



July 6, 2012

VIA ELECTRONIC COMMUNICATION: ProgramIntegrityWhitePapers@finance.senate.gov

The Honorable Max Baucus

Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch

Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

RE: American Association for Homecare Anti-fraud Recommendations to May 2, 2012 Open Letter

Dear Honorable Members of the Senate Finance Committee:

The American Association for Homecare (AAHomecare) submits the following proposals outlined in Section II of this document in response to the U.S. Senate Committee on Finance's request for recommendations on tools to combat fraud and abuse in the Medicare and Medicaid programs.

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 therapy, wheelchairs, medical supplies, inhalation drug therapy, and other medical equipment and services in their homes. AAHomecare members operate more than 3,000 homecare locations in all 50 states. In light of our members' expertise and experience, the Association is uniquely qualified to comment on the Committee's request for anti-fraud and abuse solutions.

I. Background

The Association and its members wish to assist the Centers for Medicare and Medicaid Services (CMS) and Congress in an effort to eliminate fraud and abuse from the Medicare DMEPOS benefit. Our interests in achieving these goals coincide with Congress' and CMS' interests and those of the Medicare beneficiaries our members serve.

AAHomecare has been a driving force to root out fraud and abuse in the DME sector. To that end, several years ago, the Association developed and worked to implement a 13-point anti-fraud legislative action plan. Additionally, we developed and adopted a comprehensive code of ethics for our membership to follow. Twelve of the 13 elements of the Association's anti-fraud plan have been enacted, in full or in part, by Congress or implemented by CMS. These anti-fraud initiatives included:

- More mandatory and unannounced site visits for DME providers;
- Implementation of a predictive modeling system, similar to what the credit card industry uses, to conduct real-time claims analysis to identify aberrant billing patterns;
- Monitoring of providers to ensure they are qualified and accredited to provide the specific item or service for which they are billing;
- Increased criminal and civil penalties associated with committing health care fraud; and
- Expanded federal funding for Medicare's anti-fraud and program integrity activities.

However, CMS' current anti-fraud strategy employs auditors targeting conscientious providers who are having to refund millions of dollars to Medicare for failing to satisfy confusing, ambiguous, retroactive and subjective documentation requirements for items and services furnished to Medicare beneficiaries. This strategy is unfair, inefficient, and administratively burdensome. The size and scope of these audits are severely taxing providers' operational and financial resources. This is especially true for providers on prepayment audits whose cash flow is disrupted, jeopardizing their ability to continue caring for their patients. Moreover, the current auditing strategy wastes scarce Medicare resources that could be better aimed at focusing on true criminal activity.

The majority of DME is billed for on a recurring basis, which separates it from many other types of Medicare services that are billed for under a bundled prospective payment system or fee-for-service for a specific service provided on a specific date. Most DME that is billed to Medicare occurs on a rental basis—either a 13-month capped rental period for items such as power wheelchairs, hospital beds, and CPAP devices, or, in the case of oxygen, a 36-month rental period—or on a recurring basis such as enteral nutrition and diabetic supplies that are subject to refills on a regular basis. Because of the unique nature of billing for items on a recurring basis, DME providers are subject to audits more frequently than other types of providers.

II. Proposed Anti-fraud, Waste, and Abuse Solutions

To more effectively combat fraud and abuse in the DMEPOS benefit, the Association has developed the following key recommendations for Congress to consider:

- **Conduct independent reviews of Medicare contractors to hold them accountable;**
- **Establish clear, unambiguous medical policies for DME;**
- **Enhance review of DME providers who do not respond to audit requests;**
- **Establish limitations on the number of audits a DME provider can receive during a given time period;**
- **Reinstate “clinical inference” policy;**
- **Require that electronic health records systems include elements for DME medical necessity documentation;**
- **Mandate use of an electronic clinical medical necessity template;**
- **Mandate use of a template in power mobility device (PMD) prior authorization demonstration;**
- **Provide additional physician education on medical necessity requirements; and**
- **Establish definitive policy prohibiting retroactive implementation of policies.**

Conduct independent reviews of Medicare contractors to hold them accountable: Congress should consider some method of independent review of audit contractors to hold them accountable for their audit tactics and results. These independent reviews should be conducted under strict guidelines to determine whether audit tactics were applied consistently and correctly. Claims that are subsequently overturned at any level of appeal should also factor into the review. As a part of this Congressional oversight of CMS and its audit contractors, the Senate Finance Committee should consider conducting a hearing annually, at a minimum, to evaluate CMS and its contractors in a public forum. Additionally, Congress should consider penalizing CMS and/or its contractors for audit denials that are overturned at any level of appeal.

