Fighting for Survival – DMEPOS

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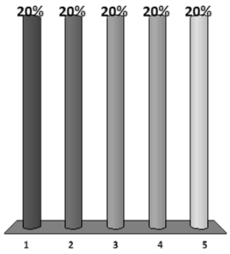
Objectives

- Understand the Impact of competitive bid-derived pricing on products in non-bid areas plus future of competitive bid rounds
- Investigate Alternative payment arrangements, including the pros and cons of submitting non-assigned claims
- Learn how to manage the continued impact of Medicare/RAC audits and new program integrity contractors
- Hodge Podge of compliance issues discussions

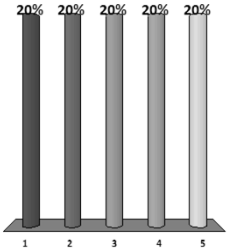
What type of company do you represent?

1. Hospital/Health system
2. Private/Family owned DMEPOS
3. Publically held DMEPOS
4. Insurer
5. Other



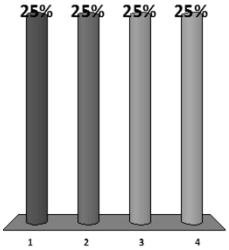
How long have you worked in DMEPOS?

1. <1 year
2. 1-5 years
3. 6-10
4. >10
5. DME? I'm in the wrong room!!



How many employees in your operation?

1. <20
2. 20-50
3. 51-100
4. >100



DMEPOS historical perspective

- DME = big business
- Customers …then and now

DMEPOS Customers

- 23 million of the Greatest Generation
- 20 million of the Korean War generation
- 78 million Baby Boomers (those born between 1946 and 1964).

CBS News Report

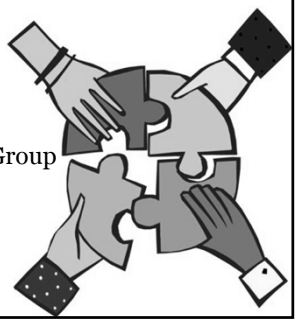
- **Amazing aging athletes**

Many customers …….

- Why the struggle to survive?

Wayne van Halem

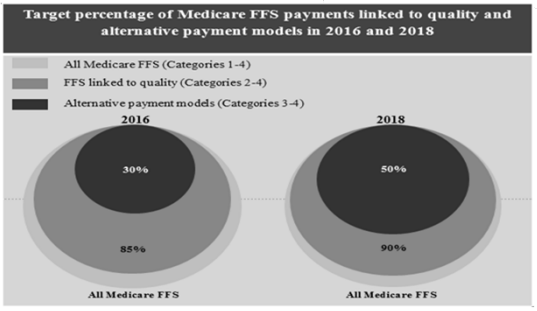
- President, The van Halem Group



Alternative Payment Arrangements

HHS categorizations for health care payments:

- Category 1 – Fee-for-service - no link to quality
- Category 2 – Fee-for-service with link to quality
- Category 3 – Alternative payment models built on fee-for-service architectures
- Category 4 – Population-based payment



Alternative Payment Models

- Accountable Care Organizations
- Bundled Payment Arrangements
- Hospital Value-Based Purchasing
- Hospital Readmission Reduction Programs

The Rise of Value-Based Care Delivery

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Healthcare Market Trends

	Current models of care are becoming unsustainable. The number of people needing care is set to quadruple by 2050, placing extreme demands on access to care and creating a looming physician shortage.
	Patients are getting sicker. According to the CDC, 25% of Americans have two or more chronic conditions, and the number is rising.
	The cost of healthcare is **expected to increase annually by >5%** through 2020.
	Re-admission penalties for hospitals require farther-reaching and longer-term care management capabilities.
	Healthcare providers are at direct financial risk for the care of patients, requiring careful evaluation of value-based care pathways and settings.
	Reimbursement is shifting to reward progress toward the "triple aim" of care: access to care, clinical outcomes, and cost-effectiveness.

