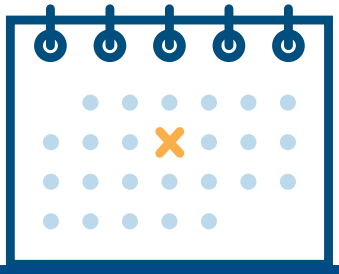
Mediware®

PREPARING FOR A MEDICARE AUDIT

Tactical Solutions for Preventing Audits and Responding When They Happen

CONTENTS



AFTER ADR LETTERS

- Suppliers generally have 30 days to respond from the date of the letter or date of receipt of the letter
- Documents are typically reviewed by the auditor within 60 days of receipt
- EOBs are provided to suppliers and denied claims can be appealed

INTRODUCTION

For every Medicare provider, audits of some type are almost certain to happen. If your medical supply business hasn't been audited, the chances are quite good that it will be. Failure to respond quickly and appropriately can be devastating to your business, but it's possible to manage the audit challenge.

To help prepare you to deal with this likely occurrence, we offer guidance for compliant documentation and timely response to auditors. These practical steps can ease the audit discomfort and enable you to focus on caring for patients.

AUDITS HAPPEN

The Centers for Medicare and Medicaid Services (CMS) has multiple tools at its disposal for audits, all of which are intended to monitor the accuracy of these Medicare fee-for-service (FFS) claims and to detect and prevent fraud and abuse. Audits can occur prior to Medicare payment as well as after payments have been received—even years later.

PRE-PAYMENT AUDITS

Prior to paying claims, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) may send additional documentation request (ADR) letters. These requests constitute pre-payment audits, and suppliers generally have 30 days from the date of the letter to provide the requested documentation. Then, claims are assessed by medical review nurses, who determine whether those claims should be paid.

While the process sounds relatively simple, the documentation must clearly meet Local Coverage Determination (LCD) requirements because the reviewing nurses are prohibited from clinical inference, meaning they can't make determinations based on patients' medical conditions. Instead, prescribers' notes must clearly explain why each patient qualifies for equipment, despite how obvious it may seem based on the diagnoses.

POST-PAYMENT AUDITS

Claims that have been paid are also targets for audit review, known as post-payment audits and can be triggered by many factors, which can include:

- Large increases in billing volume, which could be perfectly legitimate due to awarded contracts or other changes in service capabilities
- Statistical samplings of particular diagnoses or HCPCS codes
- A small number of physicians ordering items

REMAIN ALERT WITH CERT

These reviews are relatively routine, but mistakes and insufficient documentation during the CERT process can lead to more serious, costly and time-consuming audits.

Post-payment audits can be triggered by many factors.

The DMEMAC sorts claims data to look for trends and abnormalities in billing. A supplier may have their claims reviewed, and every "error" is subject to have the claim denied after it was paid. The auditor takes that error rate that was determined after the reivew of the audited claims, and then applies it to a particular "universe" of claims-without exactly reviewing that "universe"-and determines the "overpayment" that is now due back from the supplier. Therefore, small errors that may have resulted in modest overpayments can result in allegations of millions of dollars of overpayments due to the extrapolation of sample results.

AUDIT APPEALS

The timeline for appeals is limited, and the countdown typically begins when providers receive denials for either pre-payment audits and overpayment demand letters for post-payment audits. In both cases, there are several stages of appeal, and written notice and instruction is given to providers following each stage.

One of the last stages in the administrative appeals process is the Administrative Law Judge (ALJ). The good news is that a high percentage of ALJ cases can be overturned as long as the proof of need is present. However, the current wait time for ALJ review is at least two years and, in the near future, could extend well beyond that time frame.

POTENTIAL AUDITORS OF DME PROVIDERS

Three types of audits are likely for either pre-payment or post-payment claims. These include audits performed by the Comprehensive Error Rate Testing (CERT), Zone Program Integrity Contractors (ZPIC) and Recovery Audit Contractors (RAC).

1. COMPREHENSIVE ERROR RATE TESTING (CERT)

The CERT program was developed by CMS to oversee Medicare Fee-for-service payments. The program's goal is to ensure that DME MAC is paying claims in accordance with Medicare regulations. CERT audits are triggered by many things but primarily by item codes that are routinely billed or paid incorrectly.

If your documentation is in order, CERT audits should simply be a matter of providing the requested documentation to reviewers. For complete documentation that will satisfy CERT auditors, be sure that:

- all signatures are in place and are legible
- you have proof of prescribers' intentions to order medical equipment
- assure that the patient qualifies for the item(s)
- you have medical records from prescribers that detail patients' equipment needs by meeting the LCD (when applicable)

The CERT system is managed by the Office of Inspector General (OIG), but do not take these somewhat-routine reviews lightly. Denied claims could trigger more extensive post-payment audits and, eventually, demands for reimbursement of overpayments.

ZPIC auditors review certain numbers of claims and apply the error rate, via extrapolation, to larger numbers of claims, which can lead to the appearance of massive overpayments.