Establish clear, unambiguous medical policies for DME: As exemplified in the Appendix of this submission, ambiguous and inconsistently applied documentation policies are a large contributor to the DME error rate. In order to reduce the error rate significantly, CMS and its contractors must establish policies that can be clearly and consistently interpreted by CMS, its contractors, DME providers, and the ordering/referring physicians who prescribe DME. If policies can be interpreted subjectively to the point where the same claim and documentation is approved by one clinical reviewer and rejected by another like they are currently, it is impossible for DME providers and physicians to comply with these policies consistently.

Enhanced review of DME providers who do not respond to audit requests: When Medicare contractors audit DME providers, we have found that some DME providers do not respond to the audit, which results in an arbitrarily high error rate and leads to ongoing payment reviews of that item or service for all other DME providers. Widespread audits have shown that the non-response rates range from 20 percent to nearly 50 percent, presenting a significant challenge to reducing the error rate for DME.¹

Congress should mandate that CMS and its contractors place a higher level of scrutiny on DME providers who do not respond to audits. This should be done through the following actions: 1) allow for a second audit request to be submitted to the provider ensuring that the appropriate address and contact information is indicated in the initial audit request; 2) if there is no response to the second request, the audit contractor contacts the DME provider by phone to inform him of the non-response to the audit; 3) the contractor places the DME provider on a probe review for the item or service that was not responded to in the audit; and, 4) if responses are not received for the probe review, the DME provider is referred to the National Supplier Clearinghouse for an unannounced site visit to determine if that DME provider is committing outright fraud.

Establish limitations on the number of audits a DME provider can receive in a given time period: Providers receive audits from many different contractors including the Comprehensive Error Rate Testing contractor (CERT), Zone Program Integrity Contractors (ZPIC), Recovery Audit Contractors (RAC), and the DME Medicare Administrative Contractors (DME MAC), at times for the same patient and the same date of service. These contractors appear to operate largely in their own silos, with little coordination to determine whether a claim has already undergone an audit by a different contractor or audit different rental months for the same item for the same patient. CMS sets some limitations on the number of audits that a specific contractor can conduct on a DME provider. However, we believe a limit must be placed on the level of audit activity a DME provider can undergo within a given time frame across all contractors to ensure that the number of audits are not overly burdensome. Additionally, a limit should be placed on auditing the same patient month-after-month for an item that is billed on a rental or recurring basis. Auditing the same patient multiple times is duplicative and an unnecessary waste of contractors' resources and DME providers' time and effort.²

Reinstate "clinical inference" policy: Prior to 2009, auditors could use clinical inference to determine whether an item or service was medically necessary and should be paid by Medicare. This led to a much lower error rate for DME because the auditors' clinical review staff could

¹ For example: NHIC, Corp., the Jurisdiction A DME MAC, reported a 46 percent non-response rate in a widespread prepayment review for nebulizers (HCPCS code E0570) on December 22, 2011. Noridian Administrative Services LLC, the Jurisdiction C DME MAC, reported a 29 percent non-response rate in a widespread prepayment review of diabetic supplies (HCPCS code A4253KX) on March 5, 2012. NHIC, Corp., the Jurisdiction A DME MAC, reported a 24 percent non-response rate in a widespread prepayment review of enteral nutrition infusion pumps (HCPCS codes B9000 and B9002) on June 20, 2012.

² See example #1 in Appendix.

weigh the entire medical history as a factor in determining medical necessity. In 2008, the Medicare DMEPOS CERT claims error rate was approximately 9 percent. In 2009, CMS adopted new auditing criteria that resulted in a DMEPOS claims error rate of 52 percent. For 2011, the claims error rate is reported to be 61 percent, incorrectly suggesting that three out of five Medicare DMEPOS claims are paid improperly, which CMS notes is not an indicator of fraud or abuse.

For example, in 2008 and previous years, if a patient with a lifetime Certificate of Medical Necessity (CMN) for oxygen had Chronic Obstructive Pulmonary Disease (COPD) as a diagnosis in his/her medical record, the clinical reviewer could use that in determining that the patient's oxygen was medically necessary. When CMS, based on a recommendation from OIG, eliminated the use of clinical inference in 2009, many of these claims are now denied for reasons such as the physician did not document that the patient was still using oxygen during his/her last office visit. A similar issue occurs with other medical equipment that is furnished on a rental basis and/or for the treatment of chronic conditions that require power wheelchairs, hospital beds, CPAP devices, diabetic supplies, and enteral nutrition.

Require that electronic health records systems include elements for DME medical necessity documentation: While CMS encourages physicians, hospitals, and other providers to adopt electronic health record (EHR) technologies, the current Medicare-approved vendors do not contain the criteria necessary to properly prescribe DME and document all necessary elements in the patient's medical record. Mandating that approved EHR vendors include elements for ordering DME items and services would go a long way toward ensuring physician document the necessary elements in the patient's medical record and thereby aid in reducing the error rate for DME.

