

BRIEFLY...

Highlights of Report Number: 03-12-002-04-431, to the Acting Director of the Office of Workers' Compensation Programs.

WHY READ THE REPORT

The Office of Inspector General (OIG) audited claims paid by the Office of Workers' Compensation Programs (OWCP) under the Federal Employees' Compensation Act (FECA) program for durable medical equipment (DME). The FECA program provides wage replacement benefits, medical treatment, vocational rehabilitation, and other benefits to federal workers who experience work-related injury or occupational disease. DME is equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. The audit covered DME claims totaling \$12.6 million paid to 2,700 providers during the period October 1, 2009, to December 31, 2010, which represents approximately 1 percent of total medical bills paid by OWCP for the FECA program during this period.

WHY OIG CONDUCTED THE AUDIT

In response to widely publicized cases of DME fraud in federal healthcare programs, OIG conducted the audit to answer the following question:

Did OWCP have adequate controls to ensure DME payments were proper and reasonable?

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to:

<http://www.oig.dol.gov/public/reports/oa/2012/03-12-002-04-431.pdf>

March 2012

AUDIT OF FEDERAL EMPLOYEES' COMPENSATION ACT, DURABLE MEDICAL EQUIPMENT PAYMENTS

WHAT OIG FOUND

The OIG found OWCP has a series of controls over its DME payment administration process in order to reduce the risk of improper payments and ensure that DME costs are reasonable. OWCP utilizes a fee schedule to set maximum allowable amounts (MAA) that it will pay for specific items of DME.

However, we found weaknesses in the documentation of the provider enrollment process. Several procedures were required to be performed to verify that providers were legitimate, but documenting this process was not required. As a result, OWCP had no assurance that these procedures were being adequately performed. We did not analyze non-DME providers, but noted that OWCP requires its service provider to follow the same verification process for all medical providers.

We also found an increased risk of improper payments due to the high number of claims using a "miscellaneous" procedure code, a lack of documentation supporting a rental versus purchase analysis, and insufficient controls over the determination of price reasonableness for cases deemed catastrophic. Claims coded as DME–Miscellaneous are at risk of being improper payments because they are not subject to an MAA, and if approved by a Claims Examiner (CE) are "paid as billed." Our review of a sample of claims identified more than \$68,000 in questionable payments.

WHAT OIG RECOMMENDED

We recommended that OWCP establish additional controls to document the provider enrollment process; ensure CEs analyze and document a determination of cost reasonableness before authorizing payments coded as DME-Miscellaneous, direct CEs to perform and document rental versus new purchase analysis, strengthen controls over DME bills paid for catastrophic cases, and initiate recovery of any overpayments identified as a result of the audit.

In response to the draft report, OWCP indicated the enrollment verification is already adequately documented. It agreed to provide additional guidance to claims staff to reinforce existing procedures over miscellaneous DME, reinforce procedures and develop new processes for rental versus purchase analysis, and review current controls over catastrophic cases. OWCP stated it does not have authority to recover overpayments where rentals exceed purchase prices.

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The Federal Employees' Compensation Act (FECA) authorized a disability compensation program administered by the Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP). FECA provides wage replacement benefits, medical treatment, vocational rehabilitation and other benefits to federal workers or their dependents that experience work-related injury or occupational disease. FECA authorizes the payment for Durable Medical Equipment (DME), which is equipment that can withstand repeated use, serves a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. OWCP used a service provider contractor, Affiliated Computer Services (ACS), to process medical bills, including those for DME. There have been many incidents in which DME providers were investigated, charged, and convicted of fraudulent DME related billings to Medicare and Medicaid and other government programs. Therefore, there is a need for strong controls in this area. WithumSmith+Brown (WS+B), under contract with the DOL OIG, audited OWCP's process for paying medical claims for DME.

The audit objective was to answer the following question: Did OWCP have adequate controls to ensure DME payments were proper and reasonable?

