

**Post-Hearing Questions for the Record
Submitted to Peter Budetti
From Senator Claire McCaskill**

**“Durable Medical Equipment Companies Business Practices”
April 24, 2013**

Chairwoman McCaskill

The estimated improper payment rate for durable medical equipment was approximately 66% in 2012. By comparison, the overall estimated improper payment rate for Medicare fee-for-service was 8.5% in 2012. You acknowledged during the hearing that the estimated improper payments for durable medical equipment represented a crisis for potential fraud and abuse by durable medical equipment suppliers and substantial costs to the taxpayer, but argued that improper payments may be attributed to several factors including technical errors as well as potential fraud.

- 1. What is the total estimated dollar amount and percentage of estimated improper payments that were made as a result of potential fraud or abuse in 2011? In 2012?**

Answer: Under the Improper Payments Information Act of 2002, as amended, and OMB’s implementing guidance, agencies are required to establish annual error rate measurements and corrective action plans for programs susceptible to significant improper payments. CMS developed the Comprehensive Error Rate Testing (CERT) program to calculate the Medicare FFS program improper payment rate, which is reported in the DHHS Agency Financial Report, CMS Financial Report, and on www.paymentaccuracy.gov. The CERT program cannot label a claim fraudulent. The CERT program measures the improper payment rate, not the rate of fraud.

The IPIA and the OMB implementing guidance defines “improper payment” as payments that should not have been made, payments made in an incorrect amount (including both overpayments and underpayments), payment to an ineligible recipient, payment for an ineligible service, any duplicate payment, payment for services not received. HHS uses the same definition for the CERT program. To calculate the error rate, claims are selected randomly from all Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment. The CERT program uses random claim selection, and CMS collects medical records for the claims in the sample. Reviewers are often unable to see provider billing patterns or trends that may indicate potential fraud when making payment determinations.

There are various causes of improper payments – for example, payment for services where the supporting documentation submitted did not support the ordered service. While all payments stemming from fraud are considered “improper payments,” not all improper payments constitute

fraud. In order to reduce improper payments, CMS' program integrity activities target the range of causes of improper payments, and as part of its comprehensive approach, the Center for Program Integrity coordinates with other components across CMS.

Reducing the DME error rate is a key priority for CMS, and CMS is taking a number of steps to improve payment accuracy for DME. To achieve this goal, CMS implemented a demonstration on prior authorization for Power Mobility Devices, began using competitive bidding to reimburse suppliers at market rates, required enhanced screening for DME suppliers to root out bad actors, and strengthened our partnership with law enforcement.

2. What is the total estimated dollar amount and percentage of estimated improper payments that were made as a result of potential technical errors in 2011? In 2012?

Answer: CMS developed the CERT program to calculate the Medicare FFS program improper payment rate, and CERT defines an improper payment as a paid claim that should have been denied or paid at another amount (including both overpayments and underpayments). Based upon the review of the medical records, claims identified as containing improper payments are categorized into one of five error categories, which are described below.

- No Documentation—Claims are placed into this category when either the provider fails to respond to repeated requests for the medical records or the provider 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 medical reviewers could not conclude that some of the allowed services were actually provided, provided at the level billed, and/or the services were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.
- Medical Necessity—Claims are placed into this category when the medical reviewers receive adequate documentation from the medical records submitted and can make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies.
- Incorrect Coding—Claims are placed into this category when the provider or supplier submits medical documentation supporting (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).

In 2012, the Medicare FFS improper payment rate was 8.5 percent, totaling \$29.6 billion¹. This is a slight decrease from the 8.6 percent improper payment rate reported in 2011. As part of the annual error rate measurement, CMS also identifies error rates for some specific parts of the programs, including DME. In 2012, the improper payment rate for DME was 66 percent and DME remains a focus area for CMS.

Through our predictive analytics technology, DMEPOS competitive bidding, and demonstration projects such as the one for the prior authorization of power mobility devices, CMS is working to prevent improper payments and reduce incentives to conduct DME-related fraud.

