

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID
SUPPLIERS AN ESTIMATED
\$117 MILLION OVER 4 YEARS FOR
DURABLE MEDICAL EQUIPMENT,
PROSTHETICS, ORTHOTICS, AND
SUPPLIES PROVIDED TO
HOSPICE BENEFICIARIES**

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Office of Inspector General

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Report in Brief

Date: November 2021

Report No. A-09-20-03026

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

A prior OIG audit found that Medicare improperly paid suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for DMEPOS items provided to beneficiaries during inpatient stays. However, that audit did not cover payments for DMEPOS items that suppliers provided to hospice beneficiaries.

Our objective was to determine whether Medicare properly paid suppliers for DMEPOS items they provided to hospice beneficiaries.

How OIG Did This Audit

Our audit covered \$185.7 million in Medicare Part B payments to suppliers for 1.6 million DMEPOS items provided to hospice beneficiaries from January 2015 through April 2019 (audit period). We identified hospice claims with service dates during our audit period and used these claims' beneficiary information and service dates to identify DMEPOS items that had service dates within the hospice service dates. We selected 2 stratified samples, with 200 items billed by suppliers. One sample was for 115 items billed without the GW modifier. (This modifier indicates that an item is not related to the beneficiary's terminal illness and related conditions.) Another sample was for 85 items billed with the GW modifier. For each sample, we contacted the hospices that provided care to the beneficiaries to have them assess whether the items palliated or managed the beneficiaries' terminal illnesses and related conditions.

Medicare Improperly Paid Suppliers an Estimated \$117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries

What OIG Found

For 121 of 200 sampled DMEPOS items, Medicare improperly paid suppliers for DMEPOS items they provided to hospice beneficiaries. Specifically, for 58 percent of the sampled DMEPOS items billed without the GW modifier (67 of 115 items) and 63 percent of the sampled DMEPOS items billed by suppliers with the GW modifier (54 of 85 items), the items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. Medicare pays the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers.

The improper payments occurred because: (1) the majority of the suppliers were unaware that they had provided DMEPOS items to hospice beneficiaries, (2) the system edit processes that should have prevented the improper payments were not effective or did not exist, and (3) the suppliers inappropriately used the GW modifier. On the basis of our sample results, we estimated that Medicare could have saved \$116.9 million in payments during our audit period, and beneficiaries could have saved \$29.8 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS): (1) improve the prepayment edit process by instructing the durable medical equipment (DME) Medicare contractors to deny DMEPOS claims submitted by suppliers without the GW modifier for DMEPOS items provided to hospice beneficiaries; (2) implement a postpayment edit process; (3) direct the DME and hospice Medicare contractors, or other contractors as appropriate, to conduct prepayment or postpayment reviews of supplier claims billed with the GW modifier; and (4) study the feasibility of including palliative items and services not related to a beneficiary's terminal illness and related conditions within the hospice per diem.

CMS concurred with our first and third recommendations but did not concur with our second and fourth recommendations. We maintain that our second recommendation is valid, but we revised our fourth recommendation.

TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective	1
Background	2
Medicare Program.....	2
Durable Medical Equipment, Prosthetics and Orthotics, and Drugs and Nutritional Products.....	3
Medicare Part B Billing of DMEPOS	4
Medicare Part A Hospice Services for Beneficiaries.....	5
DMEPOS Provided to Hospice Beneficiaries	7
Hospice Medicare Contractors’ and DME Medicare Contractors’ Claims Processing Systems and Common Working File Edits.....	9
How We Conducted This Audit.....	10
FINDINGS	12
Federal Requirements	13
Medicare Improperly Paid Suppliers for DMEPOS Items Billed Without the GW Modifier.....	14
More Than Half of Sampled DMEPOS Items That Suppliers Billed Without the GW Modifier Were Provided To Palliate or Manage Beneficiaries’ Terminal Illnesses and Related Conditions.....	14
The Majority of Suppliers Were Unaware That They Had Provided DMEPOS Items to Hospice Beneficiaries.....	16
CWF Prepayment Edit Process Detected DMEPOS Items, but the DME Medicare Contractors’ Method of Manually Comparing DMEPOS Claims’ Diagnosis Codes With Hospice Claims’ Diagnosis Codes Was Not Effective.....	17
Some DMEPOS Claims Were Processed for Payment Before the Notice of Election Was Processed in the CWF.....	17
Medicare Improperly Paid Suppliers for DMEPOS Items Billed With the GW Modifier.....	18
Almost Two-Thirds of Sampled DMEPOS Items That Suppliers Billed With the GW Modifier Were Provided To Palliate or Manage Beneficiaries’ Terminal Illnesses and Related Conditions.....	18

CWF Prepayment Edit Process Was Not Effective in Preventing Improper Payments for DMEPOS Items Billed by Suppliers With the GW Modifier	20
There Were No Targeted Probe-and-Educate Efforts To Identify and Educate Suppliers That Routinely Use the GW Modifier for Items Related to Terminal Illnesses and Related Conditions.....	20
CONCLUSION.....	21
RECOMMENDATIONS.....	22
CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE.....	22
Second Recommendation	23
CMS Comments	23
Office of Inspector General Response	23
Fourth Recommendation	24
CMS Comments	24
Office of Inspector General Response	24
APPENDICES	
A: Audit Scope and Methodology.....	25
B: Statistical Sampling Methodology	28
C: Sample Results and Estimates for DMEPOS Items Billed Without the GW Modifier	30
D: Sample Results and Estimates for DMEPOS Items Billed With the GW Modifier	31
E: CMS Comments.....	32

INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit found that Medicare improperly paid suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for DMEPOS items provided to beneficiaries during inpatient stays.¹ However, that audit did not cover payments for DMEPOS items that DMEPOS suppliers provided to hospice beneficiaries.² From January 2015 through April 2019, Medicare paid suppliers \$185.7 million for DMEPOS items provided to hospice beneficiaries, and those beneficiaries paid \$47.5 million in deductibles and coinsurance that was collected from them or someone on their behalf. We conducted this audit to determine whether Medicare properly paid for these items. Medicare pays a hospice for DMEPOS items provided to a hospice beneficiary as part of the daily-rate payment that Medicare makes to hospices if the items are given to palliate or manage the beneficiary's terminal illness and related conditions.³ However, Medicare should not separately pay a supplier for a DMEPOS item provided to a hospice beneficiary if the item was given to palliate or manage the beneficiary's terminal illness and related conditions.⁴ Instead, such an item should be provided under arrangements between the hospice and the supplier.

OBJECTIVE

Our objective was to determine whether Medicare properly paid suppliers for DMEPOS items they provided to hospice beneficiaries.

¹ *Medicare Improperly Paid Suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Beneficiaries During Inpatient Stays* ([A-09-17-03035](#)), issued Nov. 29, 2018.

² Two other OIG reports identified nonhospice items and services other than DMEPOS that were inappropriately paid during hospice stays: *Medicare Part D Is Still Paying Millions for Drugs Already Paid for Under the Part A Hospice Benefit* ([A-06-17-08004](#)), issued Aug. 22, 2019, and *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio* ([OEI-02-16-00570](#)), issued July 30, 2018.

³ "Palliative care" is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs, and facilitating patient autonomy, access to information, and choice (42 CFR § 418.3).

⁴ In this report, we grouped DMEPOS items into three high-level categories: (1) durable medical equipment (DME), (2) prosthetics and orthotics, and (3) drugs and nutritional products. Supplies are spread throughout these three categories.

BACKGROUND

Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A covers hospice services provided to eligible beneficiaries, and Medicare Part B provides supplementary medical insurance for medical and other health services, as well as DMEPOS items. Medicare beneficiaries are responsible for certain out-of-pocket costs, such as those for deductibles and coinsurance, related to Part B DMEPOS claims.⁵

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with a hospice Medicare administrative contractor (hospice Medicare contractor) in each Medicare jurisdiction to, among other things, process and pay Medicare Part A claims submitted by hospices. CMS contracts with durable medical equipment Medicare administrative contractors (DME Medicare contractors) to process and pay Medicare Part B claims for DMEPOS items. CMS also contracts with other entities, such as the Supplemental Medical Review Contractor, Recovery Audit Contractors, and Unified Program Integrity Contractors (other contractors).⁶

Two DME Medicare contractors process claims for 4 jurisdictions covering all 50 States, the District of Columbia, and U.S. territories. (Each contractor has two jurisdictions.) Suppliers must submit a claim to the DME Medicare contractor that services the State or territory in which a Medicare beneficiary permanently resides. In addition to processing claims, these contractors' responsibilities include educating suppliers on Medicare requirements and billing procedures through CMS's Targeted Probe and Educate program, through which a DME Medicare contractor works with a supplier to identify and correct errors. To identify these suppliers, DME Medicare contractors analyze Medicare claims data to identify suppliers that have high claim error rates or unusual billing practices. DME Medicare contractors also apply system edits to claims to determine whether claims are complete and should be paid.⁷

⁵ Medicare Part B deductibles and coinsurance amounts could be paid directly by the beneficiary or paid by someone on their behalf (e.g., through another insurance program).

⁶ The Supplemental Medical Review Contractor performs medical review activities directed by CMS. Recovery Audit Contractors are tasked with identifying and recovering Medicare overpayments and identifying underpayments. Unified Program Integrity Contractors perform fraud, waste, and abuse detection, deterrence, and prevention activities for Medicare claims.

⁷ An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying claims in full or in part, denying payments, or suspending claims for manual review.

