DMEPOS Audit Trends

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They’re All Watching You

- RACs/ZPICs
- State Legislatures
- State AGs
- Congress
- Medicaid
- OIG
- PRESS
- Commercial Payors
- FTC
- HHS
- SEC
- Personal Injury Litigants
- Competitors
- Plaintiff Lawyers
- Whistle-blowers
Understanding the DME Audit Landscape

CMS Claim Review Programs

- Federal government estimates 12.1 percent of all Medicare FFS claim payments are improper
- CMS utilizes two types of claim review programs:
  - Pre-payment review to reduce improper payments
  - Post-payment review to recover improper payments
- Programs are categorized as either:
  - "Complex" – requires licensed professionals to review additional documentation associated with a claim; or
  - "Non-Complex" – does not require a clinical review of medical documentation
CMS Program Integrity

• Focuses on:
  • Enrollment
    • Provider Screening, Moratoria & Revocation
  • Payment
    • Detect fraud & improper billing
    • Deny payment, collect overpayments
    • Data mining, audits
    • Educational tools to encourage compliance
  • Information Sharing
    • Share info across programs
    • Share info with law enforcement

Who Performs Reviews?

[Diagram showing the hierarchy of reviews involving MACs, RACs, ZPICs, OIG/FBI, and Provider Enrollment Screening]
### Recovery Audit Program FY 2015 Report to Congress

<table>
<thead>
<tr>
<th>Collected Overpayments</th>
<th>Restored Underpayments</th>
<th>Total Corrected Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$359,729,011.57</td>
<td>$80,964,651.83</td>
<td>$440,693,663.40</td>
</tr>
</tbody>
</table>

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**Collected Overpayments Collected Underpayments Corrected Amount**

### Appendix C1: FY 2015 Corrections by Type of Claim

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>No. of claims</th>
<th>Overpayments Collected</th>
<th>Underpayments Restored</th>
<th>Total Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of claims</td>
<td>Amount Collected</td>
<td>No. of claims</td>
<td>Amount Restored</td>
</tr>
<tr>
<td>Part A</td>
<td>152,586</td>
<td>$297,004,864.28</td>
<td>25,790</td>
<td>$78,827,369.65</td>
</tr>
<tr>
<td>Part B</td>
<td>287,397</td>
<td>$335,043,006.79</td>
<td>5,274</td>
<td>$1,953,097.97</td>
</tr>
<tr>
<td>DME</td>
<td>146,930</td>
<td>$27,591,340.50</td>
<td>989</td>
<td>$184,184.21</td>
</tr>
<tr>
<td>Total</td>
<td>586,933</td>
<td>$359,729,011.57</td>
<td>32,053</td>
<td>$80,964,651.83</td>
</tr>
</tbody>
</table>
Can it be true?

- CMS and contractors have indicated a more “provider-friendly” approach to DMEPOS claims
- “Provider-friendly” equates to reducing appeal backlog
- DMEPOS is the largest contributor to the appeal backlog
  - Account for approximately 50% of all pending hearings
  - 7 of the top 10 appellants at OMHA are DME suppliers
Impact of “Provider-Friendly” Approach

- New friendlier appeal processes
- New Change Requests reducing unnecessary burden
  - CPAP suppliers can assume medical necessity if 13 rental payments made to other suppliers (CR 9741)
  - No new order for change in supplier (CR 9886)
- Reduced POD requirements (CR 10324)
- Improvements in O & P

- Will it last?

POD Requirements (Updated)

- Effective/Implementation Date: November 20, 2017
- Date of delivery may be entered by the beneficiary, designee, or the supplier
- Date of delivery may be the date the beneficiary received the item, or
- Date of delivery may be the date the supplier shipped the item when using a delivery/shipping service, shall be the date of service on the claim.
  - Note: The shipping date may be defined as the date the delivery/shipping service label is created or the date the item is retrieved for delivery
  - Exception: Two-day rule, The supplier shall bill the date of service on the claim as the date of discharge
Legislation in the works for O & P

- O&P Medicare Improvements Act
- Medicare O&P Improvement bill section 50402
  - Section 1834(h) of the SSA is amended by adding at the end the following paragraph:
  - Documentation Created by Orthotists and Prosthetists-For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B)