- 3. In 2012, how many criminal fraud prosecutions resulted in conviction related to durable medical equipment? How many resulted in plea agreements or other agreements in lieu of prosecution? How many civil actions resulted in judgments in favor of the government? How many resulted in settlement agreements or other agreements in lieu of final resolution by the courts? Please provide the amount of money recovered for each category.**

Answer: While criminal fraud prosecutions are the responsibility of the Department of Justice (DOJ), CMS works closely with DOJ to combat fraud. In FY 2012, the interagency Medicare Strike Force accomplishments in the nine Strike Force cities (Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Baton Rouge, LA; Tampa, FL; Chicago, IL; and Dallas, TX) included 117 indictments; information and complaints involving charges filed against 278 defendants who allegedly collectively billed the Medicare program more than \$1.5 billion; 251 guilty pleas negotiated and 13 jury trials litigated, with guilty verdicts against 29 defendants; and imprisonment for 201 defendants sentenced during the fiscal year, averaging more than 48 months of incarceration. While these figures include multiple types of fraud, examples of successful actions related to durable medical equipment are available in the FY 2012 annual report on the Health Care Fraud and Abuse Control Program.²

In your testimony, you stated that, in 2011, “Medicare DME spending totaled \$7.8 billion, down 6 percent from \$8.3 billion in 2008.” Later in your testimony, you reference the “Medicare Fee-for-Service 2011 Improper Payments Report” which states that the total paid amount for Durable Medical Equipment was \$9.7 billion. The 2011 CMS Statistics report states that FY 2011 benefit payments for durable medical equipment were \$8.5 billion.

- 4. Why does CMS have three different totals for DME spending in 2011?**

¹ <http://www.paymentaccuracy.gov/programs/medicare-fee-service>.

² <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf>. Pages 28-30.

Answer: Differences in CMS' reporting of total DME spending relate to the data set used to estimate total spending and assumptions made. Factors that might change the estimated total spending amount include which beneficiaries are included in the calculation, whether beneficiary cost sharing is included, and the reporting period, among other factors. For example, the data used in the statement that in 2011, "Medicare DME spending totaled \$7.8 billion, down 6 percent from \$8.3 billion in 2008," is from the Geographic Variation Public Use File.³ This data reports spending at the hospital referral region level and is used to evaluate geographic variation in the utilization and quality of health care services for the Medicare fee-for-service (FFS) population. Data from CMS' Office of the Actuary, in the 2011 CMS Statistics Report, makes different assumptions about the Medicare FFS population, resulting in an estimated benefits payments total of approximately \$8.5 billion for FY 2011.⁴ The Medicare FFS 2011 Improper Payments Report (CERT report) reports DME spending in the reporting period of July 1, 2010 to June 30, 2011, so it does not align with other data on CY 2011 or FY 2011 expenditures. Importantly, the CERT report extrapolates total DME spending based on the sample of claims it uses to calculate the DME error rate, and is not intended to be used as actual spending data.

5. Exactly how much did CMS pay for durable medical equipment in 2011?

Answer: DME benefit payments in FY 2011 totaled approximately \$8.5 billion.⁵

One of the companies invited to testify at the hearing by the subcommittee is Med-Care Diabetic and Medical Supply. An individual who contacted the Subcommittee about problems patients experience with durable medical equipment suppliers explained that many companies have names that sound over the phone very similar to Medicare or another U.S. government agency that patients may mistake as being a part of the federal government.

6. Under current law, what authority exists to prevent durable medical equipment supply companies from using names that are similar to Medicare or other federal government programs or agencies?

Answer: Under section 1140 of the Social Security Act, individuals or organizations may be subject to a civil money penalty for the misuse of words, symbols, or emblems or names in reference to Social Security or Medicare. If individuals have information about suppliers or others who are misusing CMS words, symbols, or emblems, they should contact the HHS Office of Inspector General.

³ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html>.

⁴ See Table III.6 in 2011 Expenditure table, available through <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/CMSStatistics.html>.

⁵ Ibid.

The Subcommittee has received information from patients and doctors who allege that durable medical equipment suppliers are harassing patients and inundating doctors with medical supply order forms which have not been requested and in some instances can result in increases in the amount of unnecessary medical equipment claims paid by Medicare.

- 7. Does the government have the authority under current law to impose a requirement that a request for durable medical equipment originate from the doctor and not from pre-generated forms sent to doctors by a third party? If no, what authorities would be required? If yes, would CMS consider imposing such a requirement?**

Answer: Under current law, Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) must be ordered by a physician or practitioner enrolled in Medicare. A supplier must have an order from the treating physician or practitioner stating the beneficiary needs the item before the supplier may dispense any DMEPOS item to the beneficiary.⁶

While CMS does not have the legislative authority to regulate or ban supplier generated forms, we do not rely solely on supplier documentation. A supplier-prepared statement by itself does not provide sufficient documentation of medical necessity, even if it is signed by the treating physician or supplier. There must be information in the beneficiary's medical record to support the medical necessity for the item, and the treating physician or practitioner's medical records must substantiate the information on a supplier-prepared statement.⁷

CMS neither prohibits nor endorses the use of templates to facilitate record keeping. However, CMS discourages the use of templates that provide limited options and/or space for the collection of information. Templates that use check boxes, predefined answers and limited space to enter information often fail to capture sufficient clinical information to demonstrate that all Medicare coverage and coding requirements are met.⁸

CMS believes that the requirement for physician-created documentation as the basis for medical necessity of DMEPOS items will be strengthened by the face-to-face encounter requirements mandated under section 6407 of the Affordable Care Act.

The HHS Inspector General and GAO have found that CMS has failed to recover the overwhelming majority of improper payments for durable medical equipment. CMS instituted surety requirements for suppliers of durable medical equipment in 2011, in part to be able to better recover these overpayments. However, the Inspector General found

⁶ Medicare Program Integrity Manual, CMS Internet-Only Manual 100-08, Ch. 5, Section 5.2.1

⁷ Medicare Program Integrity Manual, CMS Internet-Only Manual 100-08, Ch. 5, Section 5.7

⁸ Medicare Program Integrity Manual, CMS Internet-Only Manual 100-08, Ch. 3, Section 3.3.2.1.1

that CMS has collected just over \$263,000 out of over \$70 million in overpayments eligible for surety bond recovery. The Inspector General found that 98% of the companies it reviewed had overpayments in excess of \$50,000, the current level required for surety bonds.

8. Why hasn't the Secretary increased bond requirements above the current \$50,000 level in light of the Inspector General's findings?

Answer: CMS may require a surety bond in excess of \$50,000 when information on adverse actions is reported by and/or taken against enrolled suppliers. The National Supplier Clearinghouse (NSC), the CMS contractor that processes Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) enrollment applications, uses this information to determine if an elevated surety bond is appropriate. When an application is received, the NSC determines if the supplier has had an adverse legal action that resulted in a revocation within the past 10 years. If any qualifying revocation was not overturned on appeal and the reenrollment bar has expired, an elevated bond in the amount of \$100,000 is required for enrollment.

9. What is CMS doing to recover this money?

Answer: CMS oversees the DME Medicare Administrative Contractors (MACs) which perform these collection activities. The DME MACs are continuing to make requests for payments from sureties, and CMS expects additional overpayments to be collected as a result.

During the hearing, you testified that because of provisions passed in the Affordable Care Act, CMS for the first time has increased fraud detection and prevention capabilities that are helping to reduce costs to the taxpayer in substantial ways. You stated that the Affordable Care Act allows CMS to suspend payment to a business if there is credible information that a particular business is engaged in fraudulent activity and that business cannot receive payment for DME claims until the investigation is complete.

