Subcommittee estimates with 95 percent certainty that, from 2000 to 2007, Medicare paid 478,500 claims containing UPINs that were assigned to deceased physicians.[44] The total amount paid for these claims is estimated to be between $60 million and $92 million.[45] These claims contained UPINs for an estimated 16,548 to 18,240 deceased physicians. In addition, based on the results of the random sample, the Subcommittee estimates that between 2,011 and 2,895 deceased physicians still had active UPINs as of May 2008.

Notably, approximately 11,582 (54 percent) of the 21,458 claims that were paid were for dates of service after the physicians had been dead at least five years, and almost 15,599 (73 percent) of the claims paid contained the UPINs of physicians who had died before January 2000. Additionally, roughly 13,474 (63 percent) of the claims were paid with dates of service after April 1, 2002, the date CMS said it would implement new procedures to ensure claims with deceased doctors' UPINs were rejected. Table 1 presents claims reviewed by the Subcommittee:

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with dates of service after physician deaths, including claims within 12 months of the physicians' deaths, the amount of claims paid for the random sample of 1,500 doctors would have been roughly $4.1 million rather than $3.4 million. The total number of UPINs of deceased physicians would also increase from 734 to 777, and the total number of claim would also have grown from 35,717 to 43,619.

[44] For the number of claims submitted to Medicare with deceased physician UPINs, the 95-percent confidence interval ranges from a low of 384,730 claims to a high of 572,268 claims. Estimates of 95-percent confidence intervals were generated as follows. First, a statistically random sample of 1,500 doctors was drawn from the population of deceased doctors with assigned UPINs. The mean ($\frac{\sum_{i=1}^{n} x_i}{n}$) and standard deviation ($\frac{\sqrt{\sum_{i=1}^{n}(x-\bar{x})^2}}{(n-1)}$) of the number of claims filed per UPIN, and of the amount of money paid out per UPIN, was computed for the sample. These means and standard deviations were used to generate a confidence interval of the sample mean number of claims filed per UPIN, and the sample mean amount of money paid out per UPIN using an alpha of .05 and the equation: $+1.96\left(\frac{\sigma}{\sqrt{n}}\right)$. The sample means and upper and lower bounds of the sample confidence intervals were then multiplied by the population size to generate population estimates. All ranges given above are thus estimated with a 95-percent level of confidence.

[45] The 95-percent confidence interval for the Medicare expenditures on claims containing deceased physician UPINs ranges from a low of $60,317,099.12 to a high of $92,819,900.74. The mean total for this amount is estimated to be $76.6 million. As noted above, this estimate includes only claims that contained services dates that occurred more than 12 months after the physicians' deaths. Including all claims with dates of service after physicians' deaths, such as claims within 12 months of the physicians' deaths, the estimate for the amount paid by Medicare for deceased physician claims would likely have increased to more than $100 million.

Date Physician License Status Was Changed to Deceased[46]	Dates of Service on Medicare Claims	Number of Claims	Total Amount Paid
September 22, 1993	January 2000 to March 2002	396	$ 81,793
January 1, 1999	January 2000 to December 2007	653	$ 92,033
June 15, 1996	June 2000 to July 2006	101	$148,749

Table 1: Examples of Deceased Doctor Claims from the AMA Data

B. Florida Case Studies: CMS Paid Millions of Dollars for Claims Containing Deceased Physician UPINs

The Subcommittee also examined DME claims that contained UPINs of deceased Florida physicians. In its analysis, the Subcommittee considered only those claims for dates of service after April 1, 2002, the date on which Medicare was to implement new initiatives to prevent the payment of claims containing UPINs of deceased physicians. This aspect of the Subcommittee's review found that, from April 1, 2002, through December 31, 2007, more than $2 million had been paid for claims with UPINs belonging to 114 deceased Florida physicians. Moreover, the data obtained by the Subcommittee indicated that more than 27 percent of the deceased Florida physicians had active UPINs as of May 2008.

In its review, the Subcommittee found as many as 484 claims totaling $544,789 filed under a single UPIN years after the physician had died. Table 2 below outlines examples of claims filed using UPINs assigned to deceased Florida physicians who died more than 12 months before the dates of service on the claims.

[46] The date the license status was changed may not be the date of actual death. For example, for the physician identified in the following table whose license status was changed on January 29, 2002, the State of Florida Office of Vital Statistics confirmed this physician died on September 10, 1999.

Date Physician License Status Was Changed to Deceased	Dates of Service on Medicare Claims	Number of Claims	Total Amount Paid
July 2, 1999	July 1, 2002 to December 31, 2007	2,062	$ 478,985
July 7, 1999	April 17, 2003 to November 17, 2003	67	$ 61,302
October 4, 2001	October 4, 2002 to December 31, 2007	3,848	$ 354,277
November 15, 2001	December 6, 2002 to May 8, 2005	265	$ 229,527
January 29, 2002	July 1, 2003 to November 14, 2006	484	$ 544,789
March 1, 2002	March 17, 2003 to August 30, 2006	433	$ 317,698

Table 2: Examples of Deceased Doctor Claims from Florida Data

The Subcommittee's investigation has also uncovered links between claims containing deceased physician UPINs and claims found to be related to fraudulent activity. A review of the details on the claims submitted using the UPINs of the 114 deceased physicians in Florida, for example, revealed an alarming number of claims submitted by companies identified by the U.S. Department of Justice and state regulatory agencies as having submitted fraudulent Medicare claims worth millions of dollars.

In one instance, the Florida data contained claims from Professional Gluco Services, Inc. (Professional Gluco), a DME supplier. In a press release regarding the indictments of that company's officials, the Department of Justice stated the following:

> On September 25, 2007, a Miami federal grand jury returned a five (5) count indictment against two defendants in United States v. Nelson Martin and Aurelio Benavides, No. 07-20765-Cr-Huck. The Indictment charges Nelson Martin and Aurelio Benavides, with owning and operating Professional Gluco Services, Inc. ("Professional Gluco"), a Miami durable medical company, and executing a scheme to submit tens of millions of dollars in fraudulent claims to Medicare from November 2005 to September 2006 for reimbursement for durable medical equipment (DME) and related services. The Indictment alleges that the defendants submitted approximately $14.3 million in false claims on behalf of

> Professional Gluco. The claims were allegedly fraudulent in that the equipment had not been ordered by a physician and/or had never been delivered to a Medicare patient. As a result of the submission of the fraudulent claims, Medicare paid Professional Gluco approximately $1.3 million.[47]

Professional Gluco Services, Inc. is one of the companies that had submitted DME claims to Medicare using the physician's UPIN who had died in September 1999. Professional Gluco submitted 83 claims under this physician's UPIN between December 2005 and July 2006 and was paid $93,171.

Another DME supplier identified in the Subcommittee's review was the subject of a Florida Department of Health Administrative Complaint filed on June 21, 2007. The complaint stated that, when a Department of Health investigator attempted to inspect the business on December 11, 2006, the investigator found the business closed and the phone disconnected. The business did not notify the State of Florida, as required. The Florida Department of State – Division of Corporations lists the company as being voluntarily dissolved on February 1, 2007. Yet claims from this company using the same UPIN as Professional Gluco were paid by Medicare for dates of service between July 11, 2006, and November 14, 2006, in the total amount of $167,101.

A third company was also the subject of an Administrative Complaint filed by the Florida Department of Health. A Department of Health investigator attempted to inspect the purported business on February 26, 2007, and found the business closed and the phone disconnected. This business had filed claims using the same deceased physician's UPIN that Professional Gluco used for dates of service between June 16, 2006, and August 7, 2006. The total amount paid for these claims was $143,631.

Altogether, of the Florida data reviewed by the Subcommittee, at least $348,000 paid for Medicare claims containing deceased physician UPINs went to companies known to have submitted fraudulent DME claims.

C. CMS Efforts to Reject Claims Containing Deceased Physician UPINs Failed

CMS took a number of actions to stop the payment of Medicare claims containing deceased physicians UPINs, including requiring a one-time update of the UPIN registry to eliminate deceased physician UPINs and validate the remaining UPINs; instructing its claims processing contractors to deactivate UPINs with no claims activity after one year; and requiring them to reject claims with invalid or inactive UPINs after the April 1, 2002, deadline. CMS also told the

[47] *See* http://miami.fbi.gov/dojpressrel/pressrel07/mm20070928.htm.

Subcommittee that it had instituted system changes to require the CWF to automatically reject claims with invalid or inactive UPINs, and instructed the UPIN registry contractor to update the registry with deceased physician data every 15 months.

The Subcommittee's analysis of CMS payment data shows, however, that those measures were not fully effective, and claims with deceased physician UPINs continued to be paid. For example, CMS had instructed its UPIN registry contractor to update the UPIN registry and review it on a regular basis to ensure deceased physician UPINs were being deactivated. The Subcommittee's investigation demonstrated, however, that the UPIN registry continued to list deceased physician UPINs as active up to the date the registry was taken offline in May 2008. The Subcommittee found, for instance, that approximately 7 percent of the deceased physician UPIN sample from the AMA data still had active UPINs in May 2008, even though the physicians had all died prior to December 31, 2002. The Subcommittee also reviewed deceased physician data for particular States, including Alabama and Connecticut, and determined that between 5 and 7 percent of deceased physicians in those States also had active UPINs as of May 2008. Additionally, the deceased physician data from Florida indicated that approximately 27 percent of the deceased physicians in that State still had active UPINs as of April 2008.

CMS had also instructed the DMERCs and other claims processing contractors to review and update their in-house Medicare service provider lists to eliminate deceased physicians by April 1, 2002. Yet Medicare continued to pay claims with deceased physician UPINs after the April 1, 2002, implementation date. In fact, 63 percent of the deceased physician claims discovered by the Subcommittee were paid for dates of service after April 1, 2002, and thousands of claims included UPINs assigned to physicians who had died before 1999. Therefore, while CMS instructed its contractors to provide quarterly update reports to CMS on their progress in deactivating deceased physician UPINs, these efforts do not appear to have been successful.

In 2004, HHS/OIG suggested that CMS conduct post-payment reviews to ensure that the measures taken in 2002 had successfully stopped the payment of deceased physician claims. There is no evidence, however, that either CMS or its contractors performed any reviews to test the effectiveness of the measures taken to prevent the payment of deceased physician claims. HHS/OIG also failed to conduct any audits to ensure the problem had been resolved. As a result of these oversight failures, seven years after the 2001 HHS/OIG report and CMS efforts to resolve the problem, the Subcommittee found that Medicare continued to spend millions of dollars each year on improper claims containing identification numbers for deceased physicians.

V. CONCLUSION AND RECOMMENDATIONS

The Subcommittee's investigation has determined that, between 2000 and 2007, Medicare paid between $60 million and $92 million for hundreds of thousands of DME claims that contained the UPINs of thousands of dead doctors. CMS had been notified of the problem as far back as 2001, and at that time, took steps to eliminate payments for claims containing deceased doctor UPINs. Based on the Subcommittee's examination of the claims data, however, these measures were not fully implemented, and CMS, its contractors, and the HHS/OIG failed to conduct follow-up reviews to ensure that the problem had been resolved. The Subcommittee's investigation did not attempt to identify when or how the breakdowns in implementation occurred. Whether the fault lies with the UPIN registry contractor, the claims processing contractors, CMS, or the HHS/OIG, the fact is that, seven years after the problem was first identified, the claims review process is still not working properly to reject claims containing the provider numbers of deceased physicians.

The replacement of the UPIN registry with the new NPIs presents a fresh opportunity for the Medicare program to adopt new safeguards to stop the improper payment of claims containing deceased physician identification numbers. Better measures are needed to ensure that the NPI registry incorporates deceased physician information on a timely and effective basis and promptly deactivates appropriate NPIs. Better measures are also needed to ensure that claims containing deceased physician NPIs are automatically rejected and that payment is denied.

Unless new procedures are put into place to better identify and deactivate the NPIs of deceased service providers, NPIs – like UPINs – will be used to obtain payments for services allegedly performed long after the cited service provider has died. Without new safeguards, the Medicare program will continue to be susceptible to fraudulent claims using invalid identification numbers. CMS should take action now, while it is implementing new procedures and rules, to ensure that NPI numbers are managed effectively, are deactivated promptly after a service provider's death, and trigger the automatic rejection of any Medicare claim submitted after a specified time period following the date on which the service provider died.

The Subcommittee staff accordingly recommends the following measures to resolve the ongoing problem of Medicare's paying claims alleging services performed by deceased physicians.

1. **Strengthen Procedures to Deactivate NPIs after Physician Death.** CMS should examine its procedures for identifying deceased physicians to ensure timely receipt of deceased physician data, automatic deactivation of relevant NPI numbers,

and continual update of the NPI registry. CMS should develop a quality control program to ensure NPIs are deactivated within a specified period of time after receiving notice of a physician's death, such as 90 days.

2. **Initiate Regular NPI Registry and Claim Audits.** CMS should initiate periodic audits of its NPI registry to test whether NPI numbers assigned to deceased physicians have been deactivated within the specified timeframe and to test Medicare payment records to determine whether claims containing deceased physician NPIs were rejected.

3. **Consider Additional Procedures and Audits to Strengthen NPI Registry.** CMS should consider instituting additional procedures and audits to ensure the prompt deactivation of NPIs assigned to Medicare service providers who have stopped providing services due to licensure revocation, retirement, or other reasons, including automatic deactivation of any NPI that has not been used in a Medicare claim within a specified time period, such as 12 months. Consideration should also be given to developing procedures to allow deactivated NPIs to be reinstated upon proper application.

APPENDIX I: SCOPE AND METHODOLOGY

Random Sample Using American Medical Association (AMA) Data

The Subcommittee requested information from the AMA. According to AMA officials, the "Master List" contains information on medical providers in the United States from the date they enter medical school until they die. The Subcommittee received a list of physicians whose dates of death were between 1992 and 2002. From the list of more than 53,000 physicians who had died during that timeframe, the Subcommittee identified more than 33,000 who had UPINs assigned.

The Subcommittee then selected a statistically valid random sample of 1,500 physicians from the population of 33,000 deceased physicians with assigned UPINs. The 1,500 UPINs (4.5 percent) selected were forwarded to CMS to obtain data on any claims filed with those UPINs that had dates of service between January 1, 2000, and December 31, 2007.

Florida Claims Data

During a review of Medicare DME claims data provided by CMS, the Subcommittee discovered claims with dates of service between 2001 and 2006 that were paid notwithstanding UPINs linked to deceased physicians. Based on this discovery, the Subcommittee obtained additional data from the Florida Department of Health for 1,086 physicians whose license status reflected that they were deceased. Some of the physicians listed as deceased in the Florida Department of Health's database did not list dates indicating when the license statuses were changed. To conduct its examination, the Subcommittee limited its review to include only those records that indicated a date of death before January 1, 2006. The Subcommittee did not consider any record without a date in the license status change date field or with a date after January 1, 2006. The Subcommittee determined that, of the 648 physicians that met the criteria, 176 still had active UPINs as of March 25, 2008, despite the fact that the status was changed in the Florida Department of Health's database to reflect dates of death between 1999 and 2006. The 176 UPINs were submitted to CMS to obtain data for any claims paid containing these UPINs with dates of service between January 1, 2000, and December 31, 2007. The data subsequently provided by CMS was then reviewed to identify those claims that were paid more than 12 months after the physician's license status was changed to reflect they were "deceased."

The Subcommittee also considered that there may have been outstanding orders for DME items that continued after the prescribing physician's death. For example, HHS/OIG commented that wheel chairs, hospital beds, and other medical equipment can be rented for up

to 15 consecutive months, and this timeframe may extend beyond the date of the physician's death. However, during the Subcommittee's review, only those claims that were filed for dates of service at least 12 months after the physicians' deaths were considered.

APPENDIX II: CMS QUESTIONS AND RESPONSES

On May 28, 2008, in light of its findings regarding claims containing UPINs assigned to deceased physicians, the Subcommittee submitted several questions to CMS. CMS provided written responses to the Subcommittee questions on June 4, 2008. The Subcommittee's questions and the responses received from CMS are reprinted below.

1. **What processes and policies was Mr. Scully [CMS Administrator] referring to in his response [to the HHS/OIG report] that were to be implemented on April 1, 2002, that would cause any claim containing a deceased doctor's UPIN to be rejected?**

CMS Response:

CMS issued Change Request (CR) 2042, effective April 2002, that instructed the Common Working File (CWF) to reject DMEPOS claims using deceased physicians' UPINs when the date of service exceeds (i.e., is later than) the physician's date of death. This CR provided that the DME contractors must deny claims with an invalid or deceased ordering or referring physician's UPIN on claims when the date of service exceeds the physician's date of death.

2. **What other efforts as discussed in the [response] letter were taken to ensure UPINs were inactivated as indicated?**

CMS Response:

CMS released a program memorandum AB-02-1 in September 2002 that instructed contractors to educate and train providers (via newsletters and bulletins) about their responsibility to ensure that accurate UPINs are used on claims and that surrogate UPINs should not be used if ordering physicians have permanent UPINs. The effective date was October 1, 2002.

In addition, as part of the UPIN process, National Heritage Insurance Company (NHIC) (the contractor that maintains the UPIN Registry) subcontracted with the AMA to provide a physician data file, which NHIC used to validate the data submitted by contractors. Biweekly, the AMA submitted a data extract file which contained physicians' Date of Death. Contractor records submitted to the Registry were compared to the AMA physician death extract file. If, after the comparison, a physician was identified as deceased, an exception or notification was generated. Contractors were notified to update their physician records. On a monthly basis, contractors were sent a deceased physician notification list. If physician records were not updated over a period of time, the Registry would update or flag deceased physician records.

3. Are UPINs a required element of a claim and when was that requirement implemented? Since the Subcommittee is concerned only with data after January 2000, were UPINs mandatory at that point and did they ever become optional after January 2000?

CMS Response:

The effective date for requiring the UPIN of the ordering/referring physician for all services was January 1, 1992. As required by section 1833(q) of the Social Security Act, all claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, diagnostic laboratory services, diagnostic radiology services, consultative services, and durable medical equipment. Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN. All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the Medicare carrier. During CMS's NPI contingency period (October 1, 2006 - May 23, 2008), the use of the UPIN became optional when the National Provider Identifier (NPI) became an alternative option. As of May 23, 2008, only an NPI is permitted on the claim and the UPIN (and other legacy numbers) may not be reported on the claim.

CMS provided our contractors instructions in Publication 100-8, Chapter 14.6.1(A) CWF Edits and Claims Processing Requirements regarding UPIN reporting on Medicare claims. The following is an excerpt from the manual.

> If any procedure codes (HCPCS) associated in your claims processing system with CWF Type of Service (TOS) codes: 3 (consultative services), 4 (diagnostic radiology), 5 (diagnostic laboratory) (field 59, position 247 of the CWF Part B record) or durable medical equipment, orthotics and prosthetics, are shown on the claim form, the name of the physician who ordered or referred the item or service must be shown in Item 17. The ordering/referring physician's assigned or surrogate UPIN is to be entered in Item 17a of Form CMS-1500. The first position of the UPIN must always be alpha, the second and third positions must be either alpha or numeric and the last 3 positions must be numeric. For electronic claims, enter the name and UPIN in Record/Field, EAO-20.0, positions 80-94 of the Electronic Media Claims format. Only the 6-digit base number of the

UPIN will be required for CWF edits for referring and ordering. Do not use the 4-digit location identifier.

The following guidelines apply to those services that are edited by CWF:

- If the service is a diagnostic laboratory or radiology service, the assigned UPIN of the ordering/referring physician must be shown in item 17a on Form CMS-1500;
- If the performing physician is also the ordering physician, the physician must enter his/her name and UPIN in items 17 and 17a of Form CMS-1500, confirming that the service is not the result of a referral from another physician;
- If the ordering/referring physician is not assigned a UPIN, the biller may use OTH000 until a UPIN is assigned, or a surrogate may be used (See section 14.6.2)
- If the service is a consultative service, the name and UPIN of the referring physician or other person meeting the statutory definition of a physician must be shown on Form CMS-1500 in items 17 and 17a;
- If the service was referred by other limited licensed practitioner, the name and UPIN of the physician supervising the limited licensed practitioner must be shown on Form CMS-1500 in items 17 and 17a;
- If the service was the result of a referral from a person not meeting the statutory definition of a physician or a limited licensed practitioner (for example, a pharmacist, psychologist), the billing physician must enter his or her name and UPIN in items 17 and 17a, i.e., the physician completes Form CMS-1500 as though the service was initiated by the patient; and
- If durable medical equipment, prosthetics and orthotics are ordered, the name and UPIN of the ordering physician must be on Form CMS-1500 in items 17 and 17a.

4. Does the claims review process, automated and manual, validate UPINs that are submitted on claims?

CMS Response:

The claims processing system confirmed the existence of a UPIN and validated that number as to proper form. If a UPIN was not provided on the claim form or an entry was not in proper form, the contractors (including DME contractors) would reject the claim and return it as unprocessable to the provider or supplier for correction. As

of May 23, 2008, UPINs may no longer be submitted on Medicare claims. The NPI is used in secondary identifier fields.

CMS provided our contractors instructions in Publication 100-8, Chapter 14.6.1 (B) – CWF Edits and Claims Processing Requirements regarding the review and validation of UPIN reporting. The following is an excerpt from the manual.

> Deny, return or reject assigned claims requiring, but not containing, the name and UPIN of the ordering/referring physician depending on your system's capability and the cost effectiveness of the three options. If the claim is denied, afford the claimant the opportunity to appeal. Develop unassigned claims requiring a UPIN.
>
> In addition, CMS released a program memorandum AB-02-1 in September 2002 that instructed contractors to educate and train providers (via newsletters and bulletins) about their responsibility to ensure that accurate UPINs are used on claims and that surrogate UPINs should not be used if ordering physicians have permanent UPINs. The effective date was October 1, 2002.

5. What happens to a UPIN once CMS or a carrier/contractor is notified of a doctor's death? Is there an automated process used to inactivate a UPIN under these circumstances?

CMS Response:

As of April 2002, CWF rejects DMEPOS claims using deceased physicians' UPINs when the date of service exceeds the physicians' dates of death. The file containing the deceased physicians' UPINs was updated every 15 months. The claims processing contractor would deny claims with an invalid or deceased ordering or referring physician's UPIN on claims with dates of service that exceed the physician's date of death.

Yes, there is an automated process to alert contractors about deceased physicians. CMS provided contractor instructions in Publication 100-8, Chapter 14.4 – Automatic Notifications regarding how to handle deceased physician notifications. The following is an excerpt from the manual.

The Registry alerts you if a record on the MPIER requires investigation and research. Notifications are sent through the Registry telecommunication system to your output file as Record Code 7. The Notification Code is displayed in Field 37 as an alpha code. Confirm and verify your file to determine if the notifications and records you

submitted are valid. Act on all automatic notifications (except code X – recision/denial) within 30 calendar days. The conditions for which the Registry sends you notification are:

Deceased Physician/Health Care Practitioner-Notification Code D

Verify information regarding the alleged death of a physician/health care practitioner with the State Licensure Board, Medical Trade Association, or other outside entity.

If the physician/health care practitioner is deceased, generate an update record for each practice setting using Record Code 5 and update Field 20, "Date of Death," with the appropriate dates, and Field 29, "DRIP," with a "D" for deactivate for every practice setting.

If the physician/health care practitioner is not deceased, notify the Registry via a letter or TMAIL. Identify the source of your information.

APPENDIX III: CMS RESPONSE TO REPORT FINDINGS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Deputy Administrator
Baltimore, MD 21244-1850

JUN 24 2008

TO: Chairman Carl Levin
Ranking Member Norm Coleman
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

FROM: Herb Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Investigative Findings Regarding Medicare Payments to Providers Who Are Using Invalid or Inactive Physician Numbers

Thank you for the opportunity to review and comment on the Permanent Subcommittee on Investigations' findings that Medicare is continuing to pay claims to providers who are using invalid or inactive physician numbers. The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources that the Subcommittee has invested in this study and shares your concerns. CMS has already taken several steps to implement changes to its policies and procedures so this type of activity does not continue to occur.

On January 25, 2008, CMS published in the Federal Register a proposed rule titled, "Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prothetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards"(CMS-6036-P). In this proposed rule, CMS proposed requiring DMEPOS suppliers to maintain ordering and referring documentation received from a physician or other non-physician practitioner (e.g., nurse practitioner, physician assistant, etc.) for seven years. CMS believes that this change, if adopted, will strengthen our ability to identify fraudulent billing during documentation reviews. CMS is currently reviewing public comments received on this proposed rule. In addition, we are considering whether it is necessary to propose regulations requiring that physicians and nonphysician practitioners maintain documentation when ordering or referring services for Medicare patients.

Additionally, CMS is developing a data matching agreement with the Social Security Administration (SSA) which will provide CMS with monthly updates of the SSA Date of Death file. CMS will then match this information with information contained in the National Plan and Provider Enumeration System, the system that maintains information about National Provider Identifiers (NPI), and our provider enrollment database, the Provider Enrollment, Chain and Ownership System. After confirming the individual practitioner is deceased, CMS will deactivate both the NPI and the practitioner's enrollment in the Medicare program. We expect to have the data matching agreement and this new process implemented later this year.

Finally, while our current claims processing system allows an individual or organization NPI to be used for the purposes of ordering and referring services to Medicare beneficiaries, we anticipate implementing changes in 2009 that will limit ordering and referring to individual practitioners enrolled in the Medicare program.

CMS would like to again acknowledge our appreciation to the Permanent Subcommittee on Investigations for its efforts and appreciates the opportunity to review and comment on the Subcommittee's investigative findings. We believe the initiatives we have initiated will address many – if not all – of the issues surrounding the payments for claims to those health care providers who are using either invalid or inactive physician numbers. In this regard, we look forward to any additional insights the Subcommittee can provide to further assist us in strengthening our stewardship of the Medicare Trust Funds.

United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Homeland Security and Governmental Affairs
Carl Levin, Chairman
Norm Coleman, Ranking Minority Member

MEDICARE VULNERABILITIES: THE USE OF DIAGNOSIS CODES IN DME CLAIMS

MINORITY STAFF REPORT

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

SEPTEMBER 24, 2008

Permanent Subcommittee on Investigations
EXHIBIT #3

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

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PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
MINORITY STAFF REPORT
MEDICARE VULNERABILITIES:
THE USE OF DIAGNOSIS CODES IN DME CLAIMS

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# # #

U. S. SENATE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
MINORITY STAFF REPORT
ON
MEDICARE VULNERABILITIES: THE USE OF DIAGNOSIS CODES IN DME CLAIMS

I. INTRODUCTION

The Medicare program was established to provide health insurance for the elderly and the disabled. In 2007, Medicare paid more than $400 billion to cover more than 43 million beneficiaries.[1] Despite its noble intentions, the Medicare program has faced a pervasive and persistent problem with fraud, waste, and abuse. For instance, the Government Accountability Office (GAO) has designated the Medicare program as high risk, due to its size, complexity, and vulnerability to mismanagement and improper payments, for every year since 1990.[2] In its fiscal year 2005 performance and accountability report, the Department of Health and Human Services (HHS) reported that it paid an estimated $12.1 billion in improper payments for Medicare claims in that year alone.[3] The improper payments for fiscal year 2004 were even larger, amounting to an estimated $21.7 billion.[4]

Medicare Part B, the component in which Medicare pays for certain durable medical equipment and supplies (commonly called DME or DMEPOS), is particularly susceptible to abuse. According to the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Medicare program, abuses related to DME claims cost billions of dollars each year.[5] On March 8, 2007, CMS's Chief Financial Officer testified before a Congressional committee, "[t]he fraudulent business practices of unscrupulous durable medical equipment, prosthetics, orthotics, and supplies suppliers continue to cost the Medicare program billions of dollars."[6] In 2007, GAO reported that

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[1] *See* 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, at pg. 2.

[2] *See* GAO-07-310, High-Risk Series: An Update, January 2007.

[3] *See* U.S. Department of Health and Human Services, Fiscal Year 2005 Performance and Accountability Report, at pg. IV.C.8.

[4] *See id.*

[5] The Centers for Medicare and Medicaid Services was formerly called the Health Care Financing Administration (HCFA), until the entity was redesignated in 2001.

[6] *See* Testimony of CMS Chief Financial Officer Timothy B. Hill before the House Ways and Means Subcommittees on Health and Oversight, March 8, 2007.

CMS estimated that Medicare made improper payments based on mistakes, abuse, or fraud totaling approximately $700 million for DME supplies in a single year. According to GAO, these types of payments represented approximately 7.5 percent of its total payments for DME items.[7]

In light of reports of waste and abuse in the Medicare program, the U.S. Senate Permanent Subcommittee on Investigations (the Subcommittee) initiated an investigation into fraud, waste, and abuse in the Medicare program, with a particular focus on the diagnosis codes on DME claims. The Subcommittee's inquiry also examined the effectiveness of CMS's use of the codes.

Over the course of its investigation, Subcommittee staff examined extensive data concerning millions of DME claims submitted between 1995 and 2006. The Subcommittee also interviewed numerous officials from CMS, Medicare contractors, the Department of Justice Fraud Division, investigators from the Department of Health and Human Services Office of the Inspector General (HHS/OIG), as well as physicians, representatives of DME suppliers, and Medicare beneficiaries. In conjunction with that investigation, the Subcommittee held a hearing and released a bipartisan staff report on July 9, 2008, entitled *Medicare Vulnerabilities: Payments for Claims Tied to Deceased Doctors*.[8] That report estimated that, from 2000 through 2007, Medicare had paid up to $100 million for DME claims containing identification numbers assigned to doctors who had died between one and fifteen years before the claims.

In addition to its review of DME claims tied to deceased physicians, the Subcommittee examined the use of diagnosis codes associated with DME claims. This Report presents the Subcommittee staff's findings and Minority staff's recommendations with respect to that analysis.

II. EXECUTIVE SUMMARY

This Report examines several aspects of the Medicare DME benefit, with a particular focus on the requirement for and use of diagnosis codes. Diagnosis codes are the numeric or alphanumeric designations on a Medicare DME claim that identify the beneficiary's ailment. The Subcommittee's investigation found that the laws governing the use of diagnosis codes on most DME claims have been

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[7] *See* GAO 07-59, Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies, January 31, 2007.

[8] *See* U.S. Senate Permanent Subcommittee on Investigations, *Medicare Vulnerabilities: Payments for Claims Tied to Deceased Doctors* (July 9, 2008).

inconsistent from 1991 through 2003, including certain rules that appear contradictory. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the establishment and use of standardized codes (contained in the International Classification of Diseases, Ninth Revision, with Clinical Modification (ICD-9-CM)) on claims and CMS issued a regulation consistent with this requirement, which became effective in 2003.

Although diagnosis codes have been required on most DME claims since at least 2003, the Subcommittee found that CMS and its claims review contractors are not effectively utilizing the codes. For example, the Medicare claims review process examines claims to ensure that valid diagnosis codes are present, but does not review the claims to determine whether the diagnoses are remotely related to the purchased medical equipment. In short, the Subcommittee's investigation found that the diagnosis code requirement appears to be a mandate with little substantive purpose.

The Subcommittee examined data related to millions of DME claims in order to determine whether diagnosis codes submitted on claims could be utilized for beneficial purposes, including to identify questionable or improper payments and hence augment Medicare's efforts to uncover fraud, waste, and abuse. The Subcommittee's analysis of these claims identified many instances in which examining the diagnosis codes on DME claims could be a valuable tool to uncover fraudulent or abusive claims. For instance, the Subcommittee uncovered numerous claims in which the diagnosis code section contained a valid ICD-9-CM code, but the diagnosis appeared highly questionable and unrelated to the purchased medical equipment. For example, the Subcommittee reviewed hundreds of thousands of claims paid by Medicare for blood glucose test strips, which are used by diabetics to test their blood-sugar levels, and found that many contained questionable diagnoses that appear wholly unrelated to diabetes. The Subcommittee also uncovered hundreds of thousands of claims for blood glucose test strips in which the stated diagnosis was chronic airway obstruction, bubonic plague, leprosy, typhoid, or cholera. Experts interviewed by the Subcommittee – including representatives of the Centers for Disease Control and Prevention, a prominent manufacturer of blood glucose strips, and a well-known medical school – universally confirmed that such diagnoses were not appropriate for that product. The Subcommittee's analysis of blood glucose test strips and 17 other DME items found millions of claims that contained questionable diagnosis codes totaling more than $1 billion.

The Subcommittee also examined claims data from 1995 through 2006 related to $4.8 billion in Medicare payments for 60 million DME

items that contained diagnosis codes that were invalid, blank, or unprocessable. To analyze these claims, the Subcommittee conducted a detailed examination of a subset of 2,000 claim submissions. The Subcommittee could not verify more than 30 percent of the 2,000 claims as legitimate and found during the detailed review that other elements of the claim bore certain characteristics of fraudulent activity. Numerous claims, for instance, contained the identification number of a doctor who had died years before the service dates on the claims. For hundreds of other items, the doctors identified on the claims denied that they had prescribed those items, or even that they had treated those patients.

Notably, while not every instance of an invalid or questionable diagnosis code found during the Subcommittee's review necessarily reflects an improper payment, and while the number of claims with invalid diagnosis codes decreased significantly after the implementation of HIPAA in 2003, Medicare's history of weaknesses in its payment processes suggest that additional procedures are needed to ensure that payments are accurate and in compliance with program rules.[9] The Subcommittee's analysis suggests that incorporating system edits that would deny claims or flag them for medical review or follow-up, or otherwise performing analysis of diagnosis codes could be a useful tool in uncovering questionable DME claims, preventing fraud, waste, and abuse, and reducing improper payments. In fact, Congress contemplated the use of diagnosis codes for "prepayment screens" as far back as 1988.[10] The Subcommittee's findings propose that analyzing the diagnosis codes on claim submissions could be an effective control mechanism to assist Medicare's efforts to reduce improper payments.

A. REPORT FINDINGS

Based on its investigation, the Subcommittee staff makes the following findings:

1. **Rules Governing the Use of Diagnosis Codes on DME Claims from Suppliers Have Been Inconsistent.** Between 1991 and 2003, the laws and regulations governing the submission of diagnosis codes on claims from DME suppliers have been inconsistent and, in some cases, appear contradictory. Moreover, although diagnosis

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[9] The Subcommittee's review of the claims data revealed that Medicare continued to pay DME suppliers for claims that contained invalid diagnosis codes after the 2003 implementation of HIPAA. However, the volume and amount of these claims decreased after 2003, with Subcommittee analysis showing that Medicare paid more than $23 million for DME claims that contained invalid diagnosis codes.

[10] *See* 54 FR 30558, Medicare Program; Diagnosis Codes on Physician Bills (July 21, 1989).

codes have been required since the implementation of HIPAA in 2003, CMS's application of the diagnosis code requirement is inconsistent, potentially resulting in the payment of some items tied to invalid diagnosis codes and the rejection of claims that contain valid diagnosis codes.

2. **Medicare Has Not Used Diagnosis Codes Effectively in the Claims Review Process.** Although diagnosis codes have been required for DME supplier claims since at least 2003, Medicare generally does not use the codes to assist in determining the validity or medical necessity of the claims. In paying the claims, CMS's utilization of the codes is largely limited to verifying the presence of a valid code.

3. **Some Data Related to Millions of Claims Was Incorrect and Outdated.** Over the course of its investigation, the Subcommittee learned that some claims records contained incorrect and outdated information. Although the source of the flawed data is unclear, that data caused certain diagnosis codes to be described as invalid, when in fact, they were valid. This caused an overstatement of claims with invalid diagnosis codes of more than $1.4 billion.

In its communications with the Subcommittee, CMS officials stated that CMS is currently undergoing substantial changes in the way Medicare claims are processed. According to the officials, many changes that directly affect Medicare claims are in progress, such as changes to physician and DME supplier identification numbers.[11] The officials assert that these modifications will make the claims process more standardized among the claims processing contractors.[12]

B. Report Recommendations

Based upon the Subcommittee's investigation and the ongoing reform of the Medicare claims review processes, the Subcommittee minority staff makes the following recommendations:

1. **Strengthen Claims Review Process.** CMS should consider strengthening the claims review process by more effectively utilizing all diagnosis codes submitted on claims. All diagnosis codes entered onto a claim should be valid and medically relate to the supplied DME items. Claims with any invalid or incorrect codes should be rejected and returned to the biller for correction.

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[11] *See* 45 CFR Part 162, Federal Register, Vol. 69, No. 15, January 23, 2004, at pg. 3434.

[12] Subcommittee interview of CMS officials, January 10, 2008.

2. **Consider Developing Procedures to Link Diagnosis Codes with Medical Procedures.** CMS should consider developing processes that use the diagnosis codes to prevent, detect, and reject improper payments. This could include creating procedures to link ICD-9-CM diagnosis codes included on DME claims with authorized medical procedures (HCPCS), similar to what is already being performed by some contractors on select DME items.

3. **Consider Developing Procedures to Link Claims for DME Items with a Corresponding Claim for Medical Treatment.** CMS should consider incorporating an edit into the claims processing system that would check a claim for a DME item against a claim for a doctor visit that would have resulted in an order or prescription for the item, similar to what is already being performed on DME claims for select items. Furthermore, for DME claims that do not have a corresponding medical treatment claims, CMS should consider performing additional procedures in order to ensure the medical necessity and integrity of the claims.

4. **Strengthen Contractor Oversight.** CMS should consider strengthening its contractor oversight, including contractor penalties for making improper payments or maintaining unreliable data.

III. BACKGROUND

This Report examines certain aspects of the Medicare claims process in general and the durable medical equipment benefit in particular. In exploring these issues, several central concepts, terms, and entities warrant some background and context, which is presented below.

A. Overview of Medicare and Claims for Durable Medical Equipment Under Part B

1. Medicare and DME in General

Title XVIII of the Social Security Act (SSA), entitled "Health Insurance for the Aged and Disabled," established the Medicare program in 1965.[13] Medicare was created to provide health insurance for the aged, disabled, and persons with end-stage renal disease. The program is administered by the HHS through CMS.

[13] Title XVIII appears in the United States Code at 42 U.S.C. §§ 1395-1395(ccc).

Medicare is comprised of four parts. Part A, the Hospital Insurance Program, covers hospital services, post-hospital services, and hospice services. Part B, the Supplementary Medical Insurance Program, covers medical services including physician, laboratory, outpatient services, and DME. Part C covers managed care options for beneficiaries enrolled in Part A and Part B. Part D, created by the Medicare Prescription Drug Improvement and Modernization Act of 2003, covers outpatient prescription drug benefits as of January 1, 2006.[14]

Under Part B, the Medicare program will pay for certain DME for eligible Medicare beneficiaries under the DMEPOS benefit.[15] The term DME refers to medical equipment and supplies that are used in the patient's home (including an institution such as a nursing home in which the patient resides).[16] Medicare regulations define DME as:

> [E]quipment furnished by a supplier or a home health agency that:
>
> (1) Can withstand repeated use;
>
> (2) Is primarily and customarily used to serve a medical purpose;
>
> (3) Generally is not useful to an individual in the absence of an illness or injury; and
>
> (4) Is appropriate for use in the home.[17]

Examples of DME include wheelchairs, oxygen concentrators, nebulizers, canes, hospital beds, and diabetic equipment and supplies, such as blood glucose test strips.

2. DME Claims and Suppliers

The Medicare claims process for DME typically involves three parties: (1) the Medicare beneficiary, who is a patient eligible for Medicare that needs certain medical supplies or equipment; (2) the medical practitioner, such as a physician, nurse practitioner, physician assistant, clinical social worker or psychologist, who is treating the beneficiary and prescribing the equipment; and (3) the DME supplier, a private entity authorized by CMS to provide DME items to Medicare beneficiaries and bill Medicare directly. The process of a DME claim generally starts with the Medicare beneficiary receiving treatment from a

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[14] Prior to this date, certain prescription drugs were covered under Medicare Part B.

[15] *See* SSA §1833(a)(1)(I).

[16] *See* SSA §1861(n).

[17] *See* 42 CFR 414.202.

medical practitioner. If the physician writes an order or prescription for DME, the beneficiary can take the prescription to a DME supplier of his or her choosing and the DME supplier sells or rents the prescribed item to the beneficiary.[18]

In most circumstances, the DME supplier then submits a claim for payment to an entity authorized by CMS to receive, review, and process Medicare claims, Durable Medical Equipment Regional Carrier (DMERC) or other Medicare carrier.[19] DMERCs were established to standardize the coverage and payment of DME claims and were designed to be the experts in the Medicare DME claims process. Their primary role was to accept and process Medicare Part B DME claims. In doing so, DMERCs were also expected to consolidate and focus efforts to combat fraud, waste, and abuse in the DME benefit program.[20]

Physicians generally file claims to Medicare that deal with treatment, office visits, and other medical procedures, while DME claims are typically submitted by suppliers. As noted above, DME suppliers are entities that are enrolled in the Medicare program to sell or rent durable medical equipment to eligible beneficiaries and submit claims for payment directly to Medicare. DME suppliers typically include pharmacies or companies that specialize in DME such as wheelchairs, oxygen supplies, diabetic supplies and other supplies and equipment that are provided to Medicare beneficiaries, as well as other medical patients.

3. DME Must Be "Medically Necessary"

In creating Medicare, the Social Security Act provides that only items and services that are medically necessary will be covered. Section 1862 (a)(1)(A) of the Social Security Act states: "[N]o payment may be made under Part A or Part B for any expenses incurred for items or

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[18] For certain DME, including equipment that is expensive and prone to fraudulent activity, CMS regulations require the physician to provide a Certificate of Medical Necessity (CMN) in addition to a prescription. For instance, Medicare requires a CMN for oxygen or infusion pumps. A CMN is a form required to help document the medical necessity and other coverage criteria for selected DMEPOS. *See* Medicare Claims Processing Manual, Chapter 20, Section 100.2.

[19] DME Medicare Administrative Contractors (DME MACs) replaced the DMERCS beginning in January 2006 to comply with Medicare Modernization Act of 2003, which amended 42 U.S.C. Section 1874A. The DME MACS are now responsible for administering the Medicare Part B DME Claims. DMERCS were the claims processing contractors for all claims reviewed for this report.

[20] Section 911 of the Medicare Modernization Act of 2003, known as the Medicare Contracting Reform provision, required CMS to compete all currently held contracts for administration of the Medicare fee-for service program. The new contractors selected through these competitions are called Medicare Administrative Contractors (MACs). DME MACs are the new contractors for DME services.

services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS has referenced the medical necessity requirement frequently in its regulations, publications, and notices sent to DME suppliers and contractors. For instance, in a 2002 Program Memorandum sent to Medicare carriers, CMS stated, "Medicare pays for DMEPOS when it is medically necessary for use in a patient's home."[21] Similarly, the Medicare Program General Information section of CMS's website emphasizes that Part B of Medicare (which includes DME claims) covers only medically necessary items and services: "Part B helps pay for these covered services and supplies when they are medically necessary."[22]

CMS also uses the term in its Medicare Claims Processing Manual. For instance, Chapter 20, Section 10.2 of the manual contains a table that delineates the conditions that must be met before a DME claim will be paid; the first requirement in the table is that the DME must be medically necessary.[23] Medicare carriers, the contractors retained by CMS to administer many functions of the program, have also emphasized the requirement that claims for DME be medically necessary in notices they have published for the providers within their jurisdictions.[24] More recently, the Chief Financial Officer of CMS testified before the House of Representatives Committee on the Budget in July 2007 and reiterated the medical necessity requirement established in the Social Security Act, stating "Medicare contractors review claims submitted by providers to ensure payment is made only for Medicare-

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[21] *See* CMS Program Memorandum - Carriers, Transmittal B-02-087, Change Request 2453, November 8, 2002.