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Value-Based Reimbursement

- Value = quality / cost (over time)
- Insurers pay for value delivered, not for services rendered
- Financial risk shifts to providers for whole-patient, cost-effective care
- Health management and prevention becomes more important
- Populations are managed across providers: "It takes a village"

Value-Based Plans Becoming the Norm

Medicare Pilot Programs

- Bundled Payment for Care Initiatives (BPCI)
- Comprehensive Care for Joint Replacement (CJR)
  - Hip and knee replacements
  - Proposing hip and femur fractures
- Cardiac Procedure Bundle (proposed)
  - Includes incentive for cardiac rehab
- Value Based Payments for Home Health
- Value Based Reimbursement for SNFs

Value-based plans becoming the norm

Self Funded Employers and IDNs

- Generally bundled payments
- Cardiology and Orthopedic procedures
- Cleveland Clinic, Lowe's, others
- Intermountain Healthcare, Kaiser

Insurance Trend Estimates

- Medicare
  - By the end of 2016, 85% of Medicare payments tied to quality or value
  - By the end of 2018, 90% of Medicare payments tied to quality or value
- Commercial Plans
  - By the end of 2020, 75% of businesses will be operating under value-based payments.

Understanding Bundled Reimbursement

A financial incentive for providers to coordinate care, keep costs down

How Medicare Bundling Programs Work

- Providers and suppliers bill and paid as usual under regular payment systems.
- Single "price" to hospital performing surgery (knee replacement, cardiac bypass) for any services rendered as part of that procedure (through 90-days post d/c)
- End of year reconciliation between claims payment and target "price"

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Bundled Reimbursement, continued

How payments are distributed

- Savings to be shared with all post-acute providers
- Hospital negotiates criteria and shared savings with each provider

Implications of for the Industry

- Efficacy of post-acute care and appropriateness of setting is center stage
- Hospitals incented to select and work closely with most valuable post-acute partner
- PAC providers incented to deliver and demonstrate value

Value-Based Reimbursement

How is this changing care delivery?

- Conscientious discharge planning
- Cross-Provider Collaboration
- Use of protocols that deliver value over time
- Complex Care Management

Value-Based Reimbursement

How is this changing care delivery?

- "There is no standardized process for determining post-acute destination…Patients with same discharge diagnosis may be referred to different PAC settings." *AHA Trendwatch*
- In 2014, hospitalizations for heart attacks cost Medicare over $6 billion. Yet for every treatment, the cost could vary by as much as 50%

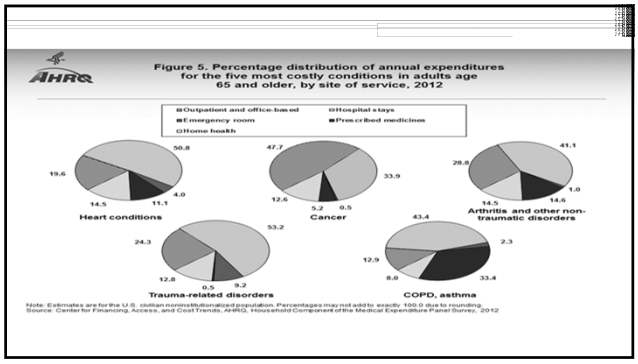
How is Value-Based Care Delivery changing the value proposition of home care providers?

Hospital & Primary Care Physician Conundrum

Which setting(s), services, and provider(s) of services will:

- Provide the best long-term outcomes for my patient
...at the best price
- Prevent readmissions, ER visits, or reduce hospital LOS
- Provide the greatest level of patient satisfaction
- Be easy for me to work with

"HCOs that do not adapt to the home care imperative risk becoming irrelevant. It seems inevitable that health care is going home."
-New England Journal of Medicine



Impact of COPD on Health Care Costs

COPD FOUNDATION

WHAT ARE THE COSTS OF COPD?

While COPD receives less attention among employers compared to other chronic diseases, it is the third leading cause of death in the U.S. and seventy percent of the 24 million individuals with COPD are under age 65. COPD is one of the most burdensome diseases for employers but with half of the 24 million not properly diagnosed, the cost burden may be greater than the data reveals.