10. Has CMS fully implemented this provision of the Act?

Answer: Yes, on February 2, 2011, CMS published the Final Rule with comment period entitled —Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers (CMS-6028-FC). This rule implemented the Affordable Care Act provision allowing the suspension of payments to a provider or supplier pending the investigation of a credible allegation of fraud and has been in effect since March 25, 2011.

11. How often has CMS used this authority with respect to DME suppliers since it came into effect?

Answer: CMS has imposed 30 payment suspensions on DME suppliers between March 2011 and April 24, 2013.

12. What other fraud and abuse prevention authority has been provided under the Affordable Care Act?

Answer: The Affordable Care Act provides CMS with powerful new anti-fraud tools and allows CMS to focus on preventing fraud before it happens. These new authorities offer more front-end protections to keep those who are intent on committing fraud out of the programs and new tools for deterring wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of the Medicare and Medicaid programs. Specifically, the Affordable Care Act requires CMS to establish risk-based provider enrollment screening measures, which CMS began implementing in March 2011. CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers under the new Affordable Care Act screening requirements. Since March 2011, CMS approved for enrollment nearly 458,435 Medicare providers and suppliers, including 30,105 DMEPOS suppliers, under these enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 159,449 enrollments, including 24,880 DMEPOS enrollments, and revoked 14,009 enrollments, including 1,753 DMEPOS enrollments.

13. With respect to durable medical equipment suppliers, how much has CMS recovered based on the authority provided under the Affordable Care Act?

Answer: CMS is using many of the new anti-fraud authorities provided in the Affordable Care Act and the Small Business Jobs Act of 2010 to strategically combat fraud, waste, and abuse, and is integrating additional tools into our current program integrity efforts. These new tools and authorities support our comprehensive strategy to prevent fraud and abuse, but are not necessarily resulting in recoveries, because CMS is focused on stopping fraudulent claims from being paid in the first place. For example, CMS has deactivated 24,880 DMEPOS enrollments and revoked 1,753 DMEPOS enrollments from March 2011 to April 2013. While we believe that these actions will protect taxpayer dollars, we are unable to estimate savings at this time.

The DMEPOS competitive bidding program is one of CMS' most powerful tools to reduce DMEPOS spending and provide greater value to the Medicare program, beneficiaries and taxpayers. The program works by establishing Medicare's DMEPOS payments based on competitive market pricing, thereby reducing beneficiary out-of-pocket costs, program outlays, and suppliers' incentive to fraudulently bill Medicare for DMEPOS. It is projected to save the Medicare Part B Trust Fund \$25.8 billion and beneficiaries \$17.2 billion over ten years.⁹ The program is already generating significant savings for the Federal Government and the

⁹ FY 2014 Congressional Justification, Page 38. Available at <http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf>

approximately 2.3 million Medicare fee-for-service beneficiaries residing in the areas where competitive bidding is in effect. According to CMS' analysis of claims from 2010 and 2011, the competitive bidding program has reduced DMEPOS spending by approximately \$202.1 million—or 42 percent overall—in the nine Round 1 Rebid areas.¹⁰ The program has significantly reduced payment amounts, with an average price reduction of 35 percent from the fee schedule.

Under 42 U.S.C. §1395m, CMS has authority to exclude suppliers who violate the telemarketing prohibitions from participation in Medicare.

14. How many times has CMS used that authority?

Answer: If CMS finds a company has inappropriately engaged in telemarketing in violation of the applicable Medicare supplier standard, we may institute appropriate corrective actions including supplier education. The supplier has an opportunity to correct the improper telemarketing behavior. However, if the supplier does not come into compliance, CMS has authority to revoke the supplier's billing privileges and as of April 24, 2013, CMS has revoked one supplier for telemarketing violations. Since then, that supplier submitted a corrective action plan demonstrating that it had come into compliance with Medicare requirements regarding telemarketing.

