Understanding and Handling (or, Better Yet, Avoiding) Medicare Audits.

Follow the rules.

Medicare is not picking on you! They are doing their due diligence. There is an unfortunate amount of Medicare fraud that occurs annually. If you follow the rules, you'll be fine.

How audits work…

Types of Audits

- CERT
- RAC
- TPE
- ZPIC

CERT - Comprehensive Error Rate Testing

- 50,000 randomly selected claims reviewed against Medicare FFS requirements.
- MACs repay underpayments or recoup overpayments
- Suppliers have the right to appeal

Improper Payment Error Categories, Definitions, and Examples

Insufficient Documentation	The documentation is insufficient to determine whether the claim was payable. This occurs when: • Medical documentation submitted is inadequate to support payment • It could not be concluded that the billed services were actually provided, were provided at the level billed, and/or were medically necessary • A specific documentation element, that is required as a condition of payment, is missing	A hospital billed for infusion of a medication provided in the outpatient department. The CERT program received a visit note to support the medical necessity of the medication. However, the order and the administration record for the infusion were missing.
Medical Necessity	Medical documentation supports: • Services billed were not medically necessary based upon Medicare coverage and payment policies	A provider billed for an inpatient rehabilitation facility (IRF) stay. There was not a reasonable expectation that the beneficiary was able to benefit from an intensive rehabilitation program because she was completely independent.
Incorrect Coding	Medical documentation supports: • A different code than what was billed • The service was performed by someone other than the billing provider • The billed service was unbundled • The beneficiary was discharged to a site other than the one coded on the claim	A provider billed for Healthcare Common Procedure Coding System (HCPCS) code 99214. The submitted documentation did not meet the requirements for 99214 but met the requirements for 99213.
No Documentation	The provider or supplier fails to respond to repeated requests for the medical records	A supplier billed for diabetic testing supplies. The provider did not submit any medical records to support the claim.
Other	An improper payment that does not fit into any of the other error categories	A DMEPOS supplier billed for an upper limb orthosis, which the CMS Pricing, Data Analysis and Coding (PDAC) contractor determined was classified as exercise equipment. Exercise equipment is not covered by Medicare.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Figure 10: Universal Errors as a Percentage of DMEPOS Improper Payments Due to Insufficient Documentation[14]

