



via Electronic Submission: [ProgramIntegrityRFI@cms.hhs.gov](mailto:ProgramIntegrityRFI@cms.hhs.gov)

November 20, 2019

Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: Request for Information on the Future of Program Integrity**

Dear Administrator Verma,

The American Association for Homecare (AAHomecare) is pleased to submit these comments in response to the Centers for Medicare and Medicaid Services (CMS) Request for Information on the Future of Program Integrity. AAHomecare is the national association representing the interests of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. AAHomecare members include a cross section of manufacturers, suppliers and other industry stakeholders that assist, make or furnish DMEPOS items that beneficiaries use in their homes. Our members are proud to be part of the continuum of care that assures that Medicare beneficiaries receive cost effective, medically necessary, safe and reliable home care products and services.

I. Executive Summary

- a. AAHomecare would like to see CMS take advantage of AAHomecare's and its members' insights and information to improve CMS' program integrity activities. We therefore recommend increased communication with the DMEPOS community, as well as between CMS' program integrity and policy groups.
- b. We recommend that CMS monitor UPIC actions more closely and urge CMS to instruct UPICs to provide their rationale for decisions regarding nonpayment of claims. We further recommend that DMEPOS suppliers be afforded due process rights before being subjected to a payment suspension. UPIC contractors should be held accountable for their work.

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- c. AAHomecare recommends that all new DMEPOS suppliers be subject to increased scrutiny during their first year of billing the Medicare program, and we have a number of detailed recommendations to enhance the provider/supplier enrollment process.
- d. AAHomecare recommends that CMS increase its education of its managed care contractors, so they better understand the Medicare coverage criteria, and are better able to accurately process electronic claims. We note that Medicare Advantage contractors have superior software systems for claims processing and data analytics.
- e. Given the prescriber's critical role in providing detailed medical need records, we recommend that CMS educate the prescriber community about the nuances and details of DMEPOS coverage requirements to help prescribers provide sufficient documentation.
- f. AAHomecare strongly urges CMS to require e-prescribing to (1) streamline the prescription process; (2) improve CMS' ability to audit documentation for DMEPOS claims, and (3) reduce costs for prescribers, suppliers and the federal government. In addition, for DMEPOS suppliers that choose to utilize an e-prescribing system, we suggest that CMS issue guidance stating that e-prescribing is an acceptable method for prescribers to create orders and documentation and for DMEPOS suppliers to utilize as required documentation.
- g. AAHomecare generally supports the increased use of prior authorizations (PAs), as long as the PA process is timely and communicated to the DMEPOS supplier and beneficiary within 24 hours or sooner, depending on the DMEPOS item. Given the significant use of PA for DMEPOS items, we have a number of specific recommendations to improve the PA program.

## II. Overall Recommendations

- a. Recommend Increased Collaboration with DMEPOS Community: The DMEPOS community would be pleased to establish better collaboration and communication with CMS. We urge CMS to establish forums and other mechanisms to facilitate greater communication between CMS and the DMEPOS supplier community. This could be accomplished by establishing a DMEPOS public forum on a semi-annual basis at which DMEPOS stakeholders could provide CMS information regarding industry trends, technology development, and other information that would be useful to CMS as it works to improve its program integrity activities. Too often, CMS initiatives involve other health care providers, but fail to include DMEPOS stakeholders, when inclusion would be helpful to CMS and the DMEPOS community. For example, the CMS Open Door Forums are largely focused on home health and hospice, rarely include CMS DMEPOS policy staff to answer DMEPOS-specific questions, and are more an opportunity for CMS to update the community on CMS initiatives. The Open Door Forums are not structured to provide two-way communication with a focus on DMEPOS issues. On the other hand, CMS' Program Integrity (PI) Group's provider compliance meetings have been positive experiences for our membership and help to improve direct communications with the provider/supplier community.

