Review of Cost and Fraud Controls and Allowances for Home Oxygen in the Federal Black Lung Program

U.S. Department of Labor
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Office of Analysis, Complaints and Evaluations

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Executive Summary

This report on medical expenditures in the Department of Labor's (DOL) Black Lung Program was initiated based on investigations by the OIG's Office of Investigations (OI) revealing fraudulent billing against the Black Lung Program in the areas of home oxygen and arterial blood gas testing. Beyond fraud issues, our review focused on concerns expressed by our criminal investigators that medical providers legally bill the Black Lung Program for home oxygen in amounts beyond what are reasonable, customary, or medically necessary. In examining both fraud and cost issues, we conducted best practice analyses of other federal programs whose claimants have comparable requirements for supplemental oxygen.

Findings

The agency which administers the Black Lung Program, the Division of Coal Mine Workers' Compensation (DCMWC), may be vulnerable to fraud and excessive billing. Additional controls may be needed to control costs and reduce fraud vulnerability by medical providers. In addition, DCMWC's automatic payment allowances for gaseous oxygen need to be reduced to both control excessive oxygen payments, and reduce incentives for providers to engage in fraudulent behavior.

The Health Care Financing Administration (HCFA) and the Veterans Administration (VA) have implemented reforms and adopted controls to contain medical fraud and medical costs in the areas of home oxygen. HCFA has cut home oxygen rates by 30% over the last two years by determining what are reasonable and customary charges. For example, HCFA allows providers to charge a maximum of $228.80 per month for the rental of oxygen concentrators (this includes claimant co-payment and all related supplies). HCFA further adjusts payment ceilings by geographic area so they pay providers in some states even less than the national average. In contrast, DCMWC permits up to $409.82 for monthly concentrator rentals regardless of geographic location, and allows a $75.00 per item charge for supplies.

HCFA is also currently engaged in a demonstration project in South Florida to examine whether they can further reduce home oxygen costs without jeopardizing claimant service. This project requires oxygen providers to bid competitively for oxygen contracts - awarding the contract to the bidder with a reasonably low bid combined with a positive claimant service record.

This competitive bidding demonstration project is similar to the VA system of competitive oxygen procurement for its oxygen patients. VA engages in competitive bidding with accredited providers in all aspects of its oxygen delivery system, including the purchase of oxygen concentrators in some cases. Competitive bidding keeps VA's maximum allowable oxygen costs significantly lower than those of the Black Lung Program. For example, in its procurement region comprising West Virginia, Tennessee, and Kentucky, VA pays $69.22 per month for oxygen concentrators (including all supplies and servicing) compared to the maximum $409.82 plus the $75.00 per item supply charge allowed by the Black Lung Program. Although VA has inherent advantages over both HCFA and DCMWC in controlling oxygen costs because it runs its own medical centers, other federal agencies can "piggyback" on VA contracts to

lower their own oxygen costs.

Recommendations

We are recommending that DCMWC review the controls and ceilings within its bill payment system for both medical procedures and supplemental oxygen to determine if additional controls are necessary to control costs and reduce fraud vulnerability. In particular, we recommend that the controls related to one specific medical procedure, arterial blood gas (ABG) testing, be reviewed and strengthened.

In addition, DCMWC should restructure its oxygen reimbursement methods and policies to control the maximum allowances for home oxygen. Our analysis, which focused on the comparability of HCFA and VA approaches to the Black Lung Program, does not indicate serious impediments to DCMWC adopting HCFA reforms, VA procurement policies, or a hybrid approach combining characteristics of both agencies. Therefore, we are recommending that DCMWC review each of these alternatives and determine which, if any, would be most helpful in reducing potentially excessive home oxygen costs and fraud.

Agency Response and OIG Conclusion

The agency's response to the OIG's draft final report agrees that Black Lung Program "medical bills, including those for home oxygen, must be carefully reviewed and costs controlled." The response also points out several steps which have already been taken by DCMWC to address the issues raised in our draft report.

However, the OIG does not believe that the agency has adequately addressed nor responded to some of the most important issues raised in the draft report. Specifically, the agency did not establish that there are impediments to the adoption of HCFA reforms and/or VA procurement practices for the procurement of home oxygen. Although some of our recommendations have been resolved, several very important recommendations remain unresolved. The agency's complete response can be found in Appendix F.

I. Purpose, Background and Methodology

This review examines cost and fraud controls and allowances for home oxygen within the federal Black Lung Program.

The Black Lung Program, established by the Federal Coal Mine Health and Safety Act of 1969, provides medical benefits to coal miners disabled by pneumoconiosis (black lung). The U.S. DOL's Division of Coal Mine Workers' Compensation (DCMWC) administers the Black Lung Program. DCMWC is a component of the Office of Workers' Compensation Programs (OWCP).

From 1997 through the present, the OIG's Office of Investigations (OI) has investigated cases of fraud by medical providers against the Black Lung Program. These investigations have revealed fraudulent billing against the Black Lung Program in the areas of arterial blood gas testing and home oxygen. Beyond fraud issues, OI investigators have been concerned that medical providers are legally billing the Black Lung Program in amounts far beyond what should be considered reasonable, customary, or medically necessary. OI referred its fraud and cost concerns to the OIG's Office of Analysis, Complaints, and Evaluations (OACE) for further analysis.

OACE representatives met with senior DCMWC officials on February 1, 1999 to explore the need for greater cost controls, and to solicit ideas from these officials as to what new policies or procedures might be useful. At this meeting, DCMWC officials did not indicate that any new or additional agency actions were under consideration to reduce possible vulnerability to fraud or to control oxygen costs. During a subsequent meeting, we were informed that DCMWC planned to implement a new bill payment computer system in 2000. However, no new controls to control costs or detect the type of fraud investigated by OI were mentioned during this meeting. Following these meetings, OACE proceeded with its analysis of the information referred to it by OI.

We reviewed the program and payment practices of DCMWC in the areas of medical procedures and home oxygen. Our review of relevant literature led us to compare and contrast the Black Lung Program with HCFA and VA, whose claimants have comparable requirements for supplemental oxygen, yet pay considerably lower prices. We also analyzed the suitability of HCFA and VA methods to the Black Lung Program. Our analysis of suitability included concerns highlighted during our review regarding patient choice; perceived problems with servicing Black Lung claimants in remote locations; potential harm to small businesses due to reduced profit margins and; clinical differences among claimants.

We conducted our review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

II. Additional Controls are Needed to Control Costs and Reduce Fraud Vulnerability for Arterial Blood Gas Testing

The Black Lung Program has been defrauded in recent years in the area of diagnostic medical procedures involving arterial blood gas (ABG) testing. Automatic controls limiting the number of times providers are automatically paid when performing ABG procedures may detect and prevent such fraudulent billing, and may also prevent unintentional over-billing. A recent case investigated by OI illustrates the vulnerability of the Black Lung program to fraud in the area of ABG procedures.

A. Fraud Case: Paul David Adkins and Mountain Respiratory Therapy

From April 1995 through January 1999, Paul David Adkins, via his company, Mountain Respiratory Therapy, defrauded the federal Black Lung Program for more than $800,000. Adkins illegally obtained the names and social security numbers of Black Lung claimants, and then billed DCMWC for diagnostic and respiratory services which were never provided. He submitted thousands of bills for 40 claimants, involving the following CPT (Physicians Current Procedural Terminology) codes:

82803 - Arterial Blood Gas Test (ABG)
36600 - Puncture for ABG
94060 - Respiratory Therapy

The ABG procedures referenced above measure the level of oxygen in the blood, and are used for diagnostic purposes (generally to establish claimant eligibility for medical benefits). ABG tests are normally not conducted frequently per claimant. Despite their diagnostic nature, Adkins billed DCMWC repeatedly per claimant for tests which were never conducted. DCMWC routinely paid many of the fraudulent bills submitted by Adkins. Payment occurred because, despite the non-routine frequency of these tests, no limit was placed by DCMWC on the number of ABG tests billable per claimant by a provider. Adkins submitted more than 10,000 bills, receiving $872,824 in fraudulent payments from DCMWC.

Adkins' scheme would have gone undetected if not for his spending habits, which were observed by a former Lieutenant with the West Virginia State Police, who questioned why many of Adkins' friends were driving new vehicles they could not afford. While Adkins was defrauding the federal Black Lung Program, he also defrauded the West Virginia State Workers' Compensation fund for Black Lung victims in the amount of $750,000. West Virginia's bill payment system had numerous controls designed to detect the kind of fraudulent schemes engaged in by Adkins. Unfortunately, program administrators had suspended these controls. Adkins was charged criminally with violations of federal wire fraud and money laundering statutes and civilly with violations of the False Claims Act. He entered a plea of guilty with respect to the criminal charges in May, 1999, and was sentenced to five years and three months in prison in August, 1999.