Durable Medical Equipment, Prosthetics and Orthotics, and Drugs and Nutritional Products⁸

Durable Medical Equipment

DME is generally defined as equipment that can withstand repeated use, primarily serves a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in a beneficiary's home (Social Security Act (the Act) § 1861(n); *Medicare Claims Processing Manual* (Claims Manual), chapter 20, § 10.1.1). Examples of DME items are oxygen and respiratory equipment and supplies, wheelchairs, and walkers (*Medicare Benefit Policy Manual* (Benefit Manual), chapter 15, § 110.1(B)(1)). In addition, wound-care supplies and fillers are considered DME and are used for openings on the body caused by surgical procedures, wounds, ulcers, or burns.⁹ Examples of wound-care supplies or fillers are adhesive tape, roll gauze, and bandages (Benefit Manual, chapter 15, § 100).

Prosthetics and Orthotics

Prosthetics are devices that replace all or part of: (1) an internal body organ or (2) the function of a permanently inoperative or malfunctioning internal body organ (the Act § 1861(s)(8); Claims Manual, chapter 20, § 10.1.2). Examples of prosthetics are artificial limbs, breast prostheses for postmastectomy patients, and devices that replace all or part of the ear or nose (Benefit Manual, chapter 15, § 120(A)). Orthotics are rigid and semirigid devices, often called braces, which are used to support a weak or deformed body member, or restrict or eliminate motion in a diseased or injured part of the body. Examples of orthotics are leg, arm, back, and neck braces (the Act § 1861(s)(9); Benefit Manual, chapter 15, § 130).

Drugs and Nutritional Products

Drugs, including biologicals, are substances that can be: (1) put directly into the DME to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment (Benefit Manual, chapter 15, § 110.3), or (2) directly prescribed to be taken orally or through injections (Benefit Manual, chapter 15, § 50.2).¹⁰ Nutritional products are for patients who

⁸ For the purpose of this report, we grouped Healthcare Common Procedure Coding System (HCPCS) codes for DMEPOS items into the following Berenson-Eggers Type of Service (BETOS) high-level categories: (1) DME, (2) prosthetics and orthotics, and (3) drugs and nutritional products. Because supplies can be used with DME, prosthetics and orthotics, or drugs and nutritional products, supplies are spread throughout these three BETOS categories. (HCPCS codes are alphanumeric codes used to identify products, supplies, and services, such as DMEPOS items on claims. BETOS categories are used to group similar types of HCPCS codes into broad classes of services.)

⁹ BETOS categorizes surgical dressings as DME.

¹⁰ Under BETOS, items classified as "drugs and nutritional products" include: (1) drugs and biologicals, and (2) nutritional products. In this report, "drugs" include drugs and biologicals.

cannot be sustained through oral feeding but must rely on either parenteral or enteral nutrition therapy, depending on their medical condition.¹¹

Medicare Part B Billing of DMEPOS

In general, for any DMEPOS item to be covered by Medicare, the item must: (1) be eligible for a defined Medicare benefit category; (2) be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member; and (3) meet all other applicable Medicare statutory and regulatory requirements (the Act §§ 1861(s), 1862(a)(1)(A), and 1832(a)(2)(B); 42 CFR § 410.38).

Before a supplier submits a claim, a DME Medicare contractor expects a supplier to have on file a standard written order (from a physician), a Certificate of Medical Necessity¹² (if applicable), information from a treating practitioner concerning the beneficiary's diagnosis, and any information required for the use of specific modifiers¹³ or attestation statements (*Medicare Program Integrity Manual*, chapter 5, §§ 5.5 and 5.10). The supplier should review the Health Insurance Portability and Accountability Act Eligibility Transaction System to determine whether the beneficiary is receiving hospice care (Claims Manual, chapter 24, § 40.2.5). (In this report, we refer to this system as the "eligibility check system.")

The supplier should obtain as much documentation from the beneficiary's medical record as it determines necessary to assure itself that coverage criteria have been met. To be paid by Medicare, the item must be reasonable and necessary for the diagnosis or treatment of illness or injury, or for improving the functioning of a malformed body member (the Act § 1862(a)(1)(A)). Medicare pays for a DMEPOS item if it is medically necessary and supported by the beneficiary's medical record. Once all this information is obtained, the supplier dispenses the DMEPOS item to the beneficiary and bills Medicare Part B. Part B pays for the item on a rental basis or pays for it in full, less any deductibles or coinsurance.

¹¹ CMS defines "prosthetics" to include parenteral and enteral nutrition (PEN) under the Benefit Manual, chapter 15, section 120; however, BETOS categorizes PEN as "drugs and nutritional products."

¹² A Certificate of Medical Necessity is a form required to help document medical necessity and other coverage criteria for a selected list of DMEPOS items, such as certain oxygen items (*Medicare Program Integrity Manual*, chapter 5, § 5.5).

¹³ A modifier on a claim provides additional information or changes the description of the service to improve accuracy or specificity.

Medicare Part A Hospice Services for Beneficiaries

Medicare Hospice Benefit

The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare hospice benefit.¹⁴ Medicare Part A covers hospice services provided to eligible beneficiaries. The goal of hospice care is to help terminally ill beneficiaries continue life with minimal disruption and support beneficiaries' families and other caregivers. The care is palliative rather than curative. The goal of palliative care is to improve an individual's quality of life by managing pain and relieving symptoms and by providing physical and emotional comfort. Hospice care may be provided to an individual residing at home or another place of residence, such as a skilled or other nursing facility.

To be eligible for Medicare hospice care, an individual must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course.¹⁵ Hospice care is available for two 90-day benefit periods and an unlimited number of 60-day benefit periods during the remainder of the hospice beneficiary's lifetime.¹⁶ When a beneficiary elects hospice care, the hospice assumes responsibility for palliative care related to the beneficiary's terminal illness and related conditions (the Act § 1861(dd); 42 CFR §§ 418.20, 418.22, and 418.24).^{17, 18} The beneficiary waives Medicare coverage for services related to treatment of the terminal illness and related conditions but retains Medicare coverage for services to treat conditions unrelated to the terminal illness and related conditions (42 CFR § 418.24(e)).

The Medicare hospice benefit covers nursing care, medical social services, home aide and homemaker services, physician services, counseling, physical therapy, occupational therapy,

¹⁴ CMS implemented the hospice benefit through regulation in the final rule that went into effect on Nov. 1, 1983 (48 Fed. Reg. 56008 (Dec. 16, 1983)).

¹⁵ 42 CFR § 418.20. Certification is based on the attending physician's or the hospice medical director's clinical judgment regarding the normal course of the disease (42 CFR § 418.22).

¹⁶ A "benefit period" refers to a 90-day or 60-day period. An "election period" is the range of time from when hospice care begins until it ends, which may include multiple 90-day and 60-day benefit periods (42 CFR § 418.21; Claims Manual, chapter 11, § 20.1.6).

¹⁷ CMS has described a "terminal illness" as an advanced and progressively deteriorating illness that has been diagnosed as incurable, and "related conditions" as physical or mental conditions that are related to or caused by either the terminal illness or the medications used to manage the illness. In the proposed rule addressing the fiscal year (FY) 2015 hospice wage index and payment rate updates, CMS solicited comments on the definitions of "terminal illness" and "related conditions" (79 Fed. Reg. 26538, 26541–42 (May 8, 2014)). However, CMS did not include these definitions in the FY 2015 final rule and has not included them in subsequent final rules.

¹⁸ An example of a terminal illness is chronic obstructive pulmonary disease. A related condition would be dyspnea (i.e., shortness of breath). Another example of a terminal illness is Alzheimer's disease. A related condition would be decubitus ulcer (i.e., bedsore) due to immobility.

and speech-language pathology services. The hospice benefit also includes short-term inpatient care, medical supplies (including drugs and biologicals), and the use of medical appliances. In addition, the hospice benefit covers any other Medicare-allowable service that is specified in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions, and for which payment may otherwise be made under Medicare.¹⁹

Levels of Care and Medicare Part A Payments to Hospices

The Medicare hospice benefit has four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Each level has an all-inclusive daily rate (i.e., per diem) that is paid through Medicare Part A. The per diem payment is intended to cover not only visit costs but also other costs that a hospice incurs for palliation and management of a beneficiary's terminal illness and related conditions, such as the costs of medical equipment.²⁰

In the 1983 final rule, CMS states: "It is our general view that the [Act § 1812(d)(1) 'exceptional and unusual circumstances'] waiver required by the law is a broad one and that hospices are required to provide virtually all the care that is needed by terminally ill patients" (48 Fed. Reg. 56008, 56010–11 (Dec. 16, 1983)). In addition, in the Federal Register CMS states that "it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life" (83 Fed. Reg. 20934, 20946 (May 8, 2018)). CMS reiterated this point in 2019, stating that its "long-standing position [is] that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit" (84 Fed. Reg. 38484, 38506 (Aug. 6, 2019)).

CMS's General View

"... we reiterated our long-standing position that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit"

Medicare should not separately pay a supplier for DMEPOS items provided to a beneficiary during a hospice stay if the items were given to palliate or manage the terminal illness and related conditions.²¹ Instead, the items should be provided under arrangements between the

¹⁹ The Act § 1861(dd)(1) and 42 CFR § 418.202.

²⁰ 42 CFR § 418.302. There has been little change in the hospice payment structure since the hospice benefit's inception. The per diem rate based on the level of care was established in 1983, and this payment structure remains today with some adjustments.

²¹ The Act § 1861(dd)(1); 42 CFR §§ 418.24(e) and 418.202(f).

hospice and the supplier.²² Medicare pays the hospice for the DMEPOS items provided to the beneficiary as part of the hospice's per diem payment.

