Medicare Referring Provider Durable Medical Equipment, Prosthetics, Orthotics and Other Supplies (DMEPOS) Transparency Data (CY2013)

Q: What are you announcing today?
A: CMS is releasing new data about DMEPOS products and services that are referred by specific physicians and other healthcare professionals and furnished by suppliers to Medicare fee-for-service beneficiaries in 2013. The data includes the number of suppliers, services, claims, submitted charges, Medicare allowed amounts and payments for each type of DMEPOS product or service referred by physicians and other healthcare professionals.

Q: Why are you releasing this information?
A: CMS recognizes the importance of data in making our healthcare system more affordable and accountable. Over the past several years we have released a number of data sets that summarize the utilization and payments for procedures and services provided to Medicare fee-for-service beneficiaries by specific inpatient and outpatient hospitals, physicians, and other suppliers. More recently, we released the Part D Prescriber public use file containing Medicare Part D Prescription Drug Event data aggregated by prescriber and drug name. The release of the Referring Provider DMEPOS PUF represents another step in making more data available publicly to drive health system transformation.

Q: What is the source of the Referring Provider DMEPOS PUF data?
A: The data used in the Referring Provider DMEPOS PUF are based upon CMS Part B non-institutional administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program. These data are available from the CMS Chronic Condition Data Warehouse (CCW), a database with 100% of Medicare enrollment and fee-for-service claims data. The file includes supplier, claim and service counts associated with DMEPOS products and services referred by the provider and the associated charges (i.e., the amount suppliers billed for the referred DMEPOS products/services), Medicare allowed amounts (i.e., the amount Medicare paid suppliers and the amount of beneficiary cost sharing) and Medicare payments (i.e., the amount Medicare paid suppliers net of beneficiary cost sharing).

The source of the referring provider demographics is the National Plan & Provider Enumeration System (NPPES), which CMS developed to assign unique identifiers, known as National Provider Identifiers (NPIs), to healthcare providers.

Q: How was the Referring Provider DMEPOS PUF data calculated?

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A: In order to create the data file, CMS aggregated data from claims submitted by individual suppliers of DMEPOS. The data are organized by the National Provider Identifier (NPI) of the referring provider, the Healthcare Common Procedure Coding System (HCPCS) code identifying the product or service, and by the supplier rental indicator derived by HCPCS modifiers. The supplier rental indicator is included in the aggregation because separate fee schedules apply for rental versus purchase of products. For each combination of referring NPI, HCPCS code, and supplier rental indicator, CMS calculated a number of statistics, including average submitted charges, average Medicare allowed amount, and average Medicare payment.

For privacy reasons, we redacted any data (i.e., NPI/HCPCS summary record rows, NPI summary record rows, HCPCS summary record rows, or in certain cases individual data cells within the aforementioned summary record rows) that were based on information from 10 or fewer individual claims.

Q: Is the Medicare allowed amount the amount that a Medicare beneficiary actually pays for the service?
A: No. For most services, beneficiaries are responsible for a cost sharing amount for services furnished under Medicare Part B. In 2013, after meeting a deductible of $147, beneficiaries paid 20 percent of the allowed amount for the service. Some beneficiaries have supplemental coverage that covers their share of the cost of each service.

Q: Who actually pays the submitted charges?
A: In the private market, patients with comprehensive coverage often do not pay full charges because insurance companies negotiate better payment rates for their policy holders. Conversely, individuals with inadequate or no insurance coverage could be billed the full charge for the service or procedure. These individuals might not be able to take advantage of a lower payment rate negotiated by a private insurance company. The Medicare fee-for-service program sets payment rates for covered services.

