What does the future hold?

**MEDICARE AUDITS**

- CERT reviewed $9.7 billion in DME Claims in 2012 and denied $6.4 billion - a paid claim error rate of 66%.
- FY 2011, RACs identified $797.4 million dollars in overpayments.
- ZPICs contract ROI
  - Zone 1 - $72.8 million
  - Zone 2 - $81.3 million
  - Zone 3 - $67.7 million
  - Zone 4 - $84.9 million
  - Zone 5 - $108 million
  - Zone 6 - $91.7 million
  - Zone 7 - $77 million
- Extrapolated overpayments
- Error rates identified by CERT and DMACs consistently high
WHAT DOES THE FUTURE HOLD?

- Supplemental Medical Review Contractors
- Zone Program Integrity Contractors vs Unified Program Integrity Contractors
- RAC Program expansion
- Managed Care risk
- Extrapolated overpayments
- Face-to-face requirements
- High dollar volume edits
- All this means...more audits

NEW PROGRAM INTEGRITY ACTIVITIES

- Supplemental Medical Review Contractor (SMRC) for CMS
  - Strategic Health Solutions will be a centralized resource to perform a large volume of Medicare Part A, Part B, and Durable Medical Equipment reimbursement claims nationally.
  - Strategic will focus on lowering improper payments in Medicare Fee-For-Service programs and increasing efficiencies in medical review functions.
  - Initially focused on power mobility claims.
  - Initial program has resulted in large volume of documentation request on claims already reviewed.

NEW PROGRAM INTEGRITY ACTIVITIES

- First they talked of ZPIC Expansion
  - Recompete of current ZPIC contracts
  - ZPIC Zone 3 issues to be ironed out
  - Transition of ZPIC Zone 6
  - Additional Task Orders for Part C and D
- Now discussing Unified Program Integrity Contractors
  - Bring in Medicaid
NEW PROGRAM INTEGRITY ACTIVITIES

• Recovery Audit Contractors
  — Expanded to include Medicaid programs
  — CMS increased the contingency for DMEPOS claims
  — CMS encouraging RACs to extrapolate
  — CMS implementing new National RAC Program
    • DMEPOS and Home Health activities removed from workload of current jurisdictional RACs
    • The new national RAC will become active in early 2014.

NEW PROGRAM INTEGRITY ACTIVITIES

• Medicare Part C
  – Increased pressure on Medicare Advantage/HMO plans to conduct program integrity functions
  – Applying policies consistently as Medicare
  – Increased prepayment review and extrapolated overpayments
  – Must be treated the same as Medicare

NEW PROGRAM INTEGRITY ACTIVITIES

• Affordable Care Act Changes
  – New Civil Monetary Penalties
    • $50,000 for anyone that knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal healthcare program
    • $15,000 per day for anyone that fails to grant timely access, upon reasonable request to HHS/OIG for purpose of audits, investigations, evaluations, or other statutory functions
NEW PROGRAM INTEGRITY ACTIVITIES

• Affordable Care Act
  – Mandatory Compliance Program Requirements
  • Written Policies and Procedures
  • Compliance Officer/Compliance Committee
  • Education and Training Program
  • Internal Audit Plan
  • Effective lines of communication
  • Disciplinary Guidelines
  • Responding promptly to detected offenses

NEW PROGRAM INTEGRITY ACTIVITIES

• Appeal Process
  – DMACs all hired Associate Medical Directors for the sole purpose of attending ALJ Hearings and defending denials.
  – DMDs or other clinicians may attend hearings as a “non-party participant.”
  – RACs are being encouraged to defend denials throughout the hearing process
  – CMS concerned over high overturn rate

NEW PROGRAM INTEGRITY ACTIVITIES

• DMEPOS Swipe Card Pilot Program in Indianapolis ended and is being evaluated
• The goal of the pilot is to implement a system that protects provider specific information, such as your NPI, from misuse or identity theft. The data received through the credit card terminals will be used to validate that the DMEPOS orders were appropriately initiated in a physician’s office and then supplied accordingly by the DMEPOS supplier.
QUITE AN INVESTMENT

- Hewlett Packard – Awarded $149.8 million in contracts to conduct data analysis and audit providers (ZPIC Zone 1 and 7)
- NCI Holdings – Awarded $189.3 million in contracts to conduct data analysis and audit providers (ZPICs Zone 2 and 5)
- Predictive Modeling – 1 year $77 million contract with 3 yearly renewals
  - National Government Services
  - Verizon
  - Northrup Grumman

