Statement Of The American Association For Homecare Before The Subcommittee On Financial And Contracting Oversight Of The United States Senate Committee On Homeland Security And Government Affairs

Oversight And Marketing Practices Of Durable Medical Equipment Companies

AAHomecare is the national trade association representing the homecare community. AAHomecare represents health care providers and manufacturers that serve the medical needs of Americans who require sleep therapy technologies, oxygen equipment and therapy, mobility assistive technologies, medical supplies, inhalation drug therapy, home infusion, and other home medical equipment, therapies, services, and supplies in their homes. Our membership reflects a broad cross-section of the homecare community including national, regional, and local providers operating in all 50 states. AAHomecare and its members are committed to advancing the value and practice of quality health care services at home.

AAHomecare strongly supports vigorous program integrity activities 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. AAHomecare has a long history of supporting program integrity measures to protect Medicare payments for durable medical equipment, prosthetics, orthotic and supplies (collectively, "DMEPOS"), many of which have been incorporated into law or regulation. In addition, AAHomecare has allocated resources to educating DMEPOS suppliers, whether or not they are AAHomecare members, to improve their awareness of the need for them to adopt compliant and ethical business practices. Consequently, the high claims payment error rate for the Medicare DMEPOS program is as troubling to the association as it is to other stakeholders in the Medicare program.

Our statement below identifies the current Medicare framework for paying and auditing DMEPOS claims. It also identifies the steps that association has taken, and continues to take, to work with CMS and other stakeholders to improve the efficiency of Medicare's audit processes and promote compliant and ethical business practices among DMEPOS suppliers.

I. BACKGROUND

CMS contracts with private companies to administer Medicare program functions such as processing and paying claims. Medicare Administrative Contractors (MACs) pay claims, develop local coverage determinations (LCDs), offer provider education, and perform complex medical reviews (*i.e.*, audits) 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 engages other contractors in more targeted roles to perform Medicare Integrity Program (MIP) activities. These contractors, known as Medicare Integrity Contractors (MICs), have a narrower scope of work, focusing almost entirely on preventing, identifying, and recovering payments that should not be paid or that were paid in error. These contractors might also engage in extensive data collection and analysis in order to both identify DMEPOS items subject to abuse and target suppliers with aberrant billing practices.

Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) are MICs tasked with these benefit integrity functions. ZPICs and PSCs also develop cases for possible civil or criminal investigations. Other contractors perform MIP activities but provide a narrower range of services. All of the contractors can perform complex audits to carry out their duties. ZPICs, PSCs, and DME MACs conduct both pre and post-payment audits. Comprehensive Error Rate Testing (CERT) contractors and Recovery Audit Contractors (RACs) only audit claims post payment, consistent with their more limited scope of work. [1]

II. THE MEDICARE DMEPOS BENEFIT ERROR RATE

The Centers for Medicare and Medicaid Services (CMS) is required by the Improper Payments Information Act (IPIA) of 2002 to identify improper Medicare payments, compute a national claims payment error rate for the Agency, and develop strategies to reduce and collect improper payments. CMS engages CERT program contractors to calculate the payment error rate for each Medicare benefit, including DMEPOS. CERT contractors perform post-payment audits of claims selected randomly on the date of submission to determine whether the affiliated contractor properly adjudicated the claim.

Prior to 2009, CERT contractors followed Medicare contractor instructions to use "clinical judgment" in conducting audits. That is, contractors were required to employ clinicians to perform audits and the clinicians were, in turn, required to use their clinical expertise to evaluate the medical necessity of equipment or services *in light of the beneficiary's claim history*. Specifically, the Medicare Program Integrity Manual (PIM), effective in 2008, stated as follows:

> During complex review, nurse and physician reviewers may call upon other health care professionals (e.g., dieticians, and physician specialists) for advice. Any determination must be documented and include the rationale for the decision. While MR [medical review] staff must follow national coverage determinations and local coverage determinations, ***they are expected*** to use their expertise ***to make clinical judgments*** when making medical review determinations. ***They must take into consideration the clinical condition of the***

[1] CMS employs contractors to administer the comprehensive error rate testing program (CERT). These contractors audit the MACs to determine their claims payment accuracy. CMS also has contracts with Recovery Audit Contractors (RACs) that work on contingency to recover improper payments that other CMS contractors have not identified.

beneficiary as indicated by the beneficiary's diagnosis and medical history when making these determinations. For example, ***if a medical record indicates that a beneficiary is a few days post-op for a total hip replacement and femur plating, even though the medical record does not specifically state that the beneficiary requires the special skills of ambulance transportation, MR nurses and physicians must use their clinical knowledge to conclude that ambulance transportation is appropriate under such circumstances.***

In 2009, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published a report that was critical of CMS' clinical judgment review policy, holding that CMS misstated the error rate because the Agency did not require contractors to adhere strictly to its coverage and documentation policies. Reacting to the OIG's input, CMS adopted new auditing practices. Under this new formulation of CMS' medical review policy, the Medicare DMEPOS error rate shot up from 10.2% to 51.9% because the bar for documenting medical necessity had increased. Since then, the Medicare error rate for DMEPOS has continued to climb to where it now is at level that has many reasonable people questioning the efficiency and reliability of CMS' approach to payment audits.