The audit covered DME medical claims totaling \$12.6 million paid by OWCP to 2,700 providers from October 1, 2009 to December 31, 2010. This represented approximately one percent of all medical bills paid under FECA during the same period. The audit included analysis of OWCP policies and procedures to determine whether controls addressed DME request and approval procedures, billing procedures, and authorized DME substitutions.

The audit reviewed OWCP actions to implement cost containment control measures by establishing a fee schedule for allowable goods and services.

WS+B conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). 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.

RESULTS IN BRIEF

OWCP has a series of controls over its DME payment administration process in order to reduce the risk of improper payments¹ and ensure that DME costs are reasonable. However, we found weaknesses in the controls related to documentation of the provider enrollment process. We also found an increased risk of improper payments due to the high number of claims using a “miscellaneous” procedure code, a lack of documentation supporting a rental versus purchase analysis, and insufficient controls over the determination of price reasonableness for cases deemed “catastrophic”.

We noted a significant weakness in the provider enrollment process due to lack of documentation of the provider verification process. DME providers submit enrollment forms to ACS for processing. Provider verification process policies and procedures required ACS to perform several procedures to verify that providers were legitimate, but documenting the verification process was not required. As a result, OWCP had no assurance that these procedures were being adequately performed. We did not analyze non-DME providers, but noted that OWCP required its service provider to follow the same verification process for all medical providers.

OWCP’s review of payment requests needs strengthening due to the excessive use of the DME–Miscellaneous procedure code for DME medical bills. We noted this procedure code had the highest dollar amount of claims paid during our audit period (\$1.5 million, or 13 percent of total DME claims) for 2,500 line items. Claims coded as DME–Miscellaneous are at a much higher risk for improper payment because they are not subject to a maximum allowable amount (MAA) and; therefore, if approved by a claims examiner (CE) are “paid as billed.” It is at the CEs’ discretion to determine if the amount is reasonable. We examined 10 of these claims and noted that determinations of price reasonableness were not documented for 6 claims.

¹ Office of Management and Budget Circular A-123, Appendix C, defines Improper Payments as any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments and underpayments (including inappropriate denials of payment or service). An improper payment includes any payment that was made to an ineligible recipient or for an ineligible service, duplicate payments, payments for services not received, and payments that are for the incorrect amount.

OWCP did not always have evidence that the CEs had analyzed the cost effectiveness to rent versus to buy for requests for new DME purchases. For 3 of the 13 DME cases for which we analyzed rental payments, we determined that the rental payments exceeded the price of a new purchase. In none of these cases was there evidence that the CEs had performed any pricing analysis. The estimated overpayment as a result of renting these three items was \$24,713.

OWCP had limited controls over catastrophic claimant cases to ensure the costs were reasonable. We performed an analysis of claimants with more than \$20,000 in claims to ensure that the billing was in line with expectations for the equipment in terms of usage and frequency based on Centers for Medicare and Medicaid Services (CMS)² and health insurance industry practices. A total of 12 claimants met these criteria, with payments totaling \$336,928. For seven claimants, we noted OWCP paid for items that were typically denied by CMS as not medically necessary (e.g., power elevating seats), at amounts that appeared excessive or for items that were not appropriately described. Seven of these claimants were designated as “catastrophic cases” and all bills were edited for duplication and limited by fee schedules, but treatment suites designed to limit payments for accepted conditions were not applied. Our analysis of the seven catastrophic cases found four claims for items that would not have been paid under CMS or that OWCP agreed had been miscoded. The total paid for these four claims was \$43,833.

We recommended that the OWCP Acting Director establish additional controls to document the provider enrollment process, the analysis and authorization of the use of the DME–Miscellaneous code, and the performance of rental versus new purchase analysis of DME. We also recommended that additional controls be implemented over bills paid for catastrophic cases. Finally, we recommended that the OWCP Acting Director initiate overpayment recovery procedures to recover the overpayments identified in this audit.

