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June 26, 2012

Bridget Dooling
Policy Analyst
Office of Management and Budget
New Executive Office Building
725 17th Street NW
Washington, DC 20503

**Re: Medicare Fee-for-Service Prepayment Review of Medical Records
CMS-10417, OCN: 0938-0969**

Dear Ms. Dooling:

The American Association for Homecare (AAHomecare) submits the following comments on the Centers for Medicare and Medicaid Services' (CMS) request for Office of Management and Budget (OMB) approval of the above referenced information collection request (ICR). CMS' Paperwork Reduction Act (PRA) submission states that the collection is required for the Agency and its contractors to perform prepayment review of claims submitted for Medicare payment. OMB has requested comments on the collection, especially with respect to the necessity, utility, and burden of collection.

AAHomecare represents durable medical equipment (DME) providers, manufacturers, and others in the homecare community that serve the medical needs of millions of Americans who require oxygen systems, wheelchairs, medical supplies, inhalation drug therapy, and other medical equipment and services in their homes. Members operate more than 3,000 homecare locations in all 50 states. In light of our members' expertise and experience, AAHomecare is uniquely qualified to comment on the request for OMB approval of the ICR.

AAHomecare strongly supports vigorous program integrity actions to protect Medicare and its beneficiaries. We agree that Medicare must be vigilant to ensure that benefit dollars are not diverted to abusive or fraudulent providers. The Social Security Act (SSA) requires the Secretary

to pay only for covered items and services that are “‘reasonable and necessary’ for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member[.]”¹ While the statute gives the Secretary the discretion to determine what is “‘reasonable and necessary,’” she is nonetheless bound by the procedural and substantive laws and rules, such as the PRA, that temper what could otherwise result in unfettered administrative power. The underlying purpose and goals of the PRA are to minimize the burden of paperwork requested by or for the Federal government.² To that end, the law requires that all paperwork collections requested by agencies or their contractors be approved by OMB.

In this case, AAHomecare recognizes CMS’ authority to identify and correct improper payments or fraudulent activity. However, the manner in which the Agency has exercised that authority in the recent past runs counter to the standards established by the PRA, especially with respect to the burden imposed on providers by the prepayment review activities of CMS and its contractors. We discuss our concerns in more detail below.

I. Background

CMS may contract with others to administer Medicare program functions such as processing and paying claims. Medicare Administrative Contractors (MAC) pay claims, develop local coverage determinations (LCD), offer provider education, and perform complex medical reviews to identify and recover overpayments. MACs are third-party administrators who perform the routine administrative tasks necessary for the day-to-day operation of the program. CMS also engages other contractors in more targeted roles to perform Medicare Integrity Program (MIP) activities. These contractors, known as Medicare Integrity Contractors (MIC), have a narrower scope of work.

CMS’ authority to engage Medicare contractors is based on different provisions of the SSA depending on the contractor’s scope of work, but all of the contractors can perform complex medical reviews to carry out their duties. Zone Program Integrity Contractors (ZPIC), Program Safeguard Contractors (PSC), and DME MACs conduct both pre- and post-payment audits. Prepayment audits are especially burdensome because they have the potential to stifle a provider’s cash flow, jeopardizing its solvency and ability to care for patients.

II. CMS Grossly Underestimated the Collection Burden of Prepayment Complex Medical Review

Contractors may conduct service-specific prepayment complex medical review when they have evidence of a high level of payment errors associated with a Medicare-covered service. If the contractor identifies a provider problem, it has the ability to put the provider on provider-specific prepayment complex medical review. Complex prepayment medical review means that

¹ §1862, Social Security Act.

² 44 U.S.C §3502(3).

the contractor requests additional documentation to support a claim after the claim is submitted but before payment is made. This documentation includes physician and/or inpatient medical records and copies of test results as well as physical therapist (PT) or occupational therapist (OT) assessments.

Contrary to the assertion in the Agency's submission, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers are not required to and do not typically collect this type of detailed medical documentation at the time they initiate service. Except for a small number DMEPOS items, providers may deliver a DME item to a beneficiary based on the physician's verbal order. Providers must have an appropriate written order in their files before submitting the claim to Medicare. This long-standing policy strikes a balance between a beneficiary's need to receive equipment quickly and the Agency's need to protect Medicare monies. Simply stated, providers do not get paid unless they have a valid written order when they submit a claim to Medicare.

Consequently, most providers will have basic medical documentation to support a claim but not the extensive documentation required for complex medical review. This is an important point because contractors cannot deviate from LCD and national coverage determination (NCD) documentation requirements in an audit. What this means is that providers must document in nearly implausible detail every element of the coverage criteria in an LCD. Some contractors have even requested documentation for ancillary LCD provisions that in themselves do not affect coverage for the DMEPOS item. CMS' submission estimates that the time and cost burdens for collecting this information is no more than 30 minutes per claim at an hourly rate of \$16.83 plus taxes and benefits for a total of \$33.66. The estimate grossly underestimates the time and money burden of CMS' current strategy of conducting widespread service-specific or provider-specific prepayment complex medical reviews.