- b. Recommend Increased Communication/Working Between PI and DMEPOS Policy Group: We urge CMS' Center for Program Integrity to work more closely with the Center for Medicare's Chronic Care Group Division of DMEPOS Policy. We believe closer coordination and communication between the two groups would enhance CMS' PI efforts because too often the program integrity activity is focused on a documentation policy that can be vague and subject to multiple interpretations. Closer coordination will create an opportunity for the Division of DMEPOS Policy to clarify or simplify the policy; this would, in turn, assist the PI efforts and lead to better consistency in reviewing compliance with documentation requirements. We are happy to provide further details and specific examples and recommendations.
- c. UPIC contractors should be held accountable for their work and CMS should more actively monitor UPIC actions
- Since the transition of the program integrity workload from ZPICs to UPICs, CMS has continued to receive complaints about actions taken by UPICs about the conduct of the UPIC investigations. UPICs seemingly act without rules or reason when performing their reviews. In a recent example, a supplier's authorized representative requested a telephone call with a UPIC manager to discuss why the UPIC was denying claims in a prepayment review. The UPIC manager's e-mail response stated, "As you are aware, I cannot provide specific details of our claim determinations, however, I may be able to provide some more general information that will be helpful for you." A contractor making a determination to deny a claim should provide details of why it believes the claim should not be paid. The Medicare Program Integrity Manual does not preclude a contractor from sharing this information, but DMEPOS suppliers have no options when a UPIC simply refuses to communicate or provide this information. In this same example, the UPIC indicated that the DME MAC denied these claims, but the DME MAC insisted that the UPIC instructed it to deny the claims. CMS should instruct UPICs to respond to supplier questions and concerns and provide detailed information about why the UPIC believes the claims should not be paid.
  - CMS should take a more active role in overseeing UPIC investigations, given the significant negative impacts these investigations have on suppliers. A complaint recently filed in the U.S. District Court for the Northern District of Illinois (Simply Home Healthcare, LLC v. AZAR et al), alleges that over 100 healthcare providers may have ceased operations or otherwise been seriously damaged by payment suspensions and extrapolations of overpayments by the UPIC AdvanceMed. Often times, these investigations do not result in any criminal or civil proceedings, but the actions taken by the UPIC can cause companies to cease operations, all due to minor technical errors or medical necessity denials that are often overturned during the appeal process. Suppliers are not afforded timely appeals due to the ALJ current backlog and are forced to refund large amounts of money while waiting for ALJ hearings. Equally as important, UPIC payment suspensions effectively serve as summary executions of DMEPOS suppliers. In virtually all instances, a payment suspension lasts for at least six months. Notwithstanding that a DMEPOS

supplier can submit a rebuttal to a payment suspension, it is extremely rare for a rebuttal to result in the lifting of a suspension. In most cases, a payment suspension results in the DMEPOS having to close its doors. While CMS must approve the recommendation by a UPIC to suspend payments, it does not appear that CMS looks at the underlying facts when approving the payment suspension. We urge CMS to adopt a process that (i) sets out clear thresholds that must be met before a UPIC can recommend a payment suspension, (ii) gives advance notice to a DMEPOS supplier of a suspension, and (iii) allows the supplier to present rebuttal evidence before the payment suspension goes into effect.

- When a new round of DMEPOS competitive bidding goes into effect, two things happen: (i) existing DMEPOS suppliers, that are awarded contracts, submit an increased number of claims; this results from fewer competitors; and (ii) there are new DMEPOS suppliers, that are awarded contracts, that are submitting claims for the first time for a product category in a competitive bid area (CBA). This increased claim submission by contract suppliers has often been identified by UPICs as a possible aberrant billing increase, when the UPICs should expect this type of increased claims activity with the start of a new round of bidding. We therefore recommend that CMS educate the UPICs about how competitive bidding will cause an expected increase in billing by a number of DMEPOS suppliers. Previous OIG reports on ZPIC contractors have found that CMS provided insufficient oversight of the ZPIC contractors.<sup>1</sup> Although CMS has since transitioned this workload to UPICs, the companies that previously held ZPIC contracts have been awarded UPIC contracts. The same issues regarding lack of oversight continue to exist with the UPICs. UPICs should be required to provide detailed information to the entities they are reviewing and a process should be established for suppliers that feel they are being treated unfairly during a UPIC audit. Further, DMEPOS suppliers should be able to contact the appropriate individuals at CMS to review and, if necessary, intervene on the suppliers' behalf.