DMEPOS Provided to Hospice Beneficiaries

Medicare conditions of participation for hospices require that medical supplies and appliances, DME, and drugs and biologicals related to the palliation and management of a beneficiary's terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the beneficiary is under hospice care (42 CFR § 418.106).²³ Therefore, a hospice must: (1) directly provide all items that are necessary for the palliation and management of a beneficiary's terminal illness and related conditions; or (2) arrange for items (either rental or nonrental items) to be provided to the beneficiary by suppliers and include the cost of those items on hospice claims submitted to Medicare.²⁴

Medicare Billing for DMEPOS Items That Suppliers Provide to Hospice Beneficiaries Not Related to the Terminal Illness and Related Conditions

A Medicare Part B payment may be made for a DMEPOS item that is unrelated to a hospice beneficiary's terminal illness and related conditions. The supplier must include on the claim the GW modifier.²⁵ The DME Medicare contractor processes the claim to determine whether the item is covered and pays the supplier. DME Medicare contractors may conduct prepayment or postpayment reviews to validate that an item billed with the GW modifier was not related to the beneficiary's terminal illness and related conditions.²⁶

Usage of the GW Modifier

The GW modifier indicates that a service is not related to the hospice beneficiary's terminal illness and related conditions. If a DMEPOS item is given to a beneficiary to treat a condition that is not related to his or her terminal illness and related conditions, the supplier may bill Medicare Part B and include the GW modifier on its claim.

²² Federal regulations define "arrangements" as those "which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services" (42 CFR § 409.3). CMS is silent on the specifics of the arrangements between the two parties.

²³ In the FY 2020 final rule, CMS modified the election statement with an addendum that includes a written list and rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions (84 Fed. Reg. 38484 (Aug. 6, 2019); 42 CFR §§ 418.24(b) and (c)). When a beneficiary elects hospice care, the beneficiary must file an election statement with a particular hospice (Benefit Manual, chapter 9, § 10).

²⁴ If a hospice determines that a rental item palliates or manages the terminal illness and related conditions, the hospice arranges with the supplier which party is responsible for paying for the item. CMS is silent on the specifics of the arrangements between the two parties.

²⁵ 79 Fed. Reg. 26538, 26549 (May 8, 2014).

²⁶ Claims Manual, chapter 11, §§ 40.2 and 50.

Medicare Part B Payments for DMEPOS Items Provided to Hospice Beneficiaries

Medicare Part B paid suppliers approximately \$185.7 million for DMEPOS items provided to beneficiaries while they were receiving hospice services from January 1, 2015, through April 30, 2019 (audit period). Beneficiaries paid approximately \$47.5 million in deductibles and coinsurance that was collected from them or someone on their behalf. Figure 1 shows a breakdown of payments by DMEPOS category.

Figure 1: Medicare Part B Payments and Beneficiary Coinsurance for DMEPOS Items Provided to Hospice Beneficiaries During Our Audit Period

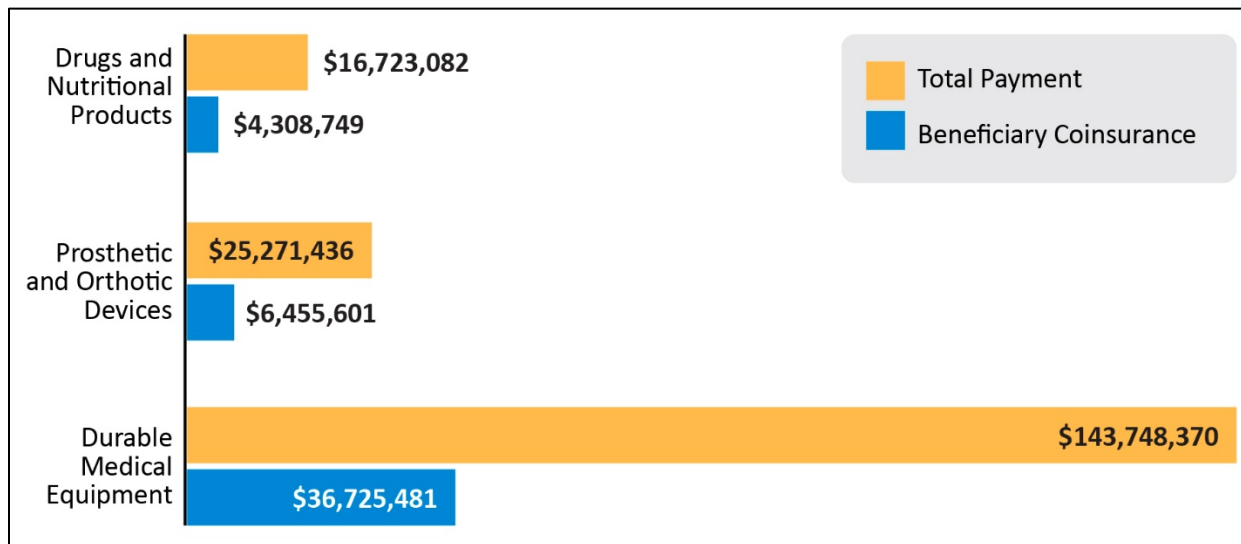


Figure 2 shows the \$143.7 million in Medicare Part B payments for DMEPOS items classified as DME according to the type of DME. The majority of DME items provided to hospice beneficiaries were for surgical dressings.

Figure 2: Payments for Types of Durable Medical Equipment Provided to Hospice Beneficiaries During Our Audit Period

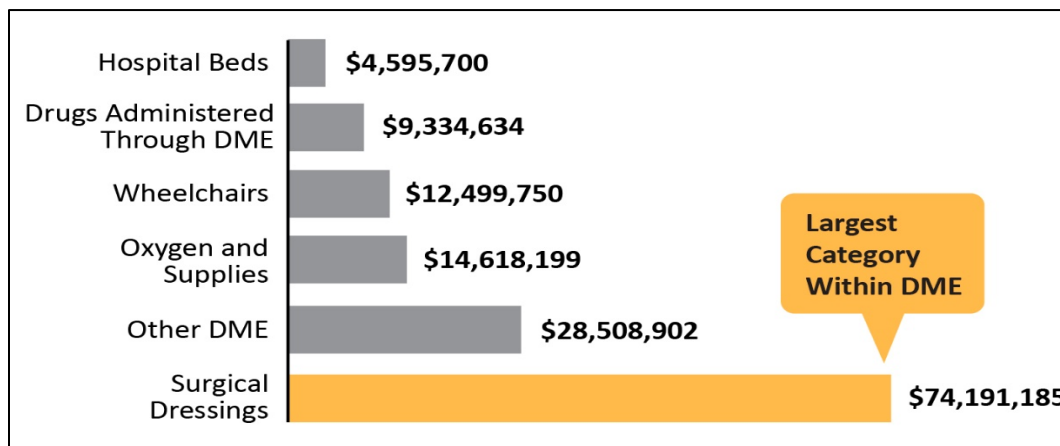
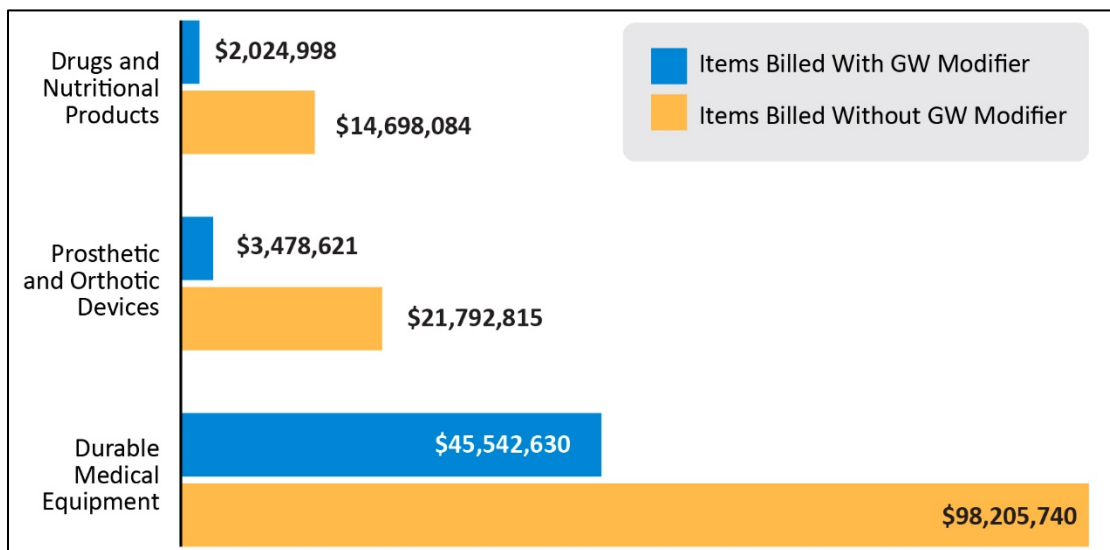


Figure 3 shows the payments for DMEPOS items provided to hospice beneficiaries for items billed with and without the GW modifier. The majority of the payments were for items billed without the GW modifier.

Figure 3: Payments for DMEPOS Items Provided to Hospice Beneficiaries During Our Audit Period Billed With and Without the GW Modifier



Hospice Medicare Contractors’ and DME Medicare Contractors’ Claims Processing Systems and Common Working File Edits

Fiscal Intermediary Standard System and Common Working File

Hospice Medicare contractors use the Fiscal Intermediary Standard System to process hospice claims submitted by hospices for services provided to hospice beneficiaries. When a beneficiary elects hospice care, the hospice must complete a notice of election,²⁷ which must be submitted to the hospice Medicare contractor within 5 calendar days of the beginning of the beneficiary’s hospice care.²⁸ The notice of election contains information such as the principal diagnosis code (which is usually the terminal illness). The hospice Medicare contractor processes the notice of election in the Common Working File (CWF). However, the notice of election may not be processed immediately after the hospice submits it. The notice of election creates an election period that could contain up to two 90-day and an unlimited number of 60-day benefit periods thereafter. Information about the election periods is stored in the CWF.

²⁷ A hospice submits a notice of election electronically or by submitting Form CMS-1450 (Medicare Learning Network (MLN) Matters SE18007, Feb. 11, 2020).

²⁸ 42 CFR § 418.24(a).