National DMEPOS and HHH RAC

- Performant Recovery
- Identified focused areas for new RACS and will be meeting monthly with CMS to identify audits
- Will be looking at postpayment claims than have been submitted within the previous 3 years from the date the claim was paid
RAC Identified Issues Process

1. RAC identifies potential issue
2. RAC communicates issues to CMS during monthly meeting
3. CMS issues provisional approval or denial
4. If approved, CMS determines volumes (500-2000)
5. RAC initiates audits
6. RAC reports findings back to CMS (including appeal data)
7. CMS may grant additional approval for more audits

RAC Issues - Automated

<table>
<thead>
<tr>
<th>Automated</th>
<th>Date Posted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP without OSA Diagnosis</td>
<td>9/8/2017</td>
</tr>
<tr>
<td>Group 3 PWC Underpayments</td>
<td>5/17/2017</td>
</tr>
<tr>
<td>Multiple DME Rentals in one month</td>
<td>3/31/2017</td>
</tr>
<tr>
<td>DME while beneficiary is in an inpatient stay</td>
<td>2/16/2017</td>
</tr>
<tr>
<td>Nebulizers</td>
<td>2/2/2017</td>
</tr>
<tr>
<td>CPM Billed without Total Knee Replacement</td>
<td>2/2/2017</td>
</tr>
<tr>
<td>Glucose Monitor</td>
<td>1/5/2017</td>
</tr>
<tr>
<td>Spring Powered Devices Billed for &gt;1 in a 6 Month Period</td>
<td>1/5/2017</td>
</tr>
</tbody>
</table>
### RAC Issues - Complex

<table>
<thead>
<tr>
<th>Complex</th>
<th>Date Posted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilators submit to DWO Requirements on or after January 1, 2016</td>
<td>1/11/2018</td>
</tr>
<tr>
<td>Respiratory Assist Device</td>
<td>12/17/2017</td>
</tr>
<tr>
<td>PAP Devices for the treatment of OSA</td>
<td>9/19/2017</td>
</tr>
<tr>
<td>Spinal Orthoses</td>
<td>8/2/2017</td>
</tr>
<tr>
<td>AFO/KAFO</td>
<td>7/7/2017</td>
</tr>
<tr>
<td>PMDs not subject to PA Demonstration</td>
<td>6/6/2017</td>
</tr>
<tr>
<td>Blood Glucose Monitors with Integrated Voice Synthesizer</td>
<td>5/12/2017</td>
</tr>
<tr>
<td>Enteral Nutrition Therapy</td>
<td>5/11/2017</td>
</tr>
<tr>
<td>Negative Pressure Wound Therapy Pumps</td>
<td>4/28/2017</td>
</tr>
<tr>
<td>Nebulizers</td>
<td>4/14/2017</td>
</tr>
<tr>
<td>Group 2 Support Surfaces</td>
<td>2/15/2017</td>
</tr>
<tr>
<td>Osteogenesis stimulators</td>
<td>2/14/2017</td>
</tr>
<tr>
<td>Chest Wall Oscillation Devices</td>
<td>2/8/2017</td>
</tr>
<tr>
<td>Tracheotomy suction catheters, suction pumps, catheters and other</td>
<td>2/8/2017</td>
</tr>
<tr>
<td>supplies</td>
<td></td>
</tr>
</tbody>
</table>

### Supplemental Medical Review Contractor (SMRC)

- Previously Strategic Healthcare Solutions
- Announced in February 2018, Noridian Healthcare Solutions beat out 4 other bidders to become the new SMRC
- 5 year contract worth $227,444,000
The audit numbers...

- They have sent a low volume of audits comparative to first round (just over 8,000 by the end of September last year)
- Audit volume rankings:
  1. DME while Inpatient
  2. Multiple DME rentals in 1 month
  3. Hospital beds with mattresses billed with Group I or II support surfaces
  4. Group III PMD Accessories Underpayment
  5. Chest Wall Oscillation Devices
  6. Automated Nebulizer review

DME MAC – Targeted Probe and Educate (TPE)

- DME MACs will no longer be performing widespread reviews
- Help suppliers reduce claim denials and appeals through one-on-one help.
- MACs use data analysis to identify:
  - Suppliers who have high claim error rates or unusual billing practices, and
  - Items and services that have high national error rates and are a financial risk to Medicare.
- Providers whose claims are compliant with Medicare policy won't be chosen for TPE.
TPE - How does it work?