B. Recommendations: DCMWC Should Limit the Number of Automatic Payments for ABG Testing and Similar Medical Procedures

The Adkins case was uncovered largely by accident, and it is possible that similar fraud by other unscrupulous providers could go undetected. Because other medical procedures may be vulnerable to the same type of fraud perpetrated by Adkins via ABG tests, DCMWC should examine the medical procedures authorized by their program to fully define which procedures would not normally be medically indicated on numerous, or even multiple, occasions. Specifically, we are recommending the following actions:

1. We recommend that DCMWC review the automated and other system controls within its bill payment system for all medical procedures, including office visits, to determine if additional controls are necessary to control costs and reduce fraud vulnerability. Medical procedures which are rarely or infrequently conducted, such as ABG testing, should be automatically rejected by DCMWC bill payment system when billed on multiple occasions by a provider. For example, DCMWC could have its system programed so that if a provider bills for an ABG twice in the same month the second bill would be automatically rejected and claims examiners would flag the bill for scrutiny before payment. Such follow-up need not be time consuming, and can be accomplished via a survey or a phone call to a patient by the claims examiner asking if the claimant has utilized the services billed. We also recommend that the controls for procedures which may be performed regularly, but only for a minority of claimants, also be reviewed.

   ESA/OWCP/DCMWC Response

"DCMWC agrees with the recommendation and has already undertaken such a review. Based on consultations with the OWCP Medical Director, DCMWC has established an annual frequency limit on ABG tests. Following the frequency edit routine, bills for ABG tests above the limit will be denied and, for reconsideration, the provider will have to submit appropriate medical justification. Simple limitations for other rarely used procedures, based on extensive program experience, have proven to be neither cost-effective nor warranted. Accordingly, additional limits are not contemplated at this time. However, the program constantly reviews bill payment activities to determine if additional edits are warranted and will continue to do so. Additionally, once the new client server system is implemented, currently scheduled for late spring 2000, additional, more sophisticated relational edits and related procedures will be considered."

OIG's Conclusion

We concur with the corrective action of placing a frequency limit on ABG tests per year, although the agency's response does not specify the amount or nature of this planned frequency limit. This recommendation is considered resolved and will be closed pending receipt of this specific information. We also continue to believe that the Black Lung Program would benefit from similar reviews of other medical procedures, including office visits, for frequency limits to control costs and possible fraud

2. Written questionnaires or other follow-up directed towards Black Lung claimants should be used on a periodic basis to inquire as to the type and frequency of medical services received over a set period of time. Audit work conducted by DCMWC or its representatives should focus on any discrepancies between survey results and billed services.

ESA/OWCP/DCMWC Response

"The DCMWC already has a procedure to verify the initial receipt of service (see DCMWC Procedure Manual Chapter 3-601, paragraph 7) and is in the process of enhancing that procedure to ensure that all requisite information is gathered in a uniform manner. Based on extensive experience, the program has determined that written questionnaires, given the demographics of our customers, are not an effective way to gather information. DCMWC is in the process of revising its telephone survey to validate that requested services are delivered as prescribed and that the patient is satisfied with the service."

OIG's Conclusion

We have reviewed the draft surveys attached with the agency's response, and concur that this is an appropriate corrective action. We also agree that telephone surveys are a more effective method of communication for some black lung claimants. This recommendation is considered resolved, and will be closed pending receipt of your final surveys, and the applicable procedures regarding survey administration.

III. Additional Controls are Needed to Control Costs and Reduce Fraud Vulnerability For Gaseous Oxygen

Although oxygen comprised 98% of all expenditures for Durable Medical Equipment (DME) used in the Black Lung Program in 1998, DCMWC, by permitting excessive gaseous tank oxygen allowances, may not be implementing sufficient controls to control costs and reduce fraud vulnerability in gaseous oxygen billing.[1] The following cases illustrate the vulnerability of the Black Lung Program to fraud by unscrupulous oxygen providers.

A. Fraud Case: Independent Home Medical Rentals and Sales

Prior to the indictments and convictions of its president and treasurer on federal felony charges including false claims and money laundering, Independent Home Medical Rentals and Sales (Independent) had for years been one of the largest vendors of gaseous tank oxygen in the Black Lung Program. After employees in DCMWC's medical audit section informed the OIG of the billing practices of Independent, OI discovered that the company had fraudulently billed the Black Lung Program $1,014,540, receiving $919,164 from the Program in fraudulent payments. In some instances, oxygen billed to DCMWC by Independent was never provided to claimants. In other cases, Independent's bills greatly inflated the amount of oxygen provided to claimants. Independent billed tremendous amounts of gaseous tank oxygen per individual claimant, far more than a Black Lung patient would normally use in oxygen therapy. These fraudulent bills were paid despite the fact (unbeknownst to DCMWC) that most of these claimants were already using oxygen concentrators as their stationary system and therefore required gaseous oxygen only as a back-up or portable system. Each of the individuals involved in this scheme has been sentenced to 21 months in prison and has also been ordered to pay restitution of over $1,000,000.

Background: Oxygen Delivery Methods

Currently, there are three methods, or modalities, through which Black Lung claimants are prescribed supplemental oxygen: compressed gas, which is available in various size tanks ranging from large stationary cylinders to small portable cylinders; oxygen concentrators, which are electrically operated machines that extract oxygen from room air; and liquid oxygen, which is available in large stationary reservoirs and portable units. A claimant uses one of these three delivery systems for use in the home as the primary or "stationary" system, and is provided small portable gaseous oxygen tanks for use outside the home. Claimants who use oxygen concentrators are provided backup gaseous oxygen in the event of an electrical failure.

[1] DME fraud is a traditional route of companies who defraud government medical programs. According to Congressional testimony by the HHS/OIG's Director of Criminal Investigations, drug dealers in South Florida were leaving the illegal drug trade to open DME companies because DME fraud was viewed as equally profitable as drug dealing but less risky. See 1998 WL (Westlaw) 18090035 (Congressional Testimony of James A. Kopf, Director, Criminal Investigations Division, HHS Office of Inspector General, before the Senate Permanent Subcommittee on Investigations, December 9, 1998).

B. Fraud Case: Southern Air Home Equipment Company

Southern Air Home Equipment Company (Southern Air) was created by former Independent employees. The employees' knowledge of the schemes perpetrated by Independent allowed them to continue with fraudulent billing practices with their own company. The schemes perpetrated against the Black Lung Program by Southern Air were similar to those committed by Independent. An investigation of Southern Air by OI revealed that the company submitted fraudulent bills in the amount of $130,574. The owner of Southern Air was indicted by a federal grand jury on charges including false claims, money laundering, and perjury. She pled guilty and is currently awaiting sentencing.

Examples of Fraudulent Oxygen Bills submitted by Independent and Southern Air

$48,000 was paid for gas oxygen for a claimant who was already using an oxygen concentrator. At DCMWC's current chargeable rate of $1.25 per cubic foot, this would have entailed 1,087,334 liters of gas oxygen or 158 of the largest tank units (H tanks) available. The claimant actually received only 2 H tanks.

$120,000 was paid for a gas oxygen system for a claimant already using a concentrator. This claimant never needed any large tanks in his home and had only used a small portable unit on one occasion. $120,000 would have purchased 11,327 portable units.

$48,000 was paid for gaseous oxygen over a sixteen month period for a claimant who actually received only one large oxygen gas tank. This claimant never used the gas oxygen because his needs were met by a concentrator. This claimant did use portable oxygen at the rate of eight small cylinders per year. $48,000 would have purchased 4,531 portable cylinders.

One claimant actually used $30,831 worth of gas oxygen, but DCMWC paid an additional $102,629 because of inflated billing. This equates to 2.4 million liters of tank oxygen, or 337 large H tanks or 9,687 portable units. When the claimant was actually using gaseous tank oxygen he required 2 to 3 large H tanks per month and up to 6 portable units per year.

C. Finding: DCMWC's Automatic Payment Allowance for Gaseous Oxygen is Too High

DCMWC permits providers to bill for high dollar amounts of gaseous tank oxygen before its automated payment system rejects a bill. This leaves the Black Lung Program vulnerable to the type of fraud committed by Independent and Southern Air. Currently, providers can bill $1.25 per cubic foot for up to 55,142 cubic feet of oxygen per year for those claimants who use gaseous tank oxygen as a stationary system at 2 liters per minute (a very common prescription rate). 55,142 cubic feet of oxygen equates to 1,561,400 liters of oxygen. A claimant would have to use 19 of the largest tanks ("H" tanks) or 543 portable tanks per month to meet this annual cap.