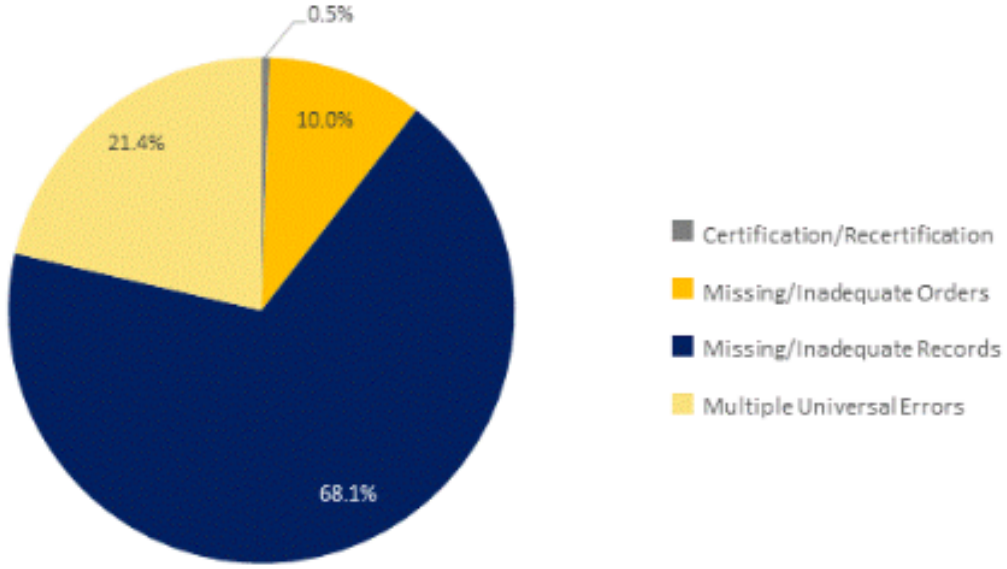


Table 3: Top Root Causes of Insufficient Documentation Errors in DMEPOS

Top Root Cause for DMEPOS	
Root Cause Description	**Universal Error Name**
Order - Inadequate	Missing/Inadequate Orders
Documentation to support coverage criteria - Missing	Missing/Inadequate Records
Documentation to support coverage criteria - Inadequate	Missing/Inadequate Records
Proof of delivery - Inadequate	Missing/Inadequate Records
Proof of delivery - Missing	Missing/Inadequate Records
Order - Missing	Missing/Inadequate Orders