- In 2010, COPD resulted in $49.9 billion in direct and indirect costs . [2]
- Commercially-insured COPD patients cost more per patient annually than those with Medicare.[3]
- Total costs incurred by COPD patients are approximately $6000 higher than non-COPD patients. [4]
- 13-14% of COPD patients had a hospital readmission; 41-49% had a readmission within 60 days.[3]
- The average direct per patient costs for commercially insured increased 6% per year between 2006 and 2009.[3]
- Treatments that reduce frequency of COPD-related exacerbations are associated with lower COPD-related medical costs.[3]
- 40% of COPD costs could be avoided by preventing complications and hospitalizations.[5]
- Individuals with COPD had more days of lost productivity than any other chronic condition. [10]

The majority of COPD expenditures are due to complications and hospitalizations, many of which are preventable. As with other chronic diseases, improved health care management can reduce poor outcomes and decrease costs related to COPD. [6] Better care and staying on treatment can lower the avoidable costs and make patients feel better, which increases productivity and decreases absenteeism. Thus, effective management of COPD patients can result in decreased costs, increased productivity, and decreased absenteeism.

Chronic Conditions and Hospital Admissions

Diagnoses producing greatest number of hospital readmissions (2010)

Principal Dx for Hospital Stay	# of Stays	# of Readmissions	Readmission Rate
Congestive Heart Failure	847,073	209,017	25%
Septicemia	696,122	145,896	21%
COPD	606,186	126,443	21%
Complication of Device, Implant, Graft	596,062	121,036	20%
Diabetes Mellitus, w/ complications	480,958	97,784	20%

Souce: HCUP/AHRQ Statistical Brief, April 2013

Cost Effectiveness of Homecare

- Need Cost-Effective Solutions
- Studies show home-based care is cost-effective
- Overall Medicare spending increased over 175% from 2000 – 2014.
- By contrast, DME spending only increased 3% overall in the past 5 years and actually declined 4% between 2012 and 2014.
- DME % of Medicare spending has declined for 10 years from 2.0% in 2004 to 1.25% ($7.7 billion) of the Medicare budget in 2014.

Cost Effectiveness of Homecare

- Oxygen therapy can be provided for one year for the cost of one day's stay in the hospital
- For every dollar spent….
  - $1 spent on mobility DME saves $16.78 in fall-related recovery
  - $1 spent on supplemental O2 therapy for COPD saves $9.62 in complications
  - $1 spent on CPAP therapy saves $6.73 in Obstructive Sleep Apnea complications

Source: http://www.vgmdclink.com/uploads/Document-Library/d1306dfcd9db67830ba14d4cd5b3be8c.pdf

Redefine Your Role in the Healthcare Value Equation

- Imperatives
  - Increase patient adherence to plan of care
  - Help patient avoid exacerbations
- Leverage your core competencies: equipment selection, delivery, maintenance
  - Equipment that patients will USE
  - Equipment for full range of conditions
  - Equipment with monitoring capabilities
  - Remote monitoring / telehealth technologies; partner with home care agencies/vendors for actual monitoring
  - Be intentional and exceptional in set up, training, and follow up

Redefine Your Role in the Healthcare Value Equation

- Market to providers in terms of value of home care, and of YOUR CARE

Assigned vs. Non-Assigned Claims

- DME Suppliers have historically accepted assignment; however, increased regulatory oversight and reimbursement reductions have made suppliers question assignment.

Assigned vs. Non-Assigned Claims

- Participating
  - Supplier agrees to accept assignment on all claims
  - Agrees to accept the Medicare allowed amount as payment in full
  - Can only collect co-payment and deductibles and for non-covered services
  - Medicare payment is sent to the supplier
- Non-Participating – Can elect to accept assignment or not on a claim by claim basis
  - A supplier can submit either assigned or non-assigned claims
  - Beneficiary can be charged up front and be billed the difference between the billed and allowed amounts
  - Payment is sent to the beneficiary

Submitting Non-Assigned Claims

- You must submit claims per the mandatory claim submission rule, but you don't have to accept assignment
  - You do not have to submit claims for non-covered services
- You must be non-participating (update status with NSC during the enrollment period)
- You can charge the beneficiary up front
- You are not bound by the "limiting charge" rule

Mandatory Assignment Situations

- Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) says mandatory assignment applies to Medicare-covered drugs
- Competitive Bid Suppliers must accept assignment
- Non-contract suppliers must accept assignment for competitively bid items
  - Traveling beneficiaries
  - Grandfathering
  - Repairs to bid equipment in CBAs
- Dual-Eligible Beneficiaries (Medicare/Medicaid)

Fragmented Billing

- A non-participating supplier accepts assignment for some services and requests payment from the beneficiary for other services performed at the same place and at the same time.
- A supplier may accept assignment on a claim by claim basis, but the decision applies to all services performed at the same place and on the same occasion.
- Exception – A supplier may choose not to accept assignment for other services as the same place or occasion in a mandatory assignment situation.