In fact, very few persons requiring oxygen therapy need tank oxygen at all as their stationary oxygen delivery system. Concentrators can easily deliver oxygen at a rate of 5 liters per minute. Studies by the HHS indicate that the vast majority of patients who require supplemental oxygen can easily use oxygen concentrators as their primary

oxygen delivery system.[2] An analysis by the General Accounting Office (GAO) puts this figure at 90%.[3]

Even those providers who provide Black Lung claimants with oxygen concentrators as a primary oxygen system are allowed to bill up to one half of the stationary annual maximum (27,571 cubic feet per year at flow rates of 2 liters per minute). Again, claimants with concentrators need gaseous oxygen only as portable or back-up systems and therefore they normally require only relatively minimal gaseous amounts per year. Yet, by automatically paying for up to 27,571 cubic feet per year, DCMWC leaves itself open to fraud by unscrupulous providers. In the cases of Independent and Southern Air, DCMWC failed to implement adequate controls to ensure that claimants even used tank oxygen, let alone needed the large amounts of tank oxygen billed to the Black Lung Program.

D. Finding: The CMN System Can be Manipulated by Dishonest Providers

Physicians are required to certify the medical necessity of treatment for their patients in the Black Lung Program via Certificates of Medical Necessity (CMNs). The purpose of the CMN is to substantiate that the physician has reviewed the patient's condition and has determined that services or supplies are medically necessary. However, DOL/OIG investigations, and investigations and audits conducted by HHS have revealed that unscrupulous DME providers steer physicians into signing or authorizing improper medical certifications. In some instances, as in the Independent fraud case, physicians are steered into signing off on CMN forms without medically verifying the actual need for specific services prescribed on the form. The doctors who prescribed gaseous oxygen for claimants in the Independent case later acknowledged that these claimants did not need the gaseous oxygen prescribed on the CMN form, and that oxygen concentrators were the proper oxygen delivery system. In other situations, a physician may enter into a "kickback" relationship with a DME provider wherein the physician receives compensation from an oxygen provider to falsely represent that expensive liquid or tank oxygen is medically indicated even though a less expensive oxygen concentrator can readily meet the patients oxygen needs.

E. Recommendations: Additional Controls are Needed for Gaseous Oxygen

1. DCMWC needs to lower the automated maximum payable amounts of gaseous oxygen for use as either a primary or supplemental system. Lowered automated payment amounts would not prevent a Black Lung claimant from receiving large amounts of gaseous tank oxygen, if actually needed. Lowered ceilings would, however, establish more reasonable automated "red flags" whereby a claims examiner or medical consultant would have to scrutinize a claimant's medical needs and

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[2] See HHS, OIG, Oxygen Concentrator Services, OEI-02-91-01710 (November, 1994).

[3] See Medicare: Access to Home Oxygen Largely Unchanged; Closer HCFA Monitoring Needed (GAO/HEHS-99-56, April 1999).

current oxygen usage before large payments of gaseous oxygen are authorized. DCMWC also needs to consider that many of its claimants using gaseous oxygen may be able to have their oxygen needs met through the use of oxygen concentrators. Concentrators are both less expensive and less subject to fraudulent billing because of set monthly rental rates (rather than cubic foot amounts).

ESA/OWCP/DCMWC Response on Automated Maximum Payable Amounts for Gaseous Oxygen

"A review of the data shows that only a very small number of miners actually use large amounts of gaseous oxygen. Accordingly, while the program will review its maximum total payable amounts and consider additional edits, because these changes will require sophisticated relational edits to be most effective, they cannot be made until the new client server system is implemented. At that time, the program will review its manual and automated procedures to determine how additional controls can be implemented. In the interim, DCMWC will also review payment amounts per cubic foot of oxygen to determine if these amounts should be lowered."

". . . for secondary oxygen service, the program will adopt the HCFA annual dollar cap allowed for tank oxygen, $4,118 for tank oxygen service for flow rates above four liters per minute. This limit will be established following the requisite notices to the provider community. " . . . "Additionally, DCMWC will implement post-payment reviews of total gaseous oxygen charges (primary and secondary combined) that exceed $10,000 for a patient in a year. Once the new client server system is in place, more sophisticated edits and audits will be explored."

OIG's Conclusion on Automated Maximum Payable Amounts for Gaseous Oxygen

Although the agency has indicated that they will conduct certain reviews of its maximum payment amounts, this recommendation is unresolved and cannot be considered resolved without documentation demonstrating that DCMWC has adequately reviewed its automatic payment allowances for both primary (stationary) and secondary (portable) gaseous oxygen. Our recommendation to lower automatic payment amounts for gaseous oxygen was not limited to flow rates of 4 liters per minute for secondary oxygen, but pertained to all flow rates, for both primary and secondary oxygen. In addition, although we annualized HCFA's caps for gaseous oxygen in the tables of our draft report (for comparison purposes with the DCMWC's annual ceilings), HCFA's caps are monthly, not yearly. Annual caps can be abused by providers billing to the annual maximum early in the year. A triggering amount of $10,000 per patient for post-payment audits of combined primary and secondary oxygen may become irrelevant as a cost or fraud control measure if the DCMWC's automatic payment allowances were lowered to reasonable/customary levels.

ESA/OWCP/DCMWC Response Regarding Increasing Concentrator Use for Claimants

"The program will modify its CMN procedures to require the examiner, in cases where a concentrator could be used in lieu of tank oxygen, to contact the physician to ask whether such a change is appropriate. If the doctor concurs, a concentrator will be approved."

OIG's Conclusion

We concur with this corrective action and will consider this aspect of the recommendation to be resolved and closed pending our receipt of the revised CMN procedures.

2. DCMWC also needs to conduct regular and thorough follow-up regarding services provided to its claimants by oxygen providers. This follow-up need not be time consuming, and can be accomplished via a survey or a phone call to a patient by a claims examiner or medical professional. Although our review indicates that DCMWC has used surveys to determine what oxygen equipment claimants have (see Appendix A), these surveys may have been inadequate, and we recommend that the survey instrument currently being used be reviewed with the following suggestions in mind:

- The survey is concerned only with the modality of oxygen prescribed to the claimant without regard to quantities provided. Thus, a stationary gaseous tank system is listed only as "Tank Oxygen with flowmeter" and the claimants are simply asked if they "have" the mode of equipment described. This means that a claimant for whom DCMWC was billed 100 tanks, but actually received 2, will correctly answer "yes" in the same manner as a claimant billed for 2 tanks and supplied 2 tanks.

- Claimants are asked on the survey if they have tank oxygen but not asked if they actually use tank oxygen. Simple survey questions such as asking if tank oxygen was being used, and, if so, how much tank oxygen was being used, may have detected the fraud committed by companies like Independent and Southern Air very quickly.

- Claimants are not asked what additional or supplemental equipment was supplied by oxygen providers on the surveys. This simple question would have detected that claimants serviced by Independent were using concentrators as their primary system, and could not possibly have needed the large amounts of gaseous tank oxygen being billed.

- The survey does not address any quality of service issues. For example, inquiries regarding whether oxygen equipment is being properly serviced, or whether associated supplies (which are billed separately to DCMWC) have been provided, can be obtained.

ESA/OWCP/DCMWC Response

"The DCMWC already has a procedure to verify the initial receipt of service (see DCMWC Procedure Manual Chapter 3-601, paragraph 7) and is in the process of enhancing that procedure to ensure that all requisite information is gathered in a uniform manner. Based on extensive experience, the program has determined that written questionnaires, given the demographics of-our customers, are not an effective way to gather information. DCWMC is in the process of revising its telephone survey to validate that requested services are delivered as prescribed and that the patient is satisfied with the service."

OIG's Conclusion

We have reviewed the draft surveys attached with the agency's response, and believe that they are a significant improvement over the DCMWC's previous written surveys referenced in our report. We therefore concur that this is an appropriate corrective action. We also agree that telephone surveys are a more effective method of communication for some black lung claimants. This recommendation is considered resolved, and will be closed pending receipt of your final surveys, and the applicable procedures regarding survey administration.

3. We also recommend that DCMWC revise its CMN form (see Appendix B). Specifically, we recommend that DCMWC:

- Revise part 13(e) of the form to reflect the fact that a false or misleading statement can also be a felony, pursuant to 18 U.S.C. 1001, subject to five years in prison and a $250,000 fine, as well as a misdemeanor under 30 U.S.C. 941.

- Include an attestation for the physician in part 13(e) that the CMN form was completed by the physician, or his/her representatives, and not by a DME company servicing the claimant.

