Statement of:

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on behalf of the
Medical Equipment Suppliers Association (MESA)

Roundtable:

Improving Audits: How We Can Strengthen the Medicare Program for Future Generations

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Good Afternoon, Chairman Nelson, Ranking Member Collins and distinguished Members of the Committee. I am Walter Gorski, Principal of the Gorski Healthcare Group, and I am presenting the views of the Medical Equipment Suppliers Association (MESA) on ways to improve the flawed audit process for durable medical equipment providers.

MESA is a non-profit organization providing news, information, education and training, and legislative and regulatory support and updates to DMEPOS providers in Arkansas, Florida, Louisiana, New Mexico, Oklahoma, and Texas. I appreciate this opportunity to describe the negative impact that audit contractors are having on durable medical equipment providers who serve Medicare and Medicaid beneficiaries and making constructive recommendations to streamline and improve the audit process in order to prevent fraud and abuse.

Prior to forming the Gorski Healthcare Group, I was Vice President of Government Affairs at the American Association for Homecare (AAHomecare), the national trade association representing the interests of durable medical equipment providers and manufacturers. Previously, I also serviced as Director of the American Orthotic & Prosthetic Association (AOPA). During this period, I saw first-hand the harmful effects that audits can have and have worked with Congress, the Centers for Medicare and Medicaid Services (CMS) and the Government Accountability Office (GAO) to improve the audit process.

The Provision of Durable Medical Equipment

The provision of durable medical equipment is unique within the Medicare program. DME providers furnish medical equipment, typically on a monthly rental basis, based on a physician's order. Therefore, the DME provider cannot affect utilization by providing more items and services to Medicare beneficiaries at his or her own discretion and relies almost exclusively on good documentation in order to be paid for work he or she does. Further, the DME provider is required to collect the physician's documentation to ensure that the item or service meets extensive and detailed coverage policies to justify medical necessity. But the requirements on the DME provider do not end there. The provider also needs to demonstrate that the medical equipment is continuing to be used and that the beneficiary continues to benefit from the equipment. At any step in this process, a Medicare audit contractor can subjectively audit a provider's claim and can recoup payment for services that have been already furnished.

If we were to apply this process to the pharmacy setting, prior to dispensing an antibiotic, the pharmacist would be required to collect the physician's documentation and evaluate the documentation to see if the antibiotic was medically necessary. The pharmacist would then need to contact the

beneficiary to see if he or she took the antibiotic. Then, the pharmacist would have to check with the beneficiary to determine if the beneficiary benefited from the antibiotic's effects.

The point of this illustration is to demonstrate that a significant portion of what the DME provider is required to do is based on the physician's documentation. While DME providers make great efforts to educate physicians on complex DME documentation requirements, the physician does not have any stake in the process to ensure that a DME provider is paid for the services provided. It also demonstrates the areas where a simple error, omission or nurse reviewer subjectivity can lead to a claims denial and the classification of the claim being "improper" or made in "error."

Error Rate

In 2009, as a result of the Comprehensive Error Rate Testing (CERT) program, CMS implemented new medical review criteria to more strictly enforce Medicare policies. The primary modification required the medical reviewers under CERT to strictly follow the documentation requirements outlined in Medicare regulation, statute, and policy, including Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective contractor's Local Coverage Determinations (LCDs), and articles rather than allowing for clinical review judgment (clinical inference) based on billing history and other available information.

A significant portion of the new errors found in FY 2009 were due to a strict adherence to policy documentation requirements, signature legibility requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim. In 2009, CMS determined that nearly 52 percent of DME claims were paid in error.

Current prepayment reviews conducted by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) show error rates between 40-70 percent for sampled claims. While the DME MACs have made efforts to educate physicians and DME providers, the error rates remain high due to the complexity of the coverage policies. Also, a significant portion of these claims are paid on appeal. As the Committee knows the appeals process is labor intensive and time consuming especially for smaller providers.

Impact of Audits

I would like to provide the Committee with several examples of audit examples that are not uncommon in the durable medical equipment sector. While the goal here is to identify and consider recommendations to the audit process, these examples demonstrate how the audit system has broken down.