Mandate use of an electronic clinical medical necessity template: Recognizing that it will take time to design and adopt DME criteria in EHR systems, CMS must allow clinical medical necessity templates for physician use in prescribing DME in the interim. The documentation requirements for DME items and services are complex and constantly changing. A clinical medical necessity template would help guide physicians through documenting the necessary elements when prescribing a specific item or service. Additionally, DME is often prescribed by family physicians, internists, and other general medical non-specialty physicians, many of whom order less than ten of a given DME item in a year. Templates would help ensure that all physicians are familiar with the required documentation elements for DME items and services. To be effective, these templates must also be considered a part of the patient's medical record.

Mandate use of a template in the power mobility device (PMD) prior authorization demonstration: CMS is in the process of developing and implementing a massive prior authorization demonstration for PMDs that will impact seven states and 43 percent of all claims for power mobility devices. CMS has begun developing an electronic clinical medical necessity template for PMDs, but the Agency has stated that this tool is on a separate track from this

demonstration and will not be used when the demonstration. Moreover, CMS has stated that the use of the electronic template will be voluntary. AAHomecare believes that if CMS wants to: 1) ensure beneficiary access to PMDs; 2) reduce incidence of fraud and abuse; and, 3) significantly reduce the error rate, it must allow physicians to use a clinical medical necessity template when this demonstration begins. Additionally, the clinical medical necessity template must be mandatory and be considered part of the patient's medical record.

Provide additional physician education on medical necessity requirements: For DME providers, a constant problem in audit denials is related to an error that occurred in some portion of the physician's documentation. Currently, the DME MACs encourage homecare providers to educate physicians on the documentation requirements. Despite attempts by DME providers to educate ordering physicians, this aspect of the error rate remains high. A representative physician group should educate CMS on medical necessity documentation to help reduce the DME error rate.

Establish definitive policy prohibiting retroactive implementation of policies: In order to reduce the error rate for DME, CMS must definitively prohibit contractors from implementing new policies retroactively. Often, DME MACs release a "clarification" to a medical policy that is truly a revision to the policy rather than a clarification. It is impossible for DME claims to withstand scrutiny in an audit when the contractors make policy changes that are implemented retroactively. A recent example of this is the DME MACs' new policy on refills for non-consumable supplies. The DME provider is now required to "assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function" and document the dysfunction of the item. This revised policy was released on June 7, 2012, with an implementation date that is retroactive to August 2, 2011. Claims for non-consumable supplies submitted during the ten-month period between the initial policy issue date and the revision date are almost certain to fail in an audit. Congress must place strict guidelines on Medicare contractors that prohibit retroactive implementation of medical policy revisions.

Further, audit contractors often target claims submitted 3 or 4 years after the date of service. If these claims do not pass medical review, the DME provider is unable to resubmit the claim because of timely filing requirements or the patient may have moved into an institutional setting or died.

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Finally, AAHomecare recommends that any local coverage determination (LCD) policy changes be issued in the proposed format with a minimum of a 30-day public comment period prior to implementation. This includes revisions, regardless of whether they are deemed as “clarifications,” that could likely result in medical necessity denials if implemented retroactively.

AAHomecare looks forward to working with the Senate Finance Committee on this important issue. If you need anything further from the Association, please contact Walt Gorski at waltg@aahomecare.org or (703) 535-1894.

Sincerely,

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

Walter J. Gorski
Vice President of Government Affairs

Appendix

Examples of Audit Inconsistencies for DME Claims

AAHomecare recognizes that the Secretary has the authority to perform pre- and post-payment complex medical reviews. However, the Agency's aggressive audit strategies call into question the necessity and utility of the information providers are required to collect. The following examples highlight this point:

1. ***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 billed for and paid on a monthly basis, 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.
2. ***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.
3. ***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 is to 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.
4. ***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.

5. ***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.
6. ***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, DME providers should not have to jump through hoops to obtain physician signature attestations.
7. ***A time limit should be considered relative to how far back an audit can go when requesting documentation in support of claims submitted.*** We have examples where one RAC submitted hundreds of audits to a provider requesting copies of sleep studies that were performed several years ago (in some cases as far back as far as 1999).
8. ***When an audit is generated as a result of a beneficiary complaint (i.e. BPU or ZPIC audit) the provider should have the right to hear the allegations being made against them in order that an appropriate response to the audit may be submitted.*** Often times the auditors refuse to provide any information relative to the audit and as a result the DME provider is forced to guess at what the concern may be. Furthermore, the DME provider should be entitled to speak with the auditor to address whatever concerns and/or questions they may have. Although contact information is usually provided, more often than not, the BPU, ZPIC and RAC auditors do not return phone messages and when DME providers are able to finally connect with a live agent, they are often treated with contempt and cannot get relevant information. This is especially true with ZPIC auditors.