It is important to remember that the high error rate is not indicative of rampant fraud among DMEPOS providers. Rather it is a reflection on Medicare's emphasis on technical documentation issues. In other words, the beneficiary has a documented medical need for the equipment or supply, but because the documentation of medical necessity does not meet contractors' heightened technical requirements, auditors determine that claims were improperly paid. Restoring the audit contractors' ability to use clinical review judgment would bring the down what we believe to be an artificially high payment error rate.

III. MEDICARE OVERSIGHT OF CONTRACTORS' AUDIT ACTIVITIES IS FRAGMENTED AND UNWIELDY

As noted above, Medicare contracts with private entities, MAC, CERTS, RACS and ZPICS, to perform payment and audit activities on behalf of the Medicare program. There are four MACs, a CERT, seven ZPICS as well as a number of RACs. As a result of the number of audit contractors with jurisdiction to audit DME claims, DME providers do not have a good understanding of who the contractors are or the reasons underlying the audits they perform. For example, many DME providers do not understand that the CERT contractor's role is to determine the Medicare error rate or that the error rate drives the MACs pre and post payment audits.

The Jurisdiction B MAC provides a typical example. In the 3rd quarter of 2011, the contractor reported an astonishing 93 percent error rate for support mattresses. However, the contractor's analysis shows that 20 percent of the DME providers audited did not respond to the additional documentation requests (ADRs). Notably, the high rate of non-responders improperly skews the DMEPOS error rate upwards. Excluding non-responders from the error rate calculation would result in a more accurate measure. DME providers who do not respond to audit requests require more targeted education. Chronic non-responders raise a red flag and should, at a minimum, receive an onsite visit to make sure they are legitimate DME providers.

IV. AAHomecare's Activities To Promote Compliance And Ethical Business Practices Among DMEPOS Providers

As noted above, AAHomecare strong program integrity measures to ensure that improper claims are not paid and those that are paid are promptly recovered. In addition to our recommendations for streamlining and improving the efficiency Medicare audit processes, AAHomecare has made recommendations that have adopted by Congress or CMS. For example, AAHomecare has been a strong advocate for mandatory accreditation of DMEPOS providers and meaningful quality and service standards for equipment and suppliers. AAHomecare has supported stronger supplier standards, including mandatory site visits for all new suppliers enrolling in Medicare and suppliers renewing their enrollment.

Currently DMEPOS suppliers must be accredited in order to obtain a Medicare billing number, and they must adhere to quality standards promulgated by CMS and administered by the accrediting bodies. Importantly, suppliers must be accredited to furnish the equipment and services they provide to beneficiaries. This means that a supplier that furnishes oxygen must demonstrate to the accrediting body that it meets the standards applicable to oxygen. Likewise, a supplier that furnishes power wheelchairs must be accredited to do so. Providers may furnish only the products and services that they are accredited to furnish.

AAHomecare believes that a more stringent enrollment process, including additional unannounced site visits for suppliers that are new to Medicare as well as close monitoring of their claims submission patterns will help Medicare end the relentless "pay and chase" cycle that has permitted "fly by night" companies to bill Medicare fraudulently and disappear.

In addition, AAHomecare promotes the need for DMEPOS suppliers to adopt ethical and compliant business practices that focus on a company's interactions with beneficiaries, payers and referral sources. AAHomecare has a voluntary Code of Business Ethics that identifies the types of compliant and ethical business practices that supplier's should adopt within their organizations. AAHomecare's goal is for every DMEPOS supplier to understand the importance of promoting a culture of ethics and compliance within their companies. The AAHomecare Code reinforces the need for suppliers adhere to quality standards when they furnish DMEPOS services to all patients. The Code also highlights the importance of understanding payers' coverage, documentation and reimbursement policies and adopting internal policies to prevent, identify and promptly resolve billing errors.

AAHomecare is also committed to assisting DMEPOS suppliers in their efforts to comply with Medicare documentation and billing requirements. AAHomecare members who are experts in Medicare billing, compliance and documentation practices have developed documentation tools for equipment and supplies that are audited frequently and have high payment error rates. These documentation tools are derived from the applicable Medicare coverage policy for the equipment or supply item and highlight specific clinical issues that must be documented the medical record to support the medical necessity the item.

V. CONCLUSION

AAHomecare is concerned about the high Medicare claims payment error rate for DMEPOS. The error rate can be attributed, at least in part, to Medicare contractors' highly technical interpretation and application of Medicare medical necessity requirements and the fragmented nature of CMS' oversight of its payment and audit contractors. Streamlining the audit process and allowing contractors to use clinical judgment when they perform audits will reduce the high claims payment error rate for DMEPOS.

AAHomecare is also committed to eliminating fraud and abuse from the Medicare DMEPOS benefit. The association has consistently supported measures to strengthen Medicare program integrity and increase the scrutiny of DMEPOS suppliers when they enroll in Medicare for the first time. Finally, AAHomecare is committed to promoting compliant and ethical business practices throughout the DMEPOS industry. The AAHomecare Code of Business Ethics addresses suppliers' interactions with patients, payers and referral sources and highlights suppliers' obligation to understand and follow payers' coverage, documentation and billing requirements. To that end AAHomecare has developed documentation tools that suppliers can use in their businesses to improve the quality of their billing practices.