PREDICTIVE MODELING

- Section 4241 of the Small Business Jobs Act of 2010 (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity.
- This new process is similar to the pre-payment analysis already done by the financial and credit card industries.
- Real Time Claims Streaming to Build Profiles and Create Risk Scores
- These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

PREDICTIVE MODELING

- Migrating away from the pay and chase model
- CMS received $100 million through the Small Business Jobs Act of 2010 to further its experiment in predictive modeling
- The Affordable Care Act provides $350 million over 10 years to bolster anti-fraud efforts, including predictive modeling programs
2014 OIG WORKPLAN

- Reasonableness of Medicare’s fee schedule amounts for selected medical equipment items compared to amounts paid by other payers (new)
  - Commode chairs, folding walkers, and transcutaneous electrical nerve stimulators.
  - OIG will compare Medicare payments made for various medical equipment items to the amounts paid by non-Medicare payers, such as private insurance companies and the Department of Veterans Affairs (VA), to identify potentially wasteful spending.
  - Context—Prior OIG work found that Medicare overpays for various types of medical equipment.
  - If CMS determines that the standard methods of determining amounts for certain categories of items result in “grossly deficient or excess amounts,” CMS may replace the current fee schedule amounts with special payment limits that are reasonable and equitable.

- Power mobility devices—Lump-sum purchase versus rental (new)
  - OIG will determine whether potential savings can be achieved by Medicare if certain power mobility devices (PMDs) are rented over a 13-month period rather than acquired through a lump-sum purchase.

- Parenteral nutrition—Reasonableness of Medicare payments compared to payments by other payers
  - OIG will determine the reasonableness of Medicare reimbursement rates for Parenteral Nutrition compared to amounts paid by other payers.
  - Context—Previous OIG work found that Medicare allowances for parenteral nutrition averaged 45 percent higher than Medicaid prices, 78 percent higher than prices available to Medicare risk-contract health maintenance organizations (HMO), and 11 times higher than some manufacturers’ contract prices.
  - In 2009, Medicare paid more than $137 million for parenteral nutrition supplies.
2014 OIG WORKPLAN

- Competitive bidding for medical equipment items and services—Mandatory post-award audit
  - OIG will review the process CMS used to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program.
  - Context—Federal law requires OIG to conduct post-award audits to assess this process.

2014 OIG WORKPLAN

- Competitive bidding for diabetes testing supplies—Mandatory market share review (new)
  - OIG will determine the market share of different types of diabetic testing strips immediately following implementation of Round 2 of the Competitive Bidding Program.
  - Context—the Medicare Improvements for Patients and Providers Act (MIPA) requires OIG to complete a review to determine the market share of diabetic testing strip types and to submit it to the Secretary before each subsequent round of the Competitive Bidding Program.
  - MIPA requires that in rounds subsequent to the Round 1 Rebid of the Competitive Bidding program, contracts for mail order diabetic testing strips be awarded to suppliers that provide at least 50 percent, by volume, of all types of diabetic testing strips.

2014 OIG WORKPLAN

- Power mobility devices—Supplier compliance with payment requirements
  - OIG will review Medicare Part B payments for suppliers of power mobility devices (PMD) to determine whether such payments were in accordance with Medicare requirements.
  - OIG will focus particularly on whether Medicare payments for PMD claims submitted by medical equipment suppliers are medically necessary and are supported in accordance with requirements at 42 CFR § 410.38.
2014 OIG WORKPLAN

- **Power mobility devices—Add-on payment for face-to-face examination (new)**
  - OIG will review payments for PMD to determine whether the F2F requirements were met.
  - Context—Medicare requires that the treating physician conduct a F2F to determine the medical necessity and write a prescription.
  - To receive compensation, the prescribing physician can bill for an E/M service and has the option of billing for an add-on payment for the sole purpose of documenting the need for the PMD.
  - Prior OIG work found that when the prescribing physician did not bill the code for the add-on payment in addition to the evaluation and management (E/M) code, the resulting PMD claim was likely to be unallowable.

- **Lower limb prosthetics—Supplier compliance with payment requirements**
  - OIG will review payments for lower limb prosthetics to determine the requirements were met.
  - Context—A national OIG review of suppliers of lower limb prosthetics identified 267 suppliers that had questionable billing.
  - Earlier OIG work found that suppliers frequently submitted claims that did not meet certain Medicare requirements; were for beneficiaries with no claims from their referring physicians; and had other questionable billing characteristics (e.g., billing for lower limb prostheses for a high percentage of beneficiaries with no history of amputations or missing limbs).