In response to our draft report, the OWCP Acting Director partially agreed with our recommendations. The OWCP Acting Director indicated the enrollment verification is already adequately documented, agreed to provide additional guidance to claims staff to reinforce existing procedures over review of miscellaneous DME, agreed to reinforce procedures and develop new processes with the medical bill processing vendor for rental versus purchase analysis, agreed to review current controls over catastrophic cases, although it is unlikely further controls will be put in place, and indicated that OWCP does not have authority to recover perceived rental versus purchase overpayments mentioned in our report. The OWCP Acting Director’s entire response is included in Appendix D.

We disagree with OWCP’s response regarding the adequacy of documentation over the enrollment verification process and continue to believe that documentation over the provider verification process should be improved. Additionally, OWCP’s response

² CMS is an operating division within the U.S. Department of Health and Human Services.

regarding collection of perceived overpayments only addressed rental versus purchase overpayments, and did not address other types of overpayments, such as those caused by miscoding. We continue to believe that OWCP should carefully review the other types of potential overpayments identified and determine where recovery attempts are an option.

RESULTS AND FINDING

Objective — Did OWCP have adequate controls to ensure DME payments were proper and reasonable?

Several of OWCP's controls to prevent DME improper payments could be strengthened.

Finding — OWCP has controls in place to reduce the risk of improper and unreasonable DME payments, but controls in several areas could be strengthened.

OWCP has a series of controls to reduce the risk of improper payments, but gaps in the design of certain controls allow for improper payments to occur and not be detected. However, we found weaknesses in the controls related to documentation of the provider enrollment process. Several procedures were required to be performed to verify that providers were legitimate, but documenting this process was not required. As a result, OWCP had no assurance that these procedures were being adequately performed.

We also found insufficient controls over the use of the DME–Miscellaneous procedure code, the process for analyzing rentals versus new purchases of DME, and the determination of DME price reasonableness in cases deemed “catastrophic.” Claims coded as DME–Miscellaneous are at risk of being improper payments because they are not subject to an MAA, and if approved by a CE are “paid as billed.” Our review of a sample of claims identified more than \$68,000 in questionable payments.

OWCP processes medical bills, including DME, through its third-party medical bill claims-processing service provider, ACS. Medical bills, including DME bills, are submitted to ACS and keyed into the medical bill processing system. The bills are then imaged into an electronic document retrieval system. The bills undergo a series of progressive edits before they can be paid. Key information from the bill is matched against information in the bill processing system. The bill must be from a provider who is enrolled in the FECA program, and for a claimant whose injury or disease has been accepted and approved for medical payments. The medical bill system checks to see if the bill is a potential duplicate payment based on the provider, dates of service, and procedure codes. Next, the system checks to see whether there is a prior authorization on file if required. Pre-authorization by a district office CE is required for all DME–Miscellaneous requests and for DME over \$2,000 with a specific Healthcare Current Procedure Coding System (HCPCS) code. The bill is then matched against the

treatment suite edits, which identify what types of DME are allowable based on the claimant's accepted conditions (diagnosis codes). The treatment suites also identify what, if any, additional authorizations are required.

OWCP developed a fee schedule for DME by using the CMS Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) Fee Schedule. The DMEPOS Fee Schedule established MAAs for Medicare purposes in all 50 states plus several territories. OWCP generally adopted the highest of these DMEPOS MAA then multiplied that amount by a factor of 1.25.³ This conversion factor (CF) multiplier was used to account for Medicare co-payment and deductible amounts since OWCP did not require an injured worker to pay either a co-payment or a deductible for covered services and the DME providers were not permitted to bill any additional costs to the injured workers.

In addition, OWCP established MAAs for certain DME not covered by CMS that used the HCPCS codes. These MAA were based on the most recent relative value units (RVU) devised by state workers' compensation data, and OWCP program-specific data. OWCP also applied a geographic practice cost index (GPCI) value to each reimbursement, and used its own CF for converting RVU and GPCI to maximum dollar amounts.

