United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

September 29, 2009

Via Electronic Transmission

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

As a senior member of the United States Senate and Ranking Member of the Senate Committee on Finance (Committee), it is my duty to conduct oversight into the actions of the executive branch, including the activities of the Department of Health and Human Services (HHS or Department). This duty includes the responsibility to monitor the Centers for Medicare and Medicaid Services (CMS or Agency) and ensure that proper programmatic oversight is in place to protect taxpayer dollars from waste, fraud, and abuse.

I write today concerning Management Implication Reports (MIRs) sent by the HHS Office of Inspector General (OIG) to HHS headquarters. A MIR is a document OIG produces identifying systematic weaknesses or vulnerabilities in federal programs to fraud, waste, or abuse, and recommending ways to correct or minimize them. Often detected in the course of an investigation, these identified weaknesses can exceed the parameters of the investigation and represent fraud, waste, or abuse across the federal healthcare system. If the Department quickly responds to them, there is the opportunity to save significant taxpayer dollars.

OIG has identified thirty MIRs for which the Department has failed to respond in recent years, including 21 at CMS. Many of these MIRs date back to 2006, and more identify serious weaknesses to fraud, waste, or abuse. For instance, on March 14, 2006, OIG Director of Investigations wrote to Kim Brandt, CMS's then-Acting Director of the Program Integrity Group, alerting her to patterns of fraudulent billing for psychiatric therapy at nursing homes. This MIR outlined four recommendations that would prevent such fraudulent billing in the future. CMS ignored these recommendations and failed to respond to the fraud alert. OIG requested a response on July 23, 2007, and again CMS ignored the alert. OIG requested a response again on April 12, 2008. CMS ignored that, too. This year, OIG again requested a response on May 8, 2009. You can guess CMS's response.

I wish this were a lone example, but there are 20 more for CMS and an additional 9 elsewhere in the Department. Here are a handful of other exasperating examples:

- 3/9/06 MIR to the CMS's Program Integrity Group alerting them to Medicare fraud and billing by non-licensed individuals: CMS ignores the report.
    - 7/23/07 follow-up memo requesting action: CMS ignores.
    - 4/12/08 follow-up memo requesting action: CMS ignores.
    - 5/8/09 follow-up memo requesting action: CMS ignores.
- 5/17/06 MIR to CMS's Program Integrity Group alerting them to illegal kickbacks among Opthalmologists and Optometrists: CMS ignores the report.
    - 7/23/07 follow-up memo requesting action: CMS ignores.
    - 4/12/08 follow-up memo requesting action: CMS ignores.
    - 5/8/09 follow-up memo requesting action: CMS ignores.
- 8/22/08 MIR to CMS's Program Integrity Group alerting them to fraudulent billing for power wheelchairs in federal disaster areas: CMS ignores the report.
    - 5/8/09 follow-up memo requesting action: CMS ignores.

Again, these are only a handful of the many instances that were brought to my attention. These are all cases where OIG has identified fraud, waste, and abuse, alerted CMS of continuing threats to taxpayer dollars, and been utterly ignored. I have attached these alerts and memos for your review. Of 35 total MIRs sent to CMS from 2006 to 2009, CMS responded to 9, was unresponsive to 3, provided no response to 21, and has 2 with responses not yet due.

At a time when our government is hemorrhaging money in its federal health programs, and when those programs are facing staggering budgetary shortfalls in the coming years, it shocks the conscience to hear that CMS is ignoring these alerts of fraud, waste, and abuse. This inactivity shows contempt for the American taxpayer and all of those committed to fighting healthcare fraud. In addition to unrecoverable losses to the taxpayer, this inactivity by CMS only emboldens those that would steal from the American people through defrauding the federal health programs.

I know that this inactivity did not begin with your tenure at the Department. However, the American people look to you to end it and make CMS more responsive to MIRs and healthcare fraud generally. In addition to ending this irresponsibility by CMS, I make the following requests:

1) Please explain what led to the problems described above, and what will change to prevent them from happening in the future.

2) Please provide a timeline in which CMS will commit to adequately responding to all outstanding MIRs.

3) Please provide a commitment that CMS will adequately respond to all future MIRs within a 60-day timeline. If this timeline is not feasible, please explain why and to what timeline CMS will commit.