EXAMPLE--ZPIC Post Payment Audit

Aug 2011 – 164 claims audited, 102 initially denied, 70 overturned 69%.

08/29/11—Initial audit request for 164 claims that were previously paid $20,023.94. Provider received the results of the audit on 05/31/13 (21 months later). ZPIC stated that 102 of the 164 claims were determined to be paid in error. Provider was paid $13,729.02 on those 102 claims; however, the ZPIC statistically extrapolated the error rate to $784,965.84 actual overpayment and the ZPIC demanded at that time or interest would begin accruing.

09/13/13—The provider's first appeal to Redetermination resulted in 55 of the remaining 102 claims still denied. The new extrapolation number based on the 55 claims was $388,223.77, which the ZPIC requested. The provider continued to appeal.

01/06/14—The provider appealed these denials to the Reconsideration level, which resulted in 32 of the remaining 55 claims still denied. The amount the provider was paid on these 32 claims totaled $3,766.13. This appeal, which was done by a contractor outside of the Medicare program, determined the extrapolation was statistically invalid and they threw it completely out.

The final outcome was $3,766.13 plus interest on an original request of $784,965.84. The provider elected to pay this amount and stop any further appeals due to the suspension of the ALJ appeals process.

EXAMPLE--ZPIC Pre-Payment Audit

Feb-Nov 2011 706 claims audited, 307 initially denied, 234 overturned 76%.

ZPIC AUDIT RESULTS – PRE PAY

	RECEIVED	PAID		DENIED	
Initial Results	706	399	57%	307	43%
Appealed & Paid		234		(234)	
Final Results after Appeal	706	633	90%	73**	10%

**72 claims were written off, 1 claim is still waiting for a hearing date at ALJ since 06/20/12.

Most of these claims were written off due to lack of medical documentation after exhausting every effort to obtain documentation that would be acceptable to the auditors. Many of these cases involved one physician that left our area abruptly in 2010;

no one has been able to contact him. We provided the information regarding his legal troubles as well as letters from the physician stating they could not obtain his records either. But this held no weight at audit. We had not one case were we did not have a valid order, signed delivery ticket and properly completed CMN, if applicable.

A few write offs were due to timely filing issues. With the amount of requests we received in such a short time period, it was inevitable that we would miss a few.

Other cases involved patients that were in a SNF or hospital and we were never made aware of this by the patient or their family and would have no way of knowing without individually checking every claim before we file it which is just not feasible. CMS systems generally catch this and deny the claim or ask for recoupment at a later time. If we discover an inpatient stay we immediately voluntarily recoup the money to CMS as required and have done so since we began in 2002.

Recommendations

The incentives under which the various audit contractors operate do not line up with the practice of medicine, nor is there sufficient oversight of the audit contractors to ensure that they are accountable for their decisions in meeting their obligations while minimizing duplication. What has been created is an overly complicated system with duplication where virtually any DME claim payment can be recouped.

Right now, we are treating healthcare like an accounting exercise where there are specific right and wrong answers. This began in 2009 when CMS terminated the duties of qualified medical reviewers to use their medical training and discretion to audit claims. At that time, the DME error rate was determined to be more than 50 percent and, despite all the efforts made and increased administrative expenses incurred to date, this error rate has only gone up, not down.

The current audit process is designed to second guess the physician by trying to interpret subjective documents. This policy creates unnecessary work for physicians and the DME providers, especially when the DME providers are targeted with high volumes of audits. One only need look at the backlog of Administrative Law Judge (ALJ) cases to see the implications of the current system.

Here is where there is a serious disconnect from the DME provider's perspective: DME providers are held accountable in the current audit system because it places the responsibility for supplying all documentation that proves medical necessity on DME providers, and for reviewing that documentation to verify medical necessity, rather than on the physicians who believe they are properly ordering medically necessary items and services. DME providers should be held to standards and actions that are within their qualifications, and shouldn't be held accountable for reviewing a physician's documentation to determine if the item is medically necessary, just as they shouldn't be made responsible for the decisions of post-payment auditors who are second-guessing physicians' determinations of medical necessity.

