

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singletra	7-10-07

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER	000014	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____	
2. DATE SIGNED BY DIRECTOR	Cleared 7/14/07, letter attached ✓	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <u>7-20-07</u> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action	

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

JUL 6 2007

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-05-04010

Ms. Deirdre Singleton, Deputy Director
Office of General Counsel
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29202-8206

Dear Ms. Singleton:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled "South Carolina Medicaid Durable Medical Equipment Provider Enrollment Practices" covering March 21, 1995, through June 30, 2005.

This draft is not to be considered final as it is subject to further review and revision. Please safeguard it against unauthorized use. To properly consider and present your views relative to the validity of the facts and reasonableness of the recommendations presented, we request that you provide us with written comments within 30 days from the date of this letter. We would also appreciate the status of any action taken or contemplated on our recommendations.

We will summarize your formal response to this report in the body of our final report and include it in its entirety as an appendix. In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR part 5.) As such, within ten business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

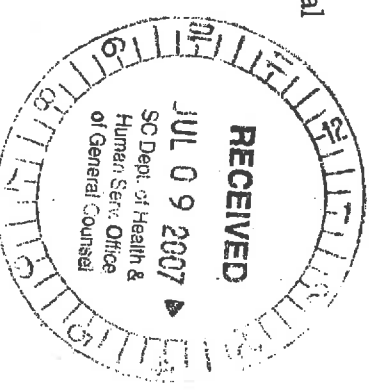
To facilitate identification, please refer to report number A-04-05-04010 in all correspondence relating to this report. We welcome questions on any aspect of this report. Please contact Maritza P. Hawrey of my staff at 305-536-5309, extension 10 or through e-mail at maritza.hawrey@oig.hhs.gov.

Sincerely,

Peter J. Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosures – as stated



Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DRAFT

SOUTH CAROLINA MEDICAID DURABLE MEDICAL EQUIPMENT PROVIDER ENROLLMENT PRACTICES

NOTICE – THIS DRAFT RESTRICTED TO OFFICIAL USE

This document is a draft report of the Office of Inspector General and is subject to revision; therefore, recipients of this draft should not disclose its contents for purposes other than for official review and comment under any circumstances. This draft and all copies thereof remain the property of, and must be returned on demand to, the Office of Inspector General.



Daniel R. Levinson
Inspector General

July 2007
A-04-05-04010

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Department of Health and Human Services
**OFFICE OF
INSPECTOR GENERAL**

DRAFT
**SOUTH CAROLINA
MEDICAID DURABLE MEDICAL
EQUIPMENT PROVIDER
ENROLLMENT PRACTICES**

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Daniel R. Levinson
Inspector General

July 2007
A-04-05-04010



EXECUTIVE SUMMARY

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) established the Medicaid program. As amended, it provides health care to individuals of low income by using State and Federal funds to reimburse providers of approved medical services. These medical services include tests and procedures performed to diagnose the treatment of illnesses and the limiting or correcting of disabilities.

The South Carolina Department of Health and Human Services (State agency) is the single State agency designated to administer the South Carolina Medicaid program. The Medicaid program in South Carolina reimburses durable medical equipment (DME) suppliers approximately \$50 million a year.

Medicare Program

The Medicare program, established under Title XVIII of the Act in 1965, provides health insurance to people age 65 and over and was expanded in 1972 to those suffering from permanent kidney failure and to certain people with disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and contracts with four regional carriers to process DME claims. The Medicare DME contractor that covers South Carolina is Palmetto Government Benefits Administrators (Palmetto).

Under Medicare, suppliers provide DME that is necessary to meet beneficiaries' health care requirements at home. DME includes hospital beds, braces, home dialysis supplies and equipment, therapeutic shoes for diabetics, wheelchairs, walkers, scooters, oxygen equipment, and other items.

National Supplier Clearinghouse

Palmetto also manages the National Supplier Clearinghouse (the Clearinghouse), which CMS established in 1993 by contract. The Clearinghouse is responsible for enrolling suppliers in Medicare, issuing all DME supplier numbers nationwide, and ensuring that suppliers comply with federally mandated supplier standards. To legitimately bill the Medicare program, Medicare DME suppliers must have a supplier number.

With CMS's approval, the Clearinghouse can revoke a Medicare DME supplier's number for failure to comply with 1 or more of the 21 federally mandated supplier standards. (See the Appendix.)

South Carolina Law

South Carolina law provides grounds for administrative sanctions against Medicaid DME suppliers that fail to meet standards required by Federal law. These sanctions include suspension or termination of the Medicaid DME suppliers from the program.