*MACs may conduct additional review if significant changes in provider billing are detected

TPE Common Claim Errors

- The signature of the certifying physician was not included
- Encounter notes did not support all elements of eligibility
- Documentation does not meet medical necessity
- Missing/incomplete initial certifications or recertification
Additional Information

- If selected for review, suppliers are not excluded from other Medical Review activities, such as, automated reviews, other pilot review programs, prior authorization, etc., as directed by CMS or other contractor reviews.
- Additionally, the DME MAC will continue to work with other CMS contractors and collaborate with referrals back and forth to the ZPIC/UPIC for concerns related to potential fraud/abuse and Recovery Auditor (RA) for collaboration of vulnerability and to prevent duplication of reviews.

Referrals to CMS

- CMS may refer to ZPIC/UPIC for a more aggressive audit, which sometimes results in:
  - Payment Suspensions
  - Extrapolated Overpayment
  - 100% Prepayment Reviews
- CMS may recommend review by RAC
- CMS could exercise their revocation authority
Revocations

- CMS issued a NEW Final Rule for safeguards to reduce Medicare fraud – December 3, 2014
  - Under authority of the ACA, CMS can and will deny or revoke enrollment of entities and individuals that pose a program integrity risk to Medicare for the following:
    - “… providers and suppliers that have a pattern and practice of billing for services that do not meet Medicare requirements. This is intended to address providers and suppliers that regularly submit improper claims in such a way that it poses a risk to the Medicare program.”

Proving a pattern or practice

- Probe & Educate + Probe & Educate + Probe & Educate = Pattern and Practice
Payment Suspensions

- 42 CFR 405.371(a)(1) affords contractors the authority to implement a payment suspension based on "reliable evidence that an overpayment exists or that the payments to be made may not be correct.
- 180 days with one chance to submit a rebuttal
- Can be renewed every 180 days
- Claims submitted are reviewed and if paid, money is put into an escrow account until such time the audit is completed.
- Seeing this occur in instances that previously wouldn’t warrant such action

Zone/Unified Program Integrity Contractors (ZPICs/UPICs)

- AdvanceMed for UPIC Jurisdiction 1 (Midwest)
  - Contract amount = $96.3 million
- Health Integrity for UPIC Jurisdiction 2 (West)
  - Contract amount = $85.3 million
- Health Integrity for UPIC Jurisdiction 3 (Southwest)
  - Contract amount = $86.9 million
- Safeguard Services for UPIC Jurisdiction 4 (Southeast)
  - Contract amount = $129.7 million
- Safeguard Services for UPIC Jurisdiction 5 (Northeast)
  - Contract amount = $96.3 million
Medicare Claim Audits & Appeals
Claim Appeals Process

- Administrative appeals process has 5 levels:
  1. Redetermination
  2. Reconsideration
  3. Administrative Law Judge Hearing Decision
  4. Medicare Appeals Council Review
  5. Judicial Review by U.S. District Court
- See 42 C.F.R. §§ 405.900 et seq.

Backlog

- As of February 28, 2017 average processing times for the OMHA reached 1,051 days
- For FY 2019, OMHA requested $251 million in program level funding, an increase of $144 million over the funding provided in FY 2018 Continuing Resolution
- According to OMHA, this request would result in 106,000 additional dispositions per year
Additional Efforts

On Nov. 3, HHS announced two additional initiatives to address the mounting Medicare appeals backlog at the ALJ level:

1. Expand the Settlement Conference Facilitation (SCF) program (no details provided yet)
2. Offer a new Low Volume Appeals (LVA) settlement option at 62 percent of the Medicare amount billed and approved for appeals filed by November 3, 2017

Recovery Audit Program Appeals Stats FY 2015

Appendix J1: FY 2015 Recovery Audit Program Appeals by Recovery Auditor and Claim Type – Level 1 (Redetermination)