- **Nebulizer machines and related drugs—Supplier compliance with payment requirements (new)**
  - OIG will review payments for nebulizer machines and related drugs to determine whether claims are medically necessary.
  - Context—Prior OIG work found that suppliers were overpaid approximately $46 million for inhalation drugs used with nebulizer machines.
2014 OIG WORKPLAN

• Frequently replaced supplies—Supplier compliance with medical necessity, frequency, and other requirements
  – OIG will review claims for frequently replaced medical equipment supplies to determine whether medical necessity, frequency, and other Medicare requirements are met.
  – Context—Prior OIG work found that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies when no physician orders for refills were in effect.

• Diabetes testing supplies—Supplier compliance with payment requirements for blood glucose test strips and lancets
  – OIG will review payments for home blood glucose test strips and lancet supplies to determine their appropriateness.
  – Context—Prior OIG reviews determined that suppliers of diabetic related supplies did not always comply with Federal requirements.
  – Suppliers of diabetes testing supplies are required to add a modifier code on claims to identify when a patient is treated with insulin or not treated with insulin. The amount of supplies allowable for Medicare reimbursement differs depending on the applicable service code modifier.

• Diabetes testing supplies—Effectiveness of system edits to prevent inappropriate payments for blood-glucose test strips and lancets to multiple suppliers
  – OIG will review Medicare’s claims processing edits (special system controls) designed to prevent payments to multiple suppliers of home blood-glucose test strips and lancets and determine whether they are effective in preventing inappropriate payments.
  – Context—Prior OIG work found that inappropriate payments were made to multiple medical equipment suppliers for test strips and lancets dispensed to the same beneficiaries with overlapping service dates.
2014 OIG WORKPLAN

• Medicare benefit integrity contractors’ activities (new)
  – OIG will review and report the level of benefit integrity activity
    performed by Medicare benefit integrity contractors in calendar
    years 2012 and 2013.
  – Context—The Centers for Medicare & Medicaid Services (CMS)
    contracts with entities to carry out benefit integrity activities to
    safeguard the Medicare program against fraud, waste, and
    abuse. Activities that these contractors perform include
    analyzing data to identify aberrant billing patterns, conducting
    fraud investigations, responding to requests for information
    from law enforcement, and referring suspected cases of fraud to
    law enforcement for prosecution.

• ZPICs and PSCs—Identification and collection status of Medicare
  overpayments (new)
  – OIG will determine the total amount of overpayments that ZPICs
    and PSCs identified and referred to claims processors in 2013
    and the amount of these overpayments that claims processors
    collected.
  – OIG will also review the procedures for tracking collections on
    overpayments identified by ZPICs and PSCs.
  – Context—OIG has issued several reports regarding the tracking
    and collection of the overpayments that Medicare’s contractors
    have made to providers.

WHAT’S YOUR STRATEGY?
WHAT DOES THE KX MODIFIER MEAN?

• Suppliers must add a KX modifier to the [Procedure Code] only if all of the coverage criteria in the “Indications and Limitations of Coverage and or Medical Necessity” section of this policy have been met and evidence of such is retained in the supplier’s files and available to the DME MAC upon request.

• Suppliers must add a KX modifier to [Procedure Code] only if all of the criteria in the “Indications and Limitations of Coverage and/or Medical Necessity” section of this policy have been met.

• If the requirements for the KX modifier are not met, the KX modifier must not be used.

• Civil Monetary Penalties for improper use of KX modifiers are around the corner

• Hold physicians accountable and request documentation as much as possible.

• How many of you have instructed your staff to refuse a referral from a particular physician?

• Determine what liability you will take on.
**IMPROPER USE OF KX MODIFIER**

- In the following policies, the instructions for use of the KX modifier clearly specify that the supplier must have the documentation *in their files* before they may submit a claim line with the modifier.
  - Ankle-Foot/Knee-Ankle-Foot Orthoses
  - Cervical Traction Devices
  - Knee Orthoses
  - Patient Lifts
  - Pressure Reducing Support Surfaces – Group 1, 2, and 3
  - Respiratory Assist Devices
  - Walkers

**IMPROPER USE OF KX MODIFIER**

- Automatic External Defibrillators
- Commodes
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Hospital Beds
- Immunosuppressive Drugs
- Manual Wheelchair Bases
- Nebulizers
- Negative Pressure Wound Therapy Pumps
- Oral Antiemetic Drugs
- Orthopedic Footwear
- Positive Airway Pressure Devices
- Power Mobility Devices
- Refractive Lenses
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators
- Urological Supplies
- Wheelchair Options and Accessories
- Wheelchair Seating