CMS often finds that when we begin investigating a supplier for improper telemarketing, we find other inappropriate behaviors. CMS may revoke a supplier's billing privileges based upon a number of different reasons, including the violation of one or more other DMEPOS supplier standards, the misuse or abuse of billing privileges, the failure to document properly or for providing false or misleading information. As a part of these efforts, CMS has revoked billing privileges of 1,753 DME suppliers – about 1.75 percent of the total DME supplier universe.

If CMS suspects fraudulent and criminal behavior, CMS can make a referral to law enforcement. For example, in April 2012, a DME supplier paid \$18 million to resolve allegations that it submitted false claims for diabetic testing supplies and other DME that was sold to beneficiaries through inappropriate telemarketing.

15. What statutory authorities are needed to expand telemarketing regulations to include e-mail, direct-mail, and modern forms of communication such as text messaging?

Answer: CMS has statutory authority only to regulate unsolicited telephone contacts by DME suppliers.

¹⁰ Competitive Bidding Update—One Year Implementation Update, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf>

16. What additional statutory authority, if any, would be required to prevent all telemarketing of durable medical equipment to Medicare patients?

Answer: We would be happy to provide technical assistance to the committee on expanding this authority.

In CMS' April 10, 2013, response to the Subcommittee's Request for Information, CMS stated that the Recovery Auditor has reviewed more than 6,100 claims from U.S. Healthcare Supply, LLC and that more than 5,600 of those were found to be improper payments. CMS also stated that the Recovery Auditor has demanded \$100,635 in overpayments from this supplier and that most of the overpayments were a result of billing for supplies after a beneficiary's death or billing for supplies while the beneficiary was in a Skilled Nursing Facility.

17. Please provide the most detailed breakdown of what constitutes an "improper payment" that is available from CMS' record keeping. For example, CMS stated that most of the overpayments were a result of two types of incorrect claims – what percentage of the 6,100 sampled claims fall under each type of incorrect claim?

Answer: The Recovery Auditors reviewed 6,100 claims using algorithms and software programs designed to identify improper payments on the face of the claim. The Recovery Auditors found that 5,600 claims were improper and the remaining 500 had no findings. The chart below provides a breakdown of the improper payments identified.

Reason for Improper Payment	Percentage of Improper Claims
Inappropriate billing of spring powered device. (More than 1 spring-powered device for lancets is not considered medically necessary according to CMS policy.)	98%
Inappropriate billing of DME while beneficiary was in an inpatient setting	1.2%
Services billed after a beneficiary's verified date of death	.8%

18. What dates did the sample of 6,100 claims cover?

Answer: These claims had dates of service from January 2008 to February 2013.

19. Is this auditing activity by the Recovery Auditor on an ongoing basis? If not, when was this particular audit performed?

Answer: This audit activity was conducted as part of the Recovery Auditors ongoing efforts to identify improper payments.

20. What methodology, in general, does the Recovery Auditor takes use to select sample claims??

Answer: All new issues for potential audits are approved by CMS before the Recovery Auditors begin widespread review. This ensures that policy and coverage staff approves the audit methodology used by the Recovery Auditors and that the correct interpretation of CMS policies is used in the audits. Once CMS approves the issue for review, the Recovery Auditor will deploy specific algorithms to identify potentially improper claims. The algorithms are based on CMS billing policy and are developed from trending, data mining, data analysis through analytical software, and CMS Regulation and Government Agency Reports such as the Office of Inspector General and General Accounting Office reports.

21. What methodology did the Recovery Auditor use to select the claims from U.S. Healthcare Supply?

Answer: Please see the response to the previous question. The Recovery Auditor reviews claims based on a specific issue, such as billing for supplies after a beneficiary's death, rather than by a specific provider. These claims were selected for review because of the approved issue rather than the Recovery Auditor reviewing claims only for this particular provider. The Recovery Auditors choose which issues to review and issues are approved regionally by Recovery Auditor.