2020 MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL IMPROPER PAYMENT DATA

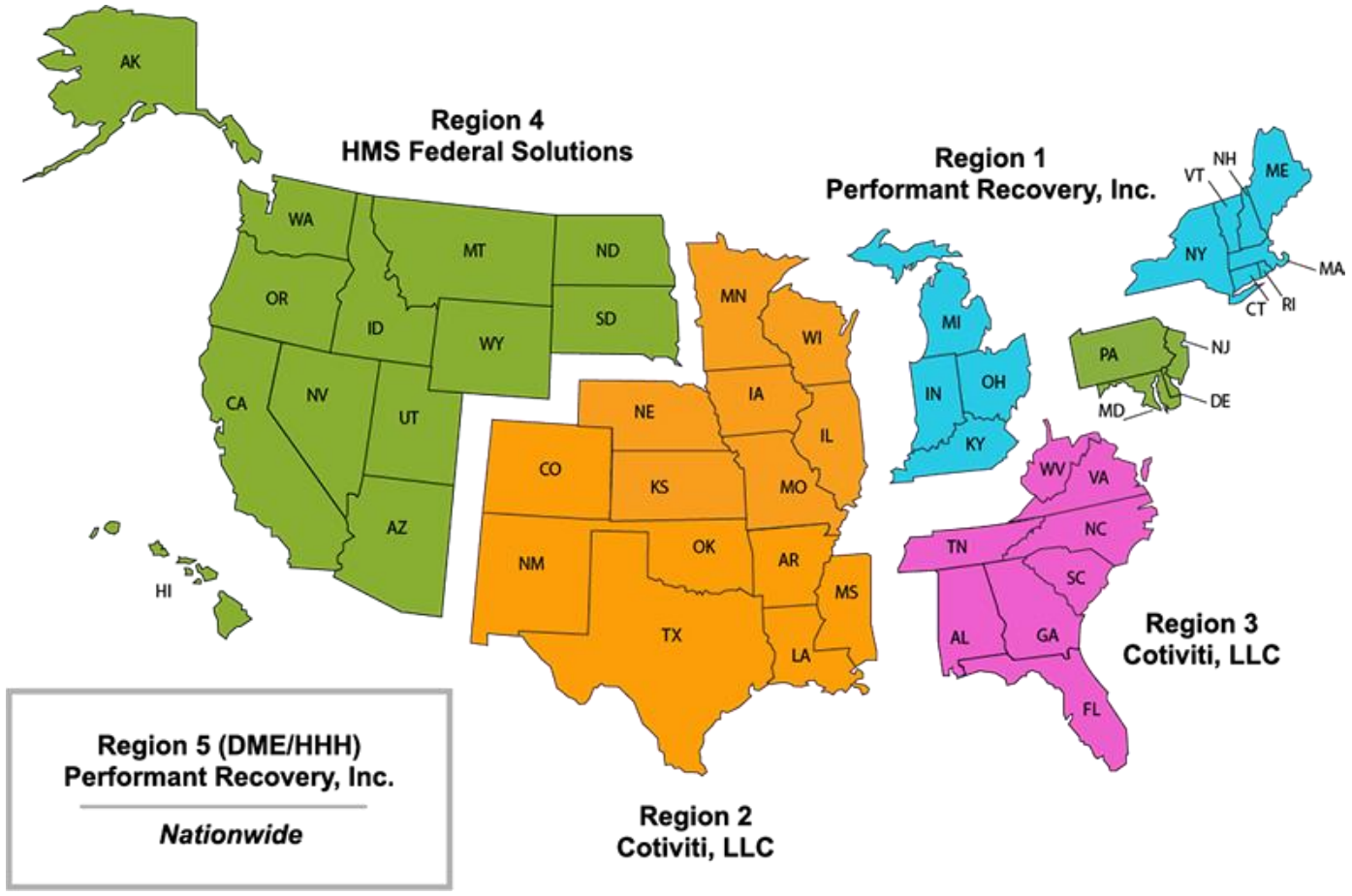
RAC – Recovery Audit Program

- The Medicare Fee for Service (FFS) RAC Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.
- RAC's review claims on a post-payment basis. The RAC's detect and correct past improper payments so that CMS and Carriers, and MACs can implement actions that will prevent future improper payments.
- Can look back 3 years.

RAC – Complex review vs Automated

- Automated reviews are random spot-checks
- Complex reviews are initiated by the RACs when they identify a significant probability that the service is not covered or when no Medicare policy, article, or coding guidelines exist.
- Complex reviews involve the use of clinical judgment by a licensed medical professional or certified coding specialist to evaluate medical records.
- In order to conduct a complex review, RACs will request medical records from the selected providers and then manually review the documents to determine the validity of the claims, corresponding reimbursements, and potential fraud/abuse.

How RAC audits work.



RAC auditors are contractors engaged by CMS to recoup improperly paid monies for Medicare.

RAC – Recovery Audit Contractor

- Preparation is the key to successful results of a Recovery Audit. Inquiries can be prevented or satisfied when your (in-house or outsourced) medical billing and coding specialists follow all Medicare rules, in these key categories:
  - Local Coverage Determination (LCD) – Local Medicare coverage policies
  - National Coverage Determination (NCD) – National Medicare coverage policies
- Medical providers are obligated to know and stringently follow each type of coverage policy. Providers must maintain detailed records from a patient's physical exam that documents specifically why a procedure or treatment was deemed necessary. For example, for Orthotics and Prosthetics providers, everything is susceptible to Medicare review, from diabetic footwear to knee orthotics to multi-component prosthetics, and more.