OBJECTIVE

Our objective was to determine whether the State agency allowed DME suppliers to remain in the Medicaid program after their Medicare supplier numbers had been revoked.

SUMMARY OF FINDINGS

The State agency took no action against eight suppliers who violated Federal standards and had their Medicare supplier numbers revoked. Of the eight suppliers that we identified, the State agency paid \$2,084,390 (Federal share \$1,459,073) to four suppliers after the Clearinghouse had revoked their Medicare supplier numbers. The payments were made for services rendered after the Medicare supplier numbers were revoked. Although four other suppliers with revoked Medicare supplier numbers still maintained active Medicaid supplier numbers, they had not billed for any DME. The Clearinghouse had revoked the Medicare supplier numbers of these eight DME suppliers between March 21, 1995, and May 31, 2005, for violating one or more of the federally mandated supplier standards. (See the Appendix.)

South Carolina law allows for administrative sanctions that include the suspension or termination of a provider that fails to meet standards required by State or Federal law. However, the State agency did not check the Medicare status of potential DME suppliers during its initial enrollment process. As a result, the State agency paid some DME suppliers whose supplier numbers had been revoked by the Clearinghouse. Further, the State agency's lack of a supplier renewal process permitted payments to continue to suppliers with revoked Medicare DME supplier numbers.

Permitting DME suppliers with revoked supplier numbers to continue participating in the South Carolina Medicaid program reduced the State Medicaid agency's assurance that the suppliers would provide appropriate health care services and that they would safeguard the Medicaid program and its beneficiaries from fraudulent or abusive billing practices. The longer the State Medicaid agency permits those suppliers to participate in the Medicaid program, the greater is the State's risk that the suppliers will exhibit behavior that is detrimental to the program.

RECOMMENDATIONS

We recommend that the State agency:

- revise the DME enrollment and renewal process to include verifying the validity of an applicant's Medicare DME supplier number and
- consider suspending or terminating Medicaid DME suppliers who have had their Medicare supplier numbers revoked.

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INTRODUCTION

BACKGROUND

Medicaid Program

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The South Carolina Department of Health and Human Services (State agency) is the single State agency designated to administer the South Carolina Medicaid program. The Medicaid program in South Carolina reimburses Durable Medical Equipment (DME) suppliers approximately \$50 million a year.

Medicare Program

The Medicare program, established under Title XVIII of the Act in 1965, provides health insurance to people age 65 and over, and was expanded in 1972 to those suffering from permanent kidney failure, and to certain people with disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program and contracts with four regional carriers to process DME claims. The Medicare DME contractor that covers South Carolina is Palmetto Government Benefits Administrators (Palmetto).

Under Medicare, suppliers provide DME that is necessary to meet beneficiaries' health care requirements at home. DME includes hospital beds, braces, home dialysis supplies and equipment, therapeutic shoes for diabetics, wheelchairs, walkers, scooters, oxygen equipment, and other items.

National Supplier Clearinghouse

In addition to being the Medicare DME contractor that covers South Carolina, Palmetto also manages the National Supplier Clearinghouse (the Clearinghouse), which CMS established in 1993 by contract. The Clearinghouse is responsible for enrolling suppliers in Medicare, issuing all DME supplier numbers nationwide, and ensuring that suppliers comply with federally mandated supplier standards. To legitimately bill the Medicare program, Medicare DME suppliers must have a supplier number issued by the Clearinghouse.

With CMS's approval, the Clearinghouse can revoke a Medicare DME supplier's number for failure to comply with 1 or more of the 21 federally mandated supplier standards. (See the Appendix.)

South Carolina Law

South Carolina law provides grounds for administrative sanctions against Medicaid DME suppliers that fail to meet standards required by Federal law. These sanctions include suspension or termination of the Medicaid DME suppliers from the program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency allowed DME suppliers to remain in the Medicaid program after their Medicare supplier numbers had been revoked.

Scope

We reviewed the listings of DME suppliers, both active and inactive, contained in the State Agency's files as of June 30, 2005, and December 31, 2004, respectively. We also reviewed the listings of DME suppliers contained in the Clearinghouse files whose supplier numbers had been revoked between October 1, 1993, and May 31, 2005.

We conducted our review at the State agency offices in Columbia, South Carolina and at Palmetto in Columbia, South Carolina.

