HME Audit Climate:
What you need to Know

Michigan Home Care & Hospice Association

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PHE is coming to an end!!!

Public Health Emergency will expire on May 11, 2023

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What is not affected?

- Major Medicare telehealth flexibilities will not be affected. The Continuing Appropriations Act passed in Dec 2022 extends these flexibilities through December 2024.
- Medicaid telehealth flexibilities
- The process for states to begin eligibility redeterminations for Medicaid will not be affected. During PHE, significant federal matching dollars were received by states to maintain coverage for beneficiaries, which was set to stop the last day of the month that PHE ends. The Continuing Appropriations Act also removed this requirement.

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What is affected?

- Waivers and flexibilities that are no longer necessary will come to an end.
  - Local Coverage Determination (LCD) and National Coverage Determination (NCD) waivers
  - Signature waivers
  - Use of CR modifier for new set ups after May 11, 2023 (for COVID waivers)
  - Appeal timeline waivers

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Post PHE Transition Workgroup

- Reference document provided to CMS for audit contractors reviewing claims
  - Divided up by product category
  - Lists normal documentation requirements for on-going rentals and supplies continued into the PHE as well as new set-ups during PHE
  - Lists any additional documentation requirements (none)
  - Lists any additional waiver and in some cases, what is NOT required (i.e. no repeat sleep study, no recert, allowing for more than 30 days supply)
- CMS has not yet published specific guidance on a transition plan for impacted patients but indicated to us it would be released first week in April (preliminary news is good!)

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Medicaid Unwinding

- Medicaid enrollment has increased since the start of the pandemic, primarily due to the continuous enrollment provision.
  - Medicaid enrollment grew to 90.9 million in September 2022, an increase in 19.8 million or 28%
- It is estimated that between 5 million and 14 million people will lose Medicaid coverage once the continuous enrollment provision ends.
- States must develop plans for how they will resume routine operations.
- States can obtain temporary waivers to pursue strategies for unwinding plans
- States can partner with MCOs, community health centers, and other partners to conduct outreach

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Current Audit Climate

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DME MAC

Product Category/HCPCS	Product Category/HCPCS
Osteogenesis Stimulators (E0747, E0748, E0760)	Knee Orthoses (L1833, L1851)
Surgical Dressings (A6010, A6196, A6197, A6212)	Ankle-Foot Orthoses (L1902, 1906, L1970, L1971, L4360, L4361, L4396, L4397)
Urological Supplies (A4351 – A4353, A4355, A4316)	Immunosuppressive Drugs (J7503, J7507, J7518, J7520, J7527)
Ostomy Supplies (A4414, A4407-A4409, A4431, A4434, A5081, A5122)	Blood Glucose Test Strips (A4253)
Therapeutic Shoes for Diabetics (A5500, A5512-A5514)	Lower Limb Prostheses (L5700, L5701)
Lumbar Sacral Orthosis (L0650)	Manual Wheelchairs (K0001-K0004)

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RAC - Complex

DMEPOS Under Complex Reviews	Date Posted
Enteral Nutrition Therapy	12/6/2021
Parenteral Nutrition Therapy	12/6/2021
Immunosuppressive Drugs	12/1/2020
Continuous Glucose Monitor	9/8/2020
Hospital Beds	3/1/2020
Manual Wheelchairs	3/1/2020
Surgical Dressings	1/1/2020

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RAC - Automated

DMEPOS Under Automated Reviews	Date Posted
CGM Supplies	9/8/2020
Cervical Orthoses RUL	1/1/2020
Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses RUL	10/1/2019
Upper Limb Orthoses RUL	5/17/2019
Knee Orthoses RUL	5/1/2019
Spinal Orthosis RUL (TLSO/LSO)	1/1/2019

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SMRC

- There are currently no DMEPOS projects published to the SMRC website

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OIG Work Plan

Project Description	Date Posted
Medicare payments for intermittent urinary catheters	July 2022
Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Orthotic Braces	Revised
Review of Medicare Payments for Power Mobility Device Repairs	Completed (partial)
Supplier Compliance with Medicare Requirements for Replacement of Positive Airway Pressure Device Supplies	October 2019
Medicare Payments of PAP Devices for OSA Without Conducting a Prior Sleep Study	August 2019
Noninvasive Home Ventilators – Compliance with Medicare Requirements	Completed (partial)

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Current Status

- Audits are back in full force although volumes are still down somewhat from previous levels.
- DME MACs and RACs are staying away from pandemic related claims so seeing increased volume on things like surgical dressings, urologicals, ostomy, hospital beds, manual wheelchairs, commodes, etc.
- Many suppliers are seeing multiple audits occurring at the same time from different entities
- UPICs are auditing pandemic claims

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SMRC

- A small number of very large SMRC audits involving thousands of claims also occurred during PHE
- Three types of SMRC Reviews
  - Provider Compliance Group
  - Program Integrity Group
  - Healthcare Fraud Prevention Partnership
- PCG audit volumes are on the rise
- Results have been tricking in and overall, "not too bad."