DME Medicare Contractors and the Common Working File's Prepayment Edit Process

DME Medicare contractors use the ViPS Medicare System to process DMEPOS claims. Before a payment is made, a DMEPOS claim from a supplier is sent to CMS's CWF for verification, validation, and payment authorization. The CWF contains a prepayment edit process to prevent improper payments. For a beneficiary who elects hospice care, the prepayment edit is applied to a DMEPOS claim only when it is processed after a beneficiary's notice of election is processed in the CWF. However, there is currently no postpayment edit process in the CWF to detect improper payments.

Once the CWF has processed a DMEPOS claim for payment, it notifies the DME Medicare contractor about any potential errors on the claim for further investigation. For a DMEPOS claim billed by a supplier without the GW modifier, the DME Medicare contractor investigates potential errors on the claim identified by the CWF to determine whether the DMEPOS item palliated or managed the beneficiary's terminal illness and related conditions by manually comparing the DMEPOS claim's diagnosis codes with the hospice claim's diagnosis codes, or with the diagnosis code listed in the election period in the CWF if no hospice claim is present.²⁹ If the diagnosis codes match, the DMEPOS claim for payment is denied. If the diagnosis codes do not match, the DMEPOS claim is approved for payment as unrelated to the beneficiary's terminal illness and related conditions. However, if a DMEPOS claim billed by a supplier has the GW modifier appended, the DME Medicare contractor automatically processes the claim for payment.³⁰

HOW WE CONDUCTED THIS AUDIT

Our nationwide audit covered \$185.7 million in Medicare Part B payments for 1.6 million DMEPOS items provided to hospice beneficiaries during our audit period. To identify these DMEPOS items, we first identified hospice claims with dates of service during our audit period. We then used the beneficiary information and service dates from those claims to identify DMEPOS items that had service dates within the hospice claims' dates of service, including the first and last days of a beneficiary's hospice services. We excluded DMEPOS items with payment amounts of less than \$10.

²⁹ During our audit, two different methods were used to compare diagnosis codes. For diagnosis codes listed in the *International Classification of Diseases (ICD)*, 9th revision, DME Medicare contractors compared the first three digits of the diagnosis codes listed on the DMEPOS claim with the hospice diagnosis codes in the CWF. If the digits matched, the claim was denied as related to the terminal illness. For diagnosis codes listed in the ICD, 10th revision, DME Medicare contractors compared diagnosis codes on the DMEPOS claim with hospice diagnosis codes in the CWF, and if there was an exact match the claim was denied as related to the terminal illness.

³⁰ Falsely appending the GW modifier to a claim for a DMEPOS item that was given to palliate or manage a beneficiary's terminal illness and related conditions may violate Federal laws governing Medicare fraud and abuse, including the False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law, Social Security Act (which includes the Exclusion Statute and the Civil Monetary Penalties Law), and other provisions of the United States Criminal Code.

We selected 2 stratified samples consisting of 200 DMEPOS line items from claims, totaling \$64,293, for 200 beneficiaries.³¹ One stratified sample, totaling 115 line items, was for DMEPOS items billed by suppliers without the GW modifier. The other stratified sample, totaling 85 line items, was for DMEPOS items billed by suppliers with the GW modifier. For each of these samples, we contacted the hospices that provided care to the beneficiaries who received the DMEPOS items to have them assess whether the items were provided to palliate or manage the terminal illnesses and related conditions (i.e., clinical assessments), and we analyzed their responses.³² For instances in which a hospice did not provide an assessment but provided only medical records, we provided those records to the hospice Medicare contractor to assess whether the DMEPOS item was provided to palliate or manage the beneficiary's terminal illness and related conditions. We also requested from the supplier the medical records for each sampled DMEPOS item and requested an assessment of whether: (1) the supplier was aware that the beneficiary was under hospice care, and (2) the item palliated or managed the beneficiary's terminal illness and related conditions.

We focused only on the Medicare Part B payments to suppliers for DMEPOS items that were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. We did not use medical review to determine whether the hospices' Medicare Part A services were medically necessary.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology. Appendix B describes our statistical sampling methodology, and Appendices C and D contain our sample results and estimates for DMEPOS items billed without and with the GW modifier, respectively.

³¹ A claim could have had more than one distinct DMEPOS item. Each DMEPOS item on a claim represented a line item.

³² To determine whether a condition is related to the terminal illness or whether a DMEPOS item treated the terminal illness or a related condition, medical records need to be assessed and a clinical judgment needs to be made on a case-by-case basis.

FINDINGS

For 121 of 200 sampled DMEPOS items, Medicare improperly paid suppliers for DMEPOS items they provided to hospice beneficiaries.³³ Specifically, for 58 percent of the sampled DMEPOS items billed without the GW modifier (67 of 115 items) and 63 percent of the sampled DMEPOS items billed with the GW modifier (54 of 85 items), the items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. Medicare pays the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers. The following summarizes our two findings:

- For the 67 DMEPOS items billed without the GW modifier, the majority of suppliers were unaware that beneficiaries were receiving hospice services when they provided the items to the beneficiaries. In addition, the CWF prepayment edit process, which included a manual review of potential errors on a claim, was not effective in preventing improper payments for items billed without the GW modifier and that were related to beneficiaries' terminal illnesses and related conditions. Lastly, there was no CWF postpayment edit process in place to detect and deny a DMEPOS claim billed without the GW modifier that was processed before the notice of election.
- For the 54 DMEPOS items billed with the GW modifier, suppliers inappropriately used the GW modifier when they billed Medicare, indicating that the items were not related to the beneficiaries' terminal illnesses and related conditions. In addition, the CWF prepayment edit process was not effective in preventing improper payments for items provided to palliate or manage beneficiaries' terminal illnesses and related conditions. Specifically, if the claim for an item had the GW modifier, the DME Medicare contractors automatically processed the claim for payment, and the contractors did not manually review the claim to determine whether the item palliated or managed the terminal illness and related conditions. Lastly, there were no targeted probe-and-educate efforts to identify and educate suppliers that routinely use the GW modifier for items related to terminal illnesses and related conditions.

³³ For 113 of 121 sampled DMEPOS items that were improperly paid, hospices provided medical records and clinical assessments that these items were given to palliate or manage the beneficiaries' terminal illnesses and related conditions. For 8 of 121 sampled items, we obtained hospice medical records but no hospice assessments. We provided these medical records to the hospice Medicare contractors, and they determined that the items palliated or managed the beneficiaries' terminal illnesses and related conditions. Thus, we have referred to all 121 items as "errors" in this report.

On the basis of our sample results, we estimated that Medicare could have saved \$116.9 million in payments made to suppliers during our audit period if the CWF prepayment edit process had prevented improper payments to suppliers and DME Medicare contractors had conducted postpayment reviews (e.g., targeted probe-and-educate efforts) to detect Medicare Part B payments improperly made to suppliers for DMEPOS items provided to hospice beneficiaries.³⁴ In addition, we estimated that beneficiaries could have saved \$29.8 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.³⁵

Estimate of Savings

Over 4 years, Medicare could have saved **\$116.9 million** and beneficiaries could have saved **\$29.8 million** in deductibles and coinsurance.

For the remaining 79 sampled DMEPOS items, Medicare properly paid suppliers for DMEPOS items they provided to hospice beneficiaries. The hospices stated that these items palliated or managed a condition not related to the terminal illness and related conditions (specifically, 48 of 115 DMEPOS items billed without the GW modifier and 31 of 85 DMEPOS items billed with the GW modifier).³⁶

FEDERAL REQUIREMENTS

Hospices are required to provide medical supplies (including drugs and biologicals) and the use of medical appliances and to provide any other item or service that is specified in the plan of care (the Act §§ 1861(dd)(1)(E) and (I)). The provision of medical supplies, including drugs and biologicals, and medical appliances are covered hospice services. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal illness and related conditions. Appliances may include covered DME as well as other self-help and personal comfort items related to the palliation or management of the beneficiary's terminal illness. Equipment is provided by the hospice for use in the beneficiary's home while he or she is under hospice care (42 CFR § 418.202(f)).

³⁴ The savings amount is \$116,904,022, which reflects adding the estimated amounts for each of our samples: \$83,559,124 for DMEPOS items billed without the GW modifier, and \$33,344,898 for items billed with this modifier.

³⁵ The savings amount is \$29,823,011.

³⁶ Nine of these sampled DMEPOS items were provided to beneficiaries at nine hospices, of which six were under investigation and three had gone out of business. We considered these sampled items as non-errors.

The hospice conditions of participation state that medical supplies³⁷ and appliances,³⁸ DME,³⁹ and drugs and biologicals related to the palliation and management of the terminal illness and related conditions must be provided by the hospice while the beneficiary is under hospice care (42 CFR § 418.106). Therefore, Medicare Part B should not separately pay for DMEPOS items if they are already covered as part of the hospices' per diem payments.

MEDICARE IMPROPERLY PAID SUPPLIERS FOR DMEPOS ITEMS BILLED WITHOUT THE GW MODIFIER

For 115 sampled DMEPOS items that suppliers billed without the GW modifier, more than half of these items (67) were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. These items were covered as part of the hospices' per diem payments and Medicare should have not paid the suppliers. The improper payments occurred because: (1) the majority of the suppliers were unaware that they had provided DMEPOS items to hospice beneficiaries; (2) the CWF prepayment edit process detected DMEPOS items, but the DME Medicare contractors' method of manually comparing the DMEPOS diagnosis codes was not effective; and (3) some DMEPOS claims were processed for payment before a notice of election was processed in the CWF. Each of these causes is discussed in greater detail below.

More Than Half of Sampled DMEPOS Items That Suppliers Billed Without the GW Modifier Were Provided To Palliate or Manage Beneficiaries' Terminal Illnesses and Related Conditions

For 67 of 115 sampled DMEPOS items that suppliers billed without the GW modifier, the hospices (for 62 items) and hospice Medicare contractors (for 5 items) stated that these items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers. Medicare pays the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments.