The FECA Procedure Manual, Part 2, Chapter 2.0810, Developing and Evaluating Medical Evidence, discusses the CE's function in evaluating medical evidence and authorizing treatment. Paragraph 17 covers special equipment and furniture and states:

OWCP authorizes durable medical equipment to aid in the relief and healing for an accepted work-related condition. These items include those routinely found in medical supply sources, such as braces, crutches, etc. However, sometimes requests are received for equipment or furnishings not commonly obtainable from medical supply sources or prescribed for treatment (e.g. whirlpools, special beds or mattress sets, lift chairs, exercise equipments, motorized scooters, etc.) The OWCP will not approve elaborate or specialized equipment where a more basic alternative is suitable.

In all instances, the CE must ensure that the equipment is necessary to treat the effects of the work related injury and that its use will be consistent with the claimant's restrictions and safety. The CE must also determine whether rental or purchase is most cost effective, and whether the cost is commensurate with the basic (unadorned) item required for treatment. . . .

The CE should obtain the following evidence from the physician:
(1) A full, specific description of the basic equipment or furnishing required to treat effects of the job-related condition, along with an explanation of

³ In 2010 only, this CF multiplier was adjusted to 1.33 due to the uncertainty surrounding Medicare's final fee schedule amounts.

how the item will address the effects of the work-related condition and the anticipated improvement. (2) The anticipated duration of the need for the item (in order to determine whether rental or purchase is appropriate).

The CE should also obtain the following evidence from the claimant: (1) The full name of two or three suppliers, along with complete contact information for each. (2) From each potential provider, a signed statement describing in detail the basic, unadorned item meeting the physician's specifications. If the claimant wants a more elaborate item . . . the claimant should submit a price quote for the basic item only. It is the claimant's responsibility to pay for any enhancements.

If the information received is incomplete or doubt exists about the suitability, appropriateness, or need for the equipment or furniture, the CE should undertake suitable development, such as requesting clarification from the AP or obtaining a second opinion examination.

The following presents the weaknesses we noted in the related processes to reduce the risk of improper and unreasonable payments. These weaknesses covered improperly documenting the provider enrollment process and determining cost reasonableness to support approval of the use of the DME–Miscellaneous procedure code. We also noted that OWCP needs to ensure it documents its determination of whether it is more cost effective to rent or purchase DME and to identify additional controls to reduce the risk of improper payments related to DME costs for catastrophic claimant cases.

Documentation of provider enrollment verification was not adequate to support approval.

In order for a DME provider to receive compensation or reimbursement under the FECA program, a DME provider must be enrolled in the OWCP Central Bill Pay system and then submit valid invoices for DME provided to FECA beneficiaries, which were physician ordered and necessary to treat an approved (accepted) medical condition.

We noted a significant weakness in the provider enrollment process due to lack of documentation of the provider verification process. DME providers submit enrollment forms to ACS for processing. ACS reviews the forms to ensure they are properly completed. Provider verification process policies and procedures required ACS to perform several procedures to verify that providers were legitimate, but documenting the verification process was not required. As a result, OWCP had no assurance that these procedures were being adequately performed.

We performed testing to determine if there were providers enrolled who did not appear to be valid. We analyzed enrollments of 40 providers — all 25 providers with more than \$100,000 of claims in our audit period, and 15 randomly selected providers. Using data in OWCP's provider databases, we conducted online searches and phone calls to verify if the provider appeared to be a legitimate business. One provider did not have a web

site and could not be reached by its business phone; therefore, we performed alternative procedures to determine the validity of the business. However, ACS did not maintain documentation to support its determination of the legitimacy of this or the other 39 providers we tested. In response to our finding, OWCP indicated a “notes field” in the data base is used for that purpose; however, our testing results did not find this field utilized for such a purpose.

Although we did not analyze non-DME providers, OWCP requires the same verification process to be followed by its service provider for all medical providers. Therefore, without adequate documentation to support that verification procedures were actually performed, controls over the provider enrollment process were not sufficient to support approval.

Documentation supporting use of the DME–Miscellaneous code was insufficient to support cost reasonableness determination.