As we noted above, CMS' estimates assume that providers have on hand the type of detailed medical record documentation required to defend a claim in an audit. Not only is the information not immediately available to providers, who must call multiple facilities and practitioners to obtain it, but providers must also take time to **review** the records in order to confirm that they satisfy the documentation burden imposed by the contractors. Moreover, because most conditions treated with DME are chronic and long term, providers often have to search a patient's entire medical history to locate records that meet the burden given that many LCDs require evidence that "other treatments have been tried and failed."

Further, CMS has embarked on a program of aggressive prepayment complex medical review, especially for DMEPOS, such that the prepayment reviews are **routine** in all four DME MAC jurisdictions. This means that service-specific widespread prepayment reviews often overlap with provider-specific prepayment reviews in any given DME MAC jurisdiction at any given time. It is also important to remember that providers **do not get paid** if a claim is denied in a prepayment review even though the beneficiary received and is using the equipment. The provider's recourse is to appeal the denial, a process that can take a year or more. So in

addition to other costs, the cost of the outstanding receivables must be included in the Agency's burden estimates. Our members report that, at a minimum, an accurate time burden would be two hours to collect, review, organize, and send in the documentation at total cost of \$ 67.32.

The cost and time burden associated with these audits escalates when the ZPIC contractors perform the audit. It is not uncommon for the ZPIC to impose 100% prepayment complex medical review on providers. This means the providers bear the cost and time burden of responding to the review and the added burden of having little or no cash flow to support its operations and – most importantly – patient care. While it may be possible for very large providers to weather this burden for a time, we are aware of many small providers who have closed their business because of the financial burdens created by these reviews.

III. The Paperwork Collection Does Not Enhance the Quality or Utility of the Information

AAHomecare recognizes that the Secretary has the authority to perform pre- and post-payment complex medical reviews and that they can be a useful tool to identify and correct instances of incorrect payment. However, the Agency's aggressive strategy of widespread prepayment reviews calls into question the necessity and utility of the information providers are required to collect. The following examples highlight this point:

The DME MACs audit the same patient's claims for the same piece of equipment repeatedly over the course of the rental period even though the claim has been audited and paid in full in a preceding rental month. Because DME is paid on a monthly fee schedule, providers submit consecutive monthly claims for the item during the rental period. Although a beneficiary's claim was audited and paid early in the rental period, contractors will continue to audit that beneficiary's claims for the remainder of the rental period.

There is no consensus on the documentation required to support medical necessity among the contractors. Contractors frequently change the standards providers must meet in order to document medical necessity. These changes are announced in informal forums such as website bulletins or contractor conference calls without notice to providers based on the contractor's assertion that the change is a "clarification" not a "modification" of existing standards.

Providers are required to recreate existing documentation that may already be a part of their files when coverage for a patient's equipment transfers from private insurance to Medicare.

One example is that providers must have "proof of delivery" for the equipment they furnish to a beneficiary. If the beneficiary received the equipment before enrolling in Medicare, the contractors require a new proof of delivery as of the date of enrollment – even though the equipment was delivered to the beneficiary before then. Practically, the only ways to accomplish this are to either "make-up" a new delivery ticket with a different date, or pick-up the equipment and "re-deliver" it as of the Medicare enrollment date. Either way, the provider

has to make a costly and wasteful trip to the beneficiary's home to document something that is already in their files.

Providers are required to submit extensive medical necessity documentation when the prepayment complex medical review in fact audits only compliance with "technical" documentation requirements. In an effort to meet CMS' targets for increased prepayment reviews, contractors are performing "technical" reviews that focus on whether the documentation the provider submits conforms to the technical requirements of an LCD, not whether it supports medical necessity. However, providers are nonetheless required to submit voluminous records to show medical necessity for the claim under review. In an over-simplified example, if an LCD requires the provider to have an order, the contractor looks for the order but does not assess whether the order shows the beneficiary's medical need for the equipment. If the order is present, then the contractor approves the claim. Because providers do not know this beforehand, they must submit the level and quality of records that would otherwise support prepayment complex medical review.

ZPIC audits that should be used to address fraud and abuse are deployed for routine matters such as patient complaints or small dollar value claims. We have an example where the ZPIC made an audit request for an item that is not even covered by Medicare.

Providers are required to obtain either an attestation or signature log when a physician's signature is illegible on a document and the physician's name is not printed on the document even though all other documentation submitted in support of the claim in fact bears the physician's printed name and the signature matches the signature on the order. Clearly, if all the other documentation submitted by a provider identifies the physician, they should not have to jump through hoops to obtain physician signature attestations.

III. Conclusion

CMS must do a better job of improving its prepayment complex medical review process in order to reduce the burden associated with audits and improve the quality and utility of the information its contractors collect. OMB should require CMS to implement a process to accomplish this before it approves the ICR under review. To this end, we recommend:

- Require contractors to develop, officially publish, and adhere to consistent documentation standards that apply prospectively in the four DME MAC jurisdictions.
- Require contractors to request only the level and quality of information necessary to perform a review.
- Require contractors to implement procedures to prevent repeat audits of a beneficiary's claims for the same piece of equipment.

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- Allow contractors to rely on documentation available in a provider's records to verify physicians' signatures or proof of delivery.

We appreciate the opportunity to submit these comments. Please feel free to contact me if you have any questions or comments regarding the above.

Sincerely,

A handwritten signature in cursive script, appearing to read "Walter J. Gorski".

Walter J. Gorski

Vice President of Government Affairs