Methodology

To accomplish our objective, we:

- evaluated Federal Medicare and Medicaid regulations, South Carolina Medicaid regulations, and South Carolina State law;
- interviewed State agency officials to determine their policies and procedures for suspending and/or terminating suppliers from the Medicaid program;
- interviewed Clearinghouse officials to determine their policies and procedures for suspending or terminating suppliers from the Medicare program;
- reviewed the portion of South Carolina's Medicaid State Plan related to DME;
- analyzed the DME supplier files maintained by the State agency;
- analyzed the Clearinghouse files for Medicare suppliers whose supplier numbers had been revoked;

- matched suppliers on the State agency and the Clearinghouse files and obtained the supplier applications from the State agency and the Clearinghouse for those suppliers whose Medicare supplier numbers had been revoked by the Clearinghouse; and
- determined the amount of payments made by the State agency to suppliers whose Medicare supplier numbers had been revoked by the Clearinghouse from October 1, 1993, to May 31, 2005.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency took no action against eight suppliers who violated Federal standards and had their Medicare supplier numbers revoked. Of the eight suppliers that we identified, the State agency paid \$2,084,390 (Federal share \$1,459,073) to four suppliers after the Clearinghouse had revoked their Medicare supplier numbers. The payments were made for services rendered after the Medicare supplier numbers were revoked. Although four other suppliers with revoked Medicare supplier numbers still maintained active Medicaid supplier numbers, they had not billed for any DME. The Clearinghouse had revoked the Medicare supplier numbers of these eight DME suppliers between March 21, 1995, and May 31, 2005, for violating one or more of the federally mandated supplier standards. (See the Appendix.)

South Carolina law allows for administrative sanctions that include the suspension or termination of a provider that fails to meet standards required by State or Federal law. However, the State agency did not check the Medicare status of potential DME suppliers during its initial enrollment process. As a result, the State agency paid some DME suppliers whose supplier numbers had been revoked by the Clearinghouse. Further, the State agency's lack of a supplier renewal process permitted payments to continue to suppliers with revoked Medicare DME supplier numbers.

Permitting DME suppliers with revoked supplier numbers to continue participating in the South Carolina Medicaid program reduced the State Medicaid agency's assurance that the suppliers would provide appropriate health care services and that they would safeguard the Medicaid program and its beneficiaries from fraudulent or abusive billing practices. The longer the State Medicaid agency permits those suppliers to participate in the Medicaid program, the greater is the State's risk that the suppliers will exhibit behavior that is detrimental to the program.

STATE LAW AND FEDERAL REQUIREMENTS

South Carolina State Law

Pursuant to South Carolina Law 126-403: Failure to meet standards required by State or Federal law for participation is grounds for administrative sanctions against Medicaid providers. These administrative sanctions include, but are not limited to, suspension or termination of the Medicaid DME provider (South Carolina Law 126-401).

Federal Medicare Requirements

Federal regulations outline 21 Medicare standards to which all DME suppliers must adhere to participate in the Medicare program (42 CFR § 424.57). CMS established these 21 supplier standards to ensure that DME suppliers are qualified to provide the appropriate health care services and to help safeguard the Medicare program and its beneficiaries from any instances of fraudulent or abusive billing practices. The standards also provide assurance to beneficiaries that the supplier operates a business that complies with Federal and State licensure and regulatory requirements. (See the Appendix for a complete list of the standards.)

MEDICAID SUPPLIERS WITH REVOKED MEDICARE SUPPLIER NUMBERS

We identified eight active Medicaid DME suppliers whose Medicare supplier numbers had been revoked by the Clearinghouse for violating one or more of the Medicare supplier standards. The State agency paid four of these suppliers \$2,084,390 (Federal share \$1,459,073) after the Clearinghouse had revoked their Medicare supplier numbers.

Of the eight suppliers that continued to participate in South Carolina's Medicaid program, five had violated multiple standards and three had violated the first standard. The first standard states that a supplier "operates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements."

STATE AGENCY ENROLLMENT AND RENEWAL PROCEDURES

To become eligible Medicaid DME suppliers in South Carolina, the State agency requires suppliers to complete a one-page form to apply for a South Carolina Medicaid DME number. In addition, potential DME suppliers are required to have a business license. However, the State agency does not check the Medicare status of potential DME suppliers during its initial enrollment process. As a result, the State agency paid some DME suppliers whose Medicare DME supplier numbers had been revoked by the Clearinghouse. Further, the State agency's lack of a supplier renewal process permitted payments to continue to suppliers with revoked supplier numbers.