[22] *See* http://www.cms.hhs.gov/MedicareGenInfo/; *see also* http://www.cms.hhs.gov/MedicareGenInfo/03_Part%20B.asp#TopOfPage.

[23] *See* Medicare Claims Processing Manual, Chapter 20, Section 10.2.

[24] *See* http://www.palmettogba.com/palmetto/providers.nsf/(Docs)/296333A85C1581A2852573310065FDC7?OpenDocument; http://www.cignagovernmentservices.com/jc/pubs/pdf/2007_winter/2007_winter_SM.pdf; https://www.noridianmedicare.com/dme/news/bulletins/dmercdialogue/winter_2005/winter05_dd.pdf.

covered items and services that are reasonable and necessary and furnished to eligible individuals."[25]

The failure to establish the medical necessity requirement has been a substantial problem in the Medicare program, according to previous annual reports issued by the HHS/OIG. The HHS/OIG analyzed Medicare claims filed over the four-year period between 1996 and 1999 and found that the failures to establish the medical necessity of the DME supplies and other errors "have been and continue to be pervasive problems."[26] The OIG reported that documentation errors and the failure to establish medical necessity accounted for more than 70 percent of the total improper payments over the four-year timeframe.

The HHS/OIG's analysis of claims filed in 1999 with respect to the medical necessity requirement is particularly noteworthy. The HHS/OIG conducted an in-depth audit of Medicare claims filed in 1999 in order to determine whether Medicare fee-for-service payments were made in accordance with the Social Security Act and implementing regulations, including the medically necessity requirement. In the report, the HHS/OIG concluded that Medicare made improper payments totaling $13.5 billion in 1999 alone. Notably, the HHS/OIG found that more than 45 percent of the total improper payments in 1999 – meaning $4.4 billion – were for claims that lacked proof of medical necessity.

4. International Classification of Diseases, Ninth Revision, with Clinical Modification (ICD-9-CM) Diagnosis Codes

Medicare regulations require that claims must contain certain information in order to qualify for payment. Claims must include valid identification numbers for the beneficiary, medical provider, and DME

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[25] *See* Testimony of Timothy B. Hill, CFO, Centers for Medicare and Medicaid Services before the House Budget Committee, Medicare Health Care Fraud and Abuse Efforts, July 17, 2007, https://www.hhs.gov/asl/testify/2007/07/t20070717b.html. Federal courts have also noted that claims under Medicare Part B must be medically necessary. The U.S. Supreme Court in Schweiker v. McClure described the Medicare Part B claims review process as follows: "Once the carrier has been billed for a particular service, it decides initially whether the services were medically necessary, whether the charges are reasonable, and whether the claim is otherwise covered by Part B." 456 U.S. 188, 191, 102 S. Ct. 1665, 1667 (1982) (citing the Social Security Act). Although the facts of Schweiker involved a claim under Part B for medical services, rather than the DME claims that are at issue in this report, the requirement of medical necessity is identical. Like the Supreme Court in Schweiker, the United States Court of Appeals for the Eleventh Circuit explained in Gulfcoast Medical Supply, Inc. v. Secretary, Department of Health and Human Services that Part B Medicare coverage "extends to only those medical services that are medically 'reasonable and necessary' for the beneficiary." 468 F.3d 1347 (11th Cir. 2006).

[26] *See* HHS/OIG, *Improper Fiscal Year 1999 Medicare Fee-for-Service Payments*, Number A-17-99-01999.

supplier.[27] Additionally, claims must contain certain codes or other information that describes the beneficiary's diagnosis.[28] For instance, if a beneficiary needs a DME item, such as a wheelchair, the claim must include a diagnosis from a medical professional of the physical condition that indicates the wheelchair is reasonable and necessary. Current CMS regulations mandate that claims that do not have valid information – including a medical diagnosis – must be returned to the supplier for correction.[29]

Medicare regulations have required that certain claims must reflect the patient's diagnoses in a standardized numeric or alphanumeric code.[30] CMS has adopted the coding system called the International Classification of Diseases, Ninth Revision, with Clinical Modification, which is commonly referred to as the ICD-9-CM. CMS described and provided the history of the ICD-9-CM as follows:

> The International Classification of Diseases, Ninth Revision (ICD-9) is a classification system developed by the World Health Organization for recording morbidity and mortality information for statistical purposes, for indexing hospital records by diseases, and for storing and retrieving data. The clinical modification to ICD-9 (that is, ICD-9-CM) is a coding system for reporting diagnostic information and procedures performed on a patient in hospitals or connected with other types of health care delivery systems.
>
> ICD-9-CM was developed under the guidance of the National Center for Health Statistics (NCHS) to adapt the ICD-9 classification system to the needs of hospitals in the United States. The modifications were intended to provide a mechanism to present a clinical picture of the patient. Thus, ICD-9-CM codes are more precise than those included in ICD-9 since greater precision is needed to describe the clinical picture of a patient than for statistical groupings and trend analysis.

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[27] *See* Medicare Claims Processing Manual, Chapter 1, Section 80.3.1 through 80.3.2.

[28] *See, e.g.*, 42 CFR 424.32 (requiring physicians to provide ICD-9-CM diagnosis code for all claims for services and items).

[29] *See* Medicare Claims Processing Manual, Chapter 1, Section 80.3.2. When a claim is valid, CMS regulations require that the claim be paid within thirty days. *See* Medicare Claims Processing Manual, Chapter 1, Section 80.2.1.1. Any claim that contains invalid data, however, is not considered received for purposes of the thirty-day prompt-payment rule. *See* Medicare Claims Processing Manual, Chapter 1, Section 80.3.2.

[30] *See id.*

> Effective January 1979, after nearly two years of development by numerous national experts on clinical technical matters, the ICD-9-CM became the single classification system intended for use by hospitals in the United States. This system replaced several earlier related but somewhat dissimilar classification systems. ...

The ICD-9-CM is a numeric and, in some circumstances, alphanumeric code that ranges from three to five digits and describes the clinical reason for a patient's treatment. Examples of valid ICD-9-CM diagnosis codes are identified in Figure 1 below.

EXAMPLES OF VALID ICD-9-CM DIAGNOSIS CODES	
Medical Diagnosis	ICD-9-CM Diagnosis Code
Asthma	493
Diabetes	250.0
Chronic airway obstruction not elsewhere classified	496
Bubonic plague	020.0
Acute but ill-defined cerebrovascular disease	436
Cholera	001
Congestive heart failure unspecified	428.0
Motor vehicle traffic accident involving collision with other vehicle injuring other specified person	E813.8

Figure 1

B. LEGISLATION AND REGULATIONS GOVERNING DME CLAIMS UNDER MEDICARE PART B

Prior to 1989, only hospitals were required to include ICD-9-CM diagnosis codes in connection with Medicare claims. In 1989, HCFA implemented rules pursuant to the Medicare Catastrophic Coverage Act of 1988 (MCCA) that required that claims submitted by physicians for items or services contain a valid diagnosis code.[31] In the conference

[31] *See* Public Law 100-360, Section 202(g)(p)(1) (amending Social Security Act, 42 U.S.C. 1395u), July 1, 1988. A Senate version of the MCCA would have required that all prescriptions from physicians contain a valid diagnosis code, but the Conference Committee determined that requirement would be too burdensome on physicians. As a result, the Conference Committee agreed that only claims for services from physicians required a diagnosis code. *See* CR 100-661. The final language of the MCCA, however, still included the term "items": "Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service."

report that accompanied the MCCA, the conferees explained their reasoning for requiring diagnostic coding for physician services under Part B as follows: "This information would be available for immediate use for utilization review of physician services (and could be used for prepayment screens)..."[32] In keeping with the use of ICD-9-CM codes for hospital claims, CMS determined that the appropriate codes for physician claims would be the ICD-9-CM as well.[33] Although DME claims submitted by hospitals and physicians were required to contain diagnosis codes, it is unclear when DME claims submitted by suppliers were required to include diagnosis codes. Below is a review of relevant laws and regulations that address the use of diagnosis codes for DME claims from suppliers.

1. The 1991 Notice

On November 29, 1991, HCFA published 56 FR 61023, a notice entitled "Medicare Program: Standard Claim Forms for Part B Claims Completed and Submitted by Physicians, Suppliers and Other Persons" (the 1991 Notice). Before the promulgation of this notice, DME suppliers had been allowed to attach supporting documents to their claims that contained relevant diagnosis information, such as medical records, narratives, or Certificates of Medical Necessity. The 1991 Notice forbade the attachment of supplemental materials and required all claims to be uniform. The notice announced that, effective April 1, 1992, Medicare would no longer accept so-called non-standard claims. The notice defined non-standard claims as claims accompanied by attachments in lieu of the biller entering the required information in the designated blocks of the prescribed claim forms. Additionally, the rule mandated that physician and supplies must submit claims on a specified form, the HCFA Form 1500.[34]

> Effective April 1, 1992, Medicare carriers will no longer accept claim attachments for information that physicians and suppliers may enter in designated blocks of prescribed claim forms. Incomplete claim forms will be returned to the billing individual or entity for proper completion and resubmission. The claim submission requirement in section 1848(g)(4)(A) of the Act is not satisfied until a standard, prescribed claim form is properly completed and submitted by the physician,

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[32] H.R. Rep. No. 661, 100th Cong., 2nd Sess. 191 (1988).

[33] *See* 54 FR 30558.

[34] The HCFA Form 1500 is the standard claim form used by physicians and suppliers to file claims for treatment and equipment provided to Medicare beneficiaries.

> supplier or authorized billing entity and received for processing by the servicing carrier.[35]

CMS explained in the notice that the change was necessary to eliminate costly and inefficient claim processing practices that were resulting from processing claims with attachments. CMS also justified the rule change by stating that non-standard claims (i) create additional administrative burdens on the carriers that process the claims, (ii) generate additional cost per claim, and (iii) slow the claim process down 30 to 50 percent. CMS also explained that each of the carriers handled claims differently.[36]

> Currently, we allow carriers to determine whether they will accept non-standard claims for processing. Some carriers accept only standard claims. Some accept non-standard claims, but may restrict which information is allowed to be included. Others accept non-standard claims without restrictions.

The notice instructed physicians, suppliers, and other persons to stop submitting claims for DME with attachments when the information contained in the attachments could be entered into the appropriate blocks of the HCFA Form 1500. Notably, the HCFA Form 1500 contains blocks for up to four diagnosis codes.

2. 1994 Final Rule from MCCA

Roughly two years later, on March 4, 1994, HCFA published a rule that affected the submission of diagnosis claims in DME claims from suppliers.[37] This rule, which was adopted pursuant to the MCCA, amended the relevant Medicare regulations to require that all claims for items and services from physicians contain a valid ICD-9-CM diagnosis code. However, in promulgating the final rule, HCFA stated, "the proposed rule did not apply to suppliers or other providers whose services are covered under Part B."[38] HCFA also responded to a comment submitted during the comment period on the proposed rule concerning the diagnosis code requirement. The commenter asserted that, even though most DME suppliers were already providing diagnosis codes with their claims, there should be no requirement for DME suppliers to provide diagnosis codes. Notably, despite the language of the 1991 Notice that required suppliers to use the Form 1500 and

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[35] *See* 56 FR 61023.

[36] *See id.*

[37] *See* 59 FR 10290, March 4, 1994, Medicare Program: Diagnosis Codes on Physician Bills.

[38] *See id.,* Section III. Provisions of the Proposed Rule.

complete the field for diagnosis codes on that form, HCFA responded that it had never required DME suppliers to provide diagnosis codes.[39] Figure 2 below presents the relevant section of the final rule.

> *Comment:* One commenter stated that suppliers cannot be required to include diagnostic coding on Part B bills even though they often provide the diagnostic codes identified by the physician on bills for equipment and supplies.
>
> *Response:* We have never required suppliers to include diagnostic coding on their Part B bills. Section 1842(p)(1) of the Act requires physicians, as defined in section 1861(r) of the Act, and subject to limitations concerning the scope of practice by each State and other provisions of title XVIII of the Act, to furnish diagnostic coding. That is, only doctors of medicine or osteopathy, dental surgery or dental medicine, podiatry, optometry, or chiropractic must furnish diagnostic coding. Durable medical equipment suppliers are not included in this requirement.

Figure 2

3. 1996 Bulletin

In February 1996, HCFA issued a bulletin to all of its providers – including DME suppliers – that articulated new rules regarding invalid and incomplete claims. Section 5.0 of the Provider Bulletin, entitled "Return/Reject Claims," stated:

> The Health Care Financing Administration (HCFA) is continuing efforts to reduce costs and administrative waste. As of April 1, 1996, a new editing process will be implemented for assigned claims which will save the Medicare Trust Fund millions of dollars. For some time, the denial of claims with incomplete or invalid information has resulted in claims surfacing inappropriately into the appeals process. This practice has not only been costly, it has resulted in an inappropriate use of the appeals system.
>
> This new editing process will return paper or electronic claims to you as unprocessable if the claim contains certain incomplete or invalid information. No appeal rights will be afforded to these claims, or portion of these claims, because the "initial determination" can not be made; rendering the claim unprocessable.

The bulletin contains a matrix that instructs providers on how to handle certain issues. The matrix states that claims will be returned as unprocessable if the information supplied for certain sections of the claim form (the HCFA Form 1500) is incomplete or invalid. The matrix

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[39] *See* 59 FR at 10291.

indicates that Medicare will reject claims if the information regarding diagnosis codes is incomplete or invalid.[40]

4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The landscape concerning the use of diagnosis codes changed once again with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on August 21, 1996. HIPAA amended various statutes including the Internal Revenue Code of 1986 and the Social Security Act. Title II of HIPAA, entitled "Preventing Health Care Fraud and Abuse; Administrative Simplification; Medical Liability Reform," mandated certain requirements for Medicare claims. In particular, Section 1173(c) mandated that the program establish standardized codes for the data required for Medicare claims. As part of that requirement, HIPAA required HHS to establish a standardized set of codes, including diagnosis codes, for all Medicare claims.[41] [As noted above, Medicare regulations already required hospitals and physicians to use ICD-9-CM for diagnoses in connection with the submission of DME claims.]

5. The Balanced Budget Act of 1997

Section 4317 of the Balanced Budget Act of 1997 expanded the requirement for medical professionals to provide diagnostic information for Medicare claims. The Act added additional medical professionals to the definition of "practitioner" in 42 U.S.C. 1395(u) such as a physician assistant, nurse practitioner or certified nurse anesthetist. This Act also stated that, when an item or service ordered by a practitioner is provided by "another entity" (including a DME supplier) and Medicare requires that entity to provide diagnostic information, the practitioner must provide the diagnostic information at the time the item or service is ordered.

6. Implementation of HIPAA in 2003

Pursuant to the requirements set forth in HIPAA, CMS published a bulletin on June 13, 2003, entitled "Establishing New Requirements for ICD-9-CM Coding on Claims Submitted to Medicare Carriers – Increased Role for Physicians/Practitioners." The bulletin stated that, pursuant to the requirements established by HIPAA, for claims with dates of service on or after October 1, 2003:

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[40] *See* February 1996 HCFA Provider Bulletin, Section 5.0.

[41] *See* Section 1173 (a) (1), Public Law 104-191, August 21, 1996.

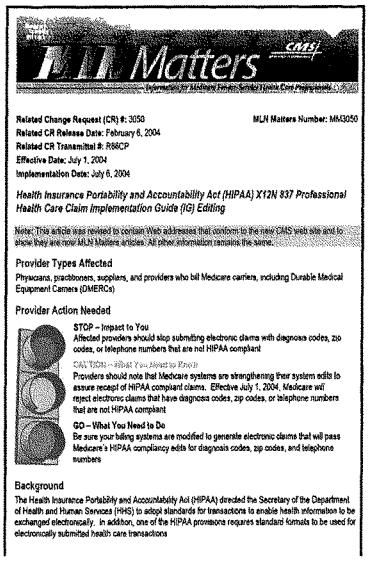
> ICD-9-CM diagnosis codes must be included on all Medicare electronic and paper claims billed to Part B carriers, with the exception of ambulance claims. Providers and suppliers rely on physicians to provide a diagnosis code or narrative diagnostic statement on orders/referrals. This guidance serves as a reminder that physician/practitioners must provide a diagnosis on all orders and referrals.

The bulletin states under the heading, "New Policy," that any claim (other than ambulance services) submitted for payment that does not contain a valid diagnosis code will be returned as unprocessable:

> Effective for dates of service on or after October 1, 2003, all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers. ... Carriers will return as unprocessable paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers. ... Therefore, the diagnosis code must be entered on the claim by the submitter.

This bulletin, like the 1996 HCFA bulletin, made clear that all claims must contain the complete and valid diagnosis code in order to be accepted for processing.

Following the implementation of the HIPAA regulations in 2003, CMS repeatedly emphasized to DME suppliers that they must provide valid diagnosis codes in their claims. For instance, in February 2004, CMS issued a bulletin instructing its claims processing contractors to strengthen the review of claims to ensure that claims containing invalid diagnosis codes, among other errors, would be rejected. This bulletin, which is reproduced in Figure 3 below, required CMS's contractors to reject all inbound electronic claims that contained an invalid diagnosis code. This change was effective as of July 1, 2004. Notably, under the headings "Provider Action Needed" and "Caution – What You Need to Know," the bulletin stated that Medicare providers – such as DME suppliers and physicians – should note that Medicare systems are strengthening system edits to ensure that submitted claims are HIPAA compliant, including containing diagnosis codes.



MLN Matters

Related Change Request (CR) #: 3050 MLN Matters Number: MM3050
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R86CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Professional Health Care Claim Implementation Guide (IG) Editing

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians, practitioners, suppliers, and providers who bill Medicare carriers, including Durable Medical Equipment Carriers (DMERCs)

Provider Action Needed

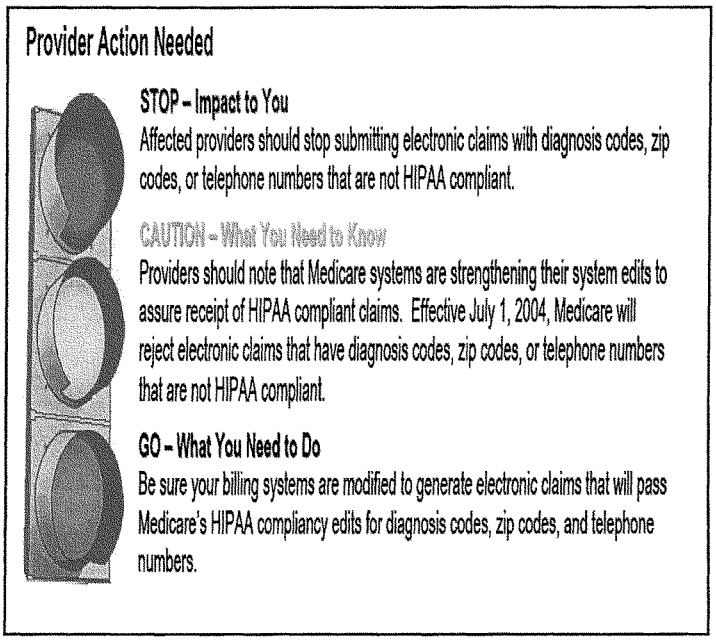
STOP – Impact to You
Affected providers should stop submitting electronic claims with diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant

CAUTION – What You Need to Know
Providers should note that Medicare systems are strengthening their system edits to assure receipt of HIPAA compliant claims. Effective July 1, 2004, Medicare will reject electronic claims that have diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant

GO – What You Need to Do
Be sure your billing systems are modified to generate electronic claims that will pass Medicare's HIPAA compliancy edits for diagnosis codes, zip codes, and telephone numbers

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically. In addition, one of the HIPAA provisions requires standard formats to be used for electronically submitted health care transactions



Provider Action Needed

STOP – Impact to You
Affected providers should stop submitting electronic claims with diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

CAUTION – What You Need to Know
Providers should note that Medicare systems are strengthening their system edits to assure receipt of HIPAA compliant claims. Effective July 1, 2004, Medicare will reject electronic claims that have diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

GO – What You Need to Do
Be sure your billing systems are modified to generate electronic claims that will pass Medicare's HIPAA compliancy edits for diagnosis codes, zip codes, and telephone numbers.

Figure 3

In 2007, CMS issued another bulletin to Medicare providers further confirming that valid diagnosis codes must be included in all DME claims. CMS published the Medicare B News bulletin, entitled *Common Billing Errors to Avoid When Billing Medicare Carriers*, which discussed frequent billing problems in Medicare claims.[42] One of the common billing errors listed involved diagnosis codes, stating:

> Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.[43]

These bulletins illustrate that, at least since the implementation of HIPAA in 2003, DME suppliers have been required to provide valid ICD-9-CM diagnosis codes. Despite the requirement to include diagnosis codes, however, it is clear based on comments made by CMS officials and the results of the Subcommittee's review that the codes are not used effectively to help ensure payments are made on claims that are medically necessary or utilized as a mechanism to prevent fraud, waste, and abuse.

IV. ANALYSIS

The Subcommittee's investigation has focused on fraud, waste, and abuse in claims submitted by DME suppliers and the efficacy of oversight by CMS and its contractors designed to prevent such abuses.[44] The Subcommittee's review reveals that the laws governing the use of diagnosis codes in DME claims have been inconsistent and, even after CMS required the submission of valid diagnosis codes for all DME supplier claims, Medicare does not fully utilize the submitted diagnosis codes to prevent fraud, waste, and abuse. For instance, Medicare has required hospitals and physicians to provide diagnosis codes on DME claims for decades; in contrast, the rules governing the use of such codes in claims from DME suppliers have been inconsistent. Moreover, even after Congress expressly required DME suppliers to provide such codes, the Medicare program does not use the codes for any significant purpose. In fact, CMS officials have emphasized to the Subcommittee that CMS requires DME claims to have diagnosis codes only to comply with HIPAA and, in the vast majority of cases, does not use them in its determination of whether a claim is valid or compliant with program

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[42] *See* Medicare B News, Issue 236, April 17, 2006, MLN Matters Number: SE0712.