2. ZONE PROGRAM INTEGRITY CONTRACTORS (ZPIC)

This post-payment audit program was established to uncover and, ultimately, prevent Medicare fraud. While ZPIC contractors have discovered some illegal activities, their broadly focused functions are creating serious problems for all DME suppliers because, for the most part, ZPIC auditors are revealing providers' procedural errors. Unfortunately, with the Medicare system, errors are labeled as fraud. Therefore, audited providers must take immediate action to address ZPIC-related issues and correct errors, so future claims are "clean" and do not raise any red flags for auditors.

CMS authorizes ZPIC auditors to perform a broad range of investigative activities, including medical reviews, data analysis and Medicare evidence-based policy auditing.

3. RECOVERY AUDIT CONTRACTORS (RAC)

These contractors' goals are to find and correct inappropriate FFS payments and to prevent future fraudulent claims. Because RAC auditors earn incentives that can range from 9 to 12 ½ percent of recovered payments, they are motivated to find every possible error in a record, making RAC audits most worrisome.

Initially, RAC took aim at large-scale facilities, such as hospitals and nursing homes, but now CMS is turning a RAC spotlight specifically on the post-acute care providers—home care, hospice and DME. The next round of RAC contractors will include a RAC to focus specifically on these providers. These audits are likely to be widespread and will target common mistakes.

PROTECT YOURSELF WITH DOCUMENTATION

When gathering the necessary documentation for audit resolution, the pieces most commonly lacking are complete prescriber medical records. Although requesting, organizing and storing this information can be time consuming, it's much better to request it at the time of service than try to piece the puzzle together at the time of an audit, which could potentially occur years after the claim has been paid.

Be Sure Your Prescribers:

1. Are Medicare enrolled
2. Order equipment only relevant to the scope of their practices
3. Have no financial relationship with you

REMEMBER

Supplier-generated forms are not valid, even if completed and signed by physicians.

DETAILED NOTES NEEDED

Remember that the medical record must specify each patient's diagnosis and detail the medical necessity for the equipment. A Written Order Prior to Delivery (WOPD) is now required for most equipment before the item can be provided to the patient.

Collecting detailed prescriber notes can be difficult. Unfortunately, the EHR doesn't generally include the required and completed information needed for post-acute treatment. Therefore, DME suppliers may have to educate prescribers and guide them through the process.

However, unlike many other post-acute services, DME suppliers may not provide orders for prescribers to sign or provide any other kinds of documents for prescribers to use to generate a medical record for your files. Instead, prescribers must provide medical records such as office notes and notes from the patient's hospital and nursing home stay.

In addition to dates of service, which should be within the three-month period prior to dispensation, prescribers' medical records must include details about:

+ What they are ordering
+ Why they are ordering it
+ How the patient meets the criteria to receive it

For items that have an LCD, documentation must clearly demonstrate that all coverage criteria outlined has been met, including all supporting lab or diagnostic testing results, x-ray reports, etc. Copies of all results or reports should be included as well.

PRESCRIBED RENTALS

If Medicare-covered items are supplied on a rental basis, the ongoing medical need must be demonstrated, and suppliers must show that the device is always in use by contacting patients and/or downloading usage data from the applicable devices.

The orders for rental equipment must be "authenticated." In other words, the source of the records must be clearly proven. If formats vary or signatures are illegible, these records may not be considered authenticated and will not be considered valid documentation for audit purposes.

GOING FORWARD: ADDITIONAL DOCUMENTATION NEEDED

WOPD

Implemented on July 1, 2013, the "Written Order Prior to Delivery" (WOPD) requirement means that the DME supplier must have a written order—complete with details about what the prescriber is ordering, why they're ordering it, how the patient meets the criteria to receive it, and how long it's needed—in hand prior to order fulfillment. Suppliers have been accountable and audited for this information since January 2014.

F2F

A new "Face-to-Face" (F2F) requirement for durable medical equipment has been indefinitely delayed for the time being. The new F2F will require that prescribers have face-to-face contact with the patient no more than six months prior to the written order, and the notes generated from that visit must address the equipment ordered.

Take Note

The F2F requirements currently in place, for mobility devices, TENS units and the like, are still in effect.

NOTIFICATION OF AN AUDIT

Audit letters requesting additional documentation can arrive in the mail, so be sure someone who knows what to do with these letters checks your mail daily and attends to them quickly. You can't afford to let the short response time you have to be wasted while the letter goes unnoticed.

The audit notification will indicate what records are being audited and what documentation you must supply to support your claims. The list will likely include:

1. Delivery ticket
2. Remittance notices; EOB
3. Physician's written orders — WOPD and (when applicable) the certificate of medical necessity (CMN)
4. Chart and progress notes
5. Physician's informational letters, if you have them
6. F2F documentation for required items
7. Lab and other test results and reports
8. Notes or records from additional healthcare professionals such as — physical therapists, occupational therapists, or home health agencies

And the medical record should include:

1. Clinical course (when applicable) as well as the patient's diagnosis and anticipated duration of the patient's condition
2. Prognosis
3. The nature and extent of functional limitations
4. Therapeutic interventions and results
5. Past experience with related equipment

MAIL TIP

Audit letters from the NSC are clearly marked, "Do Not Forward." So if you are planning to relocate your business, have someone continue to collect the mail at your former address for at least a week after the move to ensure you receive all mail that might have been in process before your change of address became official.