OWCP’s review of payment requests needs strengthening regarding its use of the DME–Miscellaneous procedure code for DME medical bills. We noted that for the audit period, the DME–Miscellaneous procedure code had the highest dollar amount of claims paid during our audit period (\$1,584,050, or 13 percent, of total DME claims) for 2,500 bill line items. The majority of these claims, \$1,265,274, were submitted by just 19 of the approximately 2,700 providers. These bills were at a much higher risk for improper payment because they were not subject to a MAA and were therefore “paid as billed.” We examined 10 of these claims and noted that the CEs’ determinations of price reasonableness were not documented for 6 of these claims.

Although OWCP had controls designed to ensure that costs paid for certain items did not exceed preset amounts, these controls can be circumvented for claims using the DME–Miscellaneous procedure code.

Our analysis of the DME–Miscellaneous claims focused on providers who had claims totaling at least \$10,000, and whose volume of E1399 claims was 10 percent or more of their total claims —15 providers met these criteria, totaling \$1,031,718 and 1,377 bill line items. We randomly selected 10 of these bill line items totaling \$8,329 for further testing. For these 10 items, we found the following:

- Four items were under \$150 and the item was paid as billed without evaluation, which was in accordance with OWCP policy.
- All six of the remaining items were paid as billed. Of these six items, four did not include the following documentation which could be used to support the reasonableness of the amount paid:
 - a manufacturer’s or wholesaler’s invoice (best practice) or manufacturer product information brochure;

- a Manufacturer's Suggested Retail Price sheet (best practice); and
- a narrative description of the product (best practice).

Although all 10 items were approved by a CE as required by the FECA Procedure Manual, we found the design of the controls did not require documentation to support how the CE determined the amount paid was reasonable.

While we analyzed only DME bills, a similar miscellaneous code exists for other HCPCS categories, which were outside the scope of this audit. Therefore we did not determine whether similar risks also exist for these other non-DME miscellaneous codes.

Lack of adequate analysis of rental versus purchased DME can result in high costs paid.

OWCP did not always have evidence that CEs analyzed the cost effectiveness to rent or purchase when reviewing requests for new DME purchases. For 3 of the 13 DME cases for which we analyzed rental payments, we determined that the rental payments exceeded the price of a new purchase. In none of these cases was there evidence that the CEs had performed any pricing analysis. The estimated overpayment as a result of renting these three items was \$24,713.

We analyzed rental equipment claims, which totaled \$3.5 million for 10,282 bill line items. We performed cost-reasonableness analysis of rentals with cumulative payments in excess of \$10,000 — 13 claims representing 142 bill line items totaling \$158,996 met these criteria.

In 3 of the 13 claims, the total rental amount paid was significantly higher than the price of a new item, even under OWCP's Fee Schedule, which provides for a maximum cost that could be paid if purchased. Furthermore, none of the three claims had any evidence that a cost analysis of rental versus purchase was performed. The following chart provides details of the three claims.

Case #	Amount Paid	Purchase Price ¹	Difference	Comment
062246837	\$12,600	\$1,458	\$11,142	New purchase would have been less than amount paid for rentals.
160206005	\$13,731	\$10,107	\$3,624	Total rental payments higher than amount paid for as a new item under OWCP fee schedule.
102051628	\$10,050	\$103	\$9,947	The item did not appear on the CMS Fee Schedule as eligible for reimbursement either as a new item or a rental. In addition, the total of the rental payments is significantly higher than the price of a new item under OWCP's Fee Schedule
Total	\$36,381	\$11,668	\$24,713	

¹MAA per OWCP Fee Schedule for new purchase

Without documentation of the required determination by the CE of whether rental or purchase is most cost effective, OWCP may have paid \$24,713 in excessive DME costs.

Cost reasonableness analysis of claims related to catastrophic cases could be improved.