Oxygen

- Nonparticipating suppliers may accept assignment on a claim by claim basis. However, 42 CFR Section 414.226 (g)(3) requires that "before furnishing oxygen equipment, the supplier must disclose to the beneficiary it's intentions as to whether it will or will not accept assignment of all monthly rental claims for the duration of the rental period."
  - So…. you cannot switch assignment for oxygen claims during the 5 year period.

Beneficiary Authorization

- Beneficiary Authorization – All claims require an authorization, assigned or unassigned.
  - one-time authorization - later claims for the same services can be billed without an authorization.
- One-time authorization *does not apply* to non-assigned DME rental claims;
  - requires a separate authorization for payment of each claim
  - can not have the patient sign all authorizations up front although industry is challenging this

Capped Rental

- Allows billing capped rental items as non-assigned, but must submit monthly rental claims just like assigned claims.
- Cannot charge the beneficiary for all months up front
- Consider getting a credit card to charge monthly

Advanced Beneficiary Notices

- ABNs apply to both assigned and non-assigned claims
  - Lack of medical necessity
  - Prohibited unsolicited phone contacts
  - Supplier number requirements not met
  - Denial of Advanced Determination of Medicare Coverage (ADMC) request
  - Noncontract supplier furnishing competitively bid DMEPOS items in a CBA
- Protect yourself and get an ABN when appropriate

Documentation Requirements

- Do not differ for assigned vs non-assigned claims
- Non-assigned claims can be audited- although probably less frequently
- If the claim is deemed to be denied and you do not have a proper ABN, the contractor could require you to refund the beneficiary
- Nothing is different, except who pays the supplier and the amount the supplier can charge

National DMEPOS and HHH RAC

- November 1, 2016 – RAC contract awarded to Performant Recovery
- RAC set to begin outreach this month
- RAC audits start March 2017

Other RAC Program Changes

- Establishing ADR limits based on a supplier's compliance with Medicare rules
- RACs must wait 30 days to allow for a discussion request before sending the claim to the DME MAC for adjustment
- SOW also says that RACs are expected to support CMS in a minimum of 50% of the cases that make it to the ALJ.
- CMS also says in the SOW that the agency has the authority to settle appeals without RAC approval or input.

Other RAC Program Changes

- No contingency fees until after 2nd level of appeal
  - Ensures RAC is properly applying Medicare rules on claims audited.
- RACs – required accuracy rate of 95% and overturn rate <10%. Failure to meet =
  - Decreased ADR limits **OR**
  - Elimination of certain reviews until problems corrected

What does that mean?

RACs are back -expect more active than ever;

- likely to immediately begin automated, semi-automated and complex reviews already approved
- looking at post payment claims than have been submitted within the previous 3 years from the date the claim was paid

Unified Program Integrity Contractors*

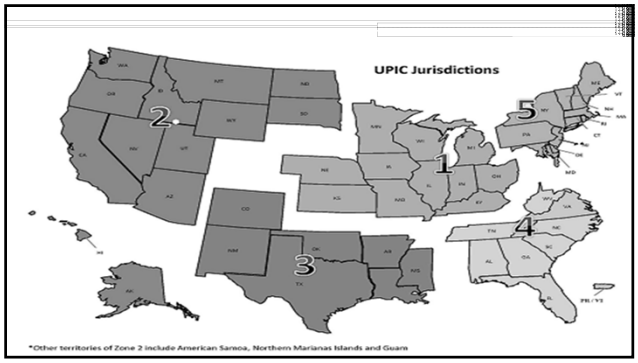
- Implementation of the UPIC* initiative began in 2016
  - Combines the audit and investigation work currently conducted by the ZPICs (and their responsibilities) with the Audit Medicaid Integrity Contractors (Audit MICs) to form the UPIC
- Contracts with ZPICs/PSCs and MICs will end as the UPIC is implemented in specific geographic regions
- Implementation of the UPICs will be over a multi-year period in order to allow current contractors to transition out
- Goal: Streamline audit structure