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UPICs

- UPIC auditors were conducting telephone interviews with beneficiaries during the pandemic and could see an uptick in UPIC audits based on those results
- Have seen the first UPIC audits of claims submitted during the pandemic for respiratory equipment with a CR modifier
  - Identifying actual overpayments
  - Continued need seems to be a focus
- UPIC audits seem to be the preferred tool to audit pandemic claims
- Currently seeing UPIC denials for CGM citing LCD requirements (which were waived) but citing general SSA 1833, which generally states that items billed to Medicare must be "reasonable and necessary"

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UPICs – Recent OIG Report

- UPICs conducted substantially more program integrity activities for Medicare than for Medicaid
- Although most people with Medicaid are enrolled in managed care, UPICs conducted minimal activities for Managed Care
- Substantial disparities existed in the number of activities conducted across UPICs
- Strategies to improve program integrity by unifying Medicare and Medicaid data did not produce significant results

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UPICs – OIG Report

- The introduction of new collaborative processes, systems, and analytical tools has laid the foundation for improvement.
- Despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and—with some limitations—continue program integrity activities
- Overall, UPICs face challenges in conducting Medicaid program integrity activities
- CONCLUSION – IMPLEMENT A PLAN TO INCREASE MEDICAID PROGRAM INTEGRITY ACTIVITES, PARTICULARLY RELATED TO MANAGED CARE

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OIG Audit – Hospice claims

- OIG Report, "Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries"
- Audited two samples of claims (with/without GW modifier) – 200 claims total
- OIG found 121/200 claims were improperly paid
  - Suppliers were unaware that they had provided items to hospice patients
  - System edits were not effective or did not exist
  - Suppliers inappropriately used the GW modifier
- Expect audit activity of hospice claims to increase

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OIG Audit – PMD Repairs

- "Medicare Improperly Paid DME Suppliers an Estimated $8 Million of the $40 Million Paid for PMD Repairs"
- 100 sampled beneficiaries, 922 PMD repairs: 637 complied, 261 did not
  - Documentation did not support the charges for repairs, labor time was not documented, or charges were not reasonable and necessary
  - $41,137 in improper Medicare payments and $10,494 in associated beneficiary coinsurance payments.
- OIG also questioned charges for 183 repairs associated with 19 sampled beneficiaries citing documentation and services not being medically necessary.
  - $20,692 in questionable Medicare payments and $5,278 in associated beneficiary coinsurance payments.

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OIG Audits

- Another PAP audit is currently underway
- Likely a follow-up to the 2018 report that identified $631.3 million in overpayments after auditing just 100 claims
  - Resulted in significant issues for suppliers throughout the US
  - Led to six-year lookback audit
- This time, OIG has indicated that they are only reviewing to determine that a valid sleep study occurred.

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Audits – Looking Ahead

- TPE started fresh, so suppliers that were in a TPE before may not get one right away and vice versa.
- Providers previously referred to CMS after failing round 3 and were in a round 4 have been picked up right away again.
- The 10-claim review that was being done prior to initiating a TPE has reconvened.

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Audits – Looking Ahead

- Audit volumes will likely continue to increase as PHE winds dow
- CMS has indicated that they would be releasing a "transition" plan shortly after the termination of the PHE is announced.
- Entities using CR modifiers on large volumes of claims could be targeted
- Industry stakeholders are still calling for transparency in CMS audit plans and clarity on unresolved issues
- There is also a potential for a significant uptick in RAC audit volume in the coming months, due to end of PHE and resolution of ALJ Backlog

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ALJ Backlog

- By the end of first quarter 2022 (most recent published data), a total of 52,641 appeals remained pending at OMHA, which is a reduction of almost 88%
- ALJ hearings are now being scheduled within 60 - 90 days
- Decisions still not being received within the 90-day timeframe, but we are getting much closer to this happening

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Why is this relevant?