We analyzed claimants with more than \$20,000 in claims to ensure that billing was in line with expectations for the equipment in terms of usage and frequency based on CMS and health insurance industry practices — 12 claimants met these criteria, with payments totaling \$336,928. We noted issues on 11 of these 12 claimants, as follows:

- For four claimants, payments were made for items that would not have been paid under CMS or that OWCP agreed had been miscoded. The total paid under these four cases relating to these claims was \$43,833.
- For seven claimants, OWCP paid for items that were typically denied by CMS as not medically necessary (e.g. power elevating seats), at amounts that appeared excessive (e.g. \$1,000 per month for an electric bill to operate an aquatic therapy unit in the home in addition to \$2,000 to \$4,000 per quarter for maintenance), and for items that were not appropriately described (e.g. “Misc. Supplies”.) In one instance, OWCP agreed it paid for too many units of oxygen, and agreed to establish unit controls for that procedure code.
- For the same seven claimants, all had been designated as “catastrophic cases”; therefore, their bills were not subject to treatment suite edits for their relation to the accepted condition or for additional authorization.

According to the FECA Procedure Manual, catastrophic cases are defined as those that are life-threatening or have extensive functional deficits where medical recovery is

expected to extend over long or indefinite periods of time. Those cases with more than 12 accepted conditions are also often catastrophic. Catastrophic cases should be rare (only 200 currently exist) and must be authorized by the District Director. We did not evaluate the establishment of the original case as a catastrophic case, which in many cases was done years before.

With catastrophic cases, treatment suite edits which are based on accepted conditions and controls checking for additional authorizations are bypassed, such as edits for relationship of prescriptions to accepted conditions, lack of authorization other than the catastrophic designation by the District Director, or billing for add-on items where the base item was not billed, which increases the risk of improper payments.

RECOMMENDATIONS

We recommend the OWCP Acting Director:

1. Direct that the procedures performed during the provider enrollment process be documented to ensure controls as to who performed the verification, when it was done, and what procedures were performed are supported.
2. Establish additional procedures to ensure CEs perform and document OWCP's requirement for an analysis of cost reasonableness when authorizing payments for items coded as E1399 – Miscellaneous, as well as any other item that is "paid as billed" and not subject to fee schedule limitations.
3. Direct CEs to perform and document a rental versus new purchase analysis for any rentals exceeding a certain time period and/or certain dollar threshold.
4. Examine controls over bills paid for catastrophic cases to identify additional controls needed to reduce the risk of improper payments and excessive costs without negatively impacting the beneficiaries of the FECA program.
5. Initiate overpayment recovery procedures to recover the overpayments identified in this audit.

We appreciate the cooperation and courtesies that OWCP and Division of Federal Employees' Compensation (DFEC) personnel extended to WithumSmith+Brown during this audit.

WithumSmith+Brown, PC

Appendices

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Appendix A

Background

FECA is one of four major disability compensation programs administered by DOL's OWCP. FECA provides wage replacement benefits, medical treatment, vocational rehabilitation and other benefits to certain workers or their dependents that experience work-related injury or occupational disease.

FECA provides workers' compensation coverage to three million Federal and Postal workers around the world. The DFEC adjudicates new claims for benefits and manages ongoing cases; pays medical expenses and compensation benefits to injured workers and survivors; and helps injured employees return to work when they are medically able to do so.

In FY 2009, 129,690 new cases were created. The program provided 253,000 workers and survivors approximately \$2.7 billion in benefits for work-related injuries or illnesses. Of these benefit payments, over \$1.7 billion was for wage-loss compensation, \$848 million for medical and rehabilitation services, and \$138 million for death benefit payments to surviving dependents.

Federal employing agencies are responsible for reimbursing the Division of Federal Employees' Compensation for their workers' compensation expenses. This reimbursement occurs once each year through the chargeback process.

DME and supplies are authorized under Section 8103(a) of FECA. Under the provisions of FECA, OWCP authorizes payment for medical services and establishes limits for fees for such services. OWCP began to reimburse medical services under a schedule of MAAs in 1986. Since June 1, 1994, the schedule has been based on the most recent RVU devised by the U.S. Department of Health and Human Services, CMS, for services described under the American Medical Association's Physicians' Current Procedural Terminology, and the HCPCS.