ESA/OWCP/DCMWC Response

"The DCMWC will change Section 13(e) of its Certificate of Medical Necessity (CMN) form to specify that a false or misleading statement on the form is a felony rather than a misdemeanor, as currently indicated on the form. You suggest application of 18 U.S.C. 1001, rather than 30 U.S.C. 941, and that the form be modified to require the physician to personally complete the form, and so certify. DCMWC has consulted with the Associate Solicitor of Labor for Black Lung Benefits and will make appropriate changes to Section 13(e) of the form. However, rather than insist that the physician personally complete the form, DCMWC will ask the physician to certify that he or she has personally reviewed the form and certifies that the information is accurate and complete. This is similar to the certification required of physicians on the HCFA CMN form."

OIG's Conclusion

We concur with the proposed corrective action and consider this recommendation to be resolved. Our recommendation did not include a requirement that the physician personally complete the CMN form. Rather, we stated that the form should be designed to ensure that the physician or his representatives, rather than the DME company servicing the claimant, complete the form. This recommendation will be closed pending receipt of your revised final form.

IV. Best Practices for Home Oxygen

A. HCFA Cost Controls

The Health Care Financing Administration (HCFA) has found ways to control fraud and unnecessary costs in the areas of home oxygen. Since 1989, HCFA has used a modality neutral payment system for oxygen whereby providers are paid the same baseline amount regardless of what type of oxygen delivery system (gaseous, liquid, or concentrator) is used. This modality neutral system may be helpful in controlling fraud because it appears to remove some incentives for providers to cheat. For example:

1. Physicians may have little incentive to engage in "kickback" scams with home oxygen providers by prescribing medically unnecessary and more expensive methods of oxygen delivery because all modalities are reimbursed at the same basic rate.

2. Oxygen providers may have less incentive to manipulate the CMN process by steering the physician toward authorizing oxygen delivery systems more profitable for their company.

3. Oxygen providers can still attempt to bill HCFA carriers for oxygen not actually provided, as in the cases of Independent and Southern Air with the Black Lung Program. However, their profits when taking such a risk would be much lower. This is because HCFA's modality neutral system does not allow for billing per cubic foot. Thus, maximum gaseous and liquid oxygen charges are fixed, regardless of the number of oxygen units billed by the oxygen provider.

HCFA has not found that its modality neutral system has impaired claimant service. To address service quality concerns, HCFA has implemented an additional payment of 50% beyond its set baseline payment for the small number of oxygen patients who require oxygen flows greater than 4 liters per minute. This allowance ensures that claimants who truly need gaseous or liquid oxygen are not denied access to those systems. However, as discussed in the next section of this report, even with this extra 50% allowance, HCFA still has much lower maximum allowances for home oxygen than DCMWC.

HCFA also requires DME providers to post $50,000 surety bonds to participate in the Medicare Program. This is an anti-fraud measure used by HCFA as insurance in the event of overpayment to providers. In addition, HCFA requires Disclosures of Ownership Interest Statements which require that medical providers disclose identification of all officers, directors, physicians, and principal partners. This helps HCFA carriers and the HHS/OIG to monitor possibly fraudulent arrangements between physicians and oxygen providers. A potentially fraudulent relationship between a doctor and an oxygen provider can occur, for example, when a physician has ownership in the same DME company to which he refers patients.

Comparison of Oxygen Cost Controls Between HCFA and DCMWC

In the last two years HCFA has cut oxygen rates by 30% by using a realistic market-based methodology to establish what are reasonable charges in the home oxygen market, by geographic region. Prior to these rate cuts, HCFA was paying what it characterized as "grossly excessive" rates for oxygen.[4] The genesis of HCFA's oxygen rate cuts was a GAO study which found that HCFA was paying about 38 percent more for home oxygen supplies than the competitive marketplace rates paid by VA.[5] The GAO determined that HCFA rates were 38 percent higher even after adding a 30-percent adjustment to VA rates to account for the higher costs associated with servicing Medicare patients. The higher costs incurred by Medicare would also apply to the Black Lung Program, with VA having an inherent edge over both programs because of their dual role as both a provider and payer of medical services. VA suppliers do not have many of the administrative costs associated with servicing programs like Medicare and the Black Lung Program. Such administrative costs include preparing CMN forms, processing claims, and administrative costs associated with collecting co-payments (Medicare).

A central premise of the GAO study was that because VA uses competitive bidding to procure oxygen for its patients, VA rates are an indicator of true marketplace rates. HCFA's own analysis supported the GAO study, and also noted that recent technological advances in oxygen delivery had significantly reduced costs to oxygen suppliers. One very significant technological development in recent years has been the improvement of oxygen conserving devices which preserve oxygen when the patient is not inhaling, reducing the amount of oxygen normally consumed by a patient by up to 50 percent. (See Appendix C.)

Comparison of Rental Costs for Oxygen Concentrators Between HCFA and DCMWC

As discussed previously, the vast majority of patients who need home oxygen therapy use oxygen concentrators to meet their oxygen needs. Both HCFA and the Black Lung Program provide for the rental of concentrators for their claimants. HCFA's maximum allowable charge for a full month of oxygen concentrator rental ranges from $194.48 to $228.80 (including claimant co-payment). This maximum charge varies based on geographic region, and includes all services and supplies. The Black Lung Program pays $409.82 per full (31 day) month of concentrator rental, regardless of geographic location, and allows providers to bill up to an additional $75.00 per item for associated supplies. The following table shows the maximum allowable monthly rental amounts oxygen providers receive from HCFA, including claimant co-payment, in comparison to some of the areas of the country where the Black Lung Program also services claimants.

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[4] See "Medicare Program; Special Payment Limits for Home Oxygen," 62 Federal Register 38100 (July 16, 1997).

[5] See Medicare: Comparison of Medicare and VA Payment Rates for Home Oxygen (GAO/HHS-97-120R, May 15, 1997).

Comparison: Oxygen Concentrators and Supplies

State	HCFA's Maximum Rental Allowance per Month	HCFA's Maximum Supply Allowance Per Item	DCMWC's Maximum Rental Allowance per Month	DCMWC's Maximum Supply Allowance Per Item
				$75.00
West Virginia	$228.80	$0	$409.82	75.00
Pennsylvania	228.80	0	409.82	75.00
Tennessee	228.80	0	409.82	75.00
Kentucky	228.80	0	409.82	75.00
Virginia	228.80	0	409.82	75.00
Colorado	198.01	0	409.82	75.00
Florida	213.11	0	409.82	

As shown above, DCMWC allows significantly more than HCFA for the rental of oxygen concentrators, and associated supplies. In West Virginia, a state with a very high concentration of Black Lung claimants, this maximum allowance is almost twice what HCFA allows. [6]

Comparison of Stationary Gaseous Oxygen Rates between HCFA and DCMWC

HCFA allows a maximum provider charge of between $194.48 and $228.80 per month for claimants requiring gaseous tank oxygen as their stationary/primary system at rates up to 4 liters per minute. At flow rates greater than 4 liters, HCFA allows an additional payment of 50 percent. In contrast, the Black Lung Program pays $1.25 per cubic foot of oxygen billed, automatically paying bills for claimants whose annual gaseous oxygen use does not exceed predetermined annual amounts. The following table shows the (annualized) payment differences between the two programs.

[6] For both HCFA and DCMWC, a provider may not bill the maximum allowable amount for an oxygen concentrator rental. This can occur for various reasons. For example, a claimant may die or can be switched to gas oxygen as a primary system. Because some claimants will not use a concentrator for a full billing period, the overall (claimant wide) average paid by either HCFA or DCMWC for concentrator rentals will not equal the established maximum allowance.

Comparison: Stationary Gaseous Oxygen

Flow Rate	Potential DCMWC Annual Maximum	Potential HCFA Annual Maximum
2 liters	$ 69,927	$2,745
3 liters	92,141	2,745
4 liters	115,355	2,745
5 liters	165,000	4,118
6 liters	194,140	4,118

Obviously, a provider can bill much higher amounts for their patients who use gaseous oxygen under the Black Lung Program than for their patients served by Medicare. Appendix D lists providers who have received gaseous oxygen payments far higher than would be allowed under HCFA. In terms of the high annual automatic allowances above, it is highly unlikely that Black Lung patients would ever legitimately need such generous home gaseous oxygen allowances. Yet, these higher maximum allowances give dishonest providers an opportunity to take advantage of this system.