Thank you for your attention to this important matter. Please respond to the questions set forth in this letter no later than October 13, 2009. We look forward to your cooperation in this matter and if you have any questions or concerns, please feel free to contact Christopher Armstrong of my Committee Staff at (202) 224-4515. All formal correspondence should be sent electronically in PDF format to Brian_Downey@finance-rep.senate.gov or via facsimile to (202) 228-2131.

Sincerely,

Charles E. Grassley
Ranking Member

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 8 2009

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare and Medicaid Services

FROM: Thomas Sowinski
Director, Investigative Branch
Office of Investigations

SUBJECT: Request for Response to Management Implication Reports Submitted to the Centers for Medicare and Medicaid Services from 2006-2008

Our office referred eight management implication reports (MIR) to you in 2008 identifying potential vulnerabilities in the Medicare program uncovered by our special agents while conducting investigations into Medicare fraud. These vulnerabilities contributed to and/or allowed the Medicare program to be billed fraudulently by unscrupulous providers. The MIRs included recommendations to correct the weaknesses and asked that your office notify us of any action planned or taken by your office. To date, we have not received a response from your office for the following MIRs:

1. 09/03/08 – Replacement Power Wheelchairs Related to Disaster Relief
2. 12/11/08 – DME Claims Using Excluded Providers as the Referring Physician
3. 12/15/08 – Unreliable and Incomplete Medicare Part D Claims Data
4. 12/22/08 – Medically Unnecessary Drug Screening Tests

In addition to the above, we are still awaiting your response to the following MIRs we referred to you in 2006 and 2007:

1. 11/30/07 – Improper Portable X-ray Set-up and Transportation Payments
2. 03/09/06 – Medicare's "Incident To" Provision
3. 03/09/06 – Limitations on Units of CPT Code 80101
4. 03/14/06 – Claims for Psychiatric Services
5. 03/14/06 – Podiatrist's Fraudulent/Improper Use of Evaluation and Management Billing Codes
6. 03/16/06 – Physician License Suspension Notification
7. 03/17/06 – Hemorrhoid Relief Centers
8. 03/20/06 – Billing of Chemotherapy Drug Wastage
9. 05/01/06 – Inappropriate Payments for Cardiac Rehab Codes 93797 and 93798
10. 05/17/06 – Co-Management Among Ophthalmologists and Optometrists

11. 05/19/06 – Verification of Provider Knowledge of Medicare Regulations
12. 05/23/06 – Regulation Change 42 CFR 405.372
13. 06/08/06 – Nominee Owners of DME Companies
14. 07/05/06 – Essential Claims Processing Data Missing from CMS's National Claims History File
15. 07/14/06 – Lack of Adequate Physician Notification When Benefits are Reassigned and When Reassignments are Terminated
16. 11/03/06 – The Need for CMS EDI and LCD Updates with Respect to Therapeutic Footwear Claims
17. 12/19/06 – Lack of Policies and Procedures Concerning the Handling and Distribution of Non-Public Information

Please notify our office in writing within 90 days of any action taken or planned by your office in the above matters. For your convenience, we have attached copies of the MIRs.

Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031 or by e-mail at cheryl.lanore@oig.hhs.gov.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 12 2008

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare & Medicaid Services

FROM: Gerald T. Roy
Assistant Inspector General for Investigations

SUBJECT: Request for Response to Management Implication Reports Submitted in 2007

Our office referred six management implication reports (MIR) to you in 2007 identifying potential vulnerabilities in the Medicare program uncovered by our agents while conducting criminal investigations. These vulnerabilities contributed to and/or allowed the Medicare program to be billed fraudulently by unscrupulous providers. The MIRs included recommendations to correct the identified weaknesses, and asked that your office notify us of any action planned or taken by your office in response to the MIRs.

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1. 06/08/07 – Beneficiary Notification Prior to Medicare Provider/Supplier Payment
2. 09/04/07 – Misuse of the 79 Modifier
3. 09/11/07 – CPT Codes for Non-Chemotherapy Infusion Services
4. 09/26/07 – Limiting Drug Screens to Qualitative Testing
5. 11/30/07 – Systemic Problems with Medicaid Managed Care Dental Services
6. 11/30/07 – Improper Portable X-Ray Set-Up and Transportation Payments

In addition to the above, we are still awaiting your response to the MIRs we forwarded to you in 2006. We followed-up the referral of all 2006 MIRs with a July 23, 2007 memorandum asking your office to provide us with the status of these MIRs. As of this date, we have received no response to any of the MIRs. A copy of the July 23, 2007 memorandum is attached.