In addition, OWCP uses program-specific data and the most recent CMS Clinical Diagnostic Laboratory National Limit data, including carrier maximum, national limit, and mid-point values, to establish RVU and conversion factors for clinical laboratory procedures provided under OWCP programs. OWCP also devises its own RVU for durable medical equipment, supplies, and other items or services such as those described under procedure codes not utilized by CMS. Such RVU are based on state workers' compensation data, and OWCP program-specific data.

OWCP also applies a schedule to certain durable medical equipment, supplies and other items or services covered under the program. For implanted durable medical equipment and prosthetic implants – most implants are paid under the Grouper/Pricer processing of inpatient acute care hospital bills. For outpatient procedures, implants must be billed on a separate line using the appropriate HCPCS code. Many implant items have maximum fees under the OWCP fee schedule. If no maximum allowable

levels are set by the fee schedule, OWCP will pay acquisition cost for implants, provided the bill is accompanied by a copy of the original invoice clearly showing invoice cost less applicable discounts.

Appendix B

Objective, Scope, Methodology, and Criteria

Objective

Our audit objective was to determine if OWCP had adequate controls to ensure DME payments were proper and reasonable.

Scope

WS+B, under contract with the DOL OIG, audited the DME process to administer payments totaling \$12,620,852 within the FECA as administrated by the OWCP for the period from October 1, 2009 to December 31, 2010. We conducted this performance audit in accordance with GAGAS. 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. The audit included onsite fieldwork at the DOL national headquarters in Washington, D.C.

Our audit focused on the DME payment process. The audit included a review of policies and procedures, system user guides, written procedures related to the internal audit process, list of DME items requiring a physician's script, bill payment history reports, lists of excluded providers, fee schedule calculations, and provider information. The audit also included the use of data mining technology to review and extract possible anomalies. We conducted interviews with various employees at OWCP.

Methodology

To accomplish our audit objectives, we followed a risk-based audit approach in order to address risks and to achieve the objectives of this audit.

The objective of the audit was not to render an opinion on the FECA DME payments for the period from October 1, 2009 to December 31, 2010, so the extent of testing performed was scoped to specifically target the subject matter of the three audit objectives in accordance with GAGAS for performance audits.

We obtained an understanding of the FECA DME program payment requirements. We conducted interviews with FECA officials from the national office and local investigators to gain an understanding of the DME payment processes. Policies and procedures followed by OWCP employees were reviewed.

We also performed data analysis of the DME payments made from a database provided by OWCP, examined selected provider enrollment documents, and examined selected bills and related authorizations and medical evidence.

Examples of the audit results and the relevance of the tests to the audits' objectives are provided in the body of the report.

Criteria

We used the following criteria to accomplish our audit:

- ✓ Government Auditing Standards as revised in 2007
- ✓ DOL OIG Office of Audit and Procedures Handbook, July 2009
- ✓ Federal Employee's Compensation Act, as amended
- ✓ Title 20, Code of Federal Regulations, Part 10, Claims for Compensation under FECA
- ✓ Office of Workers' Compensation Programs – Federal Employees' Compensation Act Procedure Manual
- ✓ Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments*.

Appendix C

Acronyms and Abbreviations

ACS	Affiliated Computer Services, Inc.
CE	Claims Examiner
CF	Conversion Factor
CMS	Centers for Medicare and Medicaid Services
DFEC	Division of Federal Employees' Compensation
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics/Orthotics & Supplies
DOL	Department of Labor
FECA	Federal Employees' Compensation Act
GAGAS	Generally Accepted Government Auditing Standards
GPCI	Geographic Practice Cost Index
HCPCS	Healthcare Current Procedure Coding System
MAA	Maximum Allowable Amount
OIG	Office of Inspector General
OWCP	Office of Workers' Compensation Programs
RVU	Relative Value Units
WS+B	WithumSmith+Brown

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OWCP Response to Draft Report

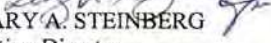
U.S. Department of Labor

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

File Number:

MEMORANDUM FOR: ELIOT P. LEWIS
Assistant Inspector General

FEB - 2 2012

FROM: 
GARY A. STEINBERG
Acting Director
Office of Workers' Compensation Programs

SUBJECT: FECA Durable Medical Equipment Payments Report

Thank you for the opportunity to comment on report number 03-12-002-04-431, in which your office reviewed to what extent the Division of Federal Employees' Compensation (DFEC) has adequate controls in place to ensure that Durable Medical Equipment (DME) payments are proper and reasonable.