<table>
<thead>
<tr>
<th>Recovery Auditor</th>
<th>Claim Type</th>
<th>Appealed Claims Dismissed</th>
<th>Appealed Claims Decided</th>
<th>Decided Claims Overturned</th>
<th>% of Decided Claims Overturned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performant</td>
<td>A</td>
<td>4,088</td>
<td>203</td>
<td>1,054</td>
<td>25.8%</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>20,837</td>
<td>905</td>
<td>17,259</td>
<td>63.5%</td>
</tr>
<tr>
<td></td>
<td>DME</td>
<td>479</td>
<td>331</td>
<td>296</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>25,794</td>
<td>1,439</td>
<td>18,499</td>
<td>72.1%</td>
</tr>
<tr>
<td>CGI</td>
<td>A</td>
<td>7,072</td>
<td>449</td>
<td>6,249</td>
<td>55.4%</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>7,026</td>
<td>377</td>
<td>6,935</td>
<td>70.3%</td>
</tr>
<tr>
<td></td>
<td>DME</td>
<td>4,009</td>
<td>26</td>
<td>3,855</td>
<td>94.7%</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>18,907</td>
<td>842</td>
<td>16,139</td>
<td>89.5%</td>
</tr>
<tr>
<td>Controllly</td>
<td>A</td>
<td>10,442</td>
<td>614</td>
<td>2,902</td>
<td>28.3%</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>1,760</td>
<td>117</td>
<td>1,320</td>
<td>75.7%</td>
</tr>
<tr>
<td></td>
<td>DME</td>
<td>2,568</td>
<td>120</td>
<td>1,390</td>
<td>54.1%</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>14,770</td>
<td>861</td>
<td>5,532</td>
<td>37.8%</td>
</tr>
<tr>
<td>HDI</td>
<td>A</td>
<td>6,395</td>
<td>400</td>
<td>2,852</td>
<td>44.6%</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>11,189</td>
<td>1,280</td>
<td>8,270</td>
<td>72.6%</td>
</tr>
<tr>
<td></td>
<td>DME</td>
<td>415</td>
<td>1,730</td>
<td>115</td>
<td>27.7%</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>18,199</td>
<td>3,614</td>
<td>11,233</td>
<td>61.7%</td>
</tr>
</tbody>
</table>

Total/Average: 77,953, 71.80, 48,182, 62.2%

* This includes claims listed as ‘Affirmed, Partially Reversed’ and ‘Fully Reversed’ in the Contractor Reporting of Operational & Workload Data (CROWD) system and claims listed as ‘Decided’ in the Medicare Appeals System (MAS).
** This includes claims listed as ‘Partially Reversed’ and ‘Fully Reversed’ in CROWD and claims listed as ‘Partially Favorable’ and ‘Favorable’ in MAS.

Source: CMS CROWD System and MAS.
Appeal Changes: Serial Appeals

- Serial Appeals – MLN Matters # SE17010
- April 26, 2017 - CMS recently directed the DME MACs to change the process by which they adjudicate appeals of serial claims.
- Once the reason for denial for one claim in a series is resolved at any appeal level, the DME MACs will identify other claims in the same series that were denied for the same or similar reasons, and take that determination into consideration when adjudicating such claims.

Appeal Changes: QIC Telephone Discussion

- Telephone discussion at the Reconsideration level
- Selected providers will have the opportunity to participate in a formal recorded telephone discussion with the QIC and offer verbal testimony.
- Providers will be able to discuss the facts of the case and provide any additional documentation that would assist in reaching a favorable determination.
- The Reopening process allows potential cases to be remanded back from the ALJ
Appeal Changes: QIC Telephone Discussion

- Provider submits the initial appeal request
- C2C will determine if appeal meets the criteria for a telephone discussion
- C2C will notify the provider of the scheduled discussion date by a mailed notification letter which includes a contact information form to be remitted indicating election to participate

Appeal Changes: Limiting the Scope of Review

- Since October 2016, CMS has limited the scope of appeal contractors to review additional claims and issues outside of what the previous denial reason was for prepayment of postpayment denials/overpayments.
  - Code in question
  - Date(s) of service in question
  - Denial reason
QUESTIONS?

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