PAYMENTS TO TERMINATED SUPPLIERS

Permitting DME suppliers that have had their Medicare DME supplier numbers revoked to continue participating in the South Carolina Medicaid program reduced the State Medicaid agency's assurance that the suppliers would provide appropriate health care services and would safeguard the Medicaid program and its beneficiaries from fraudulent or abusive billing practices. The longer the State Medicaid agency permits those suppliers to participate in the Medicaid program, the greater is the State's risk that the suppliers will exhibit behavior that is detrimental to the program.

RECOMMENDATIONS

We recommend that the State agency:

- revise the DME enrollment and renewal process to include verifying the validity of an applicant's Medicare DME supplier number and
- consider suspending or terminating Medicaid DME suppliers who have had their Medicare supplier numbers revoked.

APPENDIX

Medicare 21 Supplier Standards

Directly quoted from 42 CFR § 424.57(c)

(c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards. The supplier:

1. Operates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements;
2. Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.);
3. Must have the application for billing privileges signed by an individual whose signature binds a supplier;
4. Fills orders, fabricates, or fits items from its inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal Government Executive Branch procurement or nonprocurement program or activity;
5. Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in §414.220(a) of the subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices.);
6. Honors all warranties expressed and implied under application State laws. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, included capped rental items, as described in §414.229 of this subchapter. The supplier must provide, upon request, documentation that is had provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices;
7. Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility. In the case of a multi-state supplier, records may be maintained at a centralized location;

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8. Permits CMS, or its agents to conduct on-site inspections to ascertain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to CMS, and must maintain a visible sign and posted hours of operation;
9. Maintains a primary business telephone listed under the name of the business locally or toll-free for beneficiaries. The supplier must furnish information to beneficiaries at the time of delivery of items on how the beneficiary can contact the supplier by telephone. The exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, or an answering machine may not be used as the primary business telephone for purposes of this regulation;
10. Has a comprehensive liability insurance policy in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed;
11. Must agree not to contact a beneficiary by telephone when supplying a Medicare-covered item unless one of the following applies:
 - i. The individual has given written permission to the supplier to contact them by telephone concerning the furnishing of a Medicare-covered item that is to be rented or purchased.
 - ii. The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.
 - iii. If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.
12. Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively);
13. Must answer questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented. A supplier must refer beneficiaries with Medicare questions to the appropriate carrier. A supplier must maintain documentation of contacts with beneficiaries regarding complaints or questions;
14. Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced;

DRAFT

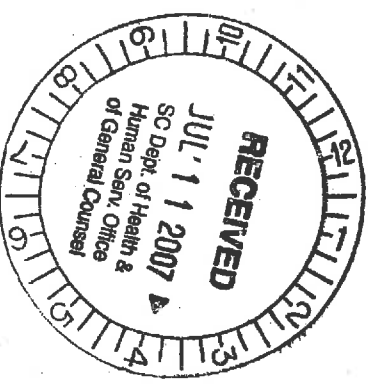
APPENDIX

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15. Must accept returns from beneficiaries of substandard (less than full quality for the particular item or unsuitable items, inappropriate for the beneficiary at the time it was fitted and rented or sold);
16. Must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;
17. Must comply with the disclosure provisions of the Code of Federal Regulations §420.206 of this subchapter;
18. Must not convey or reassign a supplier number;
19. Must have a complaint resolution protocol to address beneficiary complaints that relate to supplier standards in paragraph (c) of this section and keep written complaints, related correspondence and any notes of actions taken in response to written and oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. (This information must be kept at its physical facility and made available to CMS, upon request.);
20. Must maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:
 - i. The name, address, telephone number, and health insurance claim number of the beneficiary.
 - ii. A summary of the complaint; the date it was received; the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.
 - iii. If an investigation was not conducted, the name of the person making the decision and the reason for the decision.
21. Provides to CMS, upon request, any information required by the Medicare statute and implementing regulations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL



TO <i>Singleton</i>	DATE <i>7-10-07</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 0000014	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>7-20-07</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. <i>[Signature]</i>			
2.			
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State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Susan B. Bowling
Acting Director

July 27, 2007

Peter J. Barbera, Regional Inspector General
Office Of Inspector General, Office of Audit Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Re: Report A-04-05-04010

Dear Mr. Barbera:

The South Carolina Department of Health and Human Services (DHHS) greatly appreciates the opportunity to respond to the draft audit report titled *South Carolina Medicaid Durable Medical Equipment Provider Enrollment Practices*. We have reviewed the findings and recommendations of the report, and have taken them under advisement at this time. DHHS is always open to any opportunity to improve the administration of the Medicaid program, and will seriously consider the information presented in this report.