On the basis of our sample results, we estimated that Medicare could have saved \$83.6 million for DMEPOS items billed without the GW modifier, and beneficiaries could have saved \$21.3 million in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf. (See Table 1 on the following page.)

³⁷ Medical supplies include surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations (42 CFR § 410.36). CMS also considers supplies as items that are necessary for the use of DME. Such supplies include drugs and biologicals that are put directly into equipment to achieve the therapeutic benefit or proper function of DME (Benefit Manual, chapter 15, section § 110.3). Because supplies can be used with DME, prosthetics and orthotics, or drugs and biologicals, supplies are spread throughout three high-level BETOS categories: (1) DME, (2) prosthetics and orthotics, and (3) drugs and nutritional products.

³⁸ Appliances and devices include prosthetic devices; colostomy bags and supplies; eyeglasses and conventional contact lenses; leg, arm, back, and neck braces; and artificial legs, arms, and eyes (42 CFR § 410.36).

³⁹ Medicare pays for DME (including ventilators, oxygen equipment, hospital beds, and wheelchairs) if the equipment is used in the beneficiary's home or at an institution that is used as a home (42 CFR § 410.38).

Table 1: Medicare Improperly Paid Suppliers \$83.6 Million for DMEPOS Items Billed Without the GW Modifier⁴⁰

Type of DMEPOS Item	Sample Items	Errors	Payments for Sample Items With Errors	Estimated Improper Payments	Estimated Beneficiary Payments
Durable Medical Equipment	75	50	\$12,339	\$61,423,412	\$15,669,858
Prosthetics and Orthotics	25	8	3,182	18,302,575	4,669,008
Drugs and Nutritional Products	15	9	464	3,833,137	977,842
TOTAL	115	67	\$15,985	\$83,559,124	\$21,316,708

Examples 1 and 2 illustrate improper payments made to suppliers for DMEPOS items provided to hospice beneficiaries to palliate or manage: (1) a beneficiary’s terminal illness, and (2) a condition related to the beneficiary’s terminal illness (i.e., related condition).

Example 1: Improper Payment to a Supplier for a DMEPOS Item Provided to a Hospice Beneficiary To Palliate or Manage the Terminal Illness
<p>A Medicare beneficiary elected hospice care in July 2017. The beneficiary resided at home but was receiving services from a hospice. The beneficiary’s terminal illness was chronic obstructive pulmonary disease (COPD). A supplier had provided to the beneficiary a home ventilator (which is categorized as DME) to treat COPD before the beneficiary entered hospice care. The item was provided on a rental basis, for which Medicare paid the supplier every month.</p> <p>After the beneficiary elected hospice services on July 6, 2017, Medicare continued to pay the supplier on a monthly basis. While the beneficiary was receiving hospice services in October 2017, the supplier billed Medicare Part B without the GW modifier, and Medicare paid the supplier \$708. The hospice reviewed the medical records and provided a clinical assessment that the home ventilator was therapeutic to manage the beneficiary’s COPD and encouraged the beneficiary to use it 4 hours every night. Therefore, the home ventilator palliated or managed the beneficiary’s terminal illness.</p> <p>The supplier stated that when it billed for the home ventilator, it did not know that the beneficiary was receiving hospice services. The supplier also stated that the hospice notified the supplier in February 2018 that the beneficiary was receiving hospice care and agreed to provide payment to the supplier beginning in December 2017. Medicare should not have paid the supplier for the DME provided to the beneficiary during the hospice stay because the item was given to palliate or manage the terminal illness and related conditions. Instead, the item should have been provided under arrangements between the hospice and the supplier.</p>

⁴⁰ The confidence intervals for the total improper payment and beneficiary payment amounts are included in Appendix C. The individual stratum estimates are included to highlight the potential differences between DMEPOS types and are not intended to serve as precise estimates of the underlying frame totals.

Example 2: Improper Payment to a Supplier for DMEPOS Items Provided to a Hospice Beneficiary To Palliate or Manage a Condition Related to the Terminal Illness

A Medicare beneficiary elected hospice care in August 2015. The beneficiary resided at a nursing facility but was receiving services from a hospice. The beneficiary's terminal diagnosis was cerebral infarction (i.e., stroke).

The supplier provided collagen dressings (which are categorized as DME) on December 23, 2015, while the beneficiary was receiving hospice services at a nursing facility. The supplier billed Medicare Part B without the GW modifier, and Medicare paid the supplier \$329 for the items. The hospice reviewed the medical records and provided a clinical assessment that the beneficiary's wounds developed because: (1) the beneficiary was bed-bound and not capable of ambulating (moving or walking around), and (2) there was constant pressure from the beneficiary's bed, which contributed to development of the wounds. Therefore, the collagen dressings palliated or managed a condition related to the terminal illness.

The supplier knew that the beneficiary was under hospice care but improperly determined that the items were not related to the beneficiary's terminal diagnosis and related conditions. Medicare should not have paid the supplier for the DMEPOS items provided to the beneficiary during the hospice stay because they were given to palliate or manage a related condition of the terminal illness. Instead, the items should have been provided under arrangements between the hospice and the supplier.

The Majority of Suppliers Were Unaware That They Had Provided DMEPOS Items to Hospice Beneficiaries

Before a supplier submits a claim, a DME Medicare contractor expects a supplier to have on file a standard written order (from a physician), a Certificate of Medical Necessity (if applicable), information from a treating practitioner concerning the beneficiary's diagnosis, and any information required for the use of specific modifiers. The supplier reviews the eligibility check system to determine whether the beneficiary is receiving hospice care.

For 46 of the 67 errors, the suppliers that provided the DMEPOS items to hospice beneficiaries stated that they were unaware that the beneficiaries were receiving hospice services. For example, the suppliers stated that there was no clear communication between them and the hospices or the beneficiaries, the eligibility check system had not been updated to show that the beneficiaries were receiving hospice care, or there was no Medicare denial of claims. Therefore, the suppliers did not know whether the DMEPOS items were related to the beneficiaries' terminal illnesses and related conditions, and thus they billed for these items without the GW modifier.

CWF Prepayment Edit Process Detected DMEPOS Items, but the DME Medicare Contractors' Method of Manually Comparing DMEPOS Claims' Diagnosis Codes With Hospice Claims' Diagnosis Codes Was Not Effective

Once the CWF has processed a DMEPOS claim for payment, it electronically transmits information to the DME Medicare contractor about any potential errors on the claim. This prepayment edit is applied if a beneficiary's notice of election is processed in the CWF before a DMEPOS claim is processed. In these circumstances, once the claim is processed, the edit notifies the DME Medicare contractor that processed the claim. For DMEPOS claims billed without the GW modifier, the DME Medicare contractor investigates whether the DMEPOS item palliated or managed the terminal illness and related conditions by manually comparing the DMEPOS claim's diagnosis codes with the hospice claim's diagnosis codes or the diagnosis code listed in the election period in CWF, if no hospice claim is present. If the diagnosis codes match, the DMEPOS claim is denied. However, if they do not match, the DMEPOS claim is approved for payment as not related to the beneficiary's terminal illness and related conditions.

For all 67 errors, we compared the DMEPOS claims' diagnosis codes with the hospice claims' diagnosis codes using the same methods that the DME Medicare contractors use. For 46 of the 67 errors, the DMEPOS claims' diagnosis codes and the hospice claims' diagnosis codes did not match. Based on the DME Medicare contractors' method of manual comparison, these claims would not have been denied for payment. However, according to the hospices' clinical assessments, the DMEPOS items palliated or managed the beneficiaries' terminal illnesses and related conditions.

For the remaining 21 errors, the DMEPOS claims' diagnosis codes and the hospice claims' diagnosis codes matched. For 7 of these 21 errors, 1 DME contractor processed and paid for the items based on its method of comparing diagnosis codes. For the remaining 14 errors, another DME contractor stated that payment for the items should have been denied. These items were incorrectly paid for because: (1) the hospice claims' diagnosis codes were not available and the terminal-illness diagnosis information from the notice of election in the CWF had not been transferred to the subsequent hospice benefit periods when the diagnosis codes were compared; or (2) the DME Medicare contractor did not correctly match the diagnosis codes. Therefore, the prepayment edit process through which DMEPOS claims' diagnosis codes were manually compared with hospice claims' diagnosis codes was not an effective method to prevent DMEPOS claims from being improperly paid.

Some DMEPOS Claims Were Processed for Payment Before the Notice of Election Was Processed in the CWF

When a beneficiary elects hospice care, the hospice must complete a notice of election, which generally must be submitted to the hospice Medicare contractor within 5 calendar days of the beginning of the beneficiary's hospice care. The hospice Medicare contractor processes the notice of election in the CWF; however, it may not process the notice of election immediately.

For 4 of the 67 errors, the DMEPOS claims were processed for payment before the notice of election was processed in the CWF.⁴¹ During our audit period, there was no CWF postpayment edit process in place to detect and deny a DMEPOS claim billed without the GW modifier that was processed before the notice of election.

MEDICARE IMPROPERLY PAID SUPPLIERS FOR DMEPOS ITEMS BILLED WITH THE GW MODIFIER

For 85 sampled DMEPOS items billed with the GW modifier, almost two-thirds of these items (54) were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. These items were covered as part of the hospices' per diem payments, and Medicare should not have paid the suppliers. The suppliers inappropriately used the GW modifier to receive payment. The improper payments occurred because: (1) the CWF prepayment edit process was not effective in preventing improper payments for DMEPOS items billed by suppliers with the GW modifier; and (2) the DME Medicare contractors did not conduct targeted probe-and-educate efforts to identify and educate suppliers that routinely use the GW modifier for items related to terminal illnesses and related conditions. Each of these causes is discussed in greater detail below.