22. Did the sample of 6,100 claims cover a nationwide distribution of claims? If not, which regions were targeted and why?

Answer: Claims were identified for approved issues in:

- Recovery Audit Region C (WV, VA, NC, SC, TN, GA, AL, MS, FL, AR, LA, TX, OK, NM, CO), and
- Recovery Auditor Region D (MO, IA, ND, SD, NE, KS, WY, MT, ID, UT, AZ, NV, CA OR, WA, AK, HI).

The Recovery Auditors choose which issues to review and issues are approved regionally by Recovery Auditor. Therefore, one Recovery Auditor may be reviewing an issue that is not being reviewed in another region.

23. Did CMS make these findings known to U.S. Healthcare? If so, when and how? If not, why not?

Answer: Demand letters related to these claims were issued by CMS' Medicare Administrative Contractors (MACs) to this supplier from December 2010 to April 2013. After an improper payment is identified, the Recovery Auditor sends this information to the MACs for collection in the case of an overpayment or repayment in the case of an underpayment. In the case of an overpayment, the MACs issued a demand letter to the provider which includes the rationale for the determination and instructs providers on how to pay back the overpayment or proceed for additional adjudication or appeal. In addition, providers receive information, in writing or through a claim portal, detailing the reason for the claim denial.

24. What actions has CMS taken regarding the 5,600 improper payments?

Answer: Demand letters related to these claims were issued by the MACs to this supplier from December 2010 to April 2013. The recoupment of an overpayment may be offset against future payments. The MACs have recouped over \$75,000 through this offset method and are continuing to offset future claims.

25. Does the \$100,635 in overpayments that the Recovery Auditor has demanded from U.S. Healthcare reflect all or only part of the 5,600 improper payments?

Answer: The \$100,635 reflects all of the claims that have been identified by the Recovery Auditor as improper and demanded for repayment from the supplier.

26. When did the Recovery Auditor demand the \$100,635 in overpayments from U.S. Healthcare?

Answer: Demand letters related to these claims were issued by the Medicare Administrative Contractors to this supplier from December 2010 to April 2013.

27. What response, if any, has the Recovery Auditor received from U.S. Healthcare regarding the \$100,635 in overpayments?

Answer: Collection efforts for overpayments and repayments of underpayments are handled by the MACs and not by Recovery Auditors. The recoupment of an overpayment may be offset against future payments. The MACs have recouped more than \$75,000 through the offset of future payments made to this supplier, and recoupment through the offset of future claims continues today.

In CMS' April 10, 2013, response to Subcommittee Request for Information, CMS stated that the Recovery Auditor has reviewed more than 590 claims for Med-Care Diabetic & Medical Supplies, Inc., and that more than 400 of those were found to be improper payments. CMS also stated that the Recovery Auditor has demanded \$146,689 in overpayments from this supplier, and that most of the overpayments were a result of billing for supplies after a beneficiary's death or billing for supplies while the beneficiary was in a Skilled Nursing Facility.

28. Please provide the most detailed breakdown of what constitutes an “improper payment” that is available from CMS’ record keeping. For example, CMS stated that most of the overpayments were a result of two types of incorrect claims – what percentage of the 590 sampled claims fall under each type of incorrect claim?

Answer: The Recovery Auditors reviewed 590 claims using algorithms and software programs designed to identify improper payments on the face of the claim. The Recovery Auditors found that 400 claims were improper and the remaining 190 had no findings. The chart below provides a breakdown of the improper payments identified.

Reason for Improper Payment	Percentage of Improper Claims
Inappropriate billing of DME while beneficiary was in an inpatient setting	86%
Services billed after a beneficiary’s verified date of death	9%
Other	5%

29. What dates did the sample of 590 claims cover?

Answer: These claims had dates of service from November 2007 to January 2013.

30. Is this auditing activity by the Recovery Auditor on an ongoing basis? If not, when was this particular audit performed?