You recommended that the State agency revise the DME enrollment and renewal process to include verifying the validity of an applicant's Medicare DME supplier number, and consider suspending or terminating Medicaid DME suppliers who have had their Medicare supplier numbers revoked. We would like to submit the following comments in response to your recommendations for inclusion in the final report.

- Currently, there is neither a State nor a Federal requirement that DME suppliers wishing to provide Medicaid services maintain an active Medicare supplier number in order to receive Medicaid reimbursement. Similarly, there is no requirement that the State Medicaid agency must deny Medicare "crossover" claims if the DME supplier has a revoked Medicare supplier number. Many South Carolina DME providers have Medicaid-only clients. It would be difficult to impose a State level mandate that all Medicaid DME suppliers obtain and

maintain Medicare status if they do not intend to serve this population, without some basis in Federal Medicaid policy or regulations.

- Checking the Medicare status of DME suppliers would greatly increase the administrative burden on the State agency. Since a DME supplier could theoretically move in and out of active Medicare status during the course of one year, it could be possible that the State agency would have to check the National Supplier Clearinghouse (NSC) every time a claim for Medicaid reimbursement was made.
- The National Supplier Clearinghouse does not operate like the OIG's Exclusion process as established by 42 CFR 1001.101, by which the State Medicaid agency is notified when a provider is excluded. If the NSC automatically notified the State Medicaid agency every time a DME supplier lost and/or regained its Medicare supplier number, then it could be feasible to link Medicaid payments to a provider's Medicare status.
- The OIG audit team asked DHHS to furnish Medicaid claims payment information for a list of 76 DME suppliers which had revoked, terminated or inactive Medicare numbers. Comparing the Medicare supplier numbers provided by the OIG with the provider information in the South Carolina Medicaid Management Information System (MMIS) showed that more than two-thirds had two different Medicare numbers. In addition, for 19 of the DME suppliers with supposedly revoked or inactive Medicare numbers, MMIS showed Medicare payments of \$4,844,501.99 for the cross-over claims during the time frame under review, which may indicate that Medicare does not have such a process or does not enforce it. (The OIG was provided with this information during the audit.)
- One of the four DME suppliers, cited in the report as having received Medicaid payments during the time their Medicare supplier numbers were revoked, was paid \$1,626,003.59 from FFY 2002 through 2005, or 78% of the \$2,084,390 total payments questioned by the OIG. Again, data from the OIG and from the South Carolina MMIS showed that this provider had two different Medicare numbers and received \$805,247.57 in Medicare payments for dual eligibles during the time frame under review.
- This raises the possibility that even though these providers may have had a terminated or deactivated Medicare number, they also had an active Medicare number. If the NSC allows suppliers with inactive/revoked Medicare numbers to still retain an active number, and if CMS allows Medicare payments to providers

Mr. Peter J. Barbera

July 27, 2007

Page 3

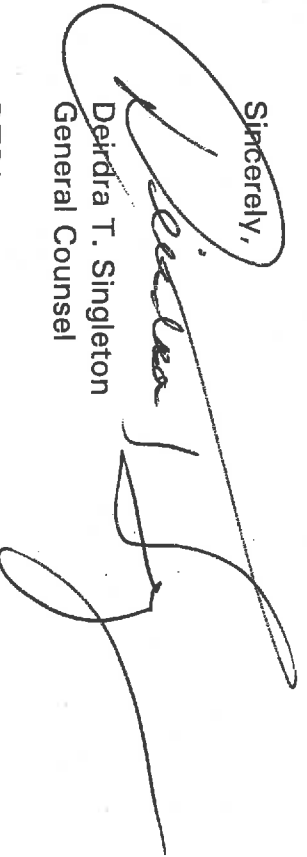
with inactive/revoked numbers, it is difficult to see how the State Medicaid agency could terminate or suspend DME providers in these circumstances.

- If the State Medicaid agency were to condition Medicaid payments upon a DME supplier's Medicare status as maintained by the NSC, this information must be reliable and unequivocal, or else the State agency would be unlikely to prevail against subsequent legal challenges should it terminate a DME provider's Medicaid privileges.

- Finally, the Medicaid payments to the four DME providers cited in the draft report are an immaterial portion of the total Medicaid DME payments during the 10-year time frame of the audit, and there is no evidence that these providers submitted claims for Medicaid payment that were fraudulent or abusive.

If you have any questions, please do not hesitate to call Kathleen Snider, Bureau Chief for Compliance and Performance Review, at (803) 898-1050.

Sincerely,


Deirdra T. Singleton
General Counsel

DTS/sm