COMMON COMPLIANCE ISSUES

The audit process will go more smoothly if your documentation is complete. Be careful to avoid these common errors in documentation.

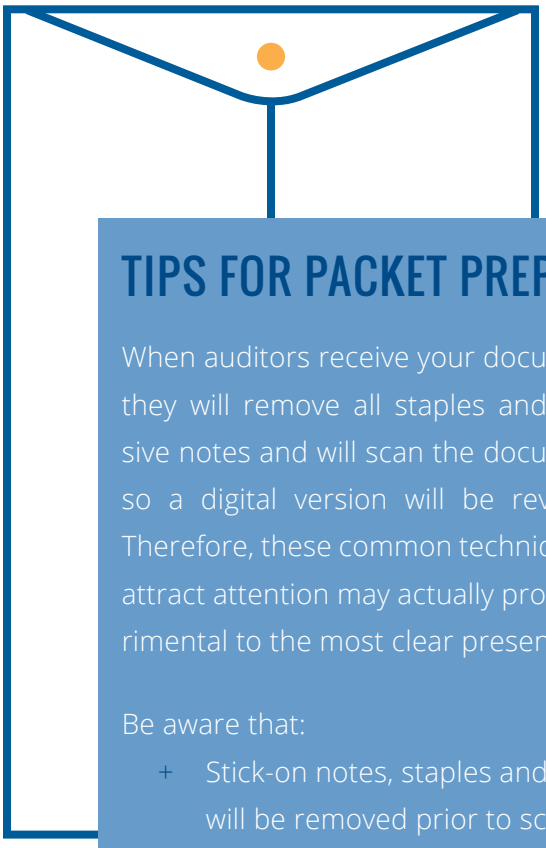
+ Incomplete oxygen documentation—the orders must specify delivery methods and flow rates, and three qualification studies must be documented
+ Incomplete F2F mobility evaluations—objective measurements are required
+ Failure to specify specific refill requests or providing refills when not actually needed
+ Illegible and/or stamped signatures
+ Incomplete forms—all required elements must be addressed
+ Incorrect diagnosis codes
+ Invalid proof of delivery
+ Failure to document ongoing medical necessity
+ Failure to follow up on re-evaluation requirements
+ Failure to document continuous use (when required)

HOW TO RESPOND TO AN AUDIT

Once you have gathered all the paperwork needed to support your claim, make two sets of copies of everything you are sending. Keep one set for yourself, so you know exactly what each packet contained.

Follow these guidelines for assembling and submitting your responses.

1. Include a cover letter explaining that you are replying to their request. Include in the cover letter the telephone number auditors should use to contact you or your representative if any questions arise.
2. Next include a copy of the ADR as the first sheet in each packet.
3. Write a individual summary of each record, detailing the medical issues addressed in your documents; include the patient's name, date of birth, HIC number, medical condition, prescribers' names, etc., and discuss what will be found in the enclosed documents.
4. If anything in the ADR is not included, mention that in the written summary. For example, if physician documentation doesn't arrive in a timely manner, note that physician documentation is lacking but will be forwarded when it becomes available.
5. Assemble the documents in the order listed on the ADR, and put each file in the same order.
6. Pack into an appropriate box with a list of all records contained in each box.
7. Keep copies of everything sent.
8. Send via any method of return receipt to ensure delivery at least one day before your deadline.



TIPS FOR PACKET PREP

When auditors receive your documents, they will remove all staples and adhesive notes and will scan the documents, so a digital version will be reviewed. Therefore, these common techniques to attract attention may actually prove detrimental to the most clear presentation.

Be aware that:

+ Stick-on notes, staples and clips will be removed prior to scanning
+ Highlighting will appear black when scanned

Instead of attempting to attract attention to an item with highlighting and stick-on notes, address all relevant details in your narratives.

PREVENTIVE MEASURES

Now that you know what to do in the event of an audit, prepare in advance for this potential occurrence. Hire a contractor or develop a team of your staff members to conduct internal audits. Look for areas that are lacking, and get them in order now before audit letters arrive.

WHAT TO LOOK FOR

Make certain your business is:

+ Collecting WOPDs
+ Prepared for collecting additional F2F documentation, which may be implemented in the future
+ Working with your referral sources by educating them to change their reporting and documentation processes

About Mediware®

Mediware is the leading expert in software solutions for the HME/DME markets. Our applications help manage documentation and avoid errors, so you're prepared for Medicare inquiries.

For information about customized solutions for your business, go to www.mediware.com/hme/audit.

Our thanks to Mary Ellen Conway, RN, BSN, president of Capital Healthcare Group, LLC, for assistance in developing this white paper. Capital Healthcare Group is a healthcare consulting firm that specializes in providing expert consultants and teams who work with providers to achieve excellent outcomes. For additional information, contact Capital Healthcare Group at www.capitalhealthcaregroup.com.