[43] *See id.*

[44] The Subcommittee's review of the database revealed that it included only claims submitted from DME suppliers and did not include claims from physicians or hospitals.

requirements.[45] The Subcommittee examined several issues concerning the requirement for and use of diagnosis codes and its findings are presented below.

A. Laws and Regulations Governing The Use of Diagnosis Codes On Claims From DME Suppliers Have Been Inconsistent

1. From 1991 to 2003, Rules Governing the Submission of Diagnosis Code for DME Supplier Claims Were Unclear and Contradictory

The laws and regulations described above illustrate the inconsistent history of the requirement for diagnosis codes on DME supplier claims. Current law, established by HIPAA in 1996 and implemented by CMS regulations in 2003, requires that DME claims submitted by suppliers must include valid ICD-9-CM diagnosis codes or else those claims will be rejected and returned to the supplier for correction.[46] Before HIPAA required the inclusion of such codes, however, the requirements regarding diagnosis codes on supplier submitted DME claims appear to shift from 1991 through 2003. Figure 4 delineates how those rules appeared to change over time.

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[45] Subcommittee interview with CMS officials, May 10, 2008; *see also* CMS Response, Appendix, at pgs. 2-3 and CMS Response, Appendix, Addendum A, at pgs. 1-2.

[46] *See* CMS Program Memorandum-Carriers, Transmittal B-03-046, Change request 2784, June 10, 2003.

HISTORY OF MEDICARE RULES GOVERNING THE USE OF DIAGNOSIS CODES FOR DME SUPPLIER CLAIMS			
Year	**Action**	**Description of Rules**	**Diagnosis codes required for DME supplier claims?***
1991	CMS issues 1991 Notice	Standardizes claim submissions, including those from suppliers, and requires completion of HCFA Form 1500, which contained blocks to enter diagnosis codes.	Yes
1994	CMS implements final rule pursuant to MCCA	Requires valid diagnosis codes for DME claims submitted only by physicians. CMS stated in Section III and in reference to comments made on the proposed rule that DME suppliers are not required to provide diagnosis codes.	No
1996	CMS issues a bulletin to all providers	States that claims submitted by providers, including DME suppliers, would be returned as unprocessable if the claim contained incomplete or invalid information. Included is a matrix that indicated Medicare would reject claims if information regarding diagnosis codes was incomplete or invalid.	Yes
2003	CMS begins implementation of HIPAA rules	Requires all providers, including suppliers, to use valid ICD-9-CM diagnosis codes on all electronic and paper claims, except ambulance claims.	Yes

*Based on Subcommittee Analysis

Figure 4

In 1991, CMS issued the 1991 Notice, which mandated that all Medicare providers – including DME suppliers – must submit claims on a completed HCFA Form 1500. Considering that the Form 1500 requires the submission of diagnosis codes and CMS emphasized that incomplete claim forms would be rejected, the 1991 Notice appears to have required DME suppliers to include diagnosis codes when submitting claims. Nevertheless, a few years later, CMS promulgated a rule in 1994 pursuant to the MCCA that required physicians to provide diagnosis codes on DME claims, but in the Provisions of the Proposed Rule section and in response to a comment, expressly excluded DME suppliers from this requirement. CMS could not have been clearer in its statement: "Durable medical equipment suppliers are not included in this requirement."[47]

Although DME suppliers were excluded from the diagnosis code requirement in the 1994 rule, the February 1996 Provider Bulletin, which was issued to DME suppliers as well as physicians and other providers, lists diagnosis codes as required data for the submission of DME claims. HCFA appears to state in the 1996 bulletin that DME claims – including claims submitted by suppliers – that did not contain valid diagnosis codes would be returned and rejected. However, in its

[47] *See id.* at 102941.

comments to the Subcommittee, CMS stated that prior to HIPAA implementation, "the DME claim processing system did not check a claim's primary diagnosis code upon submission to determine whether the code was recognized and in the appropriate format as defined by the ICD-9-CM Manual."[48] CMS goes on to comment that "one may very well find paid DME claims with invalid or illegitimate ICD-9 codes."[49] Arguably, diagnosis codes were required on claims as early as 1991, years earlier than HIPAA implementation in 2003, as CMS has suggested.

2. Since Implementation of HIPAA in 2003, Application of Diagnosis Code Requirement Has Been Inconsistent

Even after implementation of the HIPAA requirement for claims to contain diagnosis codes, CMS's application of the diagnosis code requirement is inconsistent. As described below, the manner in which the Medicare claims review process examines diagnosis codes can result in the payment of some items tied to invalid diagnosis codes and the rejection of claims that contain valid diagnosis codes.

CMS regulations require that all DME claims must use the CMS Form 1500. That claim form permits DME suppliers to enter up to six items on one form; each individual item is listed on a separate "claim line." Each claim line is essentially equivalent to a separate DME claim, and for efficiency purposes, CMS permits up to six different claim lines on a single Form 1500. Because each item may relate to a different diagnosis, the Form 1500 contains spaces for up to four diagnosis codes. The claims form instructs the DME supplier to indicate which diagnosis relates to the individual DME items. The pertinent section of the claim form (Form 1500) is reproduced in Figure 5 below. The spaces for the four diagnosis codes appear in Section 21; the codes for the DME items appear in Section 24. The form directs the supplier to link the applicable diagnosis code to the associated item through the "pointer" on the right of the DME item.

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[48] *See* CMS Response, Appendix, at pg. 2.

[49] *Id.*

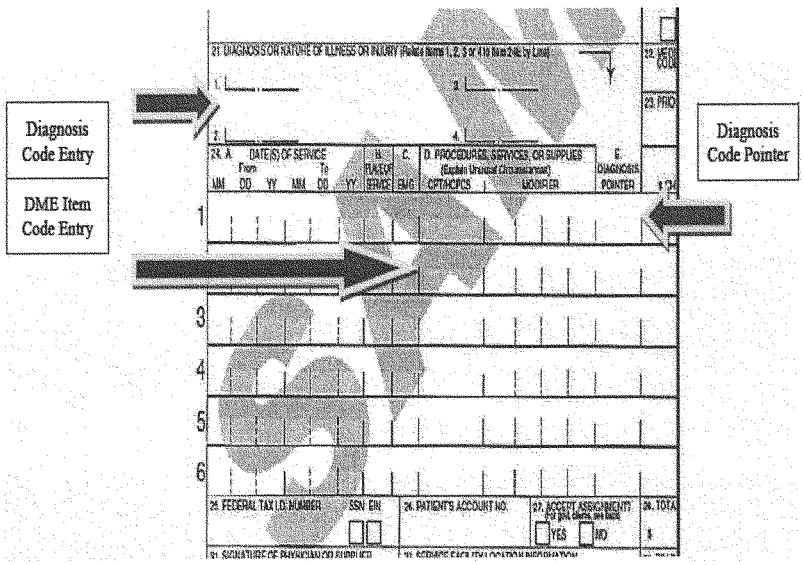

Figure 5

Even though the Form 1500 can include multiple items involving up to four different diagnoses, CMS informed the Subcommittee that the Medicare claims review system checks only whether the first diagnosis code – called the "primary" code – is valid and does not determine whether other diagnosis codes, if any, are valid:

> For claims that were processed after the installation of edits required by HIPAA began, the DME core claim system and front end started to check a claim's primary diagnosis code against the current ICD-9-CM Manual list, which is updated October 1 of every year. This means that at present—assuming all other minimum claim information is valid—a claim with a valid primary diagnosis code will pass into the claim processing system. Conversely, if a claim contains an invalid primary diagnosis code, the claim is rejected and returned to the submitting supplier as opposed to being processed and denied.[50]

[50] *See id.* at pg. 2.

According to CMS, the Medicare claims review process will examine only the first diagnosis code on each claim, even if a claim contains more than one diagnosis code.[51]

CMS's statement identifies a potential inconsistency with respect to applying the diagnosis code requirement. By checking only the primary diagnosis code on a given claim and ignoring any other diagnosis codes, the current claims review process could lead to illogical results. As illustrated in Figure 6, CMS could be paying claims that contain invalid codes and rejecting claims that contain valid diagnosis codes.[52] Specifically, if Medicare reviews only the primary code for validity, then claim lines relating to the non-primary invalid codes could be paid; as a result, a claim containing a valid primary code but three invalid non-primary codes would not be rejected and Medicare would pay for the items tied to the invalid diagnosis codes. Conversely, if a claim contained a primary diagnosis code that was invalid, but the diagnosis codes for other claim lines were valid, the entire claim would be rejected. Thus, Medicare would be rejected ostensibly valid claims simply because the first diagnosis code on the claim form was not valid. Therefore, CMS's implementation of the diagnosis code requirement appears both over-inclusive and under-inclusive at the same time.

Primary Diagnosis Code	Secondary/Tertiary Diagnosis Codes	Result
Valid	Valid	Paid
Valid	Invalid	Paid (Claims with Invalid Diagnoses Paid)
Invalid	Valid	Not Paid (Claims with Valid Diagnoses Not Paid)
Invalid	Invalid	Not paid

Figure 6

B. MEDICARE DOES NOT EFFECTIVELY UTILIZE DIAGNOSIS CODES ON DME SUPPLIER CLAIMS

The Subcommittee's investigation has established that the Medicare claims review process does not utilize diagnosis codes effectively. CMS emphasized that the Medicare claims review processes checked that the diagnosis codes submitted with suppliers' claims complied with HIPAA and CMS regulations, but in general, did

[51] *See* CMS Response, Appendix, at pg. 3; also Subcommittee interview of CMS officials, February 12, 2008.

[52] Figure 6 assumes that all other information on the claims form is correct and valid.

not use the codes to validate the integrity of the claim.[53] In other words, the claims review process verifies whether a valid diagnosis code is present (as required by HIPAA and CMS regulations), and whether the code meets the required format (the appropriate numbers and letters), but does not use the code to determine whether the diagnosis relates to the DME item purchased. In response to the Subcommittee's initial conclusions concerning the use of diagnosis codes, CMS argued that ICD-9-CM diagnosis codes were not required for suppliers' DME claims until the implementation of HIPAA in 2003 and only for the purpose of meeting HIPAA requirements: "[HIPAA] does not require that [Medicare claims review contractors] actually use any particular data element, including diagnosis codes, in its internal claims processes after it receives the claim."[54]

CMS further commented that, for select DME items, it has instituted additional precautions that include the use of a claim's diagnosis code.[55] In particular, for select claims subject to Local Coverage Determinations (LCDs),[56] edits are placed in the DME claim processing system to match a particular DME item (referred to as a HCPCS or procedure code) against a specific list of ICD-9-CM Manual codes that are identified in the LCD policy.[57] Although an exception exists for a limited number of DME items, CMS stated that "in many other instances, however, a claim's ICD-9 code is not used to determine whether a claim should process for payment."[58]

The Subcommittee examined data related to millions of DME claims in order to determine the impact of not effectively utilizing diagnosis codes in the claims review process. In particular, the Subcommittee examined claims in two categories of diagnosis codes: (i) claims that contained diagnosis codes with valid ICD-9-CM designations, and (ii) claims that contained diagnosis codes that were invalid, blank, or unprocessable. The Subcommittee's analysis of these

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[53] Subcommittee interview with CMS officials, May 10, 2008; *see also* CMS Response, Appendix, at pg. 2.

[54] *See* CMS Response, Appendix, Addendum A at pg. 1; *see also id.* at pg. 1 ("[F]or the sole purpose of achieving compliance with new healthcare industry-wide electronic claims transaction standards (mandated by HIPAA), CMS did begin to require DME suppliers to include diagnosis codes on their claims in recent years") and at pg. 2 ("The new computer processes put in place by CMS during 2003 and 2004 only check the ICD-9-CM codes on the claim for HIPAA compliance").

[55] According to CMS, the type of select items include blood glucose monitors, ankle and foot orthoses, refractive lenses, and oral anti-cancer drugs. *See* CMS Response, Appendix, at pg. 2.

[56] According to CMS, LCDs are policies and coverage guidelines that are promulgated by the DME MAC Medical Directors.

[57] *See* CMS Response, Appendix, at pg. 2.

[58] *Id.*

claims suggests that examining the diagnosis codes on DME claims could be a valuable tool to uncover fraudulent or abusive claims.

1. DME Claims With Valid But Questionable ICD-9-CM Diagnosis Codes

The Subcommittee found a significant volume of claims that contained valid ICD-9-CM diagnosis codes, but the diagnosis appeared to raise serious questions about the legitimacy of the claim. For instance, the Subcommittee found claims in which the purported diagnosis appeared unrelated to the purchased DME supplies. The Subcommittee reviewed claims data from January 2001 to December 2006 for 18 DME items that had been identified by law enforcement and Medicare oversight agencies as particularly susceptible to fraudulent claims or overpayments.[59] The Subcommittee's examination of the claims for those 18 items found payments totaling more than $1 billion in which the purported diagnosis was questionable.[60]

Claims for blood glucose test strips provide an illustrative example of the disconnect surrounding the use of diagnosis codes.[61] Numerous experts interviewed by the Subcommittee have confirmed that blood glucose test strips are used almost exclusively for patients with diabetes.[62] According to experts at a prominent manufacturer that researches, develops, and markets diabetic supplies, blood glucose test strips are used for the "quantitative measurement of blood glucose."[63]

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[59] The law enforcement and oversight agencies included the HHS/OIG, GAO, and the Health Care Fraud Unit of the U.S. Department of Justice. The 18 items were: (1) blood glucose test strips, (2) standard weight power wheelchair with control, (3) high strength lightweight wheelchair, (4) lightweight wheelchair, (5) standard wheelchair, (6) albuteral compound solution, (7) negative pressure wound therapy pump, (8) oxygen concentrator, (9) power operated vehicle, (10) continuous airway pressure device, (11) nebulizer with compression, (12) walker – folding wheeled, (13) enteral feed supply pump per day, (14) nasal application device, (15) collagen based wound filler, (16) diabetic custom molded shoe, (17) diabetic shoe for density insert, and (18) wheelchair seat pad.

[60] The Subcommittee's review of the diagnosis codes was not a medical or scientific review but based on a reasonableness review of the data, identifying only those diagnoses as questionable that did not appear to correlate with the medical device or equipment being prescribed.

[61] According to a HHS/OIG report, "Diabetics are taught to use special devices called blood glucose monitors or meters to test their blood sugar levels. Typically, patients place a tiny amount of fingertip blood on a test or reagent strip which produces a numeric read-out when inserted into the monitor. Depending on the results of the read-out, patients can adjust their insulin dosages or contact their physicians for further instructions. Patients usually test their glucose levels in this manner one or more times a day." *See* HHS/OIG, *Blood Glucose Test Strips: Inappropriate Medicare Payments*, June 2000, OEI-03-98-00230, (the HHS/OIG Blood Glucose Test Strips Report) at pg. 5.

[62] Subcommittee interviews of experts at a prominent medical school and manufacturing company of diabetic supplies.

[63] Subcommittee interview of manufacturing company officials, May 26, 2008.

For various reasons, these products are highly susceptible to fraud and abuse. For instance, a June 2000 report from HHS/OIG noted that Medicare paid more than $79 million for test strips without proper documentation and that the cost to Medicare for this item had increased sharply between 1994 and 1997.[64]

As a result, Medicare implemented several additional restrictions on claims for those items. The June 2000 HHS/OIG report observed that, unlike most DME items, only beneficiaries with diabetes would be covered for blood glucose test strips, "prior to July 1, 1998, Medicare coverage for home blood glucose monitors and test strips was restricted to beneficiaries with Type 1, or insulin-treated diabetes. Medicare expanded coverage on that date to beneficiaries with Type 2, or non-insulin treated diabetes."[65] In addition, suppliers that submit claims for blood glucose test strips must have documentation from the ordering physician that verifies that the beneficiary needs the diabetic testing supplies.[66] CMS stated that, because of the high incidence of abuse related to these products, blood glucose test strips "are governed by specific ... policies; therefore, their diagnosis codes do edit against a defined list of ICD-9 codes as the claim is processed to pay or deny."[67]

Although blood glucose test strips have been associated with fraudulent activity and claims for those items must contain specific diagnosis codes related to diabetes, the Subcommittee found numerous instances in which claims for blood glucose test strips were paid, even though the submitted diagnosis codes were quite different from diabetes, such as typhoid and paratyphoid fevers, cholera, and scabies. In total, Medicare made payments for claims for blood glucose test strips containing 2,699 different ICD-9-CM diagnosis codes. The Subcommittee's review of claims for blood glucose test strips revealed that the most frequent non-diabetes related diagnosis code for every year from 2001 through 2006 was chronic airway obstruction. Other questionable diagnosis codes for blood glucose test strips, which are presented in Figure 7 below, included leprosy, and psychosexual dysfunction, as well as respiratory, coronary, mental health and cancer conditions. Another questionable diagnosis code contained in several claims for blood glucose test strips was the bubonic plague.

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[64] *See* HHS/OIG, *Blood Glucose Test Strips: Inappropriate Medicare Payments*, June 2000, OEI-03-98-00230.

[65] *Id.*

[66] *See* http://www.cms.hhs.gov/DiabetesSelfManagement/02_ProvResources.asp.

[67] *See* CMS Response, Appendix, at pg. 2.

EXAMPLES OF PURPORTED DIAGNOSES FOR BLOOD GLUCOSE STRIPS PAID BY MEDICARE	
TYPHOID AND PARATYPHOID FEVERS	LEUKEMIA OF UNSPECIFIED CELL TYPE
SALMONELLA GASTROENTERITIS	BENIGN NEOPLASM OF PROSTATE
OTHER FOOD POISONING (BACTERIAL)	DELAY IN SEXUAL DEVELOPMENT AND PUBERTY, NOT ELSEWHERE
PRIMARY TUBERCULOUS COMPLEX	PSYCHOSEXUAL DYSFUNCTION
BUBONIC PLAGUE	ACUTE BRONCHITIS
LEPROSY, UNSPECIFIED	CONTUSION OF ELBOW
ARTHRITIS DUE TO RUBELLA	DENTAL EXAMINATION
INFECTIOUS MONONUCLEOSIS	PREGNANT STATE, INCIDENTAL
CHOLERA	SCABIES

Figure 7

Experts interviewed by the Subcommittee, including officials from the Centers for Disease Control and Prevention (CDC), a prominent medical school and a manufacturer of diabetic supplies, confirmed that none of the diagnoses in Figure 7 would justify the use of blood glucose test strips.[68] The medical school experts stated, "In general, the use of glucose test strips is justified by a diagnosis in the codes that relate to diabetes," and that if the listed diagnosis codes were used for the diagnoses listed in Figure 7, they could have been used mistakenly.[69] CDC experts confirmed that such items would not be appropriate treatment for the bubonic plague.[70] Furthermore, officials stated, "CDC is not aware of glucose strips being used to treat any of the conditions listed [in Figure 7] nor do the use of the strips diagnose infectious diseases [noted in Figure 7]."[71]

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[68] Subcommittee interviews of officials at CDC, experts at a prominent medical school, and diabetic supplies manufacturer.

[69] Subcommittee interview of experts at a prominent medical school, April 29, 2008.

[70] Subcommittee interview of CDC officials, May 23, 2008.

[71] *Id.*

The Subcommittee's review of the remaining 17 items revealed similar instances in which the reported diagnosis codes do not appear to justify the purchase of the DME item or appear medically improbable. Figure 8 below presents examples of claims that contained diagnosis codes that appear improper.

EXAMPLES OF QUESTIONABLE DIAGNOSES FOR SELECTED ITEMS	
Purchased Item	**Stated/Purported Diagnosis**
Diabetic Shoes	Traumatic Amputation of Leg(s)
Diabetic Shoe Density Insert	Precocious Sexual Development and Puberty, Not Elsewhere Defined
Walker	Sinus Congestion
Wheelchair Pad	Acquired Deformity of Nose
Blood Glucose Strips	Impotence of Organic Origin
Power Wheelchair	Sprained Wrist
Walker	Paraplegia

Figure 8

2. DME Claims With Invalid Diagnosis Codes Contain Potential Instances of Fraud, Waste, and Abuse

In addition to examining claims with valid, but questionable, diagnosis codes, the Subcommittee analyzed Medicare payment data for DME claims submitted by suppliers from 1995 through 2006 that contained blank, invalid, or unprocessable diagnosis codes. The Subcommittee's analysis revealed that Medicare spent billions of dollars on claims from DME suppliers that contained one or more invalid diagnosis codes, although the volume of such payments decreased dramatically after the implementation of HIPAA in 2003.

As noted above, a valid ICD-9-CM code is a numeric and, in some circumstances, alphanumeric code that ranges from three to five digits. Examples of valid diagnosis codes include 496 (chronic airway obstruction), E813.8 (motor vehicle traffic accident involving collision with other vehicle injuring other specified person), and 428.0 (congestive heart failure unspecified). In contrast, the data examined by the Subcommittee included codes that were obviously invalid, as indicated in Figure 9 below, such as unusual combinations of letters and numbers, as well as non-alphanumeric characters such as slashes, dashes and other "special characters." For instance, the Subcommittee observed claims in which the purported diagnosis codes were "////" "?" "@" "----" and "zzzzz."