Comparison of Reimbursement Rates for Portable Oxygen Units Between HCFA and DCMWC

Both HCFA and the Black Lung Program allow supplemental payments for patients who require small portable oxygen units for use when leaving the home or as backups. HCFA's monthly portable allowance ranges from $30.57 to $35.97 per month depending on geographic location. At flow rates of 4 liters per minute and above, HCFA allows an additional 50-percent charge so that its maximum payment for portable units ranges from $45.86 to $53.96 monthly. As with stationary gaseous oxygen systems, DCMWC allows providers to bill at $1.25 per cubic foot, with annual cubic foot allowances which would far exceed normal usage. The following table lists the current annual billable allowances for portable and back-up units under the Black Lung Program in comparison to HCFA.

Comparison: Portable Gaseous Oxygen

Flow Rate	Potential DCMWC Annual Payment Max.	Potential DCMWC Oxygen Allowance in Cubic Feet	Potential HCFA Annual Payment Max
2 liters	$34,463.75	27,571	$431.64
3 liters	$46,070.00	36,856	$431.64
4 liters	$57,677.50	46,142	$431.64
5 liters	$68,750.00	55,000	$647.46

DCMWC's maximum payment allowance of $34,463.75 (at two liters per minute) equates to eighty times the maximum HCFA payment allowance. As with their stationary gaseous payment policies, DCMWC's combination of paying per cubic foot coupled with high automatic allowances, makes the Black Lung Program vulnerable to both excessive payments and fraudulent billing.

DCMWC's Use of Procedure Code A4330 for Oxygen Supplies

Under procedure code A4330, DCMWC permits a $75.00 per item charge for disposable supplies associated with oxygen equipment, such as inexpensive nasal cannulas, masks, etc. HCFA does not allow providers to tack on additional charges for disposable supplies because these disposables are supplied to patients at minimal cost to the oxygen companies. The approximate per item market prices are listed below:

Supplies	Market Price	DCMWC Allowance
Tubing	$25.00	$75 per item
E-Cart	24.50	$75 per item
Oxygen Humidifier	2.25	$75 per item
Nasal Cannula	1.50	$75 per item

The market prices listed above are those charged to VA in contract V554P-3692. They allow the provider to make a reasonable profit, but the government is not overcharged. Because DCMWC allows $75.00 charges on a per item basis, a provider can bill $150.00 for two nasal cannulas that

cost $3.00 in the marketplace.[7] Although DCMWC officials have indicated in meetings with the OIG that the average per item payment for oxygen supplies is normally far less than $75.00, two issues remain: 1) why extra charges for oxygen supplies are authorized at all, given that oxygen providers who also service HCFA claimants cannot bill HCFA for oxygen supplies; and 2) why the code, if needed, is set at such an unnecessarily high dollar amount given its potential for abuse.

HCFA's Competitive Bidding Demonstration Project

HCFA is currently engaged in a demonstration project to examine whether they can further reduce oxygen costs and fraud without jeopardizing claimant service. This project in South Florida requires oxygen providers to bid competitively for oxygen contracts, and awards contracts to bidders with reasonably low bids combined with positive service records.[8] While not requiring providers to be professionally accredited, HCFA conducts background research on oxygen providers. Such research includes inquiries regarding the provider's historical compliance with Medicare rules, financial stability, and service reputation. HCFA also checks whether the provider has engaged in any unethical or criminal billing behavior against Medicare. The HHS maintains a list of medical providers excluded from Medicare because of criminal or ethical concerns. Our review indicates that DCMWC does not provide this list nor any similar lists to its medical audit section for cross-checking purposes.

The competitive bidding project by HCFA is similar to VA's system of oxygen procurement, which is discussed in the following section.

B. VA Oxygen Procurement Procedures

VA's Veterans Health Agency contracts for all home oxygen by using competitive bidding. They solicit contracts within 22 geographic networks or VISN's (Veterans Integrated Service Networks). Although the bidding process provides all vendors the opportunity to bid on oxygen solicitations, VA favors accredited oxygen providers with strong service standards. VA's system is superior to the system used by the Black Lung Program because it produces quality service and

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[7] Prior to June of 1997, DCMWC permitted a $200 per item charge.

[8] HCFA's authority to implement competitive bidding pilots was authorized by Congress as part of the Balanced Budget Act of 1997. The White House supports the expansion of Medicare competitive bidding programs for DME equipment beyond HCFA's current demonstration status. As stated by President Clinton on January 24, 1998, HCFA should "do what most private and other government health care purchasers do to control cost -- lower costs by injecting competition into the pricing for equipment and non-physician services." See 1998 WL (Westlaw) 24116 (White House) ("Fact Sheet on Proposals to Combat Medicare Fraud," The White House, Office of Communications, January 24, 1998).

low market-based prices. VA also permits other government agencies to use its contracts to procure home oxygen, allowing these agencies to also benefit from low prices and quality service.

VA Oxygen Costs Are Significantly Lower than DCMWC's

VA oxygen costs are lower than HCFA's, and much lower than DCMWC's. For example, the GAO found that the average VA monthly payment in 1996 for patients using oxygen concentrators was $125 including all supplies, services, and portable units.[9] VA incurs savings for concentrators in two ways: 1) competitive contracts with oxygen providers for concentrator purchase and servicing; and, 2) competitive contracts with oxygen providers for concentrator rentals and servicing. Information obtained from VA regarding contractual oxygen prices in VISN 9, (which comprises parts of West Virginia, Tennessee, and Kentucky) indicates that VA currently pays $69.22 per month for oxygen concentrators.

VA Contracts Mandate Quality Service

VA oxygen contracts have quality service clauses with specific patient support and equipment maintenance requirements. GAO's analysis of VA contracts and their review of Medicare and VA patient records showed that VA patients typically received more frequent service visits than Medicare patients. In addition, the GAO found that VA patients were generally provided with increased access to portable units, and utilized better and more modern equipment.[10] Beyond strong contractual service standards, VA uses suppliers who are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or comply with its standards.

In contrast, an oxygen provider can do business with the Black Lung Program by simply complying with the basic registration requirements associated with obtaining a supplier/billing number. This can lead to quality service and fraud problems. Paul David Adkins, for example, not only submitted fraudulent bills to the Black Lung Program, but he also was a twice convicted felon who falsified his medical credentials.

VA Procures Oxygen for Other Government Agencies

VA's VISN centers service every sector of the country. Because of VA's ability to procure home oxygen at very low prices, other government agencies have established inter-agency agreements with VA so they can "piggyback" on VA contracts to lower oxygen costs. An agency like

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[9] See Medicare: Home Oxygen Program Warrants Continued HCFA Attention (GAO-HEHS/98-17, November, 1997).

[10] Ibid.

DCMWC, which has relatively modest oxygen needs, is perhaps an ideal agency to link with VA for oxygen procurement.

C. Suitability of HCFA's and VA's Oxygen Policies to the Black Lung Program

DCMWC officials expressed concerns during our review regarding the applicability of HCFA or VA methods to the Black Lung Program. Specifically, we address concerns regarding patient choice; perceived problems with servicing Black Lung claimants in remote locations; potential harm to small businesses due to reduced profit margins; clinical differences among claimants; and, and potential delays in paying claimant bills. In addition, we have included issues addressed by HCFA when oxygen cost reforms were proposed for Medicare providers.

Patient Choice

This issue pertains to the use of competitive bidding, which if used by DCMWC, would require that the agency determine which oxygen provider services a claimant. DCMWC officials stated in our February 1, 1999 meeting that Black Lung claimants have, by law, unlimited choice as to which registered DME company provides their oxygen, and that DCMWC therefore cannot utilize a competitive bidding system.[11] HCFA *did* require legislative changes before it could implement its competitive bidding pilot in South Florida. However, there are several important distinctions between Medicare and the Black Lung Program pertaining to patient choice and competitive bidding:

1. Medicare claimants make a 20% co-payment when receiving service. It would appear to be more difficult to restrict choice from patients who are using their own funds to pay for medical care (co-payments sometimes have to be waived by HCFA). Black Lung claimants do not make co-payments.

2. HCFA's use of competitive bidding can have a significant economic impact on the home oxygen industry, including small businesses. The small size of the Black Lung Program mitigates these effects. Medicare's annual oxygen expenditures exceed $1.5 billion compared to approximately $8 million for the Black Lung Program.

3. Our review of the Black Lung Act did not identify any express prohibitions against competitive bidding, and we are unaware of any legal opinions regarding the propriety of competitive bidding in the Black Lung Program. If legal prohibitions do exist, we would suggest that DCMWC support legislation to permit competitive bidding.

[11] The idea that a Black Lung claimant normally chooses his oxygen provider may be a misconception. DME companies may, on their own initiative, solicit business from Black Lung claimants. In addition, claimants may be referred to oxygen providers by their physicians, or DCMWC.