UPICs

- Umbrella contracts awarded in May 2016
- Potential 10 year, $2.5 billion contract vehicle
- Awardees:
  - AdvanceMed
  - Health Integrity
  - Safeguard Solutions
  - Strategic Health Solutions
  - TriCenturion
  - HMS Federal
  - Noridian Healthcare Solutions

UPICs

- 2 task orders awarded thus far:
  - AdvanceMed on 5/24/2016 for UPIC Jurisdiction 1 (Midwest)
    - Contract amount = $76,874,623.22
  - Safeguard Services was awarded contract for Jurisdiction 5 (Northeast) but no details have been released publicly.
    - Transitioned March 1, 2017.



Managed Care Risk

- Increased pressure on Medicare Advantage/HMO plans to conduct program integrity functions
- Applying policies consistently as Medicare
- Increased prepayment review and extrapolated overpayments
- Must be treated the same as Medicare
- December 2015 – CMS released a request for information that outlines an expansion of Medicare's RAC program
  - ACA requires the RAC program to be expanded into Managed Care, so the plan themselves will be audited
  - Trickle-down effect to suppliers

Supplemental Medical Review Contractor (SMRC)

Strategic Health Solutions (SHS) performs a large volume of Medicare Part A, Part B, and Durable Medical Equipment reimbursement claims nationally;

- focus on lowering improper payments in Medicare Fee-For-Service programs and increasing efficiencies in medical review functions.
- includes issues identified by the OIG, CERT and CMS internal data analysis
- Focus on national claims data analysis versus MAC jurisdiction data

SMRC

- Completed Projects
  - Power Mobility Devices
  - Vacuum Erection Devices (VED)
- Current Projects
  - Diabetic Testing Strips
  - Oxygen (50,000)
  - Nebulizers (50,000)
  - CPAP (6,000)

SMRC

- Results on respiratory reviews coming in – actual overpayments
- Review results carefully
- We don't anticipate extrapolated overpayments but it can't be ruled out
- Appeal denials

Revocations

NEW Final Rule for safeguards to reduce Medicare fraud – December 3, 2014

- Under authority of the ACA, CMS can and will deny or revoke enrollment of entities and individuals that pose a program integrity risk to Medicare for the following:

"… providers and suppliers that have a pattern and practice of billing for services that do not meet Medicare requirements. This is intended to address providers and suppliers that regularly submit improper claims in such a way that it poses a risk to the Medicare program."

Other High Risk Codes

- CPAP/BiPAP
- Oxygen
- High Frequency Chest Wall Oscillation
- TENS
- Support Surfaces
- Negative Pressure Wound Therapy
- Ventilators

Appeal Changes

- October 1, 2015 – CMS limits scope of review at Redetermination and Reconsideration to the reason the claim was initially denied.
- Two instances where guideline does not apply
  - Claims denied in prepayment reviews (guideline applies only to post-payment denials);
  - Claims denied in post-payment review for insufficient documentation and appealed with never-before presented documents (guideline allows claims to be denied for an issue other than the issue that was initially denied).

Appeal Changes

- DME Pilot Program to allow for a discussion period at the Reconsideration level
- QIC will be the one to initiate
- Limited to claims for oxygen and diabetic supplies currently
- Also looking to reopen all other unfavorable claims for these products back to January 1, 2013, if they can issue a favorable decision
- Announced November 30, 2016 – program has been expanded to include all suppliers in Jurisdictions C & D; all items except PMDs

Appeal Changes – Final Rule

- Published 1/13/2017
- Precedential Final Decision by the Secretary
  - Decisions that address, resolve, or clarify recurring legal issues, rules or policies, or that may have broad application or impact, or involve issues of public interest.
- Attorney Adjudicators
  - A licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance.

ALJ Hearings Update

- December 6, 2016 – Judge issued decision in American Hospital Association lawsuit
- HHS must eliminate the backlog by 2021
  - 30% by the end of 2017
  - 60% by the end of 2018
  - 90% by the end of 2019
  - Completely by the end of 2020
- Judge was asked by HHS to reconsider and he declined their request to do so.