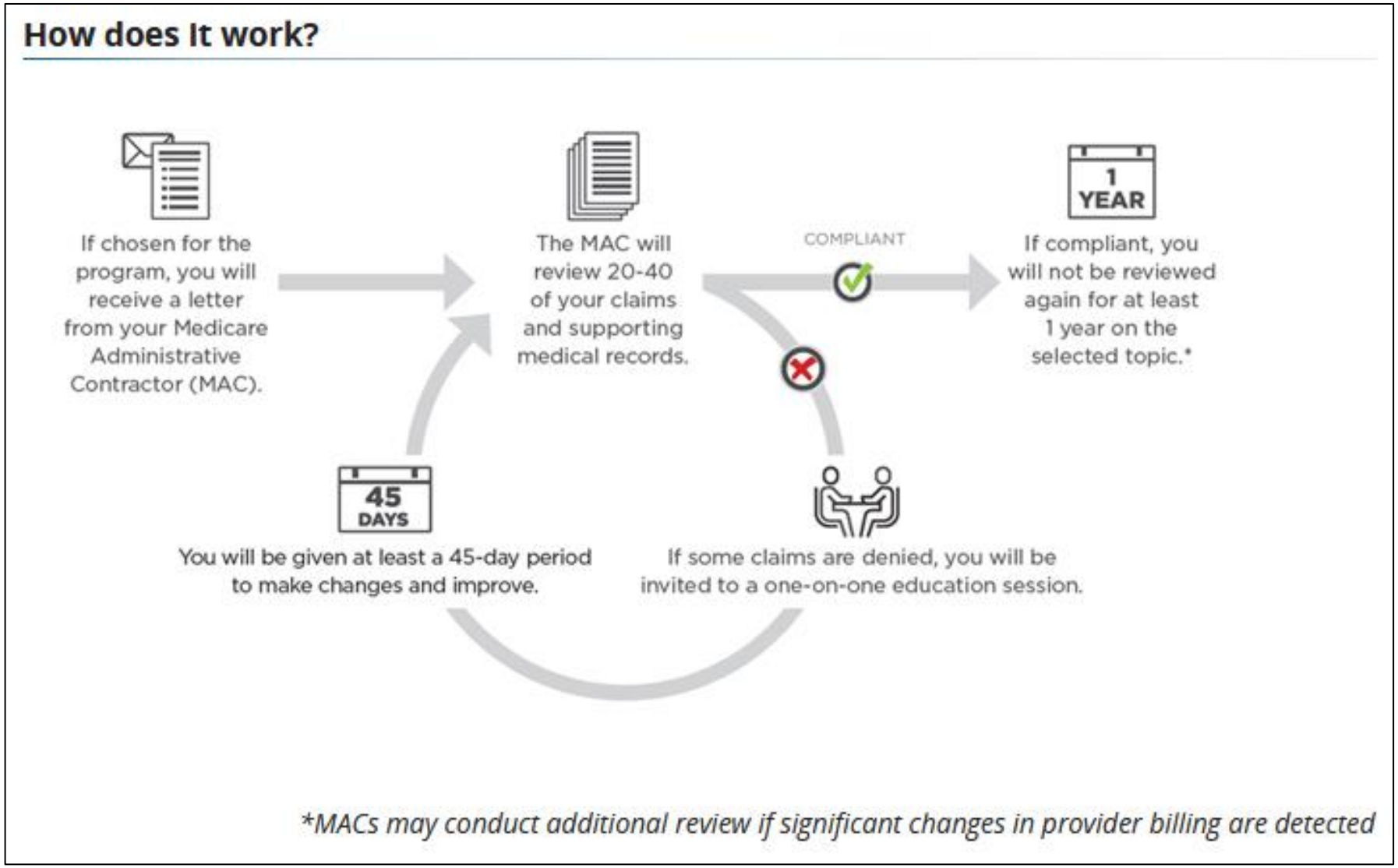
TPE – Targeted Probe and Educate

- **CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.**
  - The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

TPE – Targeted Probe and Educate

- **Most providers will never need TPE.**
  - TPE is intended to increase accuracy in very specific areas.
    MACs use data analysis to identify:
    - providers and suppliers who have high claim error rates or unusual billing practices, and
    - items and services that have high national error rates and are a financial risk to Medicare.
  - Providers whose claims are compliant with Medicare policy won't be chosen for TPE.

TPE – Targeted Probe and Educate



TPE – Targeted Probe and Educate

- **What if my accuracy still doesn't improve?**
  - This should not be a concern for most providers. The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action (like expulsion from the Medicare program).

- By most accounts, CMS is failing miserably at the “education” part of TPE.
- Instead, the MACs resort to referring healthcare providers to other agencies or contractors for “other possible action,” including audit by a RAC, which can include extrapolation or referral to HHS or OIG for investigation of fraud.

TPE – Targeted Probe and Educate

- Contrary to popular belief, TPE audits are appealable!

ZPIC - Zone Program Integrity Contractor

- Primary mission is to identify fraud—***not a random audit***
- Request medical records and documentation;
  - No specification regarding look-back period
  - Unlimited document requests
- Use extensive data analysis including probe sampling, statistical sampling & extrapolation
- Conduct employee and beneficiary interviews
- Conduct an onsite visit, without prior notice
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation
- Withhold payments
- Refer cases to law enforcement
- Are not paid on contingency fee (performance bonuses exist though)

OK. So now what?

You need a Champion!

- Your practice needs at least one person who is completely up-to-date on all the latest Medicare requirements and regulations.
- This person needs to have an intimate understanding of coverage requirements.
- Your champion needs to understand and be able to navigate the appeals process.
- AOPA has some awesome O,P&P-specific Medicare billing/coding classes. Totally worth the investment.

Avoiding Audits

- Random audits are unavoidable.
- Targeted ones are nearly always avoidable!
  - The only time targeted audits are unavoidable is when CMS (or a MAC) decides to focus on a particular code or set of codes.