Q: Can the Referring Provider DMEPOS PUF data be linked to other public datasets?
A: Yes. However, when users attempt to link data from these files to other public datasets, they should be aware of the particular Medicare populations included and timeframes used in each file that will be merged, as well as the identifiers used to merge data. For example, efforts to link the Referring Provider DMEPOS PUF data to the Physician and Other Supplier PUF would need to account for the fact that providers who refer DMEPOS products (and are thus included in the Referring Provider DMEPOS PUF) may not not bill as a rendering/performing provider of non-DMEPOS Part B services (and are thus not included in the Physician and Other Supplier PUF). In addition, users should keep in mind that the utilization and payment information provided in the Referring Provider DMEPOS PUF do not reflect the referring providers' utilization and

payments but reflect the utilization and payment associated with all the suppliers of DMEPOS products and services. Similarly, efforts to link the Referring Provider DMEPOS PUF data to the Part D Prescriber data would need to account for the fact that some beneficiaries who have fee-for-service (FFS) Part B coverage (and are thus included in the Referring Provider DMEPOS PUF) do not have Part D drug coverage (and thus not represented in the Part D Prescriber PUF). Users attempting to merge data from the Part D Prescriber PUF to publicly available Open Payments data on financial relationships should be aware that NPIs are not available in the Open Payments data and thus merges must be conducted using text-string identification fields such as name and address.

Q: Isn't this another way of penalizing providers?
A: No. This initiative brings more openness and accountability to the healthcare system. We'll be helping to make payment and utilization information more transparent so that beneficiaries and other stakeholders can better understand the Medicare portion of a physician's or other healthcare professional's practice of referring DMEPOS products and services. This information could also be useful to physicians interested in learning more about how their referring patterns compare to their peers.

Q: This data focuses on utilization and not quality – how can I trust it?
A: This data only presents one aspect of the delivery of care in the Medicare program – the referring of DMEPOS practices by providers and other healthcare professionals within fee-for-service. While utilization data is a valuable resource for stakeholders, quality information is also important. CMS has just started releasing quality data on physicians on the Physician Compare website at: http://www.medicare.gov/physiciancompare/search.html. CMS also runs the Qualified Entity (QE) program, which provides approved organizations (QEs) with Medicare data for the purposes of combining it with other claims data to develop performance reports at the individual provider level. Performance reports, which report on quality, efficiency, effectiveness, and resource use, must also be made available to the public. To see if there is a QE in your area, please visit: http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/index.html.

Q: This data only represents Medicare patients – couldn't it present a distorted picture of any given providers practice?
A: This data only represents Medicare fee-for-service patients; it does not include patients in a Medicare Advantage plan, those on Medicaid, those with commercial insurance, or self-pay patients. As a result, users of this data should recognize that it only presents a portion of a physician's referring practice of DMEPOS and that portion can vary significantly across

physicians. However, this data does present valuable information on how physicians refer DMEPOS in the Medicare program.

Q: Isn't this a gross invasion of a provider's privacy?

A: No. By providing information about the referring patterns of DMEPOS products and services by physicians and other healthcare professionals, CMS is shedding light on the number and types of services and the charges and payments provided under the Medicare program. This information educates the public on how the Medicare program operates in regard to DMEPOS products and services and the referring habits of individual physicians and other healthcare professionals.

Q: Why isn't CMS doing anything about the fraud and abuse that's going on?

A: Medicare does have programs that target fraud and abuse, programs that target and collect overpayments, and programs that specifically monitor and audit many anomalous billing patterns, such as high dollar providers. These programs work to differentiate the unusual but appropriate reasons for large payments, such as unusually large offices specializing in costly services, from inappropriate reasons that are associated with fraud, waste and abuse.

CMS is committed to the prevention and detection of fraud and abuse in the Medicare program and partners with numerous entities in this endeavor, including Federal and State law enforcement agencies, the HHS Office of Inspector General, and the U.S. Department of Justice, among others. If you suspect a potential case of Medicare fraud or abuse, please visit http://StopMedicareFraud.gov for information on how to report it.

In contrast, the Referring Provider DMEPOS PUF is a transparency initiative that provides the public with utilization, charge and payment data from 2013. This data is point in time, and does not reflect recent billing or payment activity, the referring provider's current enrollment status or any of CMS's oversight activity on a specific provider.

Q: How are you protecting beneficiary privacy?