Remote Geographic Location of Black Lung Claimants

Many Black Lung claimants live in rural areas. Of course, Medicare claimants and VA patients also live in rural areas -- indeed Medicare and VA home oxygen claimants live in every geographic sector of the country. VA's competitive contracts service all geographic areas, including those heavily concentrated with Black Lung claimants.

Ability of Providers to Absorb Lower Reimbursement Amounts from DCMWC

The same DME companies who provide oxygen to Black Lung claimants also service Medicare patients. These companies presumably profit from the much lower prices established by HCFA, although not at the potentially windfall levels permitted by DCMWC. As mentioned previously, technological advances in recent years, such as oxygen conserving devices, have cut provider costs. DME companies who receive oxygen contract awards from VA via competitive bidding profit from rates even lower than HCFA's. These profits are, however, in line with normal market pricing.

Potential Harm to Small Businesses

As part of its competitive bidding methodology, HCFA must consider small business interests, and this consideration can be built into any competitive bidding system. In HCFA's pilot, the lowest bidder doesn't necessarily receive the contract award. However, HCFA will award the contract to a company with a reasonably low bid combined with quality service, program compliance, and other factors, such as whether the firm is a small business.

It should also be noted that many of the small "local" oxygen providers who service the Black Lung Program are subsidiaries of large providers. Three firms, Apria, Lincare, and RoTech, service roughly 45% of the home oxygen market, and have networks with hundreds of branches.

Clinical Differences Among Claimants

Medicare, VA, and Black Lung patients with pulmonary insufficiency must meet the same medical eligibility criteria for home oxygen. Patients must have (1) an appropriate diagnosis of chronic pulmonary disease; and, (2) identical clinical tests documenting reduced levels of oxygen in the blood. Both Medicare and Black Lung patients require a certificate of medical necessity, signed by a physician, prescribing the volume of supplemental oxygen required in liters per minute, as well as whether the patient needs a portable unit with the home-based stationary unit.

D. Recommendations

1. DCMWC should restructure its oxygen reimbursement methods and policies to control oxygen costs and reduce vulnerability to fraud. Our analysis does not indicate serious impediments to the adoption of HCFA reforms, VA procurement policies, or a hybrid approach combining characteristics of both agencies. Therefore, we are recommending that DCMWC review each of these alternatives and determine which, if any, would be most helpful in reducing potentially excessive home oxygen costs and fraud.

ESA/OWCP/DCMWC Response

"The draft report discusses best practices for home oxygen and compares VA, HCFA and DCMWC practices and rates. The report recommends that DCMWC 'restructure its oxygen reimbursement methods and policies to control costs and reduce vulnerabilities to fraud.' Further, the report suggests that the program review VA and HCFA practices for guidance. While not all VA and HCFA practices are appropriate for application in the Black Lung program, the program agrees that the HCFA maximum allowable rates for concentrator rentals establish a de facto standard of what is 'reasonable and customary.' Accordingly, DCMWC will adopt the HCFA rate (currently $228.80 per month) as the maximum allowable charge as soon as the required notices are given to providers. Once the new client server system is implemented, the program will consider the feasibility of additional controls, such as locality rates."

"DCMWC believes that in adopting the HCFA limits for concentrator rentals we have satisfied the spirit of the OIG recommendation, reducing the maximum allowable rate for this service while obviating the cumbersome and problematic competitive bidding process. This also allows DCMWC to retain its longstanding policy of patient choice in a manner consistent with sound cost management."

OIG's Conclusion

This recommendation is unresolved. While we concur that HCFA's maximum allowable rates for concentrator rentals is a de facto standard of what is "reasonable and customary" for government agencies who do not engage in competitive bidding, we also believe that HCFA's maximum allowable rates for primary and secondary gaseous oxygen establish a similar de facto standard. Thus, in lieu of a competitive bidding process, the DCMWC should also consider using automatic payment ceilings for primary and secondary oxygen which are in line with HCFA's oxygen caps.

In addition, your response provides no explanation as to why a competitive bidding process, particularly one conducted by the VA through an interagency agreement, would be

cumbersome or problematic for the DCMWC. It also provides no justification as to why the DCMWC's longstanding position on patient choice cannot or should not be changed.

2. We recommend that DCMWC abandon its current procedures concerning the use of generic code A4330 for supplies. Alternatives can include specific codes for specific supplies at reasonable market prices or bundling supply charges with the cost of the stationary oxygen delivery system.

ESA/OWCP/DCMWC Response

"DCMWC will adopt this recommendation when it adopts the HCFA maximum allowable rate for concentrator rentals."

OIG's Conclusion

We consider this recommendation to be unresolved because DCMWC's response can be interpreted to apply only in the context of concentrator rentals and does not clearly indicate that the agency plans to abandon this code entirely and with respect to all oxygen modalities (primary gas, secondary gas, liquid oxygen).

3. We recommend that DCMWC develop a system whereby its medical audit section can review the reports of excluded medical providers maintained by HHS, as well as review similar lists which may be issued by other federal agencies or by state medical boards which publicize providers who have engaged in illegal or unethical conduct.

ESA/OWCP/DCMWC Response

"DCMWC agrees and will work with HHS to obtain current listings and will establish appropriate review procedures. "

OIG's Conclusion

We concur with this corrective action and consider this recommendation resolved. This recommendation will be closed pending our receipt of the DCMWC's review procedures.

Contributors to this Report:

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation
319 Washington Street
Johnstown, Pa. 15901

May 23, 1995

1-800-347-3754 Claim No.: JO

Coeburn, VA 24230

Dear Mr.

We have received a Certificate of Medical Necessity from your doctor prescribing the following equipment for you:
Tank Oxygen with flowmeter and humidifier
for the period May 4, 1995 to May 3, 1996

Before payment authorization can be made for this equipment, we need certain information from you. Please answer the questions below and return this letter within 10 days. A self-addressed envelope which requires no postage is enclosed for your convenience.

Sincerely,

JUDITH A. MATLIN
CLAIMS EXAMINER

****

1. Is the address shown above your correct address? Yes If not, please provide your correct address:
2. What is your telephone number? 703-[illegible]
3. Do you have the equipment described above? yes If not, please explain:
4. What company supplies or services the equipment? Independent Home Medical
5. When did you first receive this equipment? 5-4-95
6. When were you last hospitalized? 1-11-88 To 1-13-88

6-1-95
Date

[signature]
Signature

Certification of Medical Necessity

U.S. Department of Labor Appendix B 1 of 2
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care (30 U.S.C. 901 et seq. and 20 CFR 725.705 and 725.706). Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician. Collection of this information is required to obtain a benefit.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address

3. Telephone Number ( ) ____ - ____

4. Social Security Number

5. Date of Birth

6a. Date(s) of last hospitalization
From: _____
To: _____

6b. Condition(s) treated while in hospital

7. Pulmonary Condition(s) for which this prescription is written:

8a. Type of Prescription
☐ Original (New)
☐ Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date:
Ending Date:

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

☐ Tank O_2 With Flowmeter and Humidifier
☐ O_2 Concentrator
☐ O_2 Liquid System
☐ O_2 Liquid System With Portable Liquid
☐ Portable Unit (Gaseous)

9b. Other DME
☐ Manual Hospital Bed (11c.)
☐ Semi-electric Hospital Bed (11c.)
☐ Nebulizer with Motor (11a.)
☐ Wheelchair (11f.)
☐ Other (Explain in item no. 12.)

9c. Prescription for Medical Services
☐ Pulmonary Rehabilitation Services (See 11e.)
Level: _____
☐ Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report.
(Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test

Date of test: MM DD YY

Pt.'s condition:
☐ Acute
☐ Chronic

Results: (Best Effort)

	Predicted	Bronchodilation	
		Before	After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: ☐ Good ☐ Fair ☐ Poor
Miner's ability to understand instructions and follow directions: ☐ Good ☐ Fair ☐ Poor

C. Was equipment calibrated before the test? ☐ Yes ☐ No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test

Date of test: MM DD YY

Pt.'s condition:
☐ Acute
☐ Chronic

Results:

PO_2	PCO_2	PH

F. Air Intake: ☐ On room air ☐ On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced ☐ Yes ☐ No Time Sample Analyzed _____

H. Was equipment calibrated before the test? ☐ Yes ☐ No

I. Testing Facility Name and Address

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11g).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11g.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11g. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services for home nursing care and, pulmonary rehabilitation services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☐ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): MM DD YY

d. Date that the prescribed treatment or service is authorized to begin: MM DD YY

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) Date

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072.