Almost Two-Thirds of Sampled DMEPOS Items That Suppliers Billed With the GW Modifier Were Provided To Palliate or Manage Beneficiaries' Terminal Illnesses and Related Conditions

For 54 of 85 sampled DMEPOS items that suppliers billed with the GW modifier, the hospices (for 51 items) and hospice Medicare contractors (for 3 items) stated that these items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers. Medicare pays the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments. These suppliers inappropriately used the GW modifier when they billed Medicare, indicating that the DMEPOS items were not related to the beneficiaries' terminal illnesses and related conditions. On the basis of our sample results, we estimated that Medicare could have saved \$33.3 million for items billed with the GW modifier and beneficiaries could have saved \$8.5 million in deductibles and coinsurance that may have been incorrectly collected from them or someone on their behalf. (See Table 2 on the following page.)

⁴¹ For two of the four errors, the diagnosis codes for the DMEPOS and hospice claims matched; for the other two errors, the diagnosis codes did not match (as described in the previous section).

Table 2: Medicare Improperly Paid Suppliers \$33.3 Million for DMEPOS Items Billed With the GW Modifier⁴²

Type of DMEPOS Item	Sample Items	Errors	Payments for Sample Items With Errors	Estimated Improper Payments	Estimated Beneficiary Payments
Durable Medical Equipment	65	42	\$17,404	\$30,460,853	\$7,770,614
Drugs and Nutritional Products	10	9	1,631	2,622,999	669,129
Prosthetics and Orthotics	10	3	61	261,046	66,560
TOTAL	85	54	\$19,096	\$33,344,898	\$8,506,303

Example 3 illustrates improper payments made to a supplier for DMEPOS items provided to a hospice beneficiary to palliate or manage the beneficiary’s condition related to the beneficiary’s terminal illness (i.e., a related condition). The supplier billed the claim with the GW modifier, indicating that the items were not related to the beneficiary’s terminal illness and related conditions.

Example 3: Improper Payment of a Supplier for a DMEPOS Item Provided to a Hospice Beneficiary To Palliate or Manage a Condition Related to the Terminal Illness
<p>A Medicare beneficiary elected hospice care in February 2018. The beneficiary resided at a nursing facility but was receiving services from a hospice. The beneficiary’s terminal illness was congestive heart failure (CHF). A supplier provided to the beneficiary nutritional products on April 9, 2018, while the beneficiary was under hospice care. The supplier billed the nutritional products with the GW modifier, and Medicare paid the supplier \$268.</p> <p>The hospice reviewed the medical records and provided a clinical assessment that found that the nutritional products were necessary for the palliation and management of the terminal illness and related conditions. The hospice stated that because the beneficiary had difficulty ingesting food, supplemental feeding was the only way the beneficiary was able to eat. Moreover, the hospice stated that nutritional products are a necessary “supply” for its beneficiaries. Therefore, the nutritional products palliated or managed a condition related to the terminal illness.</p> <p>The supplier informed us that the nutritional products were given to treat the beneficiary’s dysphagia (difficulty or discomfort in swallowing) and pneumonitis (inflammation of the lungs) and, therefore, were not related to the beneficiary’s terminal illness. The supplier analyzed only whether the nutritional products treated the beneficiary’s CHF and did not determine whether the items treated a condition that was related to CHF. Medicare should not have paid the supplier for the nutritional products provided to the beneficiary during the hospice stay because the items were given to palliate or manage a condition related to the terminal illness. Instead, the item should have been provided under arrangements between the hospice and the supplier.</p>

⁴² The confidence intervals for the total improper payment and beneficiary payment amounts are included in Appendix D. The individual stratum estimates are included to highlight the potential differences between DMEPOS types and are not intended to serve as precise estimates of the underlying frame totals.

CWF Prepayment Edit Process Was Not Effective in Preventing Improper Payments for DMEPOS Items Billed by Suppliers With the GW Modifier

Once the CWF has processed a DMEPOS claim for payment, the CWF electronically transmits information to the DME Medicare contractor about any potential errors on the claim. This prepayment edit is applied if a beneficiary's notice of election is processed in the CWF before a DMEPOS claim is processed. In these circumstances, once the claim is processed, the edit notifies the DME Medicare contractor that processed the claim. If the claim has the GW modifier, the DME Medicare contractor automatically processes the claim for payment. The DME Medicare contractor does not investigate whether the DMEPOS item is related or unrelated to the beneficiary's terminal illness and related conditions by manually comparing the DMEPOS claim's diagnosis codes with the hospice claim's diagnosis codes.

For the 54 errors, the hospices and hospice Medicare contractors stated that the DMEPOS items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. Medicare should not have paid the suppliers for these items; instead, these items were covered as part of the hospices' per diem payments. Had the CWF edit been designed to notify the DME Medicare contractor to investigate whether the DMEPOS item billed with the GW modifier was related or unrelated to the terminal illness and related conditions, the suppliers would not have been paid for the items.

There Were No Targeted Probe-and-Educate Efforts To Identify and Educate Suppliers That Routinely Use the GW Modifier for Items Related to Terminal Illnesses and Related Conditions

The responsibilities of the two DME Medicare contractors include educating suppliers on Medicare requirements and billing procedures through CMS's Targeted Probe and Educate program, in which a DME Medicare contractor works with a supplier to identify errors and correct them. To identify these suppliers, the DME Medicare contractors analyze Medicare claims data to identify suppliers that have high claim error rates or unusual billing practices. In addition, the Claims Manual states that, if it is warranted, DME Medicare contractors may conduct prepayment or postpayment reviews to validate whether items billed with the GW modifier are related to the beneficiary's terminal illness (chapter 11, § 50). During our audit period, the DME Medicare contractors did not conduct targeted probe-and-educate efforts or any prepayment or postpayment reviews related to appropriate usage of the GW modifier by suppliers that provided DMEPOS items to hospice beneficiaries. In addition, to determine whether an item is related or unrelated to the terminal illness and related conditions, assistance from the hospice Medicare contractors would be needed.

CONCLUSION

On the basis of our sample results, we estimated that for our audit period Medicare could have saved \$116.9 million in improper payments to suppliers for DMEPOS items that palliated or managed the beneficiaries' terminal illnesses and related conditions. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers. Medicare pays the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments. In addition, we estimated that beneficiaries could have saved \$29.8 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

For DMEPOS items that suppliers billed without the GW modifier, most of the suppliers were not aware that the beneficiaries were under hospice care when the items were provided. As a result, the suppliers could not determine whether an item was given to palliate or manage the terminal illness and related conditions. In addition, the CWF prepayment edit process in which a DME Medicare contractor manually compared a DMEPOS claim's diagnosis codes with the hospice claim's diagnosis codes was not effective in preventing improper payments of DMEPOS claims. Moreover, there was no CWF postpayment edit process in place to detect and deny a DMEPOS claim that was processed before the notice of election was processed.

For DMEPOS items that suppliers billed with the GW modifier, most of the suppliers inappropriately used the GW modifier. Had the prepayment edit process been designed to detect claims with the GW modifier, these payments might not have been made to the suppliers. Moreover, during our audit period, the DME Medicare contractors had not provided supplier education, either on a prepayment or postpayment basis, on the appropriate use of the GW modifier.

Without effective CWF prepayment and postpayment edit processes, and prepayment and postpayment medical reviews of supplier claims for DMEPOS items, there is a risk that Medicare will improperly pay for these items and that beneficiaries will be inappropriately held responsible for unnecessary deductibles and coinsurance amounts.

For the sampled items for which hospices stated that these items palliated or managed a condition not related to the terminal illness and related conditions, the majority were for items that beneficiaries receive under hospice care, such as inhalation drugs, enteral formula, oxygen, wheelchairs, beds, and various types of wound care items. Therefore, CMS should perform an analysis of palliative items and services not related to the terminal illnesses and related conditions billed by nonhospice providers to determine whether these items and services should have been provided directly by the hospices or under arrangements between the hospices and the nonhospice providers.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services take the following actions for supplier claims for DMEPOS items provided to hospice beneficiaries, which could have saved Medicare an estimated \$116.9 million in improper payments and could have saved beneficiaries an estimated \$29.8 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf during our audit period:

- Improve the CWF prepayment edit process by instructing the DME Medicare contractors to deny DMEPOS claims submitted by suppliers without the GW modifier for DMEPOS items provided to hospice beneficiaries.
- Implement a postpayment edit process to detect claims submitted by suppliers processed before a beneficiary's notice of election of hospice care is processed in the CWF, and instruct the DME Medicare contractors to deny DMEPOS claims identified by the edit process if they do not have the GW modifier.
- Direct the DME and hospice Medicare contractors, or other contractors as appropriate, to: (1) conduct prepayment or postpayment reviews of supplier claims for DMEPOS items provided to hospice beneficiaries and billed with the GW modifier, and (2) analyze Medicare claims data to probe and educate suppliers that use the GW modifier inappropriately.
- Study the feasibility of including palliative items and services not related to a beneficiary's terminal illness and related conditions within the hospice per diem. Such a requirement would eliminate the need for Medicare to make additional payments for these services consistent with CMS's longstanding position that payments for services unrelated to a beneficiary's terminal illness and related conditions should be exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit. In analyzing the feasibility of such a change, CMS could consider: (1) beneficiary access to care, (2) administrative costs, (3) appropriate adjustments to the per diem rates to reflect the higher costs associated with providing hospice services, and (4) possible improvement of coordination of care.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first and third recommendations and provided information on actions that it had taken to address these recommendations. However, CMS did not concur with our second and fourth recommendations.