### III. Provider Enrollment

- a. AAHomecare recommends that all new DMEPOS suppliers be subject to increased scrutiny during their first year of billing the Medicare program. "New" suppliers should mean any DMEPOS supplier with a new Medicare supplier number and that has owners that are not on record with Medicare as having any current or previous ownership interest in an existing or previous DMEPOS supplier. CMS should focus the TPE program on these new suppliers. Once a new supplier starts billing a specific HCPCS code, it should be under a TPE audit for that code. This would enable new suppliers to be appropriately educated on medical necessity and other documentation requirements.
- b. AAHomecare recommends that CMS improve the communication system between PECOS and the National Supplier Clearinghouse (NSC). It often takes a significant amount of time for information that suppliers update in PECOS to be accurately reflected in the NSC database.

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<sup>1</sup> Office of Inspector General, Department of Health and Human Services, ZONE PROGRAM INTEGRITY CONTRACTORS' DATA ISSUES HINDER EFFECTIVE OVERSIGHT (OEI-03-09-00520). November 2011.

This was a significant issue for many DMEPOS suppliers that were submitting bids for Round 2021 of the competitive bidding program, where the NSC database must be consistent with information that bidders submit with their bids.

- c. AAHomecare recommends that DMEPOS suppliers, that CMS identifies as having unexplained aberrant billing patterns, be subject to increased scrutiny via an expansion of the TPE process.
- d. AAHomecare recommends that CMS make available a national fingerprint database. Currently, as employers, DMEPOS suppliers must research all state fingerprinting databases to screen prospective employees; this is a significant burden. In addition, each state has a separate fingerprinting process for business owners. One national database would be far more efficient.
- e. There should be a national database that combines all Medicare Part A and B enrollment, resulting in a single entity managing enrollment. By taking these steps, CMS will be better equipped to (i) track Medicare participants across Parts A and B and (ii) prevent fraudulent players from entering/re-entering the program.

#### IV. Medicare Advantage (MA)

- a. AAHomecare recommends that CMS increase its education of its managed care contractors, so they better understand the Medicare coverage criteria, and are better able to accurately process electronic claims.
- b. We understand that many MA plans outsource their program integrity efforts to outside contractors. Our experience is that those contractors are not knowledgeable about DMEPOS coverage criteria, their application of the criteria is inconsistent, and the contractors often deviate from their own managed care manual.
- c. We are aware that certain private payors utilize better and more updated software to process claims and perform data analytics. While we are not aware of the specific software/technology, our members' experience is that it is significantly superior to that used by the MA contractors. We recommend that CMS work with its contractors to utilize improved software technology to enhance the claims processing experience, particularly prepayment edits.
- d. CMS should look at private payors' policies regarding medical need for DMEPOS items. Our members have consistently found that private payors' coverage policies are less restrictive, and require less documentation, than Medicare's LCDs for DMEPOS

#### V. Education

- a. AAHomecare recommends that CMS and its contractors increase their educational activities to better assure that prescribing physicians, nurse practitioners, physician assistants and

clinical nurse specialists are better informed about (i) the details of Medicare coverage policies for DMEPOS and (ii) the types of documentation that Medicare expects prescribers to maintain to substantiate a beneficiary's medical need for a DMEPOS item.

- b. AAHomecare recommends that CMS focus educational activities on physicians associated with DMEPOS claims that are deemed to have insufficient medical documentation, for example, during TPE reviews. The physician's NPI is on the DMEPOS claims, and it would be an effective way to target physicians who are reluctant to provide the level of documentation Medicare requires.
- c. In addition, if CMS finds a prescriber who has a pattern of prescribing DMEPOS without providing sufficient supporting documentation, CMS should subject that prescriber to a TPE to educate him/her regarding the documentation requirements.
- d. Through data analytics, the DME MACs can identify which NPIs are consistently submitting incomplete documentation and they can target TPE on that specific NPI.