EXAMPLES OF VALID ICD-9-CM DIAGNOSIS CODES	SUBMITTED DIAGNOSIS CODES
493 (Asthma)	!
250.0 (Diabetes)	.
020.0 (Bubonic Plague)	////
001 (Cholera)	G
428.0 (Congestive heart failure unspecified)	---

Figure 9

To determine the magnitude of the payments for claims with blank, invalid, or unprocessable diagnosis codes, the Subcommittee examined claims data, identified invalid codes, and selected the 198 invalid diagnosis codes that had the highest total of payments in dollar amounts from 1995 to 2006.[72] The Subcommittee's analysis revealed that, from 1995 through 2006, Medicare paid almost $5 billion for more than 60 million DME items on claims that contained one or more of those 198 invalid diagnosis codes.[73] Figure 10 provides illustrations of invalid diagnosis codes, with the total volume of claims submitted with those codes and the amounts paid in connection with those claims.

EXAMPLES OF INVALID DIAGNOSIS CODES AND PAYMENTS MADE FOR ASSOCIATED CLAIMS		
INVALID DIAGNOSIS CODE	TOTAL NUMBER OF CLAIMS SUBMITTED USING THIS CODE	TOTAL AMOUNT PAID
Y0000	433,201	$ 19,558,552
G	95,905	$ 3,798,484
78720	7,436	$ 2,360,420
00000	21,832	$ 1,127,099

Figure 10

The Subcommittee found that the overwhelming majority of these claims – more than 56 million DME items on claims totaling more than $4 billion in payments – contained the word "NULL" in the diagnosis code field. CMS and its data contractor, commonly called the Statistical

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[72] The Subcommittee initially examined the claims data associated with the 300 codes that had the highest total payments from 1995 through 2006 and whose codes were described in Medicare claims data as "Invalid Diagnosis Code." CMS and its data contractor, called SADMERC, informed the Subcommittee that SADMERC data regarding the descriptions of diagnosis codes was inaccurate and out-of-date. As a result, the Subcommittee examined the actual ICD-9-CM codes for these entries; in doing so, the Subcommittee determined that 102 were valid codes that had been incorrectly described as invalid by the SADMERC. [The fact that the SADMERC, CMS's data contractor, had inaccurate data concerning millions of claims is addressed in Section C below.] Of the remaining 198 codes, the Subcommittee found that 143 codes have never been valid ICD-9-CM codes and 55 of the codes were invalid at some point from 1995 through 2006. For the diagnosis codes that had become valid at some point from 1995 to 2006, the Subcommittee included only those claims that were submitted using a diagnosis code before the code became valid.

[73] This finding does not include the $720,788,318 paid for 8,206,776 DME items on claims from 1995 through 2002 in which the associated invalid diagnosis code was "XX000." As described in Section V.B., CMS officials contend that the code XX000 was a "fictitious" code created by CMS and its contractors for use in certain narrow circumstances to comply with requirements imposed by MCCA.

Analysis DME Regional Carrier or SADMERC,[74] informed the Subcommittee that, when a claim contained an unprocessable diagnosis code or the relevant field was blank, the SADMERC would enter "NULL" into the relevant block in order to facilitate the storage and retrieval of that claim data.[75] Unprocessable entries, according to SADMERC, included diagnosis codes that had (i) symbols, such as a tilde (~), (ii) non-printable entries including a carriage return, a tab, or a space, or (iii) icons, such as a smiley face.[76] Such unprocessable entries or a blank field, according to SADMERC, would cause the relevant claims to be omitted from certain data analysis functions. In order to prevent the deletion or omission of these claims, SADMERC would enter the NULL value into the related claims data after a claim had already been paid or denied and the claim had been transferred to SADMERC for claims analysis. Thus, the claims with a NULL value in the diagnosis field do not reflect that the claim was submitted with "NULL" as the diagnosis code; to the contrary, the NULL designation identifies claims that were paid when the diagnosis code was unprocessable or blank.

To determine the accuracy and legitimacy of claims with invalid codes, the Subcommittee obtained full claims data concerning approximately 650,000 of the 60 million DME item claims that contained invalid diagnosis codes. The Subcommittee arbitrarily selected a subset of 2,000 claims from the 650,000 claims for further investigation.[77] For each of these claims, the Subcommittee contacted the doctors whose Unique Physician Identification Number (UPIN) was associated with the claims to verify the accuracy of the submitted information. The Subcommittee determined that more than 30 percent of the 2,000 claims could not be verified as legitimate and bore characteristics of fraudulent activity. Some of these suspicious claims involved the following:

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[74] SADMERC is the CMS contractor responsible for collecting and analyzing data regarding Medicare DME claims. As of August 2008, CMS has transitioned to a new data contractor.

[75] Subcommittee interview of SADMERC officials, February 28, 2008; *see also* CMS Response, Appendix, at pp. 6-7. SADMERC, which is an acronym of the Statistical Analysis DME Regional Carrier, is discussed in greater detail in Section V.C.

[76] Subcommittee communication with SADMERC officials, February 28, 2008.

[77] The Subcommittee obtained the information used in this study from claims data that had been previously provided by SADMERC and that contained complete claims information including the physician, beneficiary and supplier names and address as well as the treatment and diagnosis. The Subcommittee selected a group of claims from this data based on the diagnosis description being "invalid diagnosis code." The data was not selected based on a purely random formula and could not be described as random for statistical analysis purposes. Therefore, the results are limited to the specific claims reviewed and the Subcommittee did not extrapolate these findings to the entire universe of relevant claims.

- For 101 claims that were filed after 2001, the doctor who allegedly prescribed the DME items had died in 2004 and, according to a family member interviewed by the Subcommittee, had not practiced medicine since the early 1990s.
- For 213 claims that were submitted after 2001, the identified doctor had retired from the practice of medicine in the late 1990s, and the address listed as the place of business for the doctor was never occupied by that doctor.
- A physician that purportedly prescribed items associated with 182 claims told the Subcommittee that he had never treated the patients involved.
- For 345 claims, the doctor involved verified that he had not treated nor prescribed the DME items involved in 39 claims, which is more than 12 percent of the claims filed using his UPIN and containing invalid diagnosis codes.
- A doctor reviewed 96 claims that contained his UPIN and said that 15 claims were from patients whom he had never treated. He also said that 13 claims were monthly payments for a hospital bed for a patient who died one month after receiving the bed. The supplier continued to bill Medicare and was paid for the bed for 12 months after the patient's death.
- The Subcommittee identified 36 claims for DME that were allegedly prescribed by a pediatrician where the claims were for elderly patients.

As discussed in detail in Section V.A., CMS has asserted that Medicare rules did not require DME suppliers to provide valid diagnosis codes on their claims until the implementation of HIPAA in 2003. The Subcommittee's review of the claims data, however, revealed that Medicare continued to pay DME suppliers for claims that contained invalid diagnosis codes after the 2003 implementation of HIPAA. The volume and amount of these claims decreased precipitously since 2003, but the data indicated that Medicare paid more than $23 million for DME claims from suppliers that contained invalid diagnosis codes after HIPAA regulations were implemented.

In 2004, Medicare paid $10,746,665 for claims with invalid diagnosis codes included in the top 198 invalid diagnosis codes list. In 2005 and 2006, the amounts paid for supplier claims with invalid diagnosis codes were roughly $1,447,997 and $10,991,268 respectively. These figures likely understate the volume of claims paid with invalid diagnosis codes because the Subcommittee's analysis was limited to the

198 invalid codes with the highest total payments during the period reviewed.[78] In sum, the lower volume of payments from 2004 through 2006 indicate that Medicare has made great strides in ensuring that only claims with valid diagnosis codes are accepted, although the amounts also indicate that an unknown number of claims with invalid diagnosis codes continued to pass through the system undetected after 2003.

C. CLAIMS DATA MAINTAINED BY CMS'S DATA CONTRACTOR WAS INCORRECT AND NOT UPDATED IN A TIMELY MANNER

The Subcommittee's investigation uncovered a problem related to a large subset of DME claims data. As noted above, the Subcommittee's investigation included a detailed review of data concerning Medicare claims from DME suppliers submitted between 1995 and 2006. The Subcommittee obtained the relevant claims data from SADMERC.[79] SADMERC is the CMS contractor responsible for collecting and analyzing data regarding Medicare DME claims. SADMERC described its responsibilities as (i) providing data analysis support to the DME Program Safeguard Contractors; (ii) offering guidance to manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS) and is the means by which DME services are identified for Medicare billing; (iii) performing a variety of national pricing functions for DME services; (iv) assisting CMS with the DME Fee Schedules; and (v) analyzing DME fees to identify unreasonable or excessive reimbursement amounts.[80]

One of SADMERC's primary roles in fighting against fraud, waste, and abuse is its analyses of claims data and supplier billing patterns. In fact, CMS underscored the importance of SADMERC's role in the Medicare program and emphasized its role in combating fraud, waste, and abuse in Medicare:

> The SADMERC's data is used by many to develop policies, facilitate program integrity activities, and to support special initiatives. Further, Federal and state law enforcement agencies, including the Department of Justice and the Office of the Inspector General, have utilized the SADMERC's data

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[78] The Subcommittee noted that there were more than 39,000 different codes used on claims from 1995 through 2007, while the 2006 version of the ICD-9-CM listing only contained 13,549 diagnosis codes.

[79] During the relevant timeframe, SADMERC was the CMS contractor responsible for collecting and analyzing data regarding Medicare DME claims.

[80] *See* http://www.palmettogba.com/palmetto/Other.nsf/Home/Other+Medicare+Partners+SADMERC+Home ?OpenDocument (accessed May 7, 2008).

> and reports in both civil and criminal cases, without question.[81]

The claims data that the Subcommittee received from SADMERC contained a category of information – called the Diagnosis Description field – that described the diagnosis code associated with each individual claim. As previously explained, for the review of invalid codes, the Subcommittee initially reviewed the top 300 codes described as invalid based on the amount paid from 1995 through 2006. That analysis indicated that claims totaling more than $6.3 billion were paid in which the Diagnosis Description field stated "Invalid Diagnosis Code." After discussions with CMS and SADMERC officials, the Subcommittee examined the codes and found that 102 of the 300 purportedly invalid codes were in fact valid. This reduced the scope of review to the remaining 198 codes. Of those 198 codes, 143 codes had never been valid and 55 codes became valid at some point during the relevant timeframe. In total, the Subcommittee's analysis of the 198 diagnosis codes revealed that the amount paid for claims with invalid diagnosis codes from 1995 to 2006 was $4.8 billion. Thus, SADMERC data field of Diagnosis Descriptions overstated the amount of claims with actual invalid diagnosis codes by more than $1.4 billion. Notably, the Subcommittee's initial analysis was limited to the top 300 codes, and therefore, the extent of the overstatement related to the SADMERC Diagnosis Description field could be materially larger.

To its credit, CMS discovered that SADMERC data describing diagnosis codes was defective and informed the Subcommittee. CMS assessed the data and determined that the Diagnosis Descriptions for the entire batch of claims data was flawed: "The apparent disconnect between the SADMERC ICD-9 code description and the current ICD-9-CM Manual indicates to us that the SADMERC description field is not reliable." CMS provided a detailed explanation of the errors as follows:

> Following our meeting with the PSI staff on February 12, CMS approached its contractor, the SADMERC, to discuss the reports it had provided to the PSI staff, with a focus upon the ICD-9 description field contained in the reports. In response, the SADMERC advised CMS that they had provided the requested files to the PSI staff at their request, with the clear indication both orally and via e-mail that the source table used to determine whether a diagnosis code was valid was not regularly updated, and was believed to have last been updated in August 2003. Since this initial response, the SADMERC has now informed us that they cannot

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[81] *See* CMS Response, Appendix, at pg. 9.

> confirm the last time the file was actually updated, nor can it document the source of the ICD-9 table that it conveyed to the PSI staff. After independently reviewing the ICD-9 codes and sample claims from the SADMERC reports against actual claims history, CMS is not at all confident that the field in the SADMERC reports describing the validity of a particular ICD-9 code can be relied upon conclusively for *any* period of time.[82]

Thus, it appears that some data maintained by CMS's data contractor was (a) incorrect, (b) supplied by an unidentified source, and (c) outdated by at least four years and possibly longer. It is unclear at this stage whether the data originated with SADMERC, CMS, one or more of the Medicare carriers, or an unrelated third-party; accordingly, it would be premature to hold SADMERC or any other party responsible for that incorrect data and this report makes no finding in that regard. Nevertheless, the revelation of a large amount of flawed, unsourced, and outdated data maintained by SADMERC – Medicare's data contractor – raises concerns about both the validity of other data maintained by SADMERC and the level of oversight performed by CMS on one of the Medicare program's most important contractors. As noted above, SADMERC plays a crucial role in the prevention of fraud, waste, and abuse in the Medicare program by maintaining, examining, and reporting various analyses on the voluminous claims data. Its ability to identify abusive practices and trends is dependent on accurate claims data. While it is clear that the descriptions of diagnosis codes are not the most important data maintained by SADMERC, it is also clear that there was a breakdown of some variety in the Medicare data maintenance processes.

For the purposes of the Subcommittee's investigation, the incorrect data in the Diagnosis Descriptions field had no impact on the findings in this Report, including the analysis of more than $4.8 billion in payments from 1995 to 2006 for DME supplier claims that contained invalid diagnosis codes. The analysis in this Report did not rely on the Diagnosis Description field; in contrast, the relevant findings were based on a review of the actual diagnosis codes submitted with the claims, rather than the flawed description of those codes in SADMERC data fields.

V. CMS COMMENTS

Over the course of its investigation, the Subcommittee has had extensive interaction, including numerous interviews and briefings, with

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[82] *See* CMS Response, Appendix, at pg. 7 (emphasis in original).

officials from CMS and its contractors. In February 2008, the Subcommittee presented to CMS its preliminary findings concerning the prevalence of invalid diagnosis codes in DME supplier claims and provided supporting analysis containing examples of the claims at issue. The Subcommittee invited CMS and its contractors to comment on the Subcommittee's initial conclusions.

CMS provided substantial comments to the Subcommittee's preliminary findings and conclusions and its complete response is attached to this Report in the Appendix. While most of CMS's responses have been incorporated in this Report, several issues warrant further discussion and are examined below.

A. CMS Assertion That Diagnosis Codes Were Not Required For DME Supplier Claims Until Implementation Of HIPAA In 2003

In response to the Subcommittee's initial conclusions concerning the use of diagnosis codes, CMS argued that ICD-9-CM diagnosis codes were not required for suppliers' DME claims until the implementation of HIPAA in 2003. According to their comments:

> Historically, CMS did not generally require DME suppliers to include ICD-9-CM codes with their claims. CMS now requires DME suppliers to include diagnosis codes with their claims, and requires its DME claims processing contractors to check these codes, but this Medicare requirement is a relatively new one that was put in place during 2003 and 2004 for the sole purpose of achieving compliance with new healthcare *industry-wide* electronic claims transaction standards (mandated by the Health Insurance Portability and Accountability Act). Accordingly, depending on the date a DME claim was processed, the claim may, in fact, have been paid without a valid ICD-9 code as defined by the ICD-9-CM Manual and, regardless of the ICD-9 code's validity, it does not necessarily mean that the claim was paid inappropriately or that it was processed incorrectly[.][83]

As a threshold matter, over the course of its inquiry, the Subcommittee conducted numerous interviews concerning the requirements surrounding diagnosis codes, including frequent communications with officials from CMS, SADMERC, DME carriers, and DME suppliers. The Subcommittee repeatedly confirmed with those officials that diagnosis codes were required for DME supplier claims and confirmed that the requirement had been in place for many

[83] *See* CMS Response, Appendix, at pg. 1.

years. In fact, one CMS official stated that the requirement for diagnosis codes for DME claims from suppliers had been in effect "since the Program began."[84] Other officials stated that they believed that Medicare required diagnosis codes on supplier claims for DME have "always" been required.[85] In fact, a representative of one large DME supplier stated that Medicare required valid diagnosis codes for their claims since 1993.[86] These comments and the fact that significant claims data stretching back to 1995 included diagnosis codes further support the Subcommittee's finding that the laws and regulations governing diagnosis codes were unclear prior to 2003 and the use of the codes was inconsistent. Moreover, when the Subcommittee briefed CMS and its contractors on its initial findings in February – a meeting that included numerous officials from CMS and its contractors – not a single representative from CMS or its contractors indicated that diagnosis codes were not required for suppliers' claims until 2003. Roughly one month later, however, CMS submitted its official response and asserted – for the first time – its position that Medicare rules did not require diagnosis codes for DME claims from suppliers until the implementation of HIPAA in 2003.

Putting aside the fact that CMS's official written response to the Subcommittee's Report appears to conflict with earlier statements from its officials, contractors, and others, the assertion that diagnosis codes were not required for supplier claims until 2003 is also arguably inconsistent with its own regulations. As described above, the 1991 Notice and the bulletin issued to all providers in 1996 arguably require the use of valid diagnosis codes on all DME claims – including those submitted by suppliers. It would therefore be reasonable to conclude that any payments for claims with invalid or incorrect diagnosis codes after those bulletins were improper.

Regardless of any potential inconsistencies between CMS's official written response, prior oral statements made by CMS officials, and the governing Medicare regulations, the Subcommittee staff has accepted CMS's assertion that diagnosis codes were generally not required for DME claims submitted by suppliers until the implementation of HIPAA in 2003. Accordingly, this Report does not find that the payments made for the DME supplier claims with invalid diagnosis codes were *per se* improper. To the contrary, the relevant findings in this Report are limited: Based on the data obtained from SADMERC, the Subcommittee found payments totaling more than $4.8 billion for the DME claims submitted by suppliers that contained invalid

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[84] Subcommittee interview of CMS officials and contractors, January 10, 2008.

[85] Subcommittee interview of CMS officials and contractors, December 19, 2007.

[86] Subcommittee interviews of DME supply company representatives, March 2008.

diagnosis codes; a review of 2,000 sample claims that contained invalid codes indicated that roughly 30 percent of those claims could not be verified as legitimate.

While CMS's assertion that DME suppliers were first required to submit diagnosis codes in 2003 may impact the analysis related to claims with invalid codes, it has little impact on the analysis of claims with questionable diagnoses. To the contrary, the Subcommittee's review revealed that claims with questionable diagnosis codes continued long after Medicare required ICD-9-CM diagnosis codes.

Claims for blood glucose test strips once again provide a telling example. In 2001, Medicare paid $526,059 for claims for blood glucose strips with a diagnosis of chronic airway obstruction; Medicare paid roughly the same amount – $535,032 – for the same product with the same questionable diagnosis code in 2006. In fact, as noted above, chronic airway obstruction was the single most frequent diagnosis code for blood glucose test strips for each year from 2001 through 2006, and the amount of claims paid over those years fluctuated little from the time before diagnosis codes were required (2001-2003) through the following three years (2004-2006).

Figure 11 below presents the most frequent non-diabetes diagnosis codes for blood glucose test strips and illustrates that the use of these questionable codes did not decrease – and, in some cases, increased substantially – after diagnosis codes were required in 2003. The amount paid for blood glucose test strips for one questionable diagnosis code – urinary incontinence – more than doubled in just a few years following the requirement of valid diagnosis codes on supplier claims (2003-2006). Therefore, the analysis of claims data for these 18 prominent DME items suggests that, even after valid diagnosis codes became a required element of supplier claims in 2003, the claims review process conducted by Medicare carriers did not examine whether the diagnosis codes related to the purchased supplies.

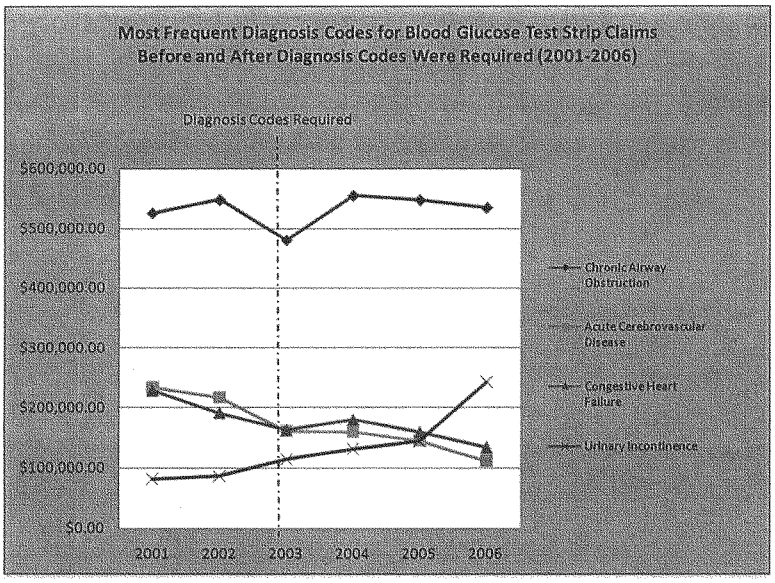

Figure 11

B. "XX000," A PROMINENT INVALID CODE, WAS CREATED BY CMS

As part of its preliminary findings, the Subcommittee identified 8,206,776 claims amounting to $720,788,318 in payments from 1995 through 2002 in which the associated diagnosis code read "XX000." XX000 is not on the ICD-9-CM list of diagnosis codes, and therefore, the Subcommittee initially considered it an invalid code. CMS has asserted that the code XX000 should not be considered invalid because it was a "fictitious" code created by CMS and its contractors to comply with requirements imposed by MCCA.

As noted above, MCCA, enacted in 1988, required that all claims for services or items submitted by physicians contain a valid diagnosis code. In requiring the inclusion of diagnosis codes, the MCCA drew a distinction between two categories of Medicare claims – "assigned" and "unassigned" claims. In general, assigned claims are those in which the physician has accepted the claim on assignment from the beneficiary and agreed with Medicare to accept the Medicare fee schedule. Unassigned claims are those in which the physician has not agreed to accept assignment of the claim or to abide by the Medicare fee schedule. [A detailed description of assigned and unassigned claims is set forth in Figure12 on this page.]