Answer: This audit activity was conducted as part of the Recovery Auditors ongoing efforts to identify improper payments.

31. What methodology did the Recovery Auditor use to select the claims from Med-Care Diabetic & Medical Supplies?

Answer: All new issues for potential audits are approved by CMS before the Recovery Auditors begin widespread review. This ensures that policy and coverage staff approves the audit methodology used by the Recovery Auditors and that the correct interpretation of CMS policies is used in the audits. Once CMS approves the issue for review, the Recovery Auditor will deploy specific algorithms to identify potentially improper claims. The algorithms are based on CMS billing policy and are developed from trending, data mining, data analysis through analytical software, and CMS Regulation and Government Agency Reports such as Office of Inspector General and General Accounting Reports.

32. Was the sample of 590 claims chosen randomly or were certain types of claims targeted? If certain types of claims were targeted, which ones and why?

Answer: Please see above. The Recovery Auditor reviews claims based on a specific issue, such as billing for supplies after a beneficiary's death, rather than by a specific provider. These claims were selected for review because of the approved issue rather than the Recovery Auditor reviewing claims only for this particular provider. The Recovery Auditors choose which issues to review and issues are approved regionally by Recovery Auditor.

33. Did the sample of 590 claims cover a nationwide distribution of claims? If not, which regions were targeted and why?

Answer: Claims were identified for approved issues in:

- Recovery Audit Region A (ME, NH, VT, MA, RI, CT, NY, NJ, PA, DE, MD, DC);
- Recovery Audit Region C (WV, VA, NC, SC, TN, GA, AL, MS, FL, AR, LA, TX, OK, NM, CO); and
- Recovery Auditor Region D (MO, IA, ND, SD, NE, KS, WY, MT, ID, UT, AZ, NV, CA OR, WA, AK, HI.)

The Recovery Auditors choose which issues to review and issues are approved regionally by Recovery Auditor. Therefore, one Recovery Auditor may be reviewing an issue that is not being reviewed in another region.

34. Did CMS make these findings known to Med-Care Diabetic & Medical Supplies? If so, when and how? If not, why not?

Answer: Demand letters for these claims were issued by the Medicare Administrative Contractors to this supplier from April 2010 to April 2013. After an improper payment is identified, the Recovery Auditor sends this information to CMS' Medicare Administrative Contractors (MACs) for collection in the case of an overpayment or repayment in the case of an underpayment. In the case of an overpayment, the MACs issue a demand letter to the supplier which includes the rationale for the determination and instructs providers on how to pay back the overpayment or proceed for additional adjudication or appeal. In addition, suppliers receive information, in writing or through a claim portal, detailing the reason for the claim denial. Demand letters for these claims were issued by the MACs to this supplier from April 2010 to April 2013.

35. What actions has CMS taken regarding the 400 improper payments?

Answer: Demand letters for these claims were issued by the MACs to this supplier from April 2010 to April 2013. The recoupment of an overpayment may be offset against future payments. The MACs have recouped over \$44,000 through this offset method and are

continuing to offset future claims.

36. Does the \$146,689 in overpayments that the Recovery Auditor has demanded from Med-Care Diabetic & Medical Supplies reflect all or only part of the 400 improper payments?

Answer: The \$146,689 reflects all of the claims that have been identified by the Recovery Auditor as improper and demanded for repayment from the provider.

37. When did the Recovery Auditor demand the \$146,689 in overpayments from Med-Care Diabetic & Medical Supplies?

Answer: Demand letters for these claims were issued by the MACs to this supplier from April 2010 to April 2013.

38. What response, if any, has the Recovery Auditor received from Med-Care Diabetic & Medical Supplies regarding the \$146,689 in overpayments?

Answer: The MACs, not Recovery Auditors, handle collection efforts for overpayments and repayments of underpayments. Overpayments may be recouped by offsetting collections against future payments. The MACs have recouped over \$44,000 of the amount by offsets, and are continuing to offset future payments.