Please notify our office in writing of any action taken or planned by your office in the above matters. For your convenience, we have attached copies of the 2007 referrals.

Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031 or by e-mail at cheryl.lanore@oig.hhs.gov.

Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

Memorandum

DATE: JUL 23 2007

FROM: Gary L. Cantrell
Acting Director, Investigative Branch

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare & Medicaid Services

SUBJECT: Request for Response to Management Implication Reports Submitted in 2006

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

Memorandum

DATE: MAR 9 2006

FROM: Matt Kochanski, Director
Investigative Branch
Office of Investigations

SUBJECT: Management Implication Reports Concerning
Medicare's "Incident-To" Provision

TO: Kimberly Brandt, Acting Director
Program Integrity Group
Centers for Medicare and Medicaid Services

PURPOSE

The purpose of this memorandum is to formally advise you of a program vulnerability involving the fraudulent use of Medicare's "incident to" provision, and to request that the Centers for Medicare and Medicaid Services (CMS) consider developing modifiers specific to identifying the non-physician (or physician) practitioner who actually performed the "incident to" service. We submit this report to share information gained during the course of three OI investigations conducted by Special Agents from our Philadelphia, Chicago and Kansas City Regional Offices.

BACKGROUND and SUMMARY OF THE VULNERABILITY

As you know, for many years now, this office and CMS contractors have investigated numerous matters involving the fraudulent utilization of Medicare's "incident to" provision. Violations of this special billing arrangement continue to be a high concern as it cuts across diverse professional specialties and numerous service modalities. An example of this are the three OI investigations mentioned above, which involve the following three provider types: chiropractors, psychiatrists/ psychologists, and internal medicine physicians. In each case, the specific program vulnerability was different, but the common denominator was the nature in which "incident to" services were being billed.

In the first matter, a doctor was billing for physical therapy services being provided by non-licensed or certified employees. These individuals were untrained office staff and the beneficiaries were being put at risk because of their lack of training and experience. Currently, the Medicare regulations allow for the billing of non-licensed personnel under the "incident to" provisions of the program.

In the second matter, psychiatrists and psychologists were billing for services being provided by employed therapists and counselors. Numerous case referrals from the Medicare contractors in the Midwest revealed a high number of providers billing for extraordinary numbers of psychiatric services being provided by employed therapists (usually uncertified or licensed). The investigations showed that the lack of tracking of these employees in the reimbursement system has allowed fraud to occur undetected.

In the third matter, a chiropractor hired a medical doctor to screen all patients. To avoid coverage issues, all claims for services were billed under the doctor's provider number under the guise that the services were being provided by the chiropractor and his staff under the "incident to" provisions. As in the other matters, the lack of accountability as to whom specifically rendered the service made this fraud go undetected for a long period of time, and the vague definitions and rules surrounding the "incident to" provisions made a criminal conviction difficult to obtain.

RECOMMENDATIONS

In reviewing the problems associated with Medicare's "incident to' provisions, this office respectfully submits the following recommendations for your review and any appropriate action you deem worthy to take:

- Consider adding modifiers to claim line items to indicate that a service was billed incident to a provider's supervision. The person who actually provided the service should be identified on the claim through a provider number or other identifier assigned by the CMS.

- CMS should also consider requiring therapists and counselors to be certified and/or licensed (if applicable) in the State where they are providing services before their services can be billed to the program. This would result in better services for the beneficiaries and reduce the fraud in this area by forcing providers to hire licensed therapists who are medically more qualified, rather than singling out and targeting low wage office staff to perform "incident to" services.

If you have any questions concerning this memo, please feel free to call me at (202) 619-2954. Please respond within 120 days. Inform us by letter or electronic mail of any action proposed or completed.

Thank you for your consideration on this issue.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 8 2009

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare and Medicaid Services

FROM: Thomas Sowinski
Director, Investigative Branch
Office of Investigations

SUBJECT: Request for Response to Management Implication Reports Submitted to the Centers for Medicare and Medicaid Services from 2006-2008

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 12 2008

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Centers for Medicare & Medicaid Services

FROM: Gerald T. Roy
Assistant Inspector General for Investigations

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Office of Inspector General
Office of Investigations

Memorandum

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Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

Memorandum

AI-6-1-1

DATE: MAR 14 2006

FROM: Matt Kochanski, Director
Investigative Branch
Office of Investigations

SUBJECT: Management Implication Reports Concerning
Claims for Psychiatric Services

TO: Kimberly Brandt, Acting Director
Program Integrity Group
Centers for Medicare and Medicaid Services

PURPOSE

The purpose of this memorandum is to formally advise you of a program vulnerability involving the fraudulent use of CPT codes related to the provision of psychiatric services and to request that the Centers for Medicare and Medicaid Services (CMS) consider developing certain payment edits for these codes. We submit this report to share information gained during the course of three OI investigations conducted by Special Agents from our New York, Chicago and Kansas City Regional Offices.

