A Look at Medicare Improper Payments in Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Introduction

Analyzing government or third-party reports and data, the Council for Medicare Integrity, a nonprofit organization advocating for proper Medicare billing, created this analysis to review the rates of improper billing among claims for Durable Medical Equipment (DME) – an area that has been previously flagged by the Centers for Medicare and Medicaid Services (CMS) as having high rates of billing errors.

The Council analyzed data provided by the CMS in the *Supplementary Appendices for the Medicare Fee-for-Service (FFS) 2015 Improper Payment Report*. The appendices contain the data that will eventually become what is known as the CMS's 2015 Comprehensive Error Rate Testing (CERT) report. The CERT Program evaluates statistically valid random samples of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.

What is DMEPOS?

Medicare Part B covers medically necessary Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These items are prescribed by a doctor for use in a beneficiary's home.

All beneficiaries with Part B coverage are eligible for services under DMEPOS. If a beneficiary is prescribed DMEPOS, he or she pays 20 percent of the Medicare-approved amount.

According to the CMS website, the following are examples of services included under DMEPOS:

- Air-fluidized beds and other support surfaces
- Blood sugar monitors
- Blood sugar (glucose) test strips
- Diabetic supplies
- Canes (except white canes for the blind)
- Commode chairs
- Continuous passive motion (CPM) machine
- Crutches
- Hospital beds

- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices
- Nebulizers and nebulizer medications
- Oxygen equipment and accessories
- Patient lifts
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

DMEPOS Error Rate

Overpayments
According to the CERT data, DMEPOS has an improper payment rate of 39.9 percent, draining $3.2 billion from the Medicare Trust Fund each year. The DMEPOS billing error rate (39.9 percent) is three times larger than the national Medicare Fee for Service improper payment rate, which stands currently at 12.1 percent.

Underpayments
Unlike other claim types with some amount of underpayments -- or claims that were underbilled according to Medicare policy and require the provider or supplier to be paid more for the services they billed – interestingly, DMEPOS had $0 in underbillings, meaning all billing errors in this service category were a result of billing the Medicare program too much for services provided, not too little.

Common Errors
The most common error in DMEPOS billing is Insufficient Documentation, which accounted for $2.6 billion of the total $3.2 billion in waste in this billing category.

According to the 2014 CERT report:

- **No Documentation Claims** are placed into this category when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.
- **Insufficient Documentation Claims** are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element, required as a condition of payment, is missing. This would include a physician signature on an order, or a form required to be completed in its entirety.

- **Medical Necessity Claims** are placed in this category when CERT reviewer makes an informed decision from medical record documentation submitted that the services billed were not medically necessary according to on Medicare coverage and payment policies.
- **Incorrect Coding Claims** are placed in this category when the provider or supplier submits medical documentation indicating (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.
- **Other Claims** are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, non-covered or unallowable service).

According to the CERT reporting, hospital beds/accessories are the DMEPOS service with the highest improper payment rate – misbilling in 85.3 percent of all claims. Claims for manual wheelchairs are overbilled in 81.3 percent of cases, and surgical dressing claims were overbilled in 72.5 percent of cases.

The table below lists the top 20 service types with the highest improper payments in DMEPOS.

Table D2: Top 20 Service Types with Highest Improper Payments: DMEPOS

DMEPOS Service (HCPCS)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payment
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Oxygen Supplies/Equipment	$541,134,091	48.5%	45.1% - 51.8%	0.7%	86.2%	1.6%	0.0%	11.5%	1.2%
CPAP	$248,346,601	40.4%	33.6% - 47.2%	0.1%	88.7%	2.9%	0.0%	8.3%	0.6%
Glucose Monitor	$139,795,750	42.9%	37.6% - 48.1%	0.7%	64.3%	13.9%	16.7%	4.5%	0.3%
Immunosuppressive Drugs	$135,696,074	45.4%	37.2% - 53.6%	0.1%	70.2%	0.0%	0.1%	29.5%	0.3%
Lower Limb Orthoses	$130,146,239	46.3%	38.0% - 54.6%	2.4%	87.3%	2.9%	0.0%	7.5%	0.3%
Lower Limb Prostheses	$127,267,572	23.7%	11.2% - 36.1%	0.0%	90.5%	0.0%	0.4%	9.0%	0.3%
Nebulizers & Related Drugs	$125,070,267	11.0%	3.5% - 18.4%	3.6%	84.5%	1.8%	0.0%	10.1%	0.3%
Infusion Pumps & Related Drugs	$119,662,255	27.9%	11.7% - 44.1%	0.5%	91.4%	2.3%	0.0%	5.7%	0.3%
Diabetic Shoes	$118,850,286	66.0%	54.8% - 77.2%	2.4%	90.3%	0.1%	0.0%	7.2%	0.3%
Enteral Nutrition	$114,939,708	51.5%	42.3% - 60.8%	0.4%	88.0%	0.2%	0.0%	11.4%	0.3%
Wheelchairs Manual	$112,771,748	81.3%	71.3% - 91.2%	1.8%	87.9%	0.8%	0.0%	9.6%	0.3%
Urological Supplies	$110,153,534	48.8%	35.5% - 62.0%	0.1%	69.2%	0.8%	0.0%	30.0%	0.3%
Surgical Dressings	$99,186,486	72.5%	63.3% - 81.7%	1.5%	87.7%	1.0%	0.0%	9.7%	0.2%
LSO	$91,265,153	51.6%	41.7% - 61.5%	5.5%	79.1%	1.2%	0.0%	14.2%	0.2%
Hospital Beds/Accessories	$85,475,145	85.3%	78.9% - 91.7%	0.4%	91.1%	1.7%	0.0%	6.8%	0.2%
Wheelchairs Options/Accessories	$81,390,780	35.6%	17.3% - 53.8%	8.3%	80.8%	5.4%	0.0%	5.5%	0.2%
Respiratory Assist Device	$75,351,493	67.7%	58.8% - 76.6%	0.6%	88.1%	2.1%	0.0%	9.2%	0.2%
Oral Anti-Cancer Drugs	$74,794,669	28.0%	17.2% - 38.7%	0.0%	71.1%	0.0%	0.0%	28.9%	0.2%
All Policy Groups with Less than 30 Claims	$74,763,549	43.1%	26.8% - 59.5%	0.4%	92.7%	0.0%	0.0%	6.9%	0.2%
Ostomy Supplies	$71,004,658	41.9%	33.4% - 50.4%	0.0%	85.4%	1.3%	0.0%	13.3%	0.2%
All Type of Services (Incl. Codes Not Listed)	$3,181,282,257	39.9%	35.6% - 44.2%	1.6%	83.0%	1.9%	0.8%	12.7%	7.3%