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room C-3526, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Note: Person are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Oxygen Conserving Devices and Modern Portable Delivery Systems

Traditional continuous flow portable tanks are exhausted very quickly in comparison to modern portables, which utilize oxygen conserving devices. A conserving device provides a pulse of oxygen on inspiration with no flow on expiration, thereby conserving oxygen dramatically. Modern portables are also smaller, lighter, and can be carried in a back pack or shoulder bag.

Oxygen Duration Comparison: Flow rate of 2 liters per minute[1]

Size	Continuous Flow	Conserving Device
Mini	N\A	10.5 hours
C	2.0 hours	14.0 hours
D	3.5 hours	24.2 hours
E	5.7 hours	40.0 hours

Many black lung claimants use the traditional continuous flow E-tank portable system, and are therefore not enjoying the benefits of the much lighter and more efficient modern mini, C, and D units. Thus, despite the high DCMWC allowances to providers for portable oxygen, claimant service quality can be substandard.

[1]The table above is based on the average clinical experience of a manufacturer of conserving devices. Oxygen conserving devices will vary in effectiveness based on the type of conserving device used, as well as the respiratory rate of the patient.

Top providers, in terms of average payment for gaseous oxygen per miner, 1994-1998.

Black Lung Provider #	Year	Avg. payment per miner	# of Miners
474107	95	$46,093	6
400032	98	$36,566	1
474107	96	$35,721	10
412341	97	$31,284	4
474107	97	$24,905	10
489633	94	$17,319	1
474107	94	$15,313	6
406909	98	$14,530	1
407794	94	$14,463	1
463009	94	$14,005	11
406909	97	$13,695	1
463009	97	$13,543	8
400032	97	$12,425	1
407649	94	$12,308	56
409643	98	$12,215	1
461194	98	$11,420	4
473807	96	$11,002	14
797283	94	$10,763	2
463009	95	$9,998	11
409643	97	$9,218	1
407794	95	$9,106	1
458987	98	$9,067	28
473807	95	$8,538	16
479707	98	$8,200	1
407649	96	$7,827	63
797283	96	$7,672	3
407649	95	$7,523	48
471466	95	$7,407	21
463009	98	$7,375	11
797283	95	$7,371	4
471466	94	$6,656	26
473807	94	$6,156	21
468852	98	$6,090	10
463009	96	$5,332	5
40769	97	$5,247	28
40769	98	$4,767	33

Note: These amounts are for gaseous oxygen billed under CPT codes E0400 or E0405. No distinction is made by providers billing with these codes as to whether the oxygen billed is for a stationary or portable system. Therefore, patients using only small amounts of gas oxygen for portable purposes are reflected in the above averages.

HCFA Maximum at 2-4 liters	$2,745
HCFA Maximum above 4 liters	$4,118

* Most prescriptions are for 2 liters per minute.

Acronyms

ABG	Arterial Blood Gas
CMN	Certificate of Medical Necessity
DCMWC	Division of Coal Mine Workers' Compensation
DME	Durable Medical Equipment
DOL	U.S. Department of Labor
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
OACE	Office of Analysis Complaints, and Evaluations
OI	Office of Investigations
OIG	Office of Inspector General
OWCP	Office of Workers' Compensation Programs
VA	U.S. Department of Veterans Affairs

Glossary

Controls	Used in the oversight of a medical bill processing/payment system to identify potential fraud or excess billing by providers. These can be automated (computerized) or human (system) interventions.
Fraud	An intentional deception or misrepresentation that an individual knows to be false and that could result in an unauthorized benefit to himself or some other person. A deception or misrepresentation made knowingly or willfully shows criminal intent to defraud.
Nasal Cannula	Used to administer oxygen therapy - two short prongs that fit directly into the nostrils allowing oxygen to flow into the nose.
Oxygen Concentrator	A device which separates the two major components of room air, nitrogen and oxygen. As room air flows through a concentrator, nitrogen is separated an discarded. Oxygen is retained and stored in a holding tank within the concentrator.
Oxygen Tank	Various sized cylinders which deliver compressed gaseous oxygen
Oxygen Therapy	Required for victims of diseases and conditions of the heart and lungs to ensure that the cells of the body are getting enough oxygen. Supplemental oxygen is available from compressed gas, liquid, or oxygen concentrators.
Pneumoconiosis	Black Lung, a respiratory condition acquired from working in coal mines.

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number:

OCT 15 1999

MEMORANDUM FOR: HOWARD L. SHAPIRO
Acting Assistant Inspector General for
Analysis, Complaints and Evaluations

FROM: T. MICHAEL KERR
Deputy Assistant Secretary

SUBJECT: Review of the Cost and Fraud Controls and Allowances for Home Oxygen in the Federal Black Lung Program

The Office of Workers' Compensation Programs (OWCP) and the Division of Coal Mine Workers' Compensation (DCMWC) have reviewed the Office of Inspector General's (OIG) draft report, "Review of the Cost and Fraud Controls and Allowances for Home Oxygen in the Federal Black Lung Program." The program agrees with the OIG that medical bills, including those for home oxygen, must be carefully reviewed and costs controlled. The program has already taken a number of significant steps to address issues raised in the report. These actions and the program's response to specific recommendations in the report are detailed below.

Before addressing the specific recommendations in the draft report, I would like to note a number of organizational, procedural and automated system changes recently implemented to identify and control over-utilization and excessive billings. First, the Black Lung Medical Bill Processing System has numerous automated edits in place to ensure the integrity of its payment process. As other state-of-the-art systems, it has eligibility, diagnostic relationship, price, and frequency edits, as well as extensive duplicate checks. Every year, it denies over 40% of the bills processed. Recently, the program has made some changes to the editing routines to allow the identification of additional types of questionable billings. Specific enhancements are discussed below in response to the OIG's recommendations. Second, DCMWC recently combined its medical audit and medical operations

units into a single unit. This will allow the program to better manage its oversight responsibilities. Additionally, the program recently augmented its oversight procedures to include post-payment audits of certain types of activities and billing patterns. This will allow the program to identify any suspicious activities early on and take appropriate actions.

The report contains a number of recommendations. The first as it appears in the body of the report is that DCMWC should "review the automated and other systems controls within its bill payment system, including office visits, to determine if additional controls are necessary to control costs and reduce fraud vulnerability. Medical procedures which are rarely or infrequently conducted, such as ABG testing, should be automatically rejected by the DCMWC bill payment system when billed on multiple occasions by a provider." (Page 3. See also page iii of the Executive Summary) DCMWC agrees with the recommendation and has already undertaken such a review. Based on consultations with the OWCP Medical Director, DCMWC has established a frequency limit for ABG tests per year. Following the frequency edit routine, bills for ABG tests above the limit will be denied and, for reconsideration, the provider will have to submit appropriate medical justification. Simple limitations for other rarely used procedures, based on extensive program experience, have proven to be neither cost-effective nor warranted. Accordingly, additional limits are not contemplated at this time. However, the program constantly reviews bill payment activities to determine if additional edits are warranted and will continue to do so. Additionally, once the new client server system is implemented, currently scheduled for late spring 2000, additional, more sophisticated relational edits and related procedures will be considered.

The report also recommends that written questionnaires be used to confirm the delivery of oxygen services and the quality of that service. (See pages 3 and 7) DCMWC already has a procedure to verify the initial receipt of service (see DCMWC Procedure Manual Chapter 3-601, paragraph 7) and is in the process of enhancing that procedure to ensure that all requisite information is gathered in a uniform manner. Based on extensive experience, the program has determined that written questionnaires, given the demographics of our customers, are not an effective way to gather information. DCWMC is

in the process of revising its telephone survey to validate that requested services are delivered as prescribed and that the patient is satisfied with the service. Draft telephone surveys to be used by the District Offices are attached.

On page 7 of the report, it is recommended that DCMWC "lower its automated maximum payable amounts of gaseous oxygen for use as either a primary or supplemental system... DCMWC also needs to consider that many of its claimants using gaseous oxygen may be able to have their oxygen needs met through the use of oxygen concentrators." A review of the data shows that only a very small number of miners actually use large amounts of gaseous oxygen. Accordingly, while the program will review its maximum total payable amounts and consider additional edits, because these changes will require sophisticated relational edits to be most effective, they cannot be made until the new client server system is implemented. At that time, the program will review its manual and automated procedures to determine how additional controls can be implemented. In the interim, DCMWC will also review payment amounts per cubic foot of oxygen to determine if these amounts should be lowered.