BACKGROUND and SUMMARY OF THE VULNERABILITY

The CPT Manual contains several codes specific to the field of psychotherapy. The services under these codes range from individual and group therapy to initial diagnostic examinations and medication management. These codes can be used in numerous places of service, among them, office, hospital, patient home and nursing homes. During the course of three separate investigations conducted by the Office of Investigations, vulnerabilities connected with these specific codes came to light, especially when the patients in question were residents of nursing homes.

In the first matter, claims for numerous group therapy sessions for nursing home residents purportedly taking place on the same day were being submitted by providers. The investigation into this matter revealed that the services were not rendered nor were medically necessary as the conditions of the majority of the residents made any meaningful therapy impossible.

In the second matter, the investigation revealed that the CPT code 90801 (initial psychiatric diagnostic interview) was being submitted for each patient of a provider every three months despite the fact that the conditions necessary for the use of the code (hospital admission, new episode of illness, etc.) were not present. Also, the provider submitted numerous claims for procedure code 90862 despite the fact that the services rendered did not meet the criteria for this code. In investigating the matter, the providers admitted to using the codes in question because of their ambiguous definitions in the CPT Manual.

In the third investigation, nursing home residents were shown to be a vulnerable population to unscrupulous psychiatric providers as hundreds of claims for various psychiatric services were submitted to the Medicare program for these residents without the patients', nursing home's or attending physicians' knowledge. In these instances, there were no orders for such services by the attending physicians.

RECOMMENDATIONS

In light of the issues raised during the course of the three investigations, this office recommends that the CMS consider the following:

- Place a limit on the number of group therapy sessions allowed for a beneficiary in a nursing home setting. The Medical Director of AdminaStar Federal gave his opinion that frequent group therapy sessions in a structured setting such as is provided by a nursing home is not beneficial to the patient. He stated that the limit should be one therapy session per day.
- Edits should be added to the reimbursement system that would deny or require prepay review for the multiple use of procedure code 90801 for the same beneficiary within a short time frame (such as three months).
- Provider education should be conducted concerning the proper use of procedure code 90862 and a focused review of the utilization of this particular procedure code should be conducted prior to and after this education effort.
- Mandate that a physician order for psychiatric services be made part of the nursing home residents' medical records and that the facility be required to assess whether the resident is actually receiving the services that are ordered.

CONCLUSION

If you have any questions please contact me by electronic mail or at (202) 619-2954. Please respond within 90 days by letter or electronic mail of any action proposed or completed. Thank you in advance for your consideration of the issues and recommendations put forward in this memo.

bcc: OI Files; MIR Files;

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 8 2009

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In addition to the above, we are still awaiting your response to the MIRs we forwarded to you in 2006. We followed-up the referral of all 2006 MIRs with a July 23, 2007 memorandum asking your office to provide us with the status of these MIRs. As of this date, we have received no response to any of the MIRs. A copy of the July 23, 2007 memorandum is attached.

Please notify our office in writing of any action taken or planned by your office in the above matters. For your convenience, we have attached copies of the 2007 referrals.

Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031 or by e-mail at cheryl.lanore@oig.hhs.gov.

Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Investigations

Memorandum

DATE: JUL 23 2007

FROM: Gary L. Cantrell
Acting Director, Investigative Branch

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare & Medicaid Services

SUBJECT: Request for Response to Management Implication Reports Submitted in 2006

Our office referred a number of management implication reports (MIRs) to you in 2006 identifying potential vulnerabilities in the Medicare program uncovered by our agents while conducting criminal investigations. These vulnerabilities contributed to and/or allowed the Medicare program to be billed fraudulently by unscrupulous providers. The MIRs included recommendations to resolve the identified weaknesses, and asked that you notify us of any action planned or taken by your office in response to the MIR.