Assigned vs. Unassigned Claims

Assigned claims are those in which the physician has entered into an agreement with Medicare to participate in the Medicare program. As part of the agreement, the physician agrees to accept assignment of claims from Medicare beneficiaries and agrees to accept the fee set by Medicare for the service or item provided. The physician cannot require the beneficiary to pay any amount other than the deductible set by the Medicare fee schedule.

Unassigned claims are those in which the physician has not agreed to participate in the Medicare program or accept the fees established by the Medicare fee schedule. Beneficiaries may still choose to receive treatment from a physician on an unassigned basis, but the beneficiary will be responsible for paying for the treatment out-of-pocket and file their own claim with Medicare. In that case, Medicare will reimbursement the beneficiary based on the fee schedule, regardless what the beneficiary actually paid the physician.

Figure12

With respect to assigned claims, the MCCA required that Medicare deny payment to claims that did not contain the proper diagnosis code. For unassigned claims, the MCCA authorized the Secretary to institute civil fines and penalties against physicians who refuse to provide valid diagnosis codes.[87]

To comply with the requirements of the MCCA, in April 1989, CMS published a revision to the Medicare Carriers Manual, Part 3, the guidance provided to Medicare DME carriers that instructed them on how to process Medicare claims. The April 1989 revision directed carriers how to process claims under the new diagnosis code requirement for physicians. The new rule also instructed carriers to deny any assigned claim submitted by a physician without a valid ICD-9-CM diagnosis code after June 1, 1989; in doing so, the rule also established a grace period until June 1989 to allow physicians to comply with the new diagnosis code rules before denying the claim.[88]

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[87] CCA did not allow unassigned claims to be denied because it was desirable to reimburse the beneficiary. Once the physician was contacted regarding the failure to provide a valid diagnosis code, however, they were subject to the fines and civil penalties if they did not promptly provide them.

[88] *See* Medicare Carriers Manual Part 3 – Claims Process, No. 1298, April 1989.

As part of the grace period, CMS established the use of the fictitious diagnosis code, XX000, which was supposed to be entered into the relevant diagnosis field when the block was improperly left blank.[89] Importantly, according to the Medicare Carriers Manual revision, this fictitious code was supposed to be used only in connection with assigned claims submitted by physicians during the grace period – i.e., up to June 1, 1989 – but not after that date.[90] Carriers could, however, continue to use the fictitious code after that grace period, in instances where a physician failed to provide a valid diagnosis code on unassigned claims. According to the Carrier Manual revision, the purpose of the fictitious XX000 code was to identify those physicians that did not comply with the rules by providing the valid diagnosis codes. The revisions stated, "The fictitious code will identify claims adjudicated without an actual ICD-9-CM code from the physician. Unassigned claims submitted without the ICD-9-CM code must be recorded on an individual physician basis. These records will be used to monitor compliance in accordance with §§7600-7604."

Section 7600 referred to that section of the Carriers Manual that directed monitoring the use of diagnosis codes on unassigned claims. Section 7601 (A) required carriers to produce a monthly report of physicians who did not furnish diagnosis codes on bills submitted with unassigned claims. The guidance indicated that, if a physician failed to provide diagnosis codes on more than 10 claims during a single month, the carrier was to contact the physician and explain the law and the physician's requirement to provide the diagnosis code.

It is clear that the fictitious code of XX000 was initially introduced as a temporary measure to comply with the requirements of MCCA. Indeed, it was initially used only for a small subset of DME claims from physicians and was intended to keep track of which physicians were failing to comply with the new diagnosis code requirements. Since physicians who did not provide a valid ICD-9-CM diagnosis code on unassigned claims were subject to fines under the MCCA, the Subcommittee asked CMS for any records of how many fines were levied annually since 1995.[91] CMS advised the Subcommittee that there have been no fines levied as there have been no reports from the carriers that physicians are refusing to provide diagnosis codes.[92]

At some point, the fictitious XX000 code was introduced for claims coming from DME suppliers as well as physicians. The data

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[89] *See id.*

[90] *See id.* at Section 4-20.1.

[91] Subcommittee interview of CMS officials, April 10, 2008.

[92] Subcommittee interview of CMS officials, April 14, 2008.

received by the Subcommittee from SADMERC indicates the XX000 code has been used on supplier claims since at least 1995, the first year of data reviewed. Because this code was designed to be used to monitor physician compliance with the requirement to provide diagnosis codes, any use of the code by non-physicians or on non-physician related claims, such as claims from DME suppliers, would appear to hamper any efforts to identify physicians who were not providing diagnosis codes. Because this code was used on more than eight million claims submitted by DME suppliers, it is impossible to determine which of these claims did not contain a diagnosis code because the physician neglected to provide one to the supplier. Therefore, the use of XX000 for claims submitted by DME suppliers would appear to undermine the central purpose behind the creation of the XX000 code.

Nevertheless, the Subcommittee staff has accepted CMS's assertion with respect to the XX000 code. Accordingly, the claims that contain that code – which amount to more than eight million claims totaling more than $720 million in payments – were not included in the Subcommittee's analysis of claims with invalid diagnosis codes. Further, the Subcommittee staff noted that the volume of claims using the code XX000 diagnosis code decreased dramatically following the implementation of HIPAA requirements in 2003. Consequently, that code does not represent a significant vulnerability for fraud, waste, and abuse going forward.

C. "MEDICAL NECESSITY" IS DETERMINED THROUGH OTHER RECORDS, NOT DIAGNOSIS CODES

As noted in Section III.3. above, the Social Security Act and Medicare regulations require that Medicare cannot pay for any DME claim unless the item is medically necessary. CMS officials stated that the claims review process does not normally examine a claim's diagnosis code to determine whether the DME item is medically necessary, instead it relies on suppliers to furnish a CMN signed by the physician or other records to document medical necessity and on the pre- and post-payment review processes.

There are several weaknesses with this practice. CMNs are not required for all DME items. CMNs are only required for select DME items, such as oxygen or infusion pumps. Further, CMNs are not routinely submitted with the Medicare claims. Instead, suppliers are required to maintain CMNs in their files and provide them during pre- and post-payment reviews. Therefore, Medicare claims are paid under the assumption that the item or items claimed are medically necessary and that the suppliers have the CMNs or other necessary supporting documentation to prove it.

According to CMS officials, medical necessity is reviewed during the pre- and post-payment review process, and that approximately three percent of paid claims are reviewed.[93] Because CMS processes billions of Medicare claims annually, this means that only a fraction of claims are reviewed for medical necessity and in some instances, only after payment has been made. As previously mentioned, past HHS/OIG reports have illustrated that providers have failed to establish the medical necessity requirement. Further, the limited number of post-payment reviews performed would be ineffective for identifying those suppliers that establish fraudulent companies.

Preventing claims from being paid in the first place would be more efficient and effective than attempting to recover improperly paid amounts after the fact. While checking that the diagnosis code correlates with the DME item claimed does not prove medical necessity, some diagnosis code and DME item combinations discovered by the Subcommittee raise the questions as to the medical necessity of the items.

VI. CONCLUSION AND RECOMMENDATIONS

Considering the fact that diagnosis codes are required to be submitted on claims, they should be used in a meaningful manner. Based on the Subcommittee's analysis, billions of DME claims have been paid where the purported diagnosis is questionable and does not appear related to the purchased equipment. CMS's failure to effectively utilize diagnosis codes have resulted in questionable payments and may have left billions of taxpayer's money susceptible to fraud, waste, and abuse. The Subcommittee believes that ensuring that diagnosis codes included on claims are both valid and consistent with the DME item supplied could be a more effective utilization of the codes by reducing costs for claims processing and review, helping ensure the medical necessity of the claim, and preventing and identifying fraud, waste, and abuse. CMS should do more to ensure integrity in the Medicare program. Strengthening internal controls on the front-end is more beneficial than attempting to recover improperly paid amounts after the fact. It is for these reasons that the Subcommittee Minority staff makes the following recommendations:

1. **Strengthen Claims Review Process.** CMS should consider strengthening the claims review process by more effectively utilizing all diagnosis codes submitted on claims. All diagnosis codes entered onto a claim should be valid and medically relate

[93] According to CMS officials, this percent includes claims for both Part A (hospital insurance) and Part B. CMS officials stated that it spent $160 million in fiscal year 2007 to conduct pre- and post-payments reviews.

to the supplied DME items. Claims with any invalid or incorrect codes should be rejected and returned to the biller for correction.

2. **Consider Developing Procedures to Link Diagnosis Codes with Medical Procedures.** CMS should consider developing processes that use the diagnosis codes to prevent, detect, and reject improper payments. This could include creating procedures to link ICD-9-CM diagnosis codes included on DME claims with authorized medical procedures (HCPCS), similar to what is already being performed by some contractors on select DME items.

3. **Consider Developing Procedures to Link Claims for DME Items with a Corresponding Claim for Medical Treatment.** CMS should consider incorporating an edit into the claims processing system that would check a claim for a DME item against a claim for a doctor visit that would have resulted in an order or prescription for the item, similar to what is already being performed on DME claims for select items. Furthermore, for DME claims that do not have a corresponding medical treatment claims, CMS should consider performing additional procedures in order to ensure the medical necessity and integrity of the claims.

4. **Strengthen Contractor Oversight.** CMS should consider strengthening its contractor oversight, including contractor penalties for making improper payments or maintaining unreliable data.

APPENDIX

Comments and Documents
Submitted to the
Permanent Subcommittee on Investigations
by CMS

Senate Homeland Security and Governmental Affairs Committee (HSGAC) Permanent Subcommittee on Investigations (PSI)
Preliminary Conclusions Surrounding DME Payments for Invalid Diagnosis Codes: CMS Response – March 7, 2008

On February 12, 2008, in a meeting between staff from the Centers for Medicare & Medicaid Services (CMS) and PSI staff investigators, PSI staff surfaced serious concerns about potential findings of incorrect claims payments as a result of an extensive review of reports shared by the Statistical Analysis Durable Medical Equipment Carrier (SADMERC), which focused on the validity of ICD-9 or diagnosis codes on durable medical equipment (DME) claims. PSI staff provided examples from the SADMERC reports which identified several thousand claims that had apparently been paid since 2001, but contained a description indicator noting that the diagnosis code was invalid. Flowing from these examples, PSI staff asked CMS to explain how a DME claim with an invalid diagnosis code could be paid, and what safeguards were in place to ensure that only claims with valid diagnosis codes are accepted to process.

Since the meeting, CMS has reviewed the SADMERC reports and claim reference examples provided by the Subcommittee on February 12 and subsequently on February 19. CMS also reviewed the diagnosis codes in the report, selected a sample of the claims listed for review by the current DME MACs, and consulted with SADMERC staff on their report to the PSI staff. Based on our review and analysis, we have come to the following conclusions:

- Historically, CMS did not generally require DME suppliers to include ICD-9-CM codes with their claims. CMS now requires DME suppliers to include diagnosis codes with their claims, and requires its DME claims processing contractors to check these codes, but this Medicare requirement is a relatively new one that was put in place during 2003 and 2004 for the sole purpose of achieving compliance with new healthcare *industry-wide* electronic claims transaction standards (mandated by the Health Insurance Portability and Accountability Act). Accordingly, depending on the date a DME claim was processed, the claim may, in fact, have been paid without a valid ICD-9 code as defined by the ICD-9-CM Manual and, regardless of the ICD-9 code's validity, it does not necessarily mean that the claim was paid inappropriately or that it was processed incorrectly;
- Based on a claim file review of a sample of the claim lines provided by the PSI staff, it appears that most of the claims listed on the SADMERC reports were processed appropriately; and
- The diagnosis description field in the SADMERC reports provided to the PSI staff is not accurate or reliable; therefore, it should not be used to conclude whether a claim was paid with an invalid diagnosis code.

The basis for these conclusions stems from several different findings, including the DME claim processing controls that have evolved over time since 2003, a review of sample claim lines presented on the SADMERC reports, the validity of the ICD-9 code descriptors presented in the SADMERC reports, and the descriptions from SADMERC staff about the contents of the data they provided the PSI staff. We outline our supporting rationale for each finding below.

I. Evolution of the DME Claims Process and Editing for ICD-9-CM Codes

Historically, CMS did not generally require DME suppliers to include ICD-9-CM codes with their claims. Instead, DME suppliers were and continue to be required to maintain a doctor's order in their files for each and every billing. Moreover, for some DME items, suppliers are expected to furnish Medicare a certificate of medical necessity signed by the physician to document medical necessity. CMS does now require DME suppliers to include diagnosis codes with their claims, and CMS requires its DME claims processing contractors to check these codes. However, this Medicare requirement is a relatively new one that was put in place during 2003 and 2004 for the sole purpose of achieving compliance with new healthcare *industry-wide* electronic claims transaction standards (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). For more information on this issue, please see Addendum A.

More specifically, prior to HIPAA requirements that were implemented beginning in May 2003, DME claims were not edited in the core DME claim processing system or at the front end of the automated adjudication process to determine whether a claim contained a valid ICD-9-CM Manual code. In other words, the DME claim processing system did not check a claim's primary diagnosis code upon submission to determine whether the code was recognized and in the appropriate format as defined by the ICD-9-CM Manual. This effectively means that for claims

adjudicated prior to the implementation of the HIPAA-mandated claims processing edits, one may very well find paid DME claims with invalid or illegitimate ICD-9 codes. For claims that processed after the installation of edits required by HIPAA began, the DME core claim system and front end started to check a claim's primary diagnosis code against the current ICD-9-CM Manual list, which is updated October 1 of every year. This means that at present—assuming all other minimum claim information is valid—a claim with a valid primary diagnosis code will pass into the claim processing system. Conversely, if a claim contains an invalid primary diagnosis code, the claim is rejected and returned to the submitting supplier as opposed to being processed and denied.

It is important to note that when a paid DME claim with an invalid ICD-9 code is identified, it would be incorrect to conclude that the claim was processed inappropriately or paid incorrectly. A DME claim's ICD-9 code is not always used to assess whether a particular service or supply meets medical necessity or coverage criteria. In some cases, some DMEPOS supplies are covered by Medicare only if they meet the parameters outlined by Local Coverage Determination (LCDs) policies and coverage guidelines promulgated by the DME MAC Medical Directors. To implement these coverage polices, edits are placed in the DME claim processing system that check a particular HCPCS code (i.e., procedure code) or range of HCPCS codes against a specific list of covered ICD-9-CM Manual codes identified in the LCD policy. Claims for supplies such as blood glucose monitors, ankle and foot orthoses, refractive lenses, and oral anti-cancer drugs, for example, are governed by specific LCD policies; therefore, their diagnosis codes do edit against a defined list of ICD-9 codes as the claim is processed to pay or deny.

In many other instances, however, a claim's ICD-9 code is not used to determine whether a claim should process for payment. Rather, the claim is paid based upon whether an appropriate certificate of medical necessity (CMN) has been submitted or is on-file for the particular claim in question, or whether an appropriate modifier code has been submitted on the claim to denote compliance with required documentation criteria (claims for power wheel-chairs and oxygen are common examples of supplies that fall under this umbrella). Practically speaking, this means that before HIPAA implementation changes began in May 2003, it would not be uncommon to find DME claims that processed and paid with an invalid or illegitimate diagnosis code, but which were nevertheless processed and paid appropriately. The diagnosis code, whether valid or not, had no bearing on whether the claim was processed appropriately or paid. Following the implementation of HIPAA implementation edits, we would expect claims history to contain only valid primary ICD-9-CM Manual codes on processed claims, but whether the code was used to determine payment would still depend upon the type of supply or service on the claim (i.e., whether the supply or service on the claim required compliance with an LCD versus a CMN or other claim modifier to process).

For precision, we would note that installation of claim submission and system changes to implement HIPAA began in May 2003 and were phased in over time. Claim submission requirements and some system edits on primary diagnosis codes for electronic claims to determine their validity began to be installed in May 2003. Other system changes to edit on electronic and paper claims were installed progressively in October 2003 and into July 2004, while additional system edits on secondary and tertiary diagnosis codes on paper claims are not scheduled to be completed until July 2008. The phased installation of HIPAA edits on different claim types and different levels of diagnosis codes on a claim means that while we would expect the number of DME claims submitted with truly invalid diagnosis codes to greatly diminish after May 2003, some paper claim lines that were relying upon secondary or tertiary diagnosis codes listed on a claim still are not edited for validity; as a result, a few DME claim lines with truly invalid ICD-9-CM Manual codes can still enter the claim processing system rather than reject.

II. ICD-9 Code Review

CMS reviewed the claim examples provided by the PSI staff during our February 12 meeting. Apart from some entries that were obviously not valid (i.e., NULL and XX000), we identified 53 distinct and separate ICD-9 diagnosis codes listed on the claims. While the diagnosis code descriptor on the SADMERC reports indicated that all these codes were invalid, our review against the ICD-9-CM Manual compiled by the National Center for Health Statistics and CMS, which contains all coding changes issued through October 1, 2007, indicates that all but three—**3515, 7155, and 7156**—are truly valid ICD-9 codes (see table below). In other words, only three codes are not and have not been listed as legitimate, defined codes in the ICD-9-CM Manual. Two additional codes identified as invalid may simply reflect an input error as similar, valid codes do exist.

ICD-9 Code Number	Code Description	Effective date of code
3515	Not a valid code	
4940	Bronchiecstasis without acute exacerbation	10/01/2000
4941	Bronchiecstasis with acute exacerbation	10/01/2000
4969	Invalid code (but 496 is Chronic Obstructive Pulmonary Disease, NEC)	
5859	y Chronic kidney disease, unspecified	10/01/2005
7155	Not a valid code	
7156	Not a valid code	
7837	Adult failure to thrive	10/01/2000
27702	Cystic fibrosus with pulmonary manifestation	10/01/2002
29410	Dementia in conditions classified elsewhere w/o behavioral disturbance	10/01/2000
32721	Primary central sleep apnea	10/01/2005
32723	Obstructive sleep apnea	10/01/2005
34831	Metabolic encephalopathy	10/01/2003
35800	Myasthenia gravis without (acute) exacerbation	10/01/2003
42820	Systolic heart failure, unspecified	10/01/2002
43884	Late effect of cerebrovascular disease, Ataxia	10/01/2002
45912	Postphlebitic syndrome with inflammation	10/01/2002
45930	Chronic venous hypertension w/o complications	10/01/2002
45933	Chronic venous hypertension w ulcer and inflammation	10/01/2002
49392	Asthma w/ (acute) exacerbation	10/01/2002
51883	Chronic respiratory failure	10/01/1998
51884	Acute and chronic respiratory failure	10/01/1998
56962	Mechanical complication of colostomy and enterostomy	10/01/1998
70700	Decubitus ulcer, unspecified site	10/01/2004
70701	Decubitus ulcer, elbow	10/01/2004
70702	Decubitus ulcer, upper back	10/01/2004
70703	Decubitus ulcer, lower back	10/01/2004
70705	Decubitus ulcer, buttock	10/01/2004
70707	Decubitus ulcer, heel	10/01/2004
70709	Decubitus ulcer, other site	10/01/2004
70710	Ulcer of lower limbs, except decubitus, ulcer of lower limb, unspecified	10/01/2000
70713	Ulcer of lower limbs, except decubitus, ulcer of ankle	10/01/2000
70715	Ulcer of lower limbs, except decubitus, ulcer of other part of foot	10/01/2000
71502	Osteoarthritis, generalized, upper arm	Not Available
71506	Osteoarthritis, generalized, lower leg	Not Available
71507	Osteoarthritis, generalized, ankle and foot	Not Available
71508	Osteoarthritis, generalized, other specified sites	Not Available
71599	Osteoarthrosis, unspecified whether generalized or localized, mult. sites	Not Available
72100	Invalid code (but 7210 is Cervical spondylosis without myelopathy)	Not Available
72887	Muscle weakness (generalized)	10/01/2003
72888	Rhabdomyolysis	10/01/2003
78079	Other malaise and fatigue	10/01/1998
78099	Other general symptoms	10/01/2002
78192	Abnormal posture	10/01/2000
78340	Lack of normal physiological development, unspecified	10/01/2000
78603	Apnea	10/01/1998
78604	Cheyne-Stokes respiration	10/01/1998
78605	Shortness of breath	10/01/1998
79901	Asphyxia	10/01/2005
79902	Hypoxemia	10/01/2005
E8880	Fall resulting in striking against sharp object	10/01/2001
E8889	Unspecified fall	10/01/2001
V5873	Aftercare following surgery of the circulatory system, NEC	10/01/2002

The apparent disconnect between the SADMERC ICD-9 code description and the current ICD-9-CM Manual indicates to us that the SADMERC description field is not reliable. We will discuss this further in section V of this summary.

III. Sample Claim Review

From the claim examples provided by the PSI staff on February 19 that contained HICNs (Health Insurance Claim Numbers) as well as CCNs (Claim Control Numbers), CMS selected a random sample of 11 claims with dates of service (DOS) ranging from January 2001 to November 2006 that were processed by the Region C DME carrier or DMERC. We then provided the CCN and HICN to the current Jurisdiction C DME MAC, Cigna Government Services (CGS), requesting that they obtain a copy of the original claim to determine whether the claim submitted contained a valid diagnosis code and whether the claim was processed correctly.

The DME MAC advised that they could retrieve eight of the 11 claims we provided them from their available on-line history. Of these, all eight contained valid ICD-9 codes at the time they were processed. Seven of the eight claims were processed and paid appropriately as they contained the appropriate supporting Certificate of Medical Necessity (CMN) information or claim modifiers. The remaining claim available on-line was denied because the amount of supplies being claimed was not supported by the claim information. (See table below for specific claim samples reviewed).