Regarding our first recommendation, CMS stated that, upon further review, it was determined that the issue of DME Medicare contractors not denying DMEPOS claims submitted by suppliers

without the GW modifier was, in part, related to the maximum number of allowable modifiers permitted on a claim. CMS stated that it had updated the Claims Manual with specific instructions for DME Medicare contractors to address this issue, with an implementation date of December 1, 2020.⁴³

Regarding our third recommendation, CMS stated that it had modified the hospice election statement content requirements for hospice elections beginning on or after October 1, 2020. CMS stated that these changes—particularly the addendum listing the items, services, and drugs not covered by hospices—should hold hospices accountable to their beneficiaries through benefit coverage transparency, which should reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to the terminal illness. CMS stated that providers and suppliers should not append the GW modifier unless they have evidence that the item or service is not related to the terminal illness. CMS also stated that it will continue to encourage the DME Medicare contractors to perform data analysis and risk assessments of claims, including those with the GW modifier.⁴⁴

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix E.

After reviewing CMS's comments, we maintain that our second recommendation is valid, but we revised our fourth recommendation. Our responses to CMS's specific comments on our second and fourth recommendations are described in the sections below.

SECOND RECOMMENDATION

CMS Comments

CMS did not concur with our second recommendation (i.e., to implement a postpayment edit process). CMS stated that before the hospice election is received by Medicare systems, a supplier that checked Medicare eligibility records would have no indication of a need to submit claims with the GW modifier. CMS stated that the Recovery Audit Contractors were approved to begin reviewing DMEPOS claims billed after the admission date and before the discharge date of a hospice election beginning in October 2018. CMS also stated that, as part of this strategy, it recovers overpayments in accordance with agency policies and procedures.

Office of Inspector General Response

After considering CMS's comments, we continue to recommend that CMS implement a postpayment edit process and instruct the DME Medicare contractors to deny DMEPOS claims identified by the edit process if they do not have the GW modifier because: (1) CMS

⁴³ Claims Manual, chapter 11, § 40.2 (Dec. 1, 2020). We have not yet validated the effectiveness of this change.

⁴⁴ We have not yet validated the effectiveness of this change.

implemented a similar postpayment edit process to detect Medicare Part B physician claims processed before the notice of election is processed in the CWF; (2) a postpayment edit process would notify the DME Medicare contractor to deny DMEPOS claims billed without the GW modifier and would give a supplier an opportunity to investigate and determine whether an item is related or unrelated to the beneficiary's terminal illness and related conditions; and (3) given the volume of claims that would need to be manually reviewed, implementing an automatic postpayment edit process in the CWF would lead to timely review of claims and recovery of improper payments.

FOURTH RECOMMENDATION

CMS Comments

CMS did not concur with our fourth recommendation as it was written in our draft report. CMS stated that hospice care is a comprehensive, holistic approach to palliative care for the relief of pain and for symptom management. CMS reiterated that effective October 1, 2020, after the OIG audit period, CMS implemented a policy for patient notification of hospice noncovered items, services, and drugs. CMS stated that these changes should hold hospices accountable to their beneficiaries through benefit coverage transparency, which should reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to the terminal illness.

Office of Inspector General Response

After considering CMS's comments, we revised our fourth recommendation. We recommend that CMS study the feasibility of including palliative items and services not related to a beneficiary's terminal illness and related conditions within the hospice per diem. Two prior OIG reports ([A-06-17-08004](#) and [OEI-02-16-00570](#)) recommended that CMS: (1) work directly with hospices to ensure that they are providing drugs covered under the hospice benefit, and (2) develop and execute a strategy to ensure that Medicare Part D does not pay for drugs that should be covered by the Part A hospice benefit. This report and the two prior OIG reports indicate that there is potential inappropriate "unbundling" of items and services from the hospice benefit.

A requirement to include palliative items and services not related to the beneficiary's terminal illness and related conditions within the hospice per diem may promote better coordination of care by making the hospice responsible for the provision and coordination of these items and services. In addition, this requirement would reduce inconsistent clinical opinions between hospice and nonhospice providers (or suppliers) on whether items, services, or drugs are related or unrelated to a beneficiary's terminal illness and related conditions. Finally, such a requirement would reduce the burden on a hospice beneficiary (or his or her representatives) to seek interpretation of the CMS policy addendum or to seek assistance from a Beneficiary and Family Centered Care Quality Improvement Organization, which is authorized to provide such interpretations if there are disagreements with the hospice's determinations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nationwide audit covered \$185,742,888 in Medicare Part B payments for 1,566,794 DMEPOS items provided to beneficiaries while they were receiving hospice services from January 1, 2015, through April 30, 2019. To identify these DMEPOS items, we first identified hospice claims with dates of service during our audit period. We then used the beneficiary information and service dates from those claims to identify DMEPOS items that had service dates within the hospice claims' dates of service, including the first and last days of a beneficiary's hospice services. We excluded DMEPOS items with payment amounts of less than \$10.

We selected 2 stratified samples consisting of 200 DMEPOS line items from claims, totaling \$64,293, for 200 beneficiaries. One stratified sample, totaling 115 line items, was for DMEPOS items billed by suppliers without the GW modifier. The other stratified sample, totaling 85 line items, was for DMEPOS items billed by suppliers with the GW modifier. For each of these samples, we contacted the hospices that provided care to the beneficiaries who received the DMEPOS items to have them assess whether the items were provided to palliate or manage the terminal illnesses and related conditions, and we analyzed their responses. We also requested from the supplier the medical records for each sampled DMEPOS item and requested an assessment of whether: (1) the supplier was aware that the beneficiary was under hospice care, and (2) the item palliated or managed the beneficiary's terminal illness and related conditions.

We focused only on Medicare Part B payments to suppliers for DMEPOS items that were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. We did not use medical reviews to determine whether the hospices' Medicare Part A services were medically necessary.

We did not perform an overall assessment of the internal control structures of CMS or its DME or hospice Medicare contractors. Rather, we limited our review to those internal controls (i.e., program safeguards) related to Medicare reimbursement requirements. We reviewed the design and implementation of four of the five components of internal controls: control environment, risk assessments, control activities, and information and communication.

To determine the effectiveness of internal controls, we interviewed CMS officials to obtain an understanding of the CWF edit process. In addition, we reviewed the policies and procedures governing the processing and payment of Medicare Part B claims billed with and without the GW modifier for DMEPOS items provided to beneficiaries receiving hospice care. As part of that review, we interviewed hospice officials and DME Medicare contractors to ensure our understanding of their policies and procedures. Furthermore, we interviewed and obtained written responses from hospices and suppliers to understand their processes for billing for DMEPOS items provided to hospice beneficiaries. Lastly, we analyzed the claims data for our

audit period to determine the potential impact of the weaknesses we identified in the processes for preventing and detecting improper Part B payments for DMEPOS items.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit from January 2020 through March 2021, which included contacting CMS in Baltimore, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- used CMS's NCH file to identify Medicare Part A hospice claims with dates of service during our audit period;
- used CMS's NCH file to identify Medicare Part B DMEPOS claims that had service dates within the hospices' dates of service, including the first and last day of each beneficiary's hospice services;
- excluded DMEPOS items with payment amounts of less than \$10;
- selected a stratified random sample of 115 DMEPOS items billed without the GW modifier and a stratified random sample of 85 DMEPOS items billed with the GW modifier (Appendix B);
- reviewed available data from CMS's CWF for the 200 sampled DMEPOS items to determine whether the claims had been canceled or adjusted;
- interviewed CMS officials and reviewed documentation they provided to understand how the CWF prepayment edit process works;
- requested that the hospices that provided care to the beneficiaries associated with the 200 sampled DMEPOS items assess whether the items provided to beneficiaries palliated or managed the beneficiaries' terminal illnesses and related conditions;
- for situations in which we did not receive a hospice assessment but received only medical records, furnished those records to the applicable hospice Medicare contractor to assess whether the DMEPOS items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions;

- estimated the amount that Medicare could have saved by not paying suppliers for DMEPOS items provided to hospice beneficiaries that palliated or managed the terminal illnesses and related conditions (Appendices C and D);
- estimated the amount that beneficiaries could have saved in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf (Appendices C and D); and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We created two sampling frames for line items provided to hospice beneficiaries during our audit period. The first sampling frame comprised 1,318,389 DMEPOS line items billed without the GW modifier for which suppliers received Medicare payments of \$134,696,639. The second sampling frame comprised 248,405 DMEPOS line items billed with the GW modifier for which suppliers received Medicare payments of \$51,046,249. Both sampling frames excluded line items with payment amounts of less than \$10.

SAMPLE UNIT

The sample unit was a DMEPOS line item.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. To accomplish this, we separated the sampling frame for line items billed without the GW modifier into six strata (Table 3) and for line items billed with the GW modifier into four strata (Table 4).