- #1 Tip: Just follow the freaking rules!
  - Medicare's rules, generally speaking, are quite simple.*
  - They are always spelled out in advance.
  - Don't play the game if you don't want to play by the rules.
- #2 Tip: Local Coverage Determinations and Policy Articles.
  - Every rule, requirement, regulation and restriction
  - Clear and concise (not written by lawyers)
- #3 Tip: See following slide.

* Simple ≠ Easy

Surviving Audits

One rule, and one rule only:

NOTHING

ever leaves your facility before you have every single last piece of required documentation on hand, and it has been checked, double-checked and triple-checked!

Expect…Anticipate…Prepare

- ***Expect*** the first denial.
  - If documentation can't support care, admit a fatal denial exists. If it can, appeal!
- ***Anticipate*** the second denial.
  - Use denial details to build your appeal case. If given opportunity, engage in a phone conference to discuss case. Learn their reasoning.
- ***Prepare*** to argue the case with the Administrative Law Judge (third appeal)
  - Review the records in detail and be prepared to argue the merits
- Remember: Usually, the providers win.

Appeal, appeal, appeal!

- **Medicare appeals process**
- The first stage of appeal will be to request a redetermination of the overpayment by the MAC.
- If the redetermination decision is unfavorable, Medicare providers and suppliers may request an independent review by filing a request for reconsideration with the applicable Qualified Independent Contractor (QIC).
- If the reconsideration decision is unfavorable, Medicare providers and suppliers are granted the opportunity to present their case in a hearing before an administrative law judge (ALJ).
- While providers or suppliers who disagree with an ALJ decision may appeal to the Medicare Appeals Council and then seek judicial review in federal district court, it is crucial to obtain experienced healthcare counsel to overturn the overpayment determination during the first three levels of review.

BUSTING MEDICARE MYTHS!

Medicare Mythbusters

- Medicare is always changing the rules
- No one knows what Medicare expects
- New diabetic shoes aren’t medically necessary if old ones aren’t worn out
- Patient can’t get new diabetic shoes if it has been less than a year since they got the last pair
- Is L5000 an annual benefit or once every 5 years?
- Are AFOs an annual benefit or every 5 years?
- Medicare requires a written prescription
- Rx and SWO are the same thing
- Signature requirements
- When will Medicare cover if less than 1 or 5 years?
- NP/PA requirements for TSD
- Will Medicare pay for L3000 or 3020?

Medicare is always changing the rules.

- No.
- They’re not.
- Changes are primarily implemented on Jan 1 of each year and the update bulletins are released in Oct or Nov of the previous year.
- There are rare exceptions like new programs or temporary codes (like the K0903 debacle).

Medicare changes the rules without telling anyone.