Of providers that bill Medicare for services related to DMEPOS, podiatry has the highest improper payment rate, overbilling in 66.8 percent of claims. Podiatry is followed by medical supply companies with pedorthic personnel (59.1 percent improper payment rate) and multispecialty clinics or group practices (57.9 percent improper payment rate).

A full list of improper payment rates and provider types can be found below.

Providers Billing to DMEPOS	Improper Payment Rate				Provider Compliance Improper Payment Rate	Percent of Overall Improper Payment
	Improper Payment Rate	Projected Improper Payments	Sampled Claims	95% Confidence Interval		
Medical Supply Company not included in 51, 52, or 53	49.9%	$1,618,058,589	5,079	46.4% - 53.5%	53.1%	3.7%
Pharmacy	27.5%	$772,541,959	2,924	19.6% - 35.4%	28.1%	1.8%
Medical Supply Company with Respiratory Therapist	48.7%	$312,424,705	1,047	44.0% - 53.3%	51.8%	0.7%
Individual prosthetic personnel certified by an accrediting organization	36.5%	$78,463,566	434	29.3% - 43.7%	41.9%	0.2%
Individual orthotic personnel certified by an accrediting organization	23.9%	$77,859,429	380	4.0% - 43.8%	25.6%	0.2%
Podiatry	66.8%	$55,235,280	101	52.8% - 80.8%	72.0%	0.1%
All Provider Types With Less Than 30 Claims	34.4%	$54,876,871	192	23.5% - 45.4%	38.3%	0.1%
Medical Supply Company with prosthetic/orthotic personnel certified by an accrediting organization	40.1%	$48,872,649	217	32.8% - 47.4%	41.7%	0.1%
Medical Supply Company with orthotic personnel certified by an accrediting organization	48.2%	$47,458,700	164	26.4% - 70.1%	47.8%	0.1%
Orthopedic Surgery	46.2%	$37,929,592	120	32.8% - 59.6%	47.9%	0.1%
Supplier of oxygen and/or oxygen related equipment	36.0%	$16,395,297	51	25.2% - 46.8%	38.4%	0.0%
Medical Supply Company with prosthetic personnel certified by an accrediting organization	40.5%	$11,642,162	55	35.2% - 45.9%	44.3%	0.0%
Ophthalmology	55.7%	$10,956,719	40	41.1% - 70.2%	62.0%	0.0%
Medical Supply Company with Pedorthic Personnel	59.1%	$10,852,341	40	49.3% - 68.9%	58.8%	0.0%
Multispecialty Clinic or Group Practice	57.9%	$8,488,909	33	29.0% - 86.8%	53.0%	0.0%
Optometry	42.0%	$8,325,298	49	25.0% - 58.9%	48.7%	0.0%
General Practice	34.0%	$7,778,853	40	23.4% 44.6%	38.8%	0.0%
Individual prosthetic/orthotic personnel certified by an accrediting organization	16.4%	$3,121,338	41	9.4% - 23.4%	20.1%	0.0%
All Provider Types	39.9%	$3,181,282,257	11,007	35.6% - 44.2%	42.0%	7.3%

Summary

Medicare loses more money to wasteful spending than any other program government-wide, with more than $60 billion in erroneous billing each year.

The consistently high rates of improper payments within the DMEPOS industry are very concerning and a significant drain on the Medicare Trust Fund. With both the Congressional Budget Office and Medicare Trustees warning that at current spending rates the Medicare program will be insolvent within the next ten to fifteen years, it is more important than ever to rein in sources of egregious misbilling and return improperly billed taxpayer dollars back to the Medicare Trust Fund.

The Recovery Audit Contractor (RAC) Program was put in place by Congress to identify and return improperly billed Medicare funds back to the Trust Fund. Since the RAC program began, more than $10 billion has been returned to Medicare, lengthening the life of the program by two full years.

Due to the egregious level of DMEPOS improper payments, CMS has decided to pull this category out of its regional auditing structure and create a fifth auditing area devoted solely to looking at DMEPOS claims. This change will go into effect shortly when new RAC contracts are executed.

Due to pressure from Medicare provider groups who oppose the auditing of the Medicare claims, the work of the RAC program has recently been scaled back significantly. Auditors used to look at 2 percent of a provider's Medicare claims. Today, Recovery Auditors can only look at .5 percent of a provider's claims, leaving 99.5 percent of Medicare claims not reviewed for billing accuracy. As a result, improper payment recoveries have plummeted, while Medicare continues to lose tens of billions of dollars each year to wasteful spending -- raising more concern than ever about the future solvency of the program.

With Medicare bankruptcy looming, now is the time to get the RAC program back up and running at previous levels to breathe life back into the fiscal future of the program for the millions of Americans who rely on it for their health care needs.