**DATA ANALYSIS**

- Most suppliers do not have a solid grasp of what their Medicare claims data looks like
- Know and understand your data and conduct on-going analysis to identify trends
- CMS analyzes the data that you send them
  - Reactive (CERT Errors, Medical Review widespread probes, Complaints)
  - Proactive (Data Analysis)
    - 95% of all audits are a direct result of data analysis
- Consider some available tools
ALGORITHMS

- Highest reimbursed codes within product categories
- Same or similar
- Maximum allowed amounts
- Physician relationships
- First claims for high-end equipment (i.e. PMDs)
- Spikes in billing
- Spikes in denials
- Diagnosis Code Data
- Peer analysis

ALGORITHMS

- Abuse of codes
- Bundling
- Accessories
- Supplies provided on a recurring basis (set parameters)
- Date of death
- Duplicate claims
- Inpatient claims
- Compromised HICNs

ALGORITHMS

- Group II vs Group III PMDs
- High $ volume claims
- New provider analysis
- Cross-claims analysis
  - Physician
  - Home Health
  - Hospital
  - Skilled Nursing Facility
  - Hospice
NEW LEGISLATION

- January 16, 2014, a $1.1 trillion appropriations bill was passed by Congress. The bill included language that will urge the HHS to address concerns that RACs are incentivized to be overly aggressive.
- HHS will provide Congress a report on its top 25 unimplemented recommendations to improve program integrity.
- CMS will have to implement feedback processes for the RACs, OMHA, and other CMS programs.
- CMS will be required to provide notes on what plans the agency has in place to make sure the MACS following CMS policies.

BEST PRACTICES

- Audit ready files
- Internal Controls
  - Quality Assurance Checklists
- Implement processes to get claims paid up front
- Prior approval process
- Consider use of reopenings
- Contact legislators and get patients involved
  - Fair Appeal Process

ALJ APPEALS

- OMHA recently sent out letter saying they had 375,000 pending claims and only 65 ALJs so they were suspending assignment for 24 months
- The huge increase in the volume of appeals is a direct result of the significant increase in the number of audits being conducted.
- CMS keeps awarding lucrative contracts to private audit entities to find T’s that aren’t crossed and i’s that aren’t dotted, yet the beneficiaries clearly needed the services that were provided.
ALJ APPEALS

• Getting before an ALJ is generally the first time where reason enters the equation and we still see a large number of claims overturned, so providers should and will continue to fight.
• Rather than spend hundreds of millions of dollars to increase the volume of audits which subsequently increases the volume of appeals, why not spend some money on increasing staff and lessening the burden on the judges in the Office of Medicare Hearings and Appeals.

WORLD JUSTICE PROJECT, “RULE OF LAW”

1. The government and its officials and agents as well as individuals and private entities are accountable under the law.
2. The laws are clear, publicized, stable and just, are applied evenly, and protect fundamental rights, including the security of persons and property.
3. The process by which the laws are enacted, administered and enforced is accessible, fair and efficient.
4. Justice is delivered timely by competent, ethical, and independent representatives and neutrals who are of sufficient number, have adequate resources, and reflect the makeup of the communities they serve.

ALJ APPEALS

• Regarding the above principles, the CFR clearly specifies that hearings must be conducted in 90 days. However, if they don’t, they are not accountable [Principle 1].
• ALJs are dismissing cases for providers for a failure to abide by certain citations in the CFR. However, they are not abiding by them themselves by not rendering decisions within 90 days - so the laws are not being applied evenly [Principle 2].
• The process is certainly not fair and efficient [Principle 3], and
• Process is not being administered by representatives who are of sufficient number or have adequate resources [Principle 4].
ALJ APPEALS

- In looking at this current situation, OMHA is unable to follow appropriate rule of law; therefore, rendering the appeal process unfair to providers.
- What is even more unfair is that the limitation on recoupment provisions do not apply after the Reconsideration level, so providers must refund the money before they have exhausted their appeal rights and now wait years before they can get it back.

ALJ APPEALS

- Not one single principle is adhered to, the government is not following the existing law and applying them arbitrarily to providers.
- This is a clear and utter failure of our government to follow the appropriate rule of law and administer a fair and efficient appeal process.

ALJ APPEALS

- For reference, the specific law being violated from 42 CFR, §405.1016 Time frames for deciding an appeal before an ALJ.
  (a) When a request for an ALJ hearing is filed after a QIC has issued a reconsideration, the ALJ must issue a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received by the entity specified in the QIC’s notice of reconsideration, unless the 90 calendar day period has been extended as provided in this subpart.