Contractor accountability

Audit contractors hold DME providers answerable for meeting strict guidelines and deadlines. We believe that Medicare contractors should also be held accountable for their decisions, and to meet audit review timelines and operate in a fair, consistent, and transparent manner. Further, we believe that audit contractors must place all information that is required in an audit in one easily accessible place; they also need to better organize and inform the public of changes in policy that will have an impact on audits. As we have previously stated, policy affecting audits can be found in many places: Medicare regulation, statute, and policy, including Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and the respective contractors' Local Coverage Determinations (LCDs), and articles. It is extremely difficult for any provider to keep track of changes that are made to any of these policies while at the same time trying to keep their staffs educated about the changes.

Finally, audit contractors need to be held accountable for audits that are overturned on appeal. Audits can be in process for several years, which can strangle the cash flow of DME providers. The DME provider can also be penalized with interest when paying back overpayments. We believe that auditing should be a two-way street. If an audit is overturned, the audit contractor should receive some type of financial penalty for its mistake.

Back out claims that are overturned on appeal

It is our understanding that some audit contractors are able to back out from error rate claims that have been reversed on appeal. CMS should require all audit contractors to make this effort since, otherwise, the error rate is artificially high and can be misused or misinterpreted to pursue additional audits; the artificially high error rates are also misleading, which does grievous damage to the credibility and the importance of a sector that does, in fact, help reduce Medicare costs by helping to make cost-saving care in the home possible.

Reinstate "Clinical Inference"

Again, without conceding that DME providers should not be held accountable for furnishing medical equipment based on a valid physician's prescription, CMS should instruct audit contractors to allow their medical review teams to use their clinical training to determine if a DME item is medically necessary. The practice of medicine is not an accounting exercise, but the current incentives that the government is pursuing in the audit arena do not allow a nurse reviewer to look in other parts of a patient's medical record to determine if an item of DME is medically necessary.

Hold physicians accountable for proper documentation

Audit contractors are holding only the DME providers accountable for providing and interpreting medical necessity information when they are simply operating in good faith and furnishing items or services to Medicare beneficiaries based on valid physicians' prescriptions. DME providers should not be penalized through audit recoupments when a prescribing physician's documentation is incomplete.

We recommend that CMS instruct its audit contractors to remove the requirement that the DME provider be held accountable for the physician's medical necessity documentation. Instead, audit contractors should focus their attention on the documentation elements that are within the control of the DME provider. Further, in order to properly align incentives, CMS can audit physician documentation to determine if the physician is properly documenting medical necessity.

Use "predictive modeling" to identify fraud and aberrant billing behavior

Technology has advanced to the level where financial institutions can quickly identify fraudulent and/or aberrant billing patterns through the use of predictive modeling. CMS should explore how predictive modeling can target true fraud in order to target scare program integrity resources.

Create guidance for physicians that can be made part of the physician's medical record to help physicians document properly

Currently, DME MACs have made efforts to help suppliers educate physicians on medical necessity documentation. Again, without conceding that DME providers should not be held responsible for a physician's documentation nor should the DME provider be tasked with educating physicians, an immediate step that could be taken would be to allow the educational material created by the DME MACs to be considered part of the patient's medical record that can be relied upon in the case of an audit. This is a common practice with other payors.

Target providers who have a high non-response rate to audits

DME providers make decisions on whether to challenge an audit based on financial reasons. In certain cases, it is more cost-effective for a DME provider to pay back an alleged overpayment because it is more costly to track down documentation that is stored off site or to contact a physician who has moved or retired. However, when DME MACs conduct probe audits there is typically a sizeable "non-response rate" to the audit. CMS contractors should first target those DME providers who consistently have a high non-response rate to better use scarce program integrity resources. Also, contractors should have clear and consistent publicly available documentation that providers can access so that they know how to be removed from widespread probe audits.

Conclusion

MESA greatly appreciates the Senate Special Committee on Aging for holding this Roundtable and its time and attention to our recommendations for DME providers. We look forward to cooperating in any way to help reduce the burden audits create for DME providers while also protecting and improving the integrity of the Medicare and Medicaid programs.