Settlement Conference Facilitation Pilot

- Pilot alternative dispute resolution process designed to bring the appellant and CMS together to discuss the potential of a mutually agreeable resolution for claims appealed to the ALJ
- If a resolution is reached, a settlement document is drafted by the settlement conference facilitator to reflect the agreement and the document is signed by the appellant and CMS at the settlement conference session

Settlement Conference Facilitation Pilot Phase 2

- For the purposes of an extrapolated statistical sample, the individual claim extrapolated amount must be $100,000 or less.
- At least 20 claims must be at issue, or at least $10,000 must be in controversy if fewer than 20 claims are involved;
- There cannot be an outstanding request for OMHA statistical sampling for the same claims;
- Claims will not be adjusted so subsequent supply or repair claims for that patient will not get paid.

- Compliance Programs
- Proper transferring of liability
- Getting patients requalified
- Quality Assurance
- PreScreening
- Working with beneficiaries
- Data analysis
- Innovation

Paula Koenig

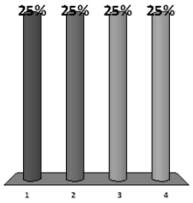
- Corporate Compliance Officer, Numotion

Medicare Competitive Bid

- Initial Round 1 July 1 2008-July 15 2008: 10 CBAs
  - ✓ Retracted by Congress after just 2 weeks
- Round 1 Re-Bid 01/01/2011 – 12/31/2013: 9 CBAs
  - ✓ average 32% reduction in allows
- Round 2 07/01/2013 – 06/31/2016: 100 CBAs
  - ✓ average 45% cuts
- Round 1 Re-Compete 01/01/2014 – 12/31/2016: 9 CBAs
  - ✓ average 37% cuts
- Round 2 Re-Compete 07/01/2016 – 12/31/2018: 117 CBAs
  - ✓ average 7% cuts
- Round 1 2017 01/01/2017 – 12/31/2018: 13 CBAs
  - ✓ 5% cut

Is Your DME business in a Round 1 or Round 2 CBA?

1. Yes, Round 1 only
2. Yes, Round 2 only
3. Yes, both Round 1 and Round 2
4. No, none of our customers are in a CBA
5. What's a CBA?



Regional Single Payment Amounts (RSPA)

Medicare is using Bid rates to adjust allowables in non-bid areas

- Split into non-rural and rural rates by bene zip codes; rural gets 10% add-on
- 01/01/16 phased in rates; blended with 2015 allowables
- 07/01/16 full implementation of RSPAs
  - 2016 cuts were in many cases more than 50% lower than 2015 allowables

RSPA

Cures Act rescinded July cut; claims for DOS 07/01/16 thru 12/31/16 to re-process at January rates

- Full RSPAs in effect 01/01/2017

RSPAs reflect an average cut of 38% from 2016

Future Bidding

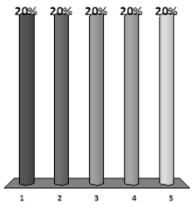
- 2019 will see new bid programs for both Round 1 and 2
- Bidding will start in 2017
- Could be different categories in Round 1 vs 2
- New Surety bond requirement
- 'lead item' groupings
- Bid ceiling at 2015 allowables

Can We Survive the Lower Allowables?

- Limit Products offered
- Non-assigned claims
- Re-define Service areas
- Retail
  - On-line

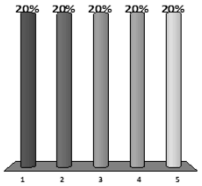
How have you dealt with lower payments?

1. Reduced staff
2. Changed product offerings
3. Redefined service area
4. Increased non-assigned claims
5. All of the above



What are the pitfalls of cash sales?

1. Mandatory Claim Filing
2. ABNs
3. Contract obligations
4. Dual-eligibles
5. All of the above



Cash Sales

More 'cash' business is enticing… but
- Medicaid implications
- Commercial contract obligations
- Medicare mandatory claim filing
- Still need documentation

On-line sales:
- How do you collect insurance info?