CLAIM CCN	HCPCS CODE	HCPCS DESC	DX CODE	SADMERC Report DX DESC	DX DESC Per CGS & CMS Review	Date of Service	Paid Amount	Found on Purged History Report?	CMN or Modifier Needed to Pay Regardless of ICD-9 Code?
01019833146000	L1845	Ko w/ adj flex/ext rotat cus	71506	INVALID DIAG CODE	Valid DX	05-Jan-01	$578.52	No	Yes
06264854453000	E0562	Humidifier heated used w PAP	78603	INVALID DIAG CODE	Valid DX	20-Jul-06	**$0.00**	Available Online	Yes
06241925709000	J7639	Dornase alpha inhal sol u d	27702	INVALID DIAG CODE	Valid DX	14-Aug-06	$1,125.42	Available Online	Yes
02157150873000	K0014	Other power whlchr base	3515	INVALID DIAG CODE	**Invalid DX**	30-Oct-01	**$0.00**	No	Yes
							$15.91	05075765369000	E0180
06195789521000	E0143	Walker folding wheeled w/o s	29410	INVALID DIAG CODE	Valid DX	11-Jun-05	$81.38	Available Online	Yes
06053746209000	E0431	Portable gaseous 02	79902	INVALID DIAG CODE	Valid DX	20-Feb-06	$25.66	Available Online	Yes
06171705235000	E0439	Stationary liquid 02	79901	INVALID DIAG CODE	Valid DX	16-Jun-06	$160.31	Available Online	Yes
05089844582000	E0431	Portable gaseous 02	51883	INVALID DIAG CODE	Valid DX	25-Mar-05	$28.78	Available Online	Yes
06310829635000	E0431	Portable gaseous 02	51883	INVALID DIAG CODE	Valid DX	02-Nov-06	$25.66	Available Online	Yes
02325150030000	E1031	Rollabout chair with casters	7156	INVALID DIAG CODE	**Invalid DX**	04-Oct-02	**$0.00**	No	Yes

The three claims out of the 11 sampled that the current DME MAC was unable to view from their on-line history were the oldest claims in the sample dating back to 2001 and 2002, respectively. Purged history reports were ordered for these claims, but either no report was available or the report that returned did not contain a CCN, date of service (DOS), and procedure code that corresponded to the information listed on the SADMERC report provided by the PSI staff. The DME MAC did note that based on the SADMERC report, two of these three claims contained truly invalid ICD-9 codes (**7156 and 3515**) and were denied. The exact reason for denial is unknown, however, and we continue to work to determine whether these claims are retrievable and if they were processed correctly.

In addition to reviewing a general sample of claims, CMS also provided the current DME MAC with the CCN and HICN information for the claims on the February 19 report provided by the PSI staff that contained what we believe to be truly invalid diagnosis codes: **3515, 7155, 7156, NULL and XX000.** All tallied, this amounted to 51 different claims with multiple claim lines on many of the claims with process dates in 2001, 2002, and 2003 respectively, with just two claims having processed after August 2003. As of this writing, the DME MAC was unable to obtain purged history reports that identify the bulk of these claims, but we continue work to determine if all the claims—including those with XX000 and NULL in the diagnosis field—are retrievable and if they were processed correctly.

IV. Report Values

Given the importance placed on code validity throughout the Medicare claims adjudication process, CMS investigated how and why NULL and XX000 appear as diagnosis codes in the SADMERC reports. Typically, values in data fields are read and loaded as received on the claims records from the Common Working File (CWF). There are exceptions, however, that require manual editing to facilitate data load:

- If special reserved characters in the database or other programs would cause the data to not load correctly, those fields are changed to blank spaces. The following field values are replaced with blanks:
  - Pipe sign (|)
  - Tilde (~)
  - Carriage return
  - End of file marker

- Any HCPCS or diagnosis field that is empty (does not contain a value) is replaced with a token value of NULL. In this instance, NULL was a value plugged into the field by the SADMERC as it loaded processed claim data from the CWF.

With respect to XX000 appearing in a diagnosis field, prior to the implementation of HIPAA edits discussed earlier, DME claims processing contractors inserted XX000 into the diagnosis field on claims that contained no diagnosis. This was necessary in order to allow the claim to enter the CWF record, which was designed to look for alpha-numeric values in the diagnosis field before allowing a claim to enter and complete processing. Since prior to HIPAA editing DME claims did not require an ICD-9 code in order to enter the claim adjudication process, the XX000 was simply used as a filler code to allow a claim entry into the CWF, but it had no bearing on whether the claim processed correctly. Contractors were instructed to cease using filler codes in this manner as part of the HIPAA implementation instructions implemented October 1, 2003. We would note that of the claim lines we reviewed that contain an XX000 in the diagnosis field, all appear to have been processed prior to October 1, 2003.

V. SADMERC Reports

Following our meeting with the PSI staff on February 12, CMS approached its contractor, the SADMERC, to discuss the reports it had provided to the PSI staff, with a focus upon the ICD-9 description field contained in the reports. In response, the SADMERC advised CMS that they had provided the requested files to the PSI staff at their request, with the clear indication both orally and via e-mail that the source table used to determine whether a diagnosis code was valid was not regularly updated, and was believed to have last been updated in August 2003. Since this initial response, the SADMERC has now informed us that they cannot confirm the last time the file was actually updated, nor can it document the source of the ICD-9 table that it conveyed to the PSI staff. After independently reviewing the ICD-9 codes and sample claims from the

SADMERC reports against actual claims history, CMS is not at all confident that the field in the SADMERC reports describing the validity of a particular ICD-9 code can be relied upon conclusively for any period of time.

CMS sincerely regrets the confusion that the SADMERC's descriptor field has generated in this instance. It is not unusual for the SADMERC to use certain files it obtains from other CMS sources or CMS contractors to fulfill requests for ad-hoc reports or for various research articles. For example, such information may include provider files from the National Supplier Clearinghouse which contain provider names and addresses, or a list of eligible Medicare beneficiaries provided by CMS. CMS has learned that in its desire to be responsive and comprehensive in the ad-hoc analysis reports and information it provides, the SADMERC has occasionally utilized information files from external sources (i.e., outside CMS or CMS contractors) to complete some specific ad-hoc reports. Prior to this event, CMS was neither aware of nor condoned the use of information from external sources.

VI. CMS Corrective Action

As a result of our analysis and findings, we have directed the SADMERC to immediately cease the practice of using externally sourced data files. The SADMERC has been directed to provide a list of any outside sources it utilizes in completing ad-hoc requests and is required to seek approval from CMS prior to utilizing data from outside sources. The SADMERC and their parent company's senior management at Palmetto Government Benefits Administrators (PGBA) have been made acutely aware of the significant ramifications of using outdated data and the serious nature of the conclusions by the PSI staff in this instance. CMS has received a complete and detailed report of the SADMERC's actions related to its use of the outdated diagnosis code/description file. The following is a summary report from the SADMERC on the subject:

> *"The SADMERC receives its claims data from CWF on a nightly basis. There is not an indicator on the claim itself regarding the validity of the diagnosis code. Apparently, Mr. Stoddard identified what he assumed were claims paid without a diagnosis code and/or with an invalid diagnosis code. He then requested the SADMERC to run a report identifying all claims paid from January 1, 1995 to January 31, 2008 with either an invalid diagnosis code or those claims that did not have a diagnosis code.*
>
> *In order to obtain this information, the SADMERC ran all claims paid for the time period against its diagnosis code file, which is only current as of August 2003. Claims containing diagnosis codes that were either not on the August 2003 diagnosis code file or where the diagnosis code descriptions had changed were identified. A report of those claims was then developed for Mr. Stoddard. The report identified those claims as either "invalid diagnosis code" or "missing diagnosis code," which indicates that the diagnosis code was either NOT on the August 2003 file or the diagnosis code did not match the August 2003 description for that code. In its cover letter to Mr. Stoddard, the SADMERC statistician advised Mr. Stoddard "Note that since the SADMERC has diagnosis code descriptions current as of August 2003, it is possible that diagnosis codes contained in your data may be currently valid." The "your data" refers to the report developed by the SADMERC. The intent of this note was to make Mr. Stoddard aware that the report is basically not reliable since it may contain claims data where the diagnosis code is now valid or where the diagnosis code did not appear on the August 2003 diagnosis description file (obviously outdated). Further, the statistician clearly explained to Mr. Stoddard by phone and the cover letter that the diagnosis description file is outdated and the SADMERC does not maintain a current diagnosis description file."*

Despite our critical view of the SADMERC's use of unauthorized external data sources in this incident, we would like to point out that producing ad-hoc reports of the kind at issue in this instance represents a very small portion of the SADMERC's role in supporting payment integrity. Since 1992, the SADMERC's operations have supported the DME Medicare Administrative Carriers (MACs) and their predecessors, DME Program Safeguard Contractors (PSCs), CMS, federal law enforcement agencies, and the National Supplier Clearinghouse (NSC) by performing the following critical functions:

- HCPCS Coding Process for DMEPOS
- Provide Medicare Coding Advice and Guidance
- Establish and Distribute Pricing Files for Certain Drugs and DMEPOS

- Statistical Analysis and Reporting

We have no reason to believe that the SADMERC has erred in fulfilling any of these primary roles as a result of this incident. The SADMERC's data is used by many to develop policies, facilitate program integrity activities, and to support special initiatives. Further, federal and state law enforcement agencies, including the Department of Justice and the Office of the Inspector General, have utilized the SADMERC's data and reports in both civil and criminal cases, without question. The SADMERC is recognized both within CMS and by the DME industry as an expert in its analytical and medical coding capabilities. CMS has confidence in the data produced by the SADMERC and its staff, and we have no reason to believe the SADMERC has compromised any of its day to day operations or work products.

VII. Conclusion

CMS thanks the HSGAC PSI staff for their interest in the Medicare program and maintaining its integrity. Further, we appreciate the opportunity to provide this feedback on the Subcommittee's preliminary findings. As discussed in this report, based on our review and analysis, we have come to the following conclusions:

- Historically, CMS did not generally require DME suppliers to include ICD-9-CM codes with their claims. CMS now requires DME suppliers to include diagnosis codes with their claims, and requires its DME claims processing contractors to check these codes, but this Medicare requirement is a relatively new one that was put in place during 2003 and 2004 for the sole purpose of achieving compliance with new healthcare *industry-wide* electronic claims transaction standards (mandated by the Health Insurance Portability and Accountability Act). Accordingly, depending on the date a DME claim was processed, the claim may, in fact, have been paid without a valid ICD-9 code as defined by the ICD-9-CM Manual and, regardless of the ICD-9 code's validity, it does not necessarily mean that the claim was paid inappropriately or that it was processed incorrectly;

- Based on a claim file review of a sample of the claim lines provided by the PSI staff, it appears that most of the claims listed on the SADMERC reports were processed appropriately; and

- The diagnosis description field in the SADMERC reports provided to the PSI staff is not accurate or reliable; therefore, it should not be used to conclude whether a claim was paid with an invalid diagnosis code.

Regardless of the ultimate conclusions drawn from the SADMERC data reports under scrutiny, CMS welcomes the external interest of the Subcommittee as a means to ensure that our programs operate as efficiently as possible and with the highest level of integrity.

ADDENDUM A

Issue: **Are DME suppliers required to include ICD-9-CM diagnosis codes on electronic and paper claims? If so, when did CMS promulgate this requirement to its claims processors and to DME suppliers? For what purpose did CMS promulgate the requirement?**

CMS Response

Historically, CMS did not generally require DME suppliers to include ICD-9-CM codes with their claims. Instead, DME suppliers were and continue to be required to maintain a doctor's order in their files for each and every billing. Moreover, for some DME items, suppliers are expected to furnish Medicare a certificate of medical necessity signed by the physician to document medical necessity.

There are several reasons why Medicare did not require DME suppliers to submit diagnosis data with their claims. First, DME suppliers do not hold clinical licenses, are not qualified to exercise clinical judgment, and sometimes have problems obtaining clinical information from the patient's physician. In addition, a physician might order the same kind of DME – e.g., a wheelchair – for many different kinds of underlying conditions, and (in these cases) it is not effective or cost-effective to try and match the diagnosis to the DME item within the claims process. Moreover, the patient's diagnosis does not affect Medicare's payment calculation for DME. For all of these reasons, Medicare did not and does not generally need these codes on DME claims to meet its own internal coverage and payment policy needs.

CMS now requires DME suppliers to include diagnosis codes with their claims, and requires its DME claims processing contractors to check these codes, but this Medicare requirement is a relatively new one that was put in place during 2003 and 2004. More specifically, for the sole purpose of achieving compliance with new healthcare *industry-wide* electronic claims transaction standards (mandated by HIPAA), CMS *did* begin to require DME suppliers to include diagnosis codes on their claims in recent years. In May 2003, CMS directed DME suppliers to begin including these codes on their electronic claims. In October 2003, this mandate was extended to DME claims billed on paper. However, due to the newness of this activity, CMS did not effectuate rigorous computer systems logic to enforce "valid" ICD-9-CM codes on DME claims until June 2004.

CMS promulgated these mandates in keeping with its understanding of the HIPAA requirements. The "implementation guide" governing HIPAA-compliant electronic health transactions seems to require that at least one current ICD-9-CM code be entered on all electronic health claims, and that all codes that are included be compliant with the current codebook.

It is important to note, however, that the HIPAA "implementation guide" does not require that a health payer actually use any particular required data element, including diagnosis codes, in its internal claims processes after it receives the claim. Moreover, the guide does not require that a payer analyze, for instance, whether a specific diagnosis code is medically consistent with a specific procedure code – this decision is left to the payer. So, the fact that a particular ICD-9-CM code is deemed "valid" for HIPAA compliance purposes does not imply that the code is the best code, or the only code, that could be used to describe the patient's condition. HIPAA compliance does not automatically confer medical accuracy, and is not equivalent to clinical judgment.

The new computer processes put in place by CMS during 2003 and 2004 only check the ICD-9-CM codes on the claim for HIPAA compliance. The DME claims processing contractors review the medical necessity of DME items, as well as complete their other claims processing tasks, through other processes within their overall claims operation. This includes the review of certificates of medical necessity for some DME. Certificates of medical necessity do include patient diagnosis codes, but – by Medicare law – only the physician is allowed to enter this data on the certificates.

For a few specific DME items, CMS's DME claims processing contractors have developed specific medical policies to adjudicate these kinds of claims. Some of these medical policies do require the presence of specific diagnosis codes on the claim or certificate of medical necessity.

In these cases, the DME claims processing contractors have checked and continue to check that the required diagnosis code(s) is/are reported.

It may seem odd, at first blush, that CMS extended the HIPAA requirement to paper claims, which are not governed by the HIPAA electronic claims implementation guide. However, Medicare does transfer many claims to other payers – for secondary payment – in electronic format after Medicare has finished processing the claim. The HIPAA-compliant electronic "coordination of benefits" transaction also requires the presence of at least one "valid" diagnosis code. Since, in effect, Medicare's claims process converts a paper claim into electronic format for transfer to such other payers, CMS ultimately determined that Medicare needed to require that even paper claims have a HIPAA-complaint diagnosis code on them.

A listing of the medical policies that require specific diagnosis/diagnoses codes is enclosed. Also enclosed are copies of the 2003 CMS transmittals that required implementation of ICD-9-CM coding for (1) electronic and (2) paper DME claims. The CMS transmittal explaining the mid 2004 upgrades to Medicare's computer systems to better validate the HIPAA compliance of ICD-9-CM codes billed on DME claims is also enclosed.

ENCLOSURES

(1) Chronology relating to diagnosis codes, HIPAA, and DME claims.

(2) List of DME claims processing contractor medical policies, with policies requiring specific diagnosis/diagnoses codes annotated.

(3) **CMS Transmittal B-03-028** (Issued April 18, 2003, for May 1, 2003 implementation). Requires DME suppliers to include a valid ICD-9-CM code on electronic claims. Note the DME supplier is given various options, including exercising its own judgment relative to the codebook, in determining the appropriate code in the event that the DME supplier cannot get this information from the physician.

(4) **CMS Transmittal B-03-045** (Issued June 6, 2003, for October 1, 2003 implementation). Implements the same ICD-9-CM coding requirement for most billers of Part B claims for electronic claims and for paper claims.

(5) **CMS Change Request 2956** (Issued December 19, 2003, for January 20, 2004, implementation). Further implements item #3 above.

(6) **CMS Change Request 3050** (Issued February 6, 2004, for July 6, 2004, implementation). Directs the maintainer of CMS's computer systems for processing DME claims to implement more rigorous computer logic to block claims with diagnoses codes that are not compliant with ICD-9-CM from processing.

(7) **CMS Change Request 3303** (Issued June 18, 2004, for October 4, 2004, implementation). Directs Medicare contractors to no longer allow providers and suppliers to implement ICD-9-CM coding updates as they occur.

CHRONOLOGY
DIAGNOSIS CODES, HIPAA, and DME CLAIMS

1979 Hospitals and other institutional providers are required to report ICD-9-CM codes on the CMS-1450 claims form. These codes are not yet required on Medicare Part B claims (including DME claims).

04/1989 Use of ICD-9-CM codes becomes mandatory for physicians' services - but not DME claims - submitted on the CMS-1500 claims form. (42 CFR 424.32).

08/1996 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-91) is enacted. Subtitle F of HIPAA requires the HHS Secretary to establish a number of standards for electronic data interchange in the healthcare sector, including standards for electronic health claims transactions and medical code sets.

08/2000 HHS announces that ICD-9-CM codes will serve as the mandatory code set for reporting patient diagnosis data within electronic health care transactions. Standards for electronic health claims transactions (ANSI X12 837) are also established. (45 CFR 162). The effective date of the regulation is October 16, 2000, with an *initial* 2-year compliance deadline (payers and providers would face penalties if they did not comply by October 16, 2002).

01/2001 The Administrative Simplification Compliance Act (ASCA) gives health payers and health care providers one additional year to comply with the HIPAA-mandated electronic claims transaction and code set standards, so long as these entities file a plan for achieving compliance with HHS. Hence, ASCA sets a de-facto industry compliance deadline of October 16, 2003.

2002-3 Medicare begins to tighten computer systems editing to validate ICD-9-CM codes against dates of service, if and when these codes are submitted by DME suppliers.

05/2003 Medicare begins requiring DME suppliers to include at least one "valid" ICD-9-CM codes on electronic claims. This requirement does not extend to paper claims. (PM-B-03-028).

10/2003 Medicare achieves HIPAA-compliance and requires the ICD-9-CM code on all electronic claims, except ambulance claims. Medicare adopts a "contingency plan" that allows a few submitters to temporarily continue using pre-HIPAA electronic formats.

10/2003 Most providers and suppliers (including DME suppliers) are required to submit electronic claims to Medicare. However, in accordance with ASCA, small DME suppliers (and some others) are allowed to continue paper billing.

10/2003 CMS announces a requirement that contractors reject paper claims that fail to include valid ICD-9-CM codes. This requirement apparently extends to DME suppliers (but excludes ambulance suppliers). The purpose of the requirement is to ensure that Medicare's "coordination of benefits" transactions meet HIPAA standards. However, Medicare's computer systems enforce the requirement only for primary diagnosis codes, and other diagnosis codes that are referenced in claims line item detail. (PM-B-03045).

07/2004 Medicare implements upgraded "front-end" computer systems logic to reject inbound *electronic* claims, including DME claims, that contain any "invalid" diagnosis codes. Systems edits now ensure that electronic DME claims will only process if all diagnosis codes on the claim are "valid" – the codes exist in the Codebook and reflect the highest level of specificity. These edits do not, of themselves, implement a medical policy – that is, the front-end edits do not check for clinical consistency between the diagnosis code(s) and the DME supplies billed on the claim. (CMS change request #3050). DME suppliers (and other billers) continue to get a 90-day "grace period" in using new diagnoses codes as annual coding updates are made.

07/2004 As of this date, Medicare's computer systems are rejecting "invalid" diagnosis codes (whether reported in the primary position or otherwise) on *electronic* DME claims.

Moreover, the DME claims processing system also validates the primary diagnosis billed on paper DME claims, as well as other diagnoses referenced in the line item detail of paper DME claims.

10/2004 CMS stops allowing providers and suppliers a 90-day "grace period" in implementing each year's coding updates. (CMS change request #3303).

10/2005 Medicare terminates its "contingency plan" for electronic health claims transactions – only HIPAA-compliant electronic claims are accepted.

MEMORANDUM

To: David Barnett

From: Adrian M. Oleck, M.D.

Date: March 5, 2008

Subject: DME MAC Medical Policies with ICD-9 Codes

Attached is the list of DMEPOS policies that identify specific ICD-9 codes that are linked to coverage. It should be noted that:

- In some policies the ICD-9 diagnosis codes relate to all HCPCS codes addressed by the policy. In other policies, the ICD-9 codes relate to only some of the HCPCS codes in the policy.
- In some policies, the ICD-9 codes are found in the Local Coverage Determination (LCD). In other policies, the ICD-9 codes are found in the related Policy Article.