- ALJ appeal backlog directly correlated to RAC audit activity
- 2018 Federal Court ruling in favor of AHA established annual deadline-based targets for reducing the backlog
- Entire backlog of appeals must be reduced by December 31, 2022
- Forced OMHA and CMS to implement corrective measures
  - OMHA has significantly increased budget
    - Hired 70 new judges
    - Opened up 7 new office throughout the US
  - Focused on resolving smaller appeals vs big box cases
  - CMS revised the way in which RAC issues were approved

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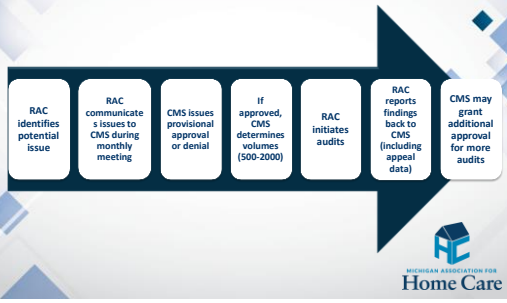
RAC Approved Issues Process



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Concerns

- OMHA is currently staffed to resolve 175,000 appeals timely (within 90 days)
- In most recent report, OMHA reported receipts of just 31,400 cases in FY 2021 and less than 10,500 in Q1 2022.
- No intent of OMHA to reduce their budget or close offices
- To increase appeal workload, CMS will likely utilize the RAC program and we will likely see increased RAC audit activity
  - Indications are CMS has already been providing provisional approval on larger volumes of claims than previously
- Appeal impact will continue to be a focus of CMS moving forward

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SIX-YEAR LOOKBACK AUDITS

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Six-Year Lookback Audits

- February 12, 2016, CMS issues its final rule that implemented Section 6402 of the Affordable Care Act.
- These rules were effective March 14, 2016.
- 1128J(d) of the Social Security Act.
- 42 CFR Section 401.305 – Requirements for reporting and returning of overpayments.

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Key Provisions

- Identification of overpayments through the exercise of reasonable due diligence, such as proactive compliance activities.
- Investigative activities in response to credible information about potential overpayments.
  - This includes, per CMS, overpayments identified by contractors, including RACs and UPICs.
- 6 months is a benchmark for investigation
- 60 days to refund
- Six-year lookback period
- No minimum monetary threshold

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Concern

- We are now seeing language in all OIG reports as well as postpayment audit letters, such as the UPIC
- An overpayment implicates the six-year lookback rule
- A supplier who does not "exercise reasonable due diligence" to comply with this rule could be subject to False Claims Act violations
- Significant concerns associated with this rule and how the federal government intends to enforce it
- Is a significant burden for suppliers who are attempting to comply

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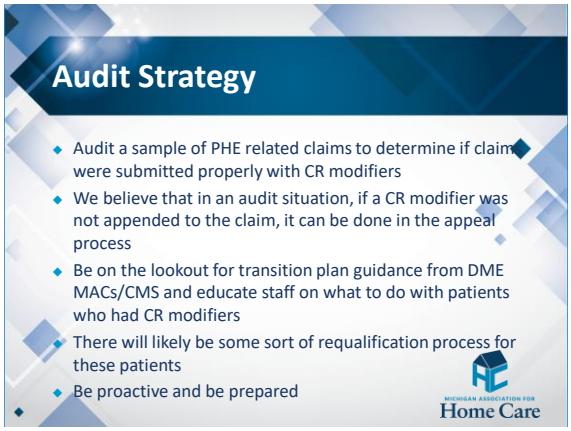
Audit Strategy
Audit a sample of PHE related claims to determine if claims were submitted properly with CR modifiers
We believe that in an audit situation, if a CR modifier was not appended to the claim, it can be done in the appeal process
Be on the lookout for transition plan guidance from DME MACs/CMS and educate staff on what to do with patients who had CR modifiers
There will likely be some sort of requalification process for these patients
Be proactive and be prepared
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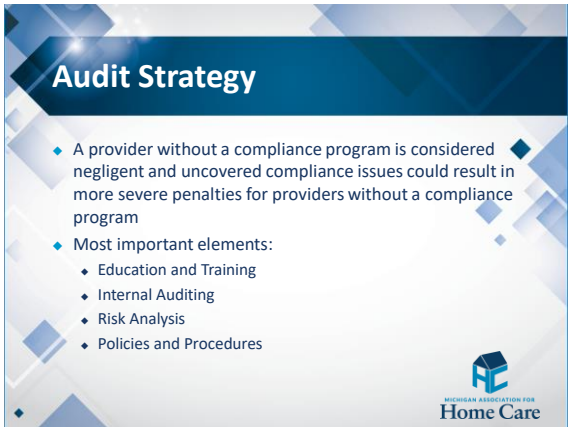
Audit Strategy
A provider without a compliance program is considered negligent and uncovered compliance issues could result in more severe penalties for providers without a compliance program
Most important elements:
Education and Training
Internal Auditing
Risk Analysis
Policies and Procedures
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