Solution: separate entity/Tax ID
✓ creates other challenges

Hodge-Podge: *A little of this, a little of that…*

- Medicare policy changes
- Modifiers – the new challenge
- Documentation – trends
- Prior Authorization: PWCs K0856 & K0861
  - starts 03/20/17
  - what items are next?

More…Compliance Issues

- Increase in social media activity challenges PHI management
- Email and Texting referral sources
  - ✓ **01/09/2017 headline: Joint Commission prohibits secure texting for patient care orders**
- Acquisitions and closures: transferring patient files
- Contract compliance non-Medicare payers

Business Trends

- Direct to Beneficiary Marketing
- National mail order bracing
- Lead generation
- Scam telehealth arrangements
- Consequences
  - ZPIC Audits
  - Prepayment Reviews
  - Revocations
  - Suspensions
  - Extrapolated overpayment

ACA "Obamacare"

- Repeal and replace?
- Possible impact on competitive bid
- Current status of legislation/political climate

Exclusions

Anyone who hires an individual or entity on a sanctions list may be subject to civil monetary penalties (CMP).

- Need to verify that new hires have not been excluded
- And re-verify all staff – monthly!
- Also: need to verify that referring practitioners have not been excluded
- And that vendors/manufacturers have not been excluded

https://oig.hhs.gov/exclusions/index.asp

Medicare Enrollment

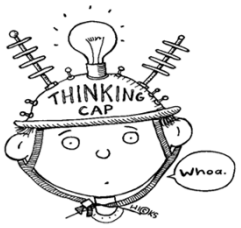
CMS appears to be getting more aggressive in revoking Medicare provider numbers

- Competitive bid contract violations
- Complaints
- Non-responses
- Patterns of 'improper' billing

Revocation Appeals

- Applicant/supplier must submit a CAP within 30 days from the postmark of the denial or revocation letter
- Request for reconsideration must be made within 60 days from the postmark of the denial or revocation letter
- Request must have the original signature of the authorized official, owner or partner on file

Final Thoughts



Questions?

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Additional information on OIG Workplan

2017 OIG Work Plan – Power Mobility

- Power mobility devices—supplier compliance with payment requirements
- OIG will review payments for power mobility devices (PMD) to determine whether such payments were medically necessary.

2017 OIG Work Plan - Nebulizers

Nebulizer machines and related drugs—supplier compliance with payment requirements

- OIG will review payments for nebulizer machines and related drugs to determine whether medical equipment suppliers' claims are medically necessary and are supported in accordance with Medicare requirements.
- For calendar year (CY) 2014, Medicare paid approximately $632.8 million for inhalation drugs. With an improper payment rate of 42 percent, inhalation drugs were sixth on a list of the top 20 DMEPOS services with the highest improper payments in the 2014 CERT report.

2017 OIG Work Plan - Osteogenesis Stimulators

- From 2012 to 2014, Medicare payments for these devices were approximately $286 million dollars.
- The OIG will examine the lump-sum purchase versus rental option to determine whether potential savings can be achieved if osteogenesis stimulators are rented over a 13-month period rather than acquired through a lump-sum purchase.

2017 OIG Work Plan - Orthotics

- Orthotic braces–supplier compliance with payment requirements
- OIG will review orthotic braces to determine whether suppliers' claims were medically necessary.
- Prior OIG work indicated that some suppliers were billing for services that were medically unnecessary (e.g. beneficiaries receiving multiple braces and referring physician did not see the beneficiary)

2017 OIG Work Plan – SNF Payments

- 2009 OIG report found Medicare Part B allowed inappropriate payments of $30 million for DMEPOS provided during non-Part A SNF stays.
- OIG intent - study the extent of inappropriate payments to nursing home patients during non-Part A stays in 2015.
- Spotlights CMS ability to determine if they have appropriate systems in place to identify improper payments and initiate recoupments.

2017 OIG Work Plan – PAP Supplies

- Medicare payments for CPAP and BiPAP supplies in 2014 and 2015 -$953 million.
- Prior OIG work found suppliers auto-shipped supplies when refills were not requested by the beneficiary and also that the physician orders were incomplete in regards to the types of supplies needed and frequency of use.
- The OIG will review supplier compliance with documentation requirements for frequency and medical necessity.