Policy	ICD-9 Codes Specified
Ankle-Foot and Knee-Ankle-Foot Orthoses	X
Automatic External Defibrillators	X
Canes and Crutches	
Cervical Traction Devices	
Cold Therapy	
Commodes	
Continuous Positive Airway Pressure (CPAP) Systems	
Enteral Nutrition	
Epoetin	
External Breast Prostheses	X
External Infusion Pumps	X
Eye Prostheses	
Facial Prostheses	
Glucose Monitors	X
High Frequency Chest Wall Oscillation Devices	X
Home Dialysis Supplies and Equipment	
Hospital Beds and Accessories	
Immunosuppressive Drugs	X
Infrared Heating Pad Systems	
Intrapulmonary Percussive Ventilation System	
Lower Limb Prostheses	
Manual Wheelchair Bases	
Mechanical In-Exsufflation Devices	X
Nebulizers	X
Negative Pressure Wound Therapy Pumps	
Oral Anticancer Drugs	X
Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)	X
Orthopedic Footwear	X
Osteogenesis Stimulators	X
Ostomy Supplies	X
Oxygen and Oxygen Equipment	
Parenteral Nutrition	
Patient Lifts	
Pneumatic Compression Devices (for Lymphedema)	
Power Mobility Devices	
Pressure Reducing Support Surfaces, Group 1	
Pressure Reducing Support Surfaces, Group 2	X
Pressure Reducing Support Surfaces, Group 3	
Refractive Lenses	X
Respiratory Assist Devices	
Seat Lift Mechanisms	
Speech Generating Devices	
Spinal Orthoses: TLSO and LSO	
Suction Pumps	
Surgical Dressings	
Therapeutic Shoes for Diabetics	X
Tracheostomy Supplies	X
Transcutaneous Electrical Nerve Stimulators (TENS)	
Urological Supplies	
Walkers	
Wheelchair Options and Accessories	
Wheelchair Seating	X

Program Memorandum Carriers	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal B-03-028	**DATE: APRIL 18, 2003**

SUBJECT: Durable Medical Equipment Regional Carriers (DMERC) – ICD-9-CM Coding

Background

The Centers for Medicare & Medicaid Services (CMS) has issued several instructions on the implementation of the 2003 Update to the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes. The ICD-9-CM diagnosis codes were adopted under the Health Insurance Portability and Accountability Act (HIPAA) as the medical code set to be used for reporting diagnosis in the HIPAA X12N 837 Health Care Claim Transaction. The X12N 837 (version 4010A1) requires a diagnosis on all claims unless there are no diagnoses (i.e., taxi claims). Since current CMS policy does not always require a diagnosis on the claim for certain services, this Program Memorandum (PM) provides additional guidance to DMERCs in implementing the HIPAA X12N 837 requirement for reporting diagnosis codes. Instructions that will address reporting the ICD-9-CM on other carrier claims will be forthcoming.

Policy

The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits". In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

For electronically submitted claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), a valid diagnosis code, which most fully explains the patient's diagnosis, is required. CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the **claim**. (Suppliers are precluded from including diagnostic information on a certificate of medical necessity per §1842(j)(2)(a) of the Social Security Act.) These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals, documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional.

Listed below is specific information about claims submission:

a) All electronic claims submitted to the DMERC must contain a valid diagnosis code for each line item on the claim.

b) Electronic claims (assigned or unassigned) **without** an ICD-9-CM code(s) shall be returned as front end rejects to the supplier. These claims do not get in the front door.

c) For all claims with an ICD-9-CM code, a valid ICD-9-CM code (the code that provides the highest level of specificity for the date the service was provided) must be used.

d) Assigned claims with an **invalid** ICD-9-CM code shall be returned as unprocessable and unassigned claims shall be denied for incorrect coding. (**NOTE**: If DMERCs are currently developing these unassigned claims prior to denial, they may continue to do so.)

e) Paper claims require an ICD-9-CM code if specified (e.g., required by a local medical review policy (LMRP)). However, if an ICD-9-CM code is required, the code will go through the same accuracy edits as electronic claims.

The DMERCs shall not deny claims where the diagnosis code on a claim does not match the diagnosis on the order or a certificate of medical necessity (CMN), so long as: 1) There is sufficient evidence in the patient's medical record to justify the use of the diagnosis code, 2) The diagnosis on the claim justifies coverage for the item or service, and 3) The diagnosis code on the claim is valid and to the highest level of specificity.

In addition, DMERCs shall not require suppliers to obtain new orders or CMNs in those cases

where ICD-9-CM codes were updated unless normal business practices would require a new order or CMN. For instance, suppliers are required to obtain new orders and/or CMNs when the patient's medical condition changes. If an ICD-9-CM code is updated, and the patient's medical condition has not changed, there is no requirement for the supplier to obtain a new order and/or CMN.

Provider Education:

Educate suppliers on the above instructions on your Web sites, next regularly scheduled bulletin, training sessions, and listservs.

The *effective date* for this PM is May 1, 2003.

The *implementation date* for this PM is May 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact your Regional Office.

Program Memorandum Carriers	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal B-03-045	Date: JUNE 6, 2003

CHANGE REQUEST 2725

SUBJECT: ICD-9-CM Coding Requirements for Claims Submitted to Medicare Carriers

I. GENERAL INFORMATION

A. Background:

This Program Memorandum (PM) implements a new policy to require an ICD-9-CM diagnosis code on all paper and electronic claims billed to carriers with the exception of ambulance claims (specialty type 59).

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), a final rule published in the **Federal Register** on August 17, 2000 established new standards, requirements, and implementation specifications for health plans, health care clearing houses, and health care providers who transmit any health information in an electronic form. The applicable electronic format for transmitting Medicare claims information is the ASC X12N 837. The implementation specifications define the new requirements for these formats. The ASC X12N 837 Professional Implementation Guide (version 4010A.1) requires a diagnosis(es) on "all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims)."

This PM clarifies that based upon the implementation specifications for HIPAA, an ICD-9-CM code is not required for all ambulance supplier claims, but is required for all other professional claims e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs. Although the HIPAA requirements do not apply to paper claims, you are to implement the ICD-9-CM requirement for paper claims as well as all electronic claims, regardless of the version of the electronic claim format.

Emergency medical technicians (EMTs) and paramedics use a trip sheet to document the condition of the beneficiary, including the patient's chief complaints, at the time that the beneficiary is loaded onto the ambulance. This documentation may later be requested by the intermediary/carrier during medical review of the claim for use in determining whether the ambulance transport and services provided were medically necessary.

However, EMTs and paramedics do not have the training necessary to make a diagnosis. Thus, no diagnosis is available at the time of transport. Moreover, it is the condition of the beneficiary at the time of transport, rather than the beneficiary's diagnosis, that determines whether the transport and services provided are payable under the Medicare ambulance benefit.

B. Policy:

A diagnosis code must be included on all Medicare claims (electronic and paper) submitted to Part B carriers, except those claims submitted by ambulance suppliers. Professional suppliers of service include: physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, and ASCs.

CMS-Pub. 60B

The claim should contain the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits". In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

C. Implementation:

Editing of Claims Submitted to Carriers for the Presence of a Diagnosis Code

Effective for dates of service on or after October 1, 2003, all paper and electronic claims submitted to carriers must contain a valid diagnosis code with the exception of claims

submitted by ambulance suppliers (specialty type 59). Carriers must return as unprocessable, paper and electronic claims that do not contain a valid diagnosis code with the exception of claims submitted by ambulance suppliers (specialty type 59).

Program Memorandum B-03-028, Change Request 2672, implemented requirements for submittal of a diagnosis for electronic claims processed by durable medical equipment regional carriers. This PM expands the requirements for submittal of the diagnosis required in PM B-03-028 to include paper claims.

If any carriers are currently placing invalid or valid diagnosis codes on any claims prior to sending the claim to CWF and their coordination-of-benefits trading partners, they must discontinue this practice.

Carriers and CWF must not reject an ambulance claim on the basis that it does not contain a diagnosis code.

Physicians Reporting Diagnosis Codes When A Diagnostic Test Is Ordered

Section 4317 of the Balanced Budget Act of 1997 provides, with respect to diagnostic laboratory and certain other services, that "if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the services to provide diagnostic or other medical information to the entity, the physician or practitioner ordering the service shall provide that information to the entity at the time the service is ordered by the physician or practitioner." A laboratory or other provider must report on a claim for Medicare payment the diagnostic code(s) furnished by the ordering physician. In the absence of such coding information, the laboratory or other provider may determine the appropriate diagnostic code based on the ordering physician's narrative diagnostic statement or seek diagnostic information from the ordering physician/practitioner. However, a laboratory or other provider may not report on a claim for Medicare payment a diagnosis code in the absence of physician-supplied diagnostic information supporting such code.

Provider Education

Carriers must notify suppliers of these changes through your Web sites within two weeks of receipt and publish the information in your next regularly scheduled bulletin. In addition, if you have a listserv that targets the affected provider communities, you shall use it to notify subscribers that important information about "ICD-9-CM Coding Requirements" is available on your Web site. The CMS will publish a national provider education article shortly that addresses these guidelines.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1.1	Carriers must return paper and electronic claims as unprocessable from all specialty types except "59" that does not have a diagnosis code(s) on the claim.	Carriers
1.2	Carriers may not return as unprocessable a paper or electronic claim for an ambulance service (specialty type 59) because the claim has no diagnosis code.	Carriers
1.3	CWF may not reject an ambulance service claim (specialty type 59) because the claim has no diagnosis code.	Common Working File
1.4	Carriers must not enter a diagnosis code (valid or invalid) on any claim type.	Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting/Workload Impact:

E. Dependencies:

F. Testing Considerations:

IV. ATTACHMENT(S)

Version:	**Effective Date: October 1, 2003**
Implementation Date: October 1, 2003 Discard Date: October 1, 2004 Post-Implementation Contact: regional offices	Funding: These instructions should be implemented within your current operating budget. Pre-Implementation Contact: If you have any questions, contact your regional office.

CMS Manual System Pub. 100-04 Medicare Claims Processing	Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)
Transmittal 47	Date: DECEMBER 19, 2003
	CHANGE REQUEST 2956

I. SUMMARY OF CHANGES: This instruction manualizes the return as unprocessable requirements concerning ICD-9-CM diagnosis coding for Medicare Part B claims previously released in Program Memorandum Transmittal B-03-045, Change Request (CR) 2725, dated June 6, 2003. Chapter 1, section 80.3.2.1.1 is revised to include a sentence stating that the requirements are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Chapter 1, section 80.3.2.1.3 subparagraph p. is deleted and following subparagraphs redesignated accordingly.

NOTE: Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the Medicare Claims Processing Manual will further incorporate the provisions of CR 2725 when that chapter is next revised.

NEW/REVISED MATERIAL-EFFECTIVE DATE: October 1, 2003
IMPLEMENTATION DATE: January 20, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/80.3.2.1.1/Carrier Data Element Requirements
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

III. FUNDING: Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Business Requirements

Pub. 100-04	Transmittal: 47	Date: December 19, 2003	Change Request 2956

I. GENERAL INFORMATION

A. Background: The Medicare Carriers Manual return as unprocessable instructions had provided in two subparagraphs that claims for physician and nonphysician specialty claims, and for other services where required, must submit diagnosis code(s) in item 21 of the CMS-1500 claim form or electronic equivalent. If the code(s) was missing, incorrect, or truncated, the claim was to be returned by the carrier as unprocessable. Change Request (CR) 2725, Transmittal B-03-045, June 6, 2003 requires that valid diagnosis code(s) must be submitted for all claims with the exception of claims submitted by ambulance suppliers. Thus, CR 2725 had expanded the types of services where valid diagnosis codes were required on claims.

B. Policy: Effective for claims with dates of service on or after October 1, 2003, carriers must return Form CMS-1500 paper claims or electronic equivalent claims as unprocessable where a claim is required to have ICD-9-CM diagnosis code(s) on the claim but required diagnosis code(s) are not entered on the claim. This policy was set forth in CR 2725.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
1	Carriers shall return paper and electronic claims with dates of service on or after October 1, 2003 as unprocessable for all specialty types that require diagnosis code(s) on the claim where the claim does not have valid diagnosis code(s). All specialty types except 59, ambulance, require diagnosis code(s) on the claim.	**Carrier**

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES: N/A

Citation	Change

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 **Implementation Date: January 20, 2004** **Pre-Implementation Contact(s): appropriate CMS regional office** **Post-Implementation Contact(s): Appropriate regional office**	**These instructions should be implemented within your current operating budget**

80.3.2.1.1 - Carrier Data Element Requirements
(Rev. 47, 12-19-03)
B3-3005.4
A - Required Data Element Requirements
1 - Paper Claims
The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:
Item 3 - Patient's Birth Date
Item 9b - Other Insured's Date of Birth
Item 11a - Insured's Date of Birth
Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.
If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable. They use remark code MA 52 on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.
If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.
For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24a), when dates are provided, either a 6-digit date or 8-digit date may be provided.
If 8-digit dates are furnished for any of items 11b, 14, 16, 18, 19, or 24a (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24a, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;
- Item 24a must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24a will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24a;
- Do not compress or change the font of the "year" item in item 24a to keep the date within the confines of item 24a. If a continuous number is furnished in item 24a with no spaces between month, day, and year, you will not need to compress the "year" item to remain within the confines of item 24a;
- The "from" date in item 24a must not run into the "to" date item, and the "to" date must not run into item 24b;
- Dates reported in item 24a must not be reported with a slash between month, day, and year; and
- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24a (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24a. The same applies to those who wish to submit 6-digit dates for any of these items.

Carriers must return claims as unprocessable if they do not adhere to these requirements.
2 - Electronic Claims
Carriers must return all electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported. They use remark code MA52 on the remittance advice. For formats other than the remittance, carriers use code(s)/message(s) that are consistent with the above remark codes.
If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b,

or 11a and the birth date is not in 8-digit format. However, if carriers do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark codes if the claim is returned through the remittance advice or notice process. In most cases, reason code 16, Claim/service lacks information that is needed for adjudication, will be used in tandem with the appropriate remark code that specifies the missing information. Carriers use the following:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1A or contains an invalid HICN in item 1A. (Remark code MA61.)
2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card. (Remark code MA36.)
3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)
4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one. Remark code MA75.)
5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A. (Remark code M52.)
6. If a claim lacks a valid place of service (POS) code in item 24b, or contains an invalid POS in item 24b, return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.
7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Remark code M20 if the HCPCS is missing, or M51 for an invalid/obsolete HCPCS.)

Note: Level 3 HCPCS will be going away with HIPAA.

8. If a claim lacks a charge for each listed service. (Remark code M79.)
9. If a claim does not indicate at least one day or unit in item 24G (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the FI must program the system to automatically default to "1" unit).
10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See "Exceptions," bullet number one; Remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)
11. If a claim does not contain in item 33:
    a. A billing name, address, ZIP code, and telephone number of a provider of service or supplier. (Remark code MA82.)

    AND EITHER

    b. A valid PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for the performing provider of service or supplier who is not a member of a group practice. (Remark code MA82 or M57 if another provider is involved.)

    OR

    c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for performing providers of service or suppliers who are members of a group practice. (Remark code MA112.)

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services
(Rev.47, 12-19-03)

Carriers must return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:
   1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.
   2. If the initial date "actual" treatment occurred is not entered in item 14. (Remark code MA122 is used.)
b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, ZIP code, and PIN (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K. (Remark code MA112 is used.)
c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP code of the location where the order was accepted were not entered in item 32. (Remark code MA 114 is used.)
d. For physicians who maintain dialysis patients and receive a monthly capitation payment:
   1. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's PIN (or NPI when effective) is not entered in item 24K. (Remark code MA112 is used.)
   2. If the name, address, and ZIP code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.
e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) is not present in item 19. (Remark code MA104 is used.)
f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 is used.)
g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 is used.)
h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.
i. For independent laboratory claims:
   1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Remark code MA116 is used.)
   2. If the name, address, and ZIP code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.
j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)
k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code MA102 is used.)
l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) are not entered in items 17 or 17A. (Remark code MA102 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A. (Remark code MA102 is used.)
n. For outpatient services provided by a qualified, independent physical, or occupational therapist:
    1. If the UPIN (or NPI when effective) of the attending physician is not present in item 19. (Remark code MA104 is used.)
    2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code MA104 is used.)
o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP code, and PIN (or NPI when effective) where the laboratory services were performed in item 32, if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)
p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA51 is used.)
q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23. (Remark code MA50 is used.)
r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

MLN Matters CMS
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 3050 **MLN Matters Number:** MM3050
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R86CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

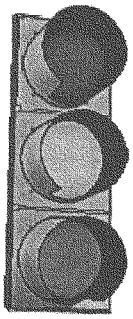
Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Professional Health Care Claim Implementation Guide (IG) Editing

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians, practitioners, suppliers, and providers who bill Medicare carriers, including Durable Medical Equipment Carriers (DMERCs).

Provider Action Needed



STOP – Impact to You
Affected providers should stop submitting electronic claims with diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

CAUTION – What You Need to Know
Providers should note that Medicare systems are strengthening their system edits to assure receipt of HIPAA compliant claims. Effective July 1, 2004, Medicare will reject electronic claims that have diagnosis codes, zip codes, or telephone numbers that are not HIPAA compliant.

GO – What You Need to Do
Be sure your billing systems are modified to generate electronic claims that will pass Medicare's HIPAA compliancy edits for diagnosis codes, zip codes, and telephone numbers.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically. In addition, one of the HIPAA provisions requires standard formats to be used for electronically submitted health care transactions.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

CMS is committed to implementing the 837 COB transaction set per the HIPAA implementation guide (IG), and it recognizes that a change in its systems is needed to:

1) Comply with the 837 Professional IG; and

2) To allow the creation of compliant coordination of benefits (COB) claim files.

To accomplish this, Medicare systems will be changed to include edits that reject electronic claims that contain:

- Invalid diagnosis codes;
- A dash, a space, or special character in any zip code field; and
- A dash, space, special character, or a parenthesis in telephone numbers.

Implementation

July 6, 2004.

Related Instructions

The ANSI X12N 837 implementation guides are the standards of compliance for claim transactions and are available electronically at **http://www.wpc-edi.com/hipaa/HIPAA_40.asp** on the CMS web site.

The *Medicare Claims Processing Manual, Chapter 24* has been updated to include the new *Section 40.7.2, Professional Implementation Guide (IG) Edits*. This new section is included below:

> **40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits**
>
> *The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to or not.*
>
> *The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain a dash, space, or special character in any zip code.*
>
> *The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain dashes, spaces, special characters or parentheses in any telephone number.*

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub. 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 210	Date: JUNE 18, 2004

CHANGE REQUEST 3303

I. SUMMARY OF CHANGES: This instruction is CMS' annual reminder to the contractors of the ICD-9-CM update that is effective for the dates of service on and after October 1, 2004, as well as discharges on or after October 1, 2004 for institutional providers.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	23/10.2 Relationship of ICD-9-CM Codes and Date of Service

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment – Business Requirements

Pub. 100-04	Transmittal: 210	Date: June 18, 2004	Change Request 3303

SUBJECT: Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

I. GENERAL INFORMATION

A. Background: In 1979, use of ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450. On April 1, 1989, use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500. Effective October 1, 2003 (refer to Transmittal B-03-045, dated June 6, 2003) an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59).

Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers (billing carriers/DMERCs) to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. Institutional providers did not have a grace period, they were always required to bill the new ICD-9-CM codes for discharges on or after October 1.

The ICD-9-CM codes are updated annually. The CMS sends the ICD-9-CM Addendum out to the regional offices and Medicare contractors annually.

B. Policy: This instruction serves as a reminder to contractors regarding the annual ICD-9-CM coding update to be effective for dates of service on or after October 1, 2004 (effective for discharges on or after October 1, 2004 for institutional providers).

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims. However, an ICD-9-CM code is not required for ambulance supplier claims.

The CMS posts the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at www.cms.hhs.gov/medlearn/icd9code.asp on an annual basis. The updated diagnosis codes are effective for dates of service on and after October 1. Providers can view the new updated codes at this site in June. Providers can also visit the National Center for Health Statistics (NCHS) Web site at www.cdc.gov/nchs/icd9.htm. The NCHS will post the new ICD-9-CM Addendum on their Web in June. Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3303.1	Carriers/DMERCs shall accept the new and revised 2004 ICD-9-CM update in order to process claims with dates of service on or after October 1, 2004. **NOTE:** Reminder Medicare carriers/DMERCs can no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes.	Local Part B carrier and DMERCs
3303.2	FISS shall install and FIs shall accept the new and revised 2004 ICD-9-CM update in order to process claims with dates of service on or after October 1, 2004 for outpatient claims and for inpatient claims, with discharges on or after October 1, 2004.	FI, FISS
3303.3	Intermediaries shall encourage/remind hospitals to send a copy of the Addendum to the Director of Medical Records.	FI
3303.4	Intermediaries shall handle questions on the operation of GROUPER, MCE and OCE, in accordance with regular procedures.	FI

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: Grouper v22.0, Medicare Code Editor v21.0, non-OPPS v20, and Outpatient Code Editor v5.3.

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: Two attachments: the table and the Addendum.

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** April Billingsley, abillingsley@cms.hhs.gov or 410-786-0140 (carriers), and Sarah Shirey, sshirey@cms.hhs.gov or 410-786-0187 (FIs) **Post-Implementation Contact(s):** Appropriate regional office	**These instructions shall be implemented within your current operating budget.**

10.2 – Relationship of ICD-9-CM Codes and Date of Service
(Rev. 210, 06-18-04)

PM B-02-027 (CR-2108), B-03-063, B-02-064, B-03-002

Diagnosis codes must be reported based on the date of service (including, when applicable, the date of discharge) on the claim and not the date the claim is prepared or received. Medicare contractors are required to be able to edit claims on this basis, including providing for annual updates each October. The effective date for this requirement is:

- Claims to DMERCs – April 1, 2003;
- Claims to carriers – October 1, 2002; and
- Claims to intermediaries – October 1, 1983.

Shared systems must establish date parameters for diagnosis editing. Use of actual effective and end dates is required when new diagnosis codes are issued or current codes become obsolete with the annual ICD-9-CM updates. During implementation, for codes already established on the shared system files, the effective date could be defaulted to January 1, 1990. Any codes on claims to carriers and DMERCs currently identified as no longer effective upon implementation could be considered to have an end date of December 31, 2001. Thereafter, any additions or terminations must have the actual effective and end date.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD-9-CM diagnosis codes are a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable. For dates of service beginning October 1, 2004, physicians, practitioners, and suppliers must use the current and valid diagnosis code that is then in effect. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised and discontinued codes on the following Web site: http://www.cms.hhs.gov/medlearn/icd9code.asp

The CMS sends the updated ICD-9-CM addendum to contractors on an annual basis via a recurring update notification instruction. The addendum is normally released to contractors each June. The addendum contains the new, revised, and discontinued diagnosis codes which are effective for dates of service on and after October 1st.