To date, we have not received a response from your office for the following referrals:

1) 03/09/06 – Medicare's "Incident To" Provision
2) 03/09/06 – Limitations on Units of CPT Code 80101
3) 03/14/06 – Claims for Psychiatric Services
4) 03/14/06 – Podiatrist's Fraudulent/Improper Use of Evaluation and Management Billing Codes
5) 03/16/06 – Physician License Suspension Notification
6) 03/17/06 – Hemorrhoid Relief Centers
7) 03/20/06 – Billing of Chemotherapy Drug Wastage
8) 05/01/06 – Inappropriate Payments for Cardiac Rehabilitation Codes 93797 and 93798
9) 05/17/06 – Co-Management Among Ophthalmologists and Optometrists
10) 05/19/06 – Verification of Provider Knowledge of Medicare Regulations
11) 05/23/06 – Regulation Change 42 CFR 405.372
12) 06/08/06 – Nominee Owners of DME Companies
13) 07/05/06 – Essential Claims Processing Data Missing from CMS's National Claims History File
14) 07/14/06 – Lack of Adequate Physician Notification When Benefits Are Reassigned and When Reassignments are Terminated (06-02)
15) 11/3/06 – The Need for CMS EDI and LCD Updates with Respect to Therapeutic Footwear Claims
16) 12/19/06 - Lack of Policies and Procedures Concerning the Handling and Distribution of Non-Public Information

Please notify us in writing of any action taken or planned by your office in the above matters. For your convenience, we have attached copies of the referrals.

Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031.

Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Memorandum

DATE: MAY 17 2006

FROM: Matt Kochanski, Director
Investigative Branch
Office of Investigations
SD Bauman for MK

TO: Kimberly Brandt, Acting Director
Program Integrity Group
Centers for Medicare and Medicaid Services

SUBJECT: MIR: 03-0019, Co-Management Among Ophthalmologists and Optometrists

Purpose

The purpose of this memorandum is to advise you of a potential vulnerability concerning the issue of co-management among ophthalmologists and optometrists with regard to cataract surgery.

Overview

The Office of Investigations (OI) became aware of this vulnerability during the course of an investigation conducted by our Kansas City Regional Office. Based upon witness testimony, co-management of cataract patients between ophthalmologists and optometrists has resulted in questionable informal business arrangements between the two groups of practitioners. In the case of cataract surgeries, the initial referrals to the surgeons (ophthalmologists) come from the optometrists and that same optometrist arranges with the surgeon to provide post-operative care. The allegation made by several witnesses is that co-management amounts to nothing more than a finder's fee for optometrists to refer cataract patients to ophthalmologists who are cooperative. The result, according to the witnesses, is that ophthalmologists who do not cooperate in the co-management scheme are "pushed out of the market" and patient care suffers. Such agreements and practices may result in violations of the anti-kickback statute.

Discussion

As part of the review process, the Office of Investigations consulted with members of the Centers for Medicare and Medicaid Services (CMS). CMS indicated that they are aware of issues regarding co-management of cataract patients, have been in contact with special agents in the field, and indicated that there are regulations in place to address these concerns. The three areas that address the co-management issue are lack of safe harbor protection, specific guidance for claims submission and the special claims review requirement.

First, the Office of Inspector General removed the safe harbor provision for optometrists in co-management arrangements in 1999. The removal of this particular safe harbor provision came as a direct result of ophthalmologists' concerns regarding the apparent routine agreements to split global Medicare fees with referring optometrists. By removing this safe harbor, the Department of Health and Human Services (HHS) did not indicate that all fee splitting relationships violated the anti-kickback statute. HHS stipulated that such arrangements would be analyzed on a case-by-case basis. The analysis would examine whether the specialty services would be medically,

If you have any questions, please contact Thomas Sowinski, Inspector, Investigative Resource Staff at (202) 205-5200. Please respond within 120 days. Inform us by letter or electronic mail of any action proposed or completed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 8 2009

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare and Medicaid Services

FROM: Thomas Sowinski
Director, Investigative Branch
Office of Investigations

SUBJECT: Request for Response to Management Implication Reports Submitted to the Centers for Medicare and Medicaid Services from 2006-2008

Our office referred eight management implication reports (MIR) to you in 2008 identifying potential vulnerabilities in the Medicare program uncovered by our special agents while conducting investigations into Medicare fraud. These vulnerabilities contributed to and/or allowed the Medicare program to be billed fraudulently by unscrupulous providers. The MIRs included recommendations to correct the weaknesses and asked that your office notify us of any action planned or taken by your office. To date, we have not received a response from your office for the following MIRs:

1. 09/03/08 – Replacement Power Wheelchairs Related to Disaster Relief
2. 12/11/08 – DME Claims Using Excluded Providers as the Referring Physician
3. 12/15/08 – Unreliable and Incomplete Medicare Part D Claims Data
4. 12/22/08 – Medically Unnecessary Drug Screening Tests

In addition to the above, we are still awaiting your response to the following MIRs we referred to you in 2006 and 2007:

1. 11/30/07 – Improper Portable X-ray Set-up and Transportation Payments
2. 03/09/06 – Medicare's "Incident To" Provision
3. 03/09/06 – Limitations on Units of CPT Code 80101
4. 03/14/06 – Claims for Psychiatric Services
5. 03/14/06 – Podiatrist's Fraudulent/Improper Use of Evaluation and Management Billing Codes
6. 03/16/06 – Physician License Suspension Notification
7. 03/17/06 – Hemorrhoid Relief Centers
8. 03/20/06 – Billing of Chemotherapy Drug Wastage
9. 05/01/06 – Inappropriate Payments for Cardiac Rehab Codes 93797 and 93798
10. 05/17/06 – Co-Management Among Ophthalmologists and Optometrists

11. 05/19/06 – Verification of Provider Knowledge of Medicare Regulations
12. 05/23/06 – Regulation Change 42 CFR 405.372
13. 06/08/06 – Nominee Owners of DME Companies
14. 07/05/06 – Essential Claims Processing Data Missing from CMS's National Claims History File
15. 07/14/06 – Lack of Adequate Physician Notification When Benefits are Reassigned and When Reassignments are Terminated
16. 11/03/06 – The Need for CMS EDI and LCD Updates with Respect to Therapeutic Footwear Claims
17. 12/19/06 – Lack of Policies and Procedures Concerning the Handling and Distribution of Non-Public Information

Please notify our office in writing within 90 days of any action taken or planned by your office in the above matters. For your convenience, we have attached copies of the MIRs.

Thank you for your attention to this matter. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031 or by e-mail at cheryl.lanore@oig.hhs.gov.

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

AUG 2 2 2008

TO: Kimberly Brandt
Director, Program Integrity Group
Centers for Medicare and Medicaid Services

FROM: Thomas Sowinski
Acting Director, Investigative Branch
Office of Investigations

SUBJECT: Management Implication Report – Replacement Power Wheelchairs Related to Disaster Relief

Purpose

The purpose of this management implication report (MIR) is to notify you of a vulnerability that has allowed Medicare beneficiaries to receive medically unnecessary power wheelchairs.

Background

Medicare beneficiaries located in federally declared disaster areas who lost their power wheelchairs or whose power wheelchairs were made inoperable due to the disaster are allowed to receive replacements without an additional certificate of medical necessity (CMN) from a doctor. Durable medical equipment (DME) providers can submit claims for these power wheelchairs without the CMNs using a "CR" modifier. The modifier identifies the claim as a replacement item lost or made inoperable due to the disaster.

Discussion

Our office recently found that DME providers were submitting claims for power wheelchairs using the replacement "CR" modifier for beneficiaries who did not previously own power wheelchairs. The DME providers used the disaster as an opportunity to take advantage of the waived CMN requirement, and thus provided power wheelchairs to beneficiaries whose conditions did not make them eligible to receive the wheelchairs. The DME providers were able to get claims paid simply by coding the claim with the "CR" modifier. The claim was then fast tracked for payment as a replacement item for a beneficiary living in a disaster area.

Note that the "CR" modifier is used for any DME item replaced as a result of being lost or made inoperable due to a federally declared disaster. Although recent investigations conducted by our office found that the modifier was misused for power wheelchairs, it is possible that the modifier is similarly being misused for other DME items.

Recommendation

We recommend that an edit be created to check any DME claims submitted on behalf of a beneficiary using the "CR" modifier with the beneficiary's previous claims history to verify that the beneficiary previously owned the item. If the check shows the beneficiary did not previously own the item, then the claim should be denied.

Please notify our office in writing within 90 days of any action taken or planned in this matter.

Thank you for your attention to this MIR. If you have any questions, please contact Investigations Analyst Cheryl LaNore at (202) 619-0031.

cc: Kerry Weems
CMS Administrator