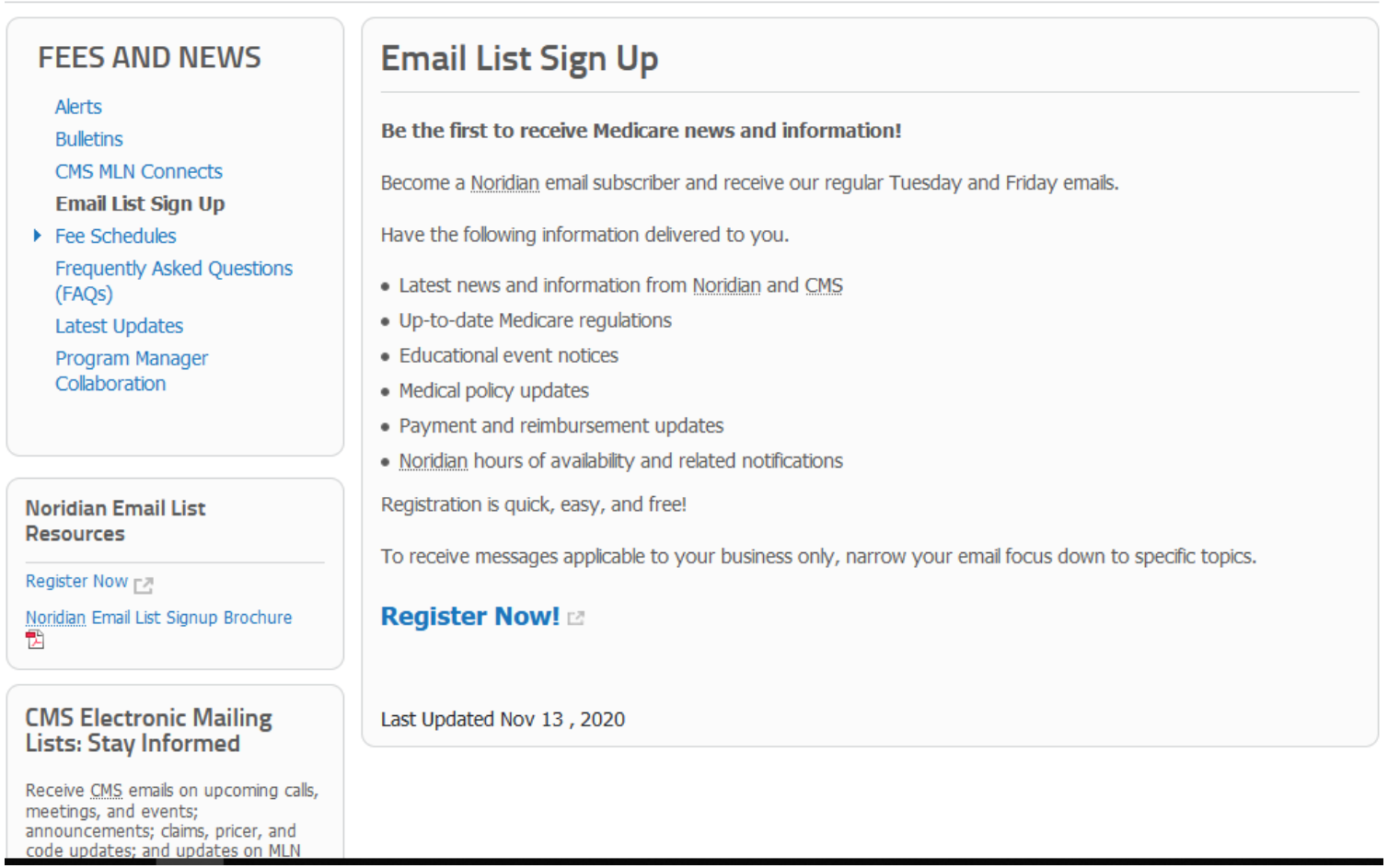
- No.
- They don’t.
- Ever.
- Like never, ever.
- EVER.
- Bulletins, mailing list, LCDs, Policy Articles…

Medicare Learning Network

- https://med.noridianmedicare.com/web/jddme/fees-news/email

Electronic Mailing Lists

Find out when we release new and revised MLN Matters® Articles and other MLN publications



Medicare won’t pay for a brace if the previous one is less than five years old.

- **Reasonable Useful Lifetime - Clarification**
  - **Original Effective Date: 12/12/2002**
    Revision Effective Date: 11/01/2013
- Replacement during the first five years of use, during the "reasonable useful lifetime," is covered if the item is *lost, irreparably damaged or the patient's medical condition changes such that the current equipment no longer meets the patient's needs*.
- Replacement due to irreparable wear during the period of reasonable useful lifetime is not covered.
- The term *"irreparable damage"* is often confused with *"irreparable wear."* Irreparable damage, like loss or theft, is a rare, unexpected event that is an exception to the reasonable useful lifetime rule. Medicare considers irreparable damage to have occurred when an item is damaged beyond repair by a specific incident or accident.
- *Wear* is deterioration sustained from day-to-day usage over time and a specific event cannot be identified that caused the deterioration.

Medicare won’t pay for a partial foot prosthesis if the previous one is less than five years old.

- Lower limb prosthetic devices are not subject to the orthotic “5-year rule” (or the calendar year rule for Therapeutic Shoes).
- All coverage of lower limb prosthetic devices is subject only to Medical Necessity.
  - Benefits Improvement and Protection Act of 2000…requires Medicare payment to be made for the replacement of prosthetic devices…or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.
- An LMN is never a bad idea here.