VI. E-prescribing

- a. AAHomecare urges CMS to require e-prescribing to (i) streamline the prescription process; (ii) improve CMS' ability to audit documentation for DMEPOS claims; and (iii) reduce costs for prescribers, suppliers and the federal government. In the past, CMS mandated that DMEPOS suppliers submit claims electronically, and refused to accept paper claims. Requiring e-prescribing would be similar. If CMS does not believe it has the authority to do so, it should seek the authority from Congress.
- b. CMS should issue guidance stating that e-prescribing is an acceptable method for prescribers to create orders and documentation and for DMEPOS suppliers to utilize as required documentation. AAHomecare believes that many DMEPOS suppliers would invest in e-prescribing platforms if there was a clear CMS policy stating that e-prescribing is an acceptable means of creating, transmitting and collecting required documentation. CMS guidance should state that all electronic documentation must meet the same requirements as other documentation requirements.
- c. CMS should issue guidance clarifying that e-prescribing applications are considered an extension of the prescriber's medical records. When the prescriber, or his/her designee, is using e-prescribing to order DMEPOS, that electronic record is part of the medical record because it is being created and communicated by or on behalf of the prescriber.
- d. The clinical data elements (CDEs) that were developed by CMS should be mandated. CDEs will help guide physicians in answering structured questions and will result in contract nurse reviewers not having to rely on notes from the medical record. Adopting CDEs will improve the consistency and objectivity of the reviews.

VII. Prior Authorization

- a. AAHomecare generally supports the increased use of PA, as long as the PA process is timely and communicated to the DMEPOS supplier and beneficiary within 24 hours or sooner, depending on the DMEPOS item. For example, PA for oxygen would have to be performed on a much quicker timeline than the DME MACs are currently doing for other DMEPOS items. We note that managed care plans issue prior authorizations in a timely manner.
- b. While CMS thinks of PA as primarily a fraud and abuse tool, AAHomecare believes that PA is an equally important efficiency tool that is made possible through the use of newer technology. We urge CMS to build upon the current PA foundation and require more electronic PA communications, which will further expedite the PA process and allow it to be used for items that require more immediate approvals (e.g., oxygen therapy).
- c. AAHomecare supports CMS' proposal to include in the PA decision for power, mobility devices the accessories that are used with the PMD base. This is consistent with CMS' current Advance Determination of Medicare Coverage (ADMC) process.
- d. While AAHomecare supports PA, CMS should be aware that there are significant administrative burdens for DMEPOS suppliers. We therefore recommend that CMS provide ample advance notice (e.g., 180 days) to allow suppliers to appropriately prepare systems, policies and procedures, to assist them in being fully in compliance by the date that the PA will be required.
- e. In the past, when CMS has added a new DMEPOS item to the PA requirement, it has first implemented the PA process on a limited geographic basis to ensure that the four DME MACs are capable of timely processing the PA requests. AAHomecare urges CMS to continue this practice to ensure a smooth transition to national implementation.
- f. When CMS adds a new item to the required prior authorization list, we strongly recommend that CMS and the DME MAC conduct significant education. That education should be focused on the DME MAC PA reviewers and prescribers to better inform all stakeholders about the nuances and details of Medicare coverage requirements for DMEPOS items. For example, recent experience with the PA process for support surfaces, added nationally last month, has shown that the PA reviewers were applying erroneous and outdated coverage criteria.
- g. AAHomecare has previously made a number of written recommendations to CMS regarding PA for DMEPOS items, we reiterate them here in summary form. To promote the timely delivery of equipment and services to beneficiaries, CMS should incorporate the following guidelines for PA:
  - o PA decisions must be completed and communicated to the provider, supplier and beneficiary within 24 hours or sooner. While CMS has instituted longer timelines for power mobility devices subject to PA, many DMEPOS items such as oxygen equipment and services, would need a much faster approval timeframe;

- A PA request for equipment that is needed on an emergency basis must be “fast tracked” and decided within two or fewer hours;
- Communication between the supplier and the contractor must be in an electronic format. A PA decision for a DMEPOS item must be conclusive with respect to the medical necessity of that item for that beneficiary, although claims could be audited subsequently for technical issues such as proof of delivery;
- An affirmative PA decision for a DMEPOS item must be conclusive with respect to the medical necessity for all of the options, supplies, and accessories that may be used with the item;
- An affirmative PA decision for a DMEPOS item must be conclusive with respect to the medical necessity for repairs to the DMEPOS item approved;
- When an item that is submitted for PA is the same or similar to an item the beneficiary is already using, the need for the new item should be considered as part of the PA; and
- An affirmative PA is specific to the beneficiary with respect to the DMEPOS item approved. If the beneficiary moves or changes to a new supplier, the beneficiary should not need a new PA for the item.

VIII. Conclusion

AAHomecare appreciates the opportunity to provide CMS with these recommendations, and we are happy to provide further details. Please contact me at [kimb@aahomecare.org](mailto:kimb@aahomecare.org) or (202) 372-0750.

Sincerely,



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