Table 3: Strata for Line Items Billed Without the GW Modifier

Stratum	DMEPOS Category	No. of DMEPOS Line Items	Total Payments	Sample Size
1	Drugs and nutritional products	123,788	\$14,698,084	15
2	Durable medical equipment (\$10 to \$27.53)	386,536	6,406,357	15
3	Durable medical equipment (\$27.54 to \$61.53)	348,592	15,106,365	15
4	Durable medical equipment (\$61.54 to \$311)	254,737	30,592,133	20
5	Durable medical equipment (more than \$311)	60,922	46,100,885	25
6	Prosthetics and orthotics	143,814	21,792,815	25
Total		1,318,389	\$134,696,639	115

Table 4: Strata for Line Items Billed With the GW Modifier

Stratum	DMEPOS Category	No. of DMEPOS Line Items	Total Payments	Sample Size
1	Drugs and nutritional products	16,086	\$2,024,998	10
2	Durable medical equipment (\$10 to \$311.52)	148,917	14,970,913	35
3	Durable medical equipment (more than \$311.52)	40,817	30,571,717	30
4	Prosthetics and orthotics	42,585	3,478,621	10
Total		248,405	\$51,046,249	85

SOURCE OF RANDOM NUMBERS

The source of the random numbers for our sample was the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the items in each stratum of each sampling frame. We then generated the random numbers for our samples according to our sample design, and we selected the corresponding items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to separately estimate the amounts that Medicare improperly paid suppliers for DMEPOS items billed without and with the GW modifier. We similarly estimated the amounts of deductibles and coinsurance that may be incorrectly collected from beneficiaries or someone on their behalf for DMEPOS items billed without and with the GW modifier. These estimates apply only to items listed in our sampling frames.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES
FOR DMEPOS ITEMS BILLED WITHOUT THE GW MODIFIER**

Table 5: Sample Results⁴⁵

Stratum	No. of DMEPOS Line Items in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Incorrectly Billed Line Items	Value of Improper Payments in Sample
1	123,788	14,698,084	15	\$2,662	9	\$464
2	386,536	6,406,357	15	256	9	153
3	348,592	15,106,365	15	606	11	436
4	254,737	30,592,133	20	2,455	14	1,817
5	60,922	46,100,885	25	15,260	16	9,933
6	143,814	21,792,815	25	6,574	8	3,182
Total	1,318,389	\$134,696,639	115	\$27,813	67	\$15,985

**Table 6: Estimated Improper Payments for Items Billed Without the GW Modifier
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$83,559,124
Lower limit	52,734,162
Upper limit	114,384,086

**Table 7: Estimated Improper Beneficiary Payments (Deductibles and Coinsurance)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$21,316,708
Lower limit	13,453,201
Upper limit	29,180,215

⁴⁵ The weighted error rate for this frame was 63 percent. The unweighted error rate for items billed without the GW modifier was 58 percent (67 of 115 items). Given the similarity between the weighted and unweighted percentage error rates, we refer to the unweighted sample results throughout this report.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES
FOR DMEPOS ITEMS BILLED WITH THE GW MODIFIER**

Table 8: Sample Results⁴⁶

Stratum	No. of DMEPOS Line Items in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Incorrectly Billed Line Items	Value of Improper Payments in Sample
1	16,086	2,024,998	10	\$1,750	9	\$1,631
2	148,917	14,970,913	35	3,076	24	2,343
3	40,817	30,571,717	30	31,242	18	15,061
4	42,585	3,478,621	10	412	3	61
Total	248,405	\$51,046,249	85	\$36,480	54	\$19,096

**Table 9: Estimated Improper Payments for Items Billed With the GW Modifier
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$33,344,898
Lower limit	23,825,878
Upper limit	42,863,919

**Table 10: Estimated Improper Beneficiary Payments (Deductibles and Coinsurance)
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$8,506,303
Lower limit	6,077,987
Upper limit	10,934,620

⁴⁶ The weighted error rate for this frame was 62 percent. The unweighted error rate for items billed with the GW modifier was 63 percent (54 of 85 items). Given the similarity between the weighted and unweighted percentage error rates, we refer to the unweighted sample results throughout this report.

APPENDIX E: CMS COMMENTS



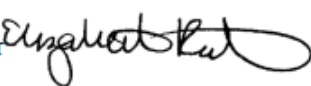
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: May 7, 2021

TO: Christi Grimm
Principal Deputy Inspector General

FROM: Elizabeth Richter
Acting Administrator 

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Suppliers an Estimated \$117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries (A-09-20-03026)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to high quality hospice care while protecting taxpayer and beneficiary dollars by preventing improper payments. CMS has made significant changes in hospice payment policy in recent years to better align payments with the cost of care and to provide beneficiaries with more transparency about what items and services are the responsibility of the hospice to provide versus those that the hospice has determined are unrelated to the palliation and management of the beneficiary's terminal condition.

CMS has also focused on the integrity of the hospice benefit and strengthened its monitoring of hospice claims to reduce improper payments. CMS has initiated prepayment medical review, including targeted probe and educate reviews, of hospice services from certain providers. Further, CMS has taken action to reduce and prevent Medicare improper payments for items and services unrelated to the terminal condition of the beneficiary (i.e., the beneficiary's terminal illness and related conditions) that are paid separate from the hospice service. For example, CMS's Recovery Audit Contractors were approved to begin reviewing durable medical equipment billed after the admission date and before the discharge date of a hospice election in October 2018.¹ As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Hospices are required to educate each patient and their primary caregiver(s) on the palliative versus curative nature of the Medicare hospice benefit and outline the services needed for the palliation and management of the patient's terminal illness and related conditions on the plan of care and document the patient's or representatives' level of understanding, involvement, and agreement with the plan of care. To promote greater transparency regarding coverage under the

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics-Items/0114-DME-while-in-Hospice>

Medicare hospice benefit and potentially reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to their terminal illness, CMS modified the hospice election statement content requirements in the FY 2020 Hospice Payment Rate Update and Final Rule (CMS-1714-F).² Effective for hospice elections beginning on or after October 1, 2020, the hospice election statement must include, among other requirements, information about the holistic, comprehensive nature of the Medicare hospice benefit, as well as a statement that, although it would be rare, there could be some necessary items, drugs, or services that would not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.

Also for hospice elections beginning on or after October 1, 2020, hospices would be required, upon request, to provide the beneficiary (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors an addendum to the hospice election statement with a written list and rationale for any conditions, items, services, or drugs that the hospice has determined are unrelated to the individual's terminal illness and related conditions. The election statement addendum must include, among other requirements, a list of the individual's conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions. It must also include a written clinical explanation as to why they identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. CMS believes this is necessary information for patients and their families to make informed care decisions and to anticipate any financial liability associated with needed items, services, and drugs not provided under the Medicare hospice benefit.

Additionally, CMS has taken action to educate health care providers on proper billing hospice services, as well as for durable medical equipment, prosthetics, orthotics, and supplies.^{3, 4} CMS has also taken steps to educate health care providers regarding the recent changes to the hospice election statement and addendum. For example, CMS published a Medicare Learning Network article regarding the manual updates related to the hospice election statement and the implementation of the election statement addendum and released a hospice election statement example.⁵

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services improve the CWF prepayment edit process by instructing the DME Medicare contractors to deny DMEPOS claims submitted by suppliers without the GW modifier for DMEPOS items provided to hospice beneficiaries.

² <https://www.govinfo.gov/content/pkg/FR-2019-08-06/pdf/2019-16583.pdf>

³ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice_pay_svs_fs.pdf

⁴ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedDMEPOSInpatient-MLN1541573.pdf>

⁵ <https://www.cms.gov/files/document/mm12015.pdf>; <https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf>

CMS Response

CMS concurs with this recommendation. Upon further review, it was determined that this issue was, in part, related to the maximum number of allowable modifiers permitted on a claim. As a result, CMS updated Chapter 11, Section 40.2 of the Medicare Claims Processing Manual with specific instructions for DME Medicare contractors to address this issue. The implementation date for this change was December 1, 2020.⁶

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services implement a postpayment edit process to detect claims submitted by suppliers processed before a beneficiary's notice of election of hospice care is processed in the CWF, and instruct the DME Medicare contractors to deny DMEPOS claims identified by the edit process if they do not have the GW modifier.

CMS Response

CMS does not concur with this recommendation. Before the hospice election is received by Medicare systems, a supplier who did due diligence by checking Medicare eligibility records would have no indication of a need to submit claims with the GW modifier. As noted above, Recovery Audit Contractors were approved to begin reviewing durable medical equipment billed after the admit date and before the discharge date of a hospice election beginning in October 2018. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the DME and hospice Medicare contractors, or other contractors as appropriate, to conduct prepayment or postpayment reviews of supplier claims for DMEPOS items provided to hospice beneficiaries and billed with the GW modifier and analyze Medicare claims data to probe and educate suppliers that use the GW modifier inappropriately.

CMS Response

CMS concurs with the recommendation. As stated above, CMS modified the hospice election statement content requirements for hospice elections beginning on or after October 1, 2020. These changes, particularly the addition of the addendum listing the items, services, and drugs not covered by the hospice should hold the hospices accountable to their beneficiaries through benefit coverage transparency, which should reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to their terminal illness. Providers and suppliers should not append the GW modifier unless they have evidence that the item or service is not related to the terminal illness, such as if it is indicated as such on the newly implemented addendum.

CMS will continue to encourage the DME Medicare Administrative Contractors to perform data analysis and risk assessments of claims, including those with the GW modifier, as part of the annual improper payment reduction strategy process and to continue to take any action deemed necessary.

⁶ <https://www.cms.gov/files/document/r10485cp.pdf>, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf>

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services study the feasibility of including selected curative services within the hospice per diem. Such a requirement would eliminate the need for Medicare to make additional payments for these services consistent with CMS's longstanding position that payments for services unrelated to beneficiary's terminal illness and related conditions should be exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit. In analyzing the feasibility of such a change, CMS could consider: (1) beneficiary access to care, (2) administrative costs, (3) appropriate adjustments to the per diem rates to reflect the high costs associated with providing hospice services, and (4) possible improvement of coordination of care. Implementing such a change would necessitate CMS seeking legislative authority as necessary and would prevent the types of improper Medicare payments identified in this report. Including curative services within the hospice per diem could also create incentives for hospices to operate more efficiently.

CMS Response

CMS does not concur with this recommendation. Hospice care is a comprehensive, holistic approach to palliative care for the relief of pain and symptom management. As indicated by the OIG, this change would require additional legislative authority and would substantially change the meaning and scope of the hospice benefit.

In addition, as noted above, effective October 1, 2020, after the OIG audit period, CMS implemented a policy for patient notification of hospice non-covered items, services, and drugs. These changes, particularly the addition of the addendum listing the items, services, and drugs not covered by the hospice should hold the hospices accountable to their beneficiaries through benefit coverage transparency, which should reduce the need for beneficiaries to seek care outside of the hospice benefit for services related to their terminal illness. Providers and suppliers should not append the GW modifier unless they have evidence that the item or service is not related to the terminal illness, such as if it is indicated as such on the newly implemented addendum.