The program will take a number of actions immediately to improve the oversight of gaseous oxygen services. First, for secondary oxygen service, the program will adopt the HCFA annual dollar cap allowed for tank oxygen, $4,118 for tank oxygen service for flow rates above four liters per minute. This limit will be established following the requisite notices to the provider community. Additionally, DCMWC will implement post-payment reviews of total gaseous oxygen charges (primary and secondary combined) that exceed $10,000 for a patient in a year. Once the new client server system is in place, more sophisticated edits and audits will be explored.

You also suggest that patients be encouraged to use concentrators rather than tank oxygen in order to save money. (Pages 5 and 6) The program will modify its CMN procedures to require the examiner, in cases where a concentrator could be used in lieu of tank oxygen, to contact the physician to ask whether such a change is appropriate. If the doctor concurs, a concentrator will be approved.

You also recommend that DCMWC change Section 13(e) of its Certificate of Medical Necessity (CMN) form to specify that a false or misleading statement on the form is a felony rather than a misdemeanor, as currently indicated on the form. (Page 8) You suggest application of 18 U.S.C. 1001, rather than 30 U.S.C. 941, and that the form be modified to require the physician to personally complete the form, and so certify. DCMWC has consulted with the Associate Solicitor of Labor for Black Lung Benefits and will make appropriate changes to Section 13(e) of the form. However, rather than insist that the physician personally complete the form, DCMWC will ask the physician to certify that he or she has personally reviewed the form and certifies that the information is accurate and complete. This is similar to the certification required of physicians on the HCFA CMN form.

The draft report discusses best practices for home oxygen and compares VA, HCFA and DCMWC practices and rates. The report recommends that DCMWC "restructure its oxygen reimbursement methods and policies to control costs and reduce vulnerabilities to fraud." Further, the report suggests that the program review VA and HCFA practices for guidance. (See page 18) While not all VA and HCFA practices are appropriate for application in the Black Lung program, the program agrees that the HCFA maximum allowable rates for concentrator rentals establish a de facto standard of what is "reasonable and customary." Accordingly, DCMWC will adopt the HCFA rate (currently $228.80 per month) as the maximum allowable charge as soon as the required notices are given to providers. Once the new client server system is implemented, the program will consider the feasibility of additional controls, such as locality rates.

DCMWC believes that in adopting the HCFA limit for concentrator rentals we have satisfied the spirit of the OIG recommendation, reducing the maximum allowable rate for this service while obviating the cumbersome and problematic competitive bidding process. This also allows DCMWC to retain its longstanding policy of patient choice in a manner consistent with sound cost management.

The report goes on to recommend "that DCMWC abandon its current procedures concerning the use of generic code A4330 for supplies. Alternatives can include … bundling supply charges with the cost of the stationary oxygen delivery

system." (Page 18) DCMWC will adopt this recommendation when it adopts the HCFA maximum allowable rate for concentrator rentals.

Finally, the report recommends that "DCMWC develop a system whereby its medical audit section can review the reports of excluded medical providers maintained by HHS..." (Page 18) DCMWC agrees and will work with HHS to obtain current listings and will establish appropriate review procedures.

The report contains one minor technical error. On page 18, the report suggests that the Prompt Payment Act applies to the payment of medical bills. The act does not apply to the payment for beneficiary procured medical treatment or drugs. The act does apply to medical services ordered by DCMWC, such as diagnostic charges for certain exams and consultant services.

The Black Lung program believes that, over time, it has implemented a comprehensive set of manual and automated procedures to control medical costs and abuses in a cost effective and responsible manner. Such controls must be consistent with both our patients' rights and needs and sound management principles. By adopting most of the OIG's recommendations as described above, the integrity of the program will be further enhanced.

Thank you for the opportunity to comment on the draft report. If you have any questions, please contact James DeMarce, Director, DCMWC on 202-693-0046.

Attachment

CMN PHONE VERIFICATION - HOME OXYGEN

CMN PHONE VERIFICATION - HOME OXYGEN

Claim No.:____-___-_____ Beneficiary Name:_____

(SUGGESTED INTRODUCTORY STATEMENT:)
We have received/approved a prescription from your doctor which indicates that you need: (State specific oxygen equipment prescribed.) _____
_____
for the period _____ to _____.

Before payment can be authorized for this equipment, we need to ask you a few questions to assure that you are getting the oxygen equipment you are entitled to.

(SUGGESTED WORDING OF QUESTIONS:)

1. (Verify beneficiary's current address.)

2. Have you received the oxygen equipment as prescribed by the doctor? Yes __, (if No__, please explain: _____).

3. Are you using the oxygen equipment as prescribed by the doctor? Yes __, (if No__, please explain: _____).

4. When did you first receive the oxygen equipment? _____.

5. **(IF APPLICABLE)** How many tanks of oxygen did the supplier give you? (_____) On what date? (_____).

6. Have oxygen equipment supplies **(SPECIFY)** been provided? Yes __, (if No__, please explain: _____).

7. Are you satisfied with the service provided? Yes___, if No___, please explain: _____).

OTHER CMN CERTIFICATION COMMENTS:_____
_____.

(NOTE to CE: At this point provide the beneficiary with the district office 800 phone number and explain that he should call if there are any problems/concerns with this CMN-related equipment. After dating and signing below, place this phone verification in the claim file directly above the approved CMN.)

(CE signature)_____ (Date)_____

(See BLBA PM Chapter 3-601.7)

CMN PHONE VERIFICATION - OTHER THAN HOME OXYGEN

CMN PHONE VERIFICATION - OTHER THAN HOME OXYGEN

Claim No.:____-___-_____ Beneficiary Name:_____.

(SUGGESTED INTRODUCTORY STATEMENT:)
We have received/approved a prescription from your doctor which indicates that you need: (State specific CMN equipment or service prescribed.)

_____

_____

for the period _____ *to* _____.

Before payment can be authorized for this equipment, we need to ask you a few questions to assure that you are getting the equipment (service) you are entitled to.

(SUGGESTED WORDING OF QUESTIONS:)

1. (Verify beneficiary's current address.)

2. Have you received the medical equipment (service) as prescribed by the doctor? Yes __, (if No__, please explain: _____).

3. Are you using the medical equipment (service) as prescribed by the doctor? Yes __, (if No__, please explain: _____).

4. When did you first receive the equipment (service)? _____.

5. Are you satisfied with the equipment (service) provided? Yes___, if No___, please explain: _____).

OTHER CMN CERTIFICATION COMMENTS:_____

_____.

(NOTE to CE: At this point provide the beneficiary with the district office 800 phone number and explain that he should call if there are any problems/concerns with this CMN-related equipment. After dating and signing below, place this phone verification in the claim file directly above the approved CMN.)

(CE signature)_____ (Date)_____

(See BLBA PM Chapter 3-601.7)

CMN PHONE VERIFICATION - HOME OXYGEN - RECERT

CMN PHONE VERIFICATION - HOME OXYGEN - RECERT

Claim No.:____-___-_____ Beneficiary Name:_____

(SUGGESTED INTRODUCTORY STATEMENT:) *We have received a certification from your doctor that you need to continue using: (State specific oxygen equipment prescribed.)*

_____

for the period _____ *to* _____. *Before payment can be authorized for this equipment, we need to ask you a few questions to assure that you are getting the oxygen equipment you are entitled to.*

(SUGGESTED WORDING OF QUESTIONS:)

1. (Verify beneficiary's current address.)

2. Have you been receiving, and are you still using, the oxygen equipment as prescribed by the doctor? Yes __ No __
   If not, please explain:_____

3. **(IF APPLICABLE)** How many tanks of oxygen did the supplier most recently give you? (_____) On what date? (_____)

5. Are oxygen equipment supplies **(SPECIFY)** being provided, and are you satisfied with the service provided? Yes___ No___
   If not, please explain:_____

   OTHER CMN CERTIFICATION COMMENTS:_____
   _____

(NOTE to CE: At this point provide the beneficiary with the district office 800 phone number and explain that he should call if there are any problems/concerns with this CMN-related equipment. After dating and signing below, place this phone verification in the claim file directly above the approved CMN.)

(CE signature)_____ (Date)_____

(See BLBA PM Chapter 3-601.7)

(TELEPHONE CALL-IN LETTER)

(TELEPHONE CALL-IN LETTER)

(SUGGESTED WORDING OF TELEPHONE CALL-IN LETTER)

Dear _____:

We need for you to call us concerning your Black Lung medical benefits. We have been unable to contact you by phone. We need to ask you a few questions in order to determine that you are receiving the **(insert a discription of the CMN related equipment/service)** that your doctor prescribed for you.

Please call me as soon as possible, but not later than 30 days at the toll-free phone number at the top of this page.

Thank you,

_____
(Claims Examiner)

(See BLBA PM Chapter 3-601.7)