Therapeutic Footwear

Medicare only pays for new shoes/inserts if the old ones are more than a year old.

- For beneficiaries meeting the coverage criteria, coverage is limited to one of the following ***within one calendar year (January – December)***:
  - One pair of custom molded shoes (A5501) (which includes inserts provided with these shoes) and 2 additional pairs of inserts (A5512, A5513, or A5514); or
  - One pair of depth shoes (A5500) and 3 pairs of inserts (A5512, A5513, or A5514) (not including the non-customized removable inserts provided with such shoes).

Medicare only pays for new shoes/inserts if the old ones are worn out.

- Medical Necessity

Statement of Certifying Physician for Therapeutic Shoes

Patient Name:_____

HIC #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity
   f) Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature: _____

Date Signed:_____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

_____

Medicare requires a prescription for all DME.

Medical Records

In the event of a claim review, information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to treating physician/practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary. DMEPOS suppliers are reminded that:

- Supplier-produced records, even if signed by the prescribing physician/practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS CMNs, are subject to corroboration with information in the medical record.
- A prescription is not considered to be part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

SWO vs Rx

- Standard Written Order
  - All Medicare DME claims require SWO.
  - SWO may be generated and populated by Supplier and signed by Prescriber.
  - Replaces Detailed Written Order (01/01/20)
- Prescription
  - Written order from physician, PA, NP or CN. (Supplier may ***not*** create prescription)
  - View it as an “authorization to begin treatment”.
  - Meaningless for billing Medicare as Medicare does not consider Rx part of a medical record.
  - ABC requires you to have a Rx on file.
  - Still considered *best practice* to have Rx on file.

“Medicare always pays me for L3020.”

- You will get audited eventually. You will lose.

- L3020 is only covered if it is integral to a shoe attached to a brace and is being billed by the provider of the brace.
    - *June 03, 2011* Shoes and Foot Inserts - Coverage Reminder

Only an MD or DO can certify the need for therapeutic shoes.

Coverage of Therapeutic Shoes and Inserts

Provided by Nurse Practitioners and Physician Assistants "Incident To"

NPs or PAs providing ancillary services as auxiliary personnel could meet the "incident to" requirements for therapeutic shoes to beneficiaries when ***all*** of the requirements are met:

1. The supervising physician has documented in the medical record the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; ***and,***
2. The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient; ***and,***
3. The supervising physician must review and verify (sign and date) all of the NP or PA notes in the medical record pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the NP or PA
   - Practicing ***"incident to"*** the supervising physician

- Joint DME MAC Article
  - "Nurse Practitioners and Physician Assistants as Certifying Physicians for Therapeutic Shoes and Inserts"
    - Jurisdiction B: https://www.cgsmedicare.com/jb/pubs/news/2020/11/cope19409.html
    - Jurisdiction C: https://www.cgsmedicare.com/jc/pubs/news/2020/11/cope19409.html

Revised: February 2021

Primary Care First Model

- Nurse Practitioners practicing independently may certify the need for therapeutic footwear.
- Must be enrolled in the PCF Model Program.
- Program is *not* nationwide.
  - Primary Care First is offered in 26 regions: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide).

Other reminders…

Signature Requirements

- In order for a signature to be valid, the following criteria are used:
  - Services that are provided/ordered must be authenticated by the author
  - Signatures shall be handwritten or an electronic signature
  - **Signatures are legible**
  - Rubber Stamps for signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that he/she has reviewed the document.
  - Medical record entries completed by a scribe must be authenticated by the treating physician's signature and date.

Signature Requirements

Dated Signature:

- To be in compliance with conditions of participation and receive accreditation, all signatures need to be dated and timed; however, Medical Review (MR) must be able to determine on which date the service was performed or ordered.
- If the entry immediately above or below the entry is dated, MR may reasonably assume the date of the entry in question.
- Specific signature requirements found in NCDs, LCDs or other CMS manuals supersede the instructions in CR9225.

The End