Regarding the individual recommendations, OWCP responds as follows:

Recommendation #1: Direct that the procedures performed during the provider enrollment process be documented to ensure controls as to who performed the verification, when it was done, and what procedures were performed are supported.

Management Response: The Central Bill Pay (CBP) vendor already utilizes a process that documents their verification activity when enrolling a provider. Specifically, ACS documents all their calls for enrollment verifications via the CRN which is located in the SIR application.

Recommendation #2: Establish additional procedures to ensure CEs perform and document OWCP's requirement for an analysis of cost reasonableness when authorizing payments for items coded as E1399 – Miscellaneous, as well as any other item that is "paid as billed" and not subject to fee schedule limitations.

Management Response: OWCP agrees with audit recommendation that claims staff needs to review the Miscellaneous DME Code E-1399 request thoroughly for proper coding and cost reasonableness. Additional guidance will be provided to the claims staff to reinforce the existing DME procedures. However, there will not be any additional procedures established as the processes described in FECA PM 2-0810(17)(c) are adequate to address the concerns raised by the audit team. Specifically, that section of the procedure manual directs the claims staff to "advise the claimant in writing" of the approval. That written approval documents the cost reasonableness analysis that has been undertaken.

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The auditors noted that Manufacturer's Suggested Retail Price sheet and a narrative description of the product were not included, calling it a "best practice". However, this type of additional documentation is not a requirement for OWCP claims and will not serve to improve the required analysis for DME purchases. As such, OWCP will not add this additional requirement to existing procedures.

Recommendation #3: Direct CEs to perform and document a rental versus new purchase analysis for any rentals exceeding a certain time period and/or certain dollar threshold.

Management Response: OWCP agrees with the recommendation and will reinforce the current procedures with claims staff. In addition processes are being developed with the new CBP vendor that will also address the rental versus purchase issue. The processes used by the vendor will supplement the claims process and increase performance in this area. It is expected that the new process will be in place when the new bill processing contractor begins, which is currently slated for the end of 2012.

Recommendation #4: Examine controls over bills paid for catastrophic cases to identify additional controls needed to reduce the risk of improper payments and excessive costs without negatively impacting the beneficiaries of the FECA program.

Management Response: OWCP will agree to the recommendation to review our current controls over catastrophic cases. However, it is noted that there are currently less than 100 catastrophic cases in the system. These cases are only added by the District Director, are reviewed annually, and the bills in these cases are still subject to the duplicate edits and the OWCP Fee Schedule. Given the limited number of claims and the truly unique circumstances they represent, it is unlikely that further controls will be put in place.

Nonetheless, there will be enhancements made to the claimant eligibility records in 2012 that should reduce the need to classify some cases as "catastrophic". Specifically, the number of accepted conditions that can be stored in the claimant eligibility systems will be expanded, allowing many more specific diagnosis' in a given claim. Those cases that can have all of their specific diagnosis' enumerated in the system will then be treated like normal cases, and not need the "catastrophic" designation.

Recommendation #5: Initiate overpayment recovery procedures to recover the overpayments identified in this audit.

Management Response: As noted in previous responses, OWCP lacks the authority to attempt collection on perceived rental versus purchase overpayments that the auditors have identified. The services that have been paid were authorized by OWCP claims staff, and there is no authority to retroactively rescind these authorizations. Since they were

billed and paid as authorized, they are not overpayments and not subject to collection activity.

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