A: CMS continues to be committed to protecting the privacy of Medicare beneficiaries. In this data file, we have redacted any data (i.e., NPI/HCPCS summary record rows, NPI summary record rows, HCPCS summary record rows, or in certain cases individual data cells within the aforementioned summary record rows) that were based on information from 10 or fewer individual claims in order to prevent potential re-identification and protect beneficiary privacy.

Q: I have found a strange referring pattern of DMEPOS products for Dr. XXXX in CITY YYYY. Isn't this fraud? What are you doing about it?

A: The Referring Provider DMEPOS PUF data release is a transparency initiative, and provides the public with billing and paid claims data from 2013. This data is based only on claims from 2013, and does not reflect recent billing or payment activity, the referring provider's current enrollment status or any of CMS's oversight activity on a specific provider.

CMS has a range of tools that we use to perform program integrity oversight of Medicare providers. Medicare has programs that target fraud and abuse, programs that target and collect overpayments, and programs that specifically monitor and audit many anomalous billing patterns, such as high dollar providers. These programs work to differentiate the unusual but appropriate reasons for large payments, such as unusually large offices specializing in costly services, from inappropriate reasons that are associated with fraud, waste and abuse. We are unable to provide additional detail about these program integrity activities on a provider-level basis to supplement the Referring Provider DMEPOS PUF data release due to our obligations under the Privacy Act.

However, when an individual that is a provider or an owner of a Medicare enrolled provider that has been convicted of health or other types of fraud, the Office of Inspector General excludes the provider from all federal healthcare programs, and CMS revokes that provider from the Medicare program.

Information about excluded providers can be found at: https://oig.hhs.gov/exclusions/exclusions_list.asp.

Information about currently enrolled providers can be found at http://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/about.html.

If you suspect a potential case of Medicare fraud or abuse, please visit http://StopMedicareFraud.gov for information on how to report it.

Q: Do people have to pay for this data?
A: No. It is available for download on the CMS website.

Q: Will CMS be releasing a tool for consumers to be able to look up their physician or other healthcare professional?
A: CMS is currently exploring ways to make this data set more consumer-friendly.

Q: You've posted 2013 data. How frequently will this data be updated?
A: CMS anticipates updating this data on an annual basis. Data are not available for prior years.

Q: May I download this data or must I view it on the website?
A: The data is currently only available for download. However, CMS is exploring ways to make these data easier for consumers to access.

Q: How is this different than Physician Compare?
A: Physician Compare is a CMS website required by the Affordable Care Act that allows beneficiaries to find and choose Physicians and Other Healthcare Professionals enrolled in the Medicare program. The purpose of Physician Compare is to help beneficiaries make informed choices about the health care they receive through Medicare. Physician Compare provides information about physician and other healthcare professionals, including participation in CMS quality reporting programs and, beginning in 2014, Physician Compare includes ratings for Group Practices. Ratings for individual physicians and other healthcare professionals will be added in the future.

On the other hand, the Referring Provider DMEPOS PUF only contains the cost and utilization information associated with DMEPOS services that have been referred by the physician or other healthcare professional. While this resource use information is valuable to consumers, such as Medicare beneficiaries, it does not reflect the quality of care.

Q: How is this different than the QE program? Is the QE program still needed?
A: The Qualified Entity (QE) program was authorized by section 10332 of the Affordable Care Act. Under the QE program, approved QEs receive standardized extracts of Medicare data and must combine this data with other claims data to create public performance reports on providers and suppliers. The Referring Provider DMEPOS PUF only contains information about the Medicare program; however, reports issued by QEs will include data from at least one other payer in addition to the Medicare data providing consumers with a better picture of a physician's overall practice. In addition, QEs will not only be reporting on resource use – QEs may use a variety of measures to evaluate the performance of providers and suppliers including quality, efficiency, and effectiveness measures.

Q: How long does it take CMS process claims?
A: Providers choose whether they wish to receive paper checks or via electronic funds transfer (EFT). Clean electronic claims are paid no sooner than the 14th day after receipt and no later than the 30th day after receipt. Clean paper claims are paid no earlier than the 29th day after receipt. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf