HME Audit Climate

Michigan Home Care & Hospice Association

Kelly Grahovac, General Manager, The van Halem Group

1

CURRENT AUDIT CLIMATE

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2

DME MAC

Targeted Probe and Educate (TPE) Program

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3

DME MAC Jurisdiction B

Product Category/HCPCS	Product Category/HCPCS
Ankle-Foot Orthoses (L1900-L1990, L2000, L2005, L2010-L2136, L4350-L4387, L4396-L4397, L4631)	Commodes (E0163, E0165)
Continuous Airway Positive Pressure (CPAP) (E0601) and Supplies (A7027-A7034, A7044)	Enteral Nutrition (B4035)
External Infusion Pump (J1559, J1569, J1575)	Glucose Monitor and Supplies (A4233-A4236, A4239, A4253, A4256, A4258, A4259, E0607, E2103)
Hospital Beds (E0260, E0261, E0303)	Immunosuppressive Drugs (J7503, J7507, J7518, J7520, J7527)
Knee Orthoses (L1832, L1843, L1844, L1845, L1851, L1852, L2397)	Manual Wheelchairs (K0001-K0004)
Nebulizer Inhalation Drugs (J7605, J7606, J7613, J7620, J7626)	Oxygen and Oxygen Equipment (E0424, E0439, E1390, E1391)
Spinal Orthoses (L0450-L0651)	Surgical Dressings (A4316, A4351, A4352, A4353, A4355)
Therapeutic Shoes for Diabetics (A5500, A5512, A5513)	Urological Supplies (A4351 – A4353, A4355, A4316)

4

TPE Results – Jurisdiction B

- 10-Claim Preview – 33% compliance
- Round 1 – 89% compliance
- Round 2 – 56% compliance
- Round 3 – 72% compliance

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5

RAC

Recovery Audit Contractor

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6

RAC Approved Issues Process

7

RAC - Complex

DMEPOS Under Complex Reviews	Date Posted
Wearable Automatic External Defibrillators	6/8/2023
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

8

RAC - Automated

DMEPOS Under Automated Reviews	Date Posted
Hip Orthoses within the Reasonable Useful Lifetime: Excessive Units	9/15/2023
Medical Supplies Billed from Consolidated Billing List During a Home Health Episode: Unbundling	6/8/2023
Canes, Crutches, and Walkers within the Reasonable Useful Lifetime: Excessive Units	5/1/2023

9

SMRC

Supplemental Medical Review Contractor

10

SMRC

DMEPOS Under Automated Reviews	DOS under review
Urinary Catheters (A4351, A4352, and A4353)	January 1, 2022 - November 30, 2024
Surgical Dressings (A6010, A6011, A6021-A6024, A6196-A6199, A6209-A6215)	January 1, 2023 - December 31, 2024

11

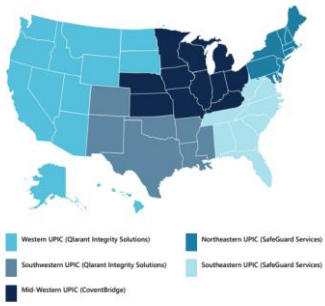
UPIC

Unified Program Integrity Contractor

12

UPICs

- Qlarant Western and Southwest
  - Total Funding = $115,325,516
- CoventBridge Midwest
  - Total Funding = $155,389,846
- Safeguard Services Southeast and Northeast
  - Total Funding = $257,936,858



13

UPICs

- Respiratory
  - Oxygen
  - PAP devices and supplies
  - Ventilators
- Surgical dressings
- CGMs
- Complex Rehabilitation Technology (CRT)
- Urological Supplies

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14

OFFICE OF INSPECTOR GENERAL (OIG)

OIG Work Plan, Office of Audit Services and Office of Evaluations and Inspections

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15

OIG Work Plan

Project Description	Date Posted
CMS's Use of Surety Bonds To Protect Medicare Part B From Overpayments to Durable Medical Equipment Suppliers	February 2025
Status of State Medicaid Provider Enrollment and Screening Activities	December 2024
Wheelchair Repair Services for Medicare Enrollees	October 2024
Medicare Payments to Suppliers for Oxygen and Oxygen Equipment	October 2024
Follow up Review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided by Suppliers During Inpatient Stays	July 2024
Durable Medical Equipment Fraud and Safeguards in Medicare	June 2024
Medicare Payments for Intermittent Urinary Catheters	Revised

16

OIG Work Plan

Durable Medical Equipment Fraud and Safeguards in Medicare

- OIG review will provide information about current fraud schemes and the safeguards and monitoring that CMS has in place to prevent fraud, waste, and abuse.
- First review: Billing for DMEPOS in **Medicare Advantage**, specifically by suppliers that are not enrolled in Medicare fee-for-service.

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17

OIG Work Plan

Status of State Medicaid Provider Enrollment and Screening Activities

- Federal law requires State Medicaid agencies to screen providers as part of the Medicaid enrollment process.
- Prior OIG work has identified issues with States' implementation of provider enrollment and screening requirements for both fee-for-service Medicaid and Medicaid managed care
- OIG will determine the status of States' required Medicaid provider enrollment and screening and will assess States' standards and processes for screening.

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18

OIG Work Plan

Follow up Review of DMEPOS Provided by Suppliers During Inpatient Stays

- OIG will review Medicare payments to certain types of inpatient hospitals to determine whether claims billed to Part B for certain DMEPOS items provided during inpatient stays were made in accordance with Federal requirements.
- Additionally, OIG will review the CMS Common Working File system edits that should deny claims for DMEPOS items furnished during an inpatient stay.

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19

OIG Work Plan

CMS's Use of Surety Bonds To Protect Medicare Part B From Overpayments to DME Suppliers

- To limit the financial risk that fraudulent suppliers of DME pose to Medicare, CMS implemented a surety bond requirement to: (1) deter fraud and (2) recover overpayments
- OIG plans to determine:
  - The total amount of outstanding DME overpayments that became eligible for surety bond collection in CY 2023,
  - The total amount of outstanding DME overpayments that have been collected and left uncollected from surety bonds,
  - Potential obstacles DME Medicare Administrative Contractors and CMS face in collecting outstanding DME overpayments from surety bonds, and
  - Potential changes that could make surety bonds a more effective tool to deter fraud and recover DME overpayments.

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20

MANAGED CARE

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21

Current Landscape

- Plans more active in auditing
- Plans are required by law to perform program integrity functions
- Pre and Postpayment reviews
- Medicaid Recovery Audit Contractors (RACs)
- Medicaid Integrity Contractors (MICs)
- Additional CMS oversight on managed care plans
- CMS applying pressure on states to increase their own program integrity functions
- OIG identified Managed Care as one of the top 6 priorities for 2024

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22

Recent OIG Report

- Unified Program Integrity Contractors 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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23

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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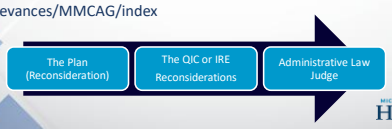
24

Medicare Advantage Appeals

- In-network providers are bound to the appeal and grievance process outlined in their contract.
- The Medicare Managed Care Manual (Pub 100-16) used to outline the appeal process for out-of-network providers.
- Recent regulatory changes required updates to the Part C Appeal process and can be found here now, effective 8/3/2022: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index



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25

Organization Determination

- (b) *Actions that are organization determinations.* An organization determination is any determination made by an MA organization with respect to any of the following:
  - (2) Payment for any other health services furnished by a provider…that the enrollee believes—
    - (i) Are covered under Medicare; or
    - (ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.
- Some plans are indicating that extrapolated overpayments are not "organizational determinations" as defined in 42 CFR 422 Subpart M and therefore appeal rights are not afforded.

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26

Adverse Initial Determination

- We've made the argument is that the overpayment notification is an adverse initial determination.
- According to Section 50 of the new Medicare Managed Care Appeal Manual for Part C & D, any of the following parties has a right to a reconsideration of an "adverse initial determination" –
  - The enrollee or his/her representative
  - As assignee of the enrollee (i.e. a physician or other provider who has furnished a service to the enrollee and formerly agrees to waive any right to payment from the enrollee for the service
  - Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.

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27

Appeal Process

- Providers must submit waivers of liability along with the requests indicating that they will not hold the patient liable for denied charges.
- Section 50.1.1 of the manual further indicates that a non-contractor provider acting on his/her behalf, "…may request a reconsideration for a denied claim…" if they complete the Waiver of Liability.
- They are not representing the enrollee, they are representing their own interests as a non-contract provider.
- Once the Reconsideration is complete, if the Plan issues an "adverse" or partially favorable decision, they are required to submit to an Independent Review Entity (formerly QIC).

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28

Extrapolations

- Increase in extrapolated overpayments in managed care.
- Plans do not seem to understand that this action should be appealable as well.
- An extrapolation is an adverse initial determination.
- The appeal manual makes no mention of a process for extrapolated overpayments, but these actions are certainly appealable under FFS claims
- QIC has confirmed that they have the ability to review extrapolations and do so on occasion.
- Plans should adhere to guidance outlined in the Medicare Program Integrity Manual (Pub 100-8, Chapter 8)

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29

PROVIDER ENROLLMENT UPDATES

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30

Noncompliance

- 42 C.F.R. §424.535(a)(1)
- The provider or supplier has violated an enrollment requirement listed on the application it/he/she uses for enrollment purposes (e.g., 855S)

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31

Site Inspections

A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. (Standard 8)

32

Site Inspections – How to Prepare

- Adhere to posted hours of business (ensure posted hours match the hours reported on the 855S)
- Make certain that qualified staff is available to answer questions and have accessibility to files and documentation
- Have current licensure & certification prominently displayed
- Be able to provide inspector with accessibility to review Medicare beneficiary files if requested
- Provide proof of business records including warranties, delivery information, rental agreements
- Ensure sufficient inventory on-site or evidence of contractual agreements for volume of Medicare beneficiaries served

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33

Site Inspections – What to expect

- MACs/NPEs will send a letter to the contact person or the correspondence address in advance of the site visit (only applies to application-based site visits
- Two attempts are made to complete a site visit
  - If the facility is still under construction, finds other obvious indications the facility is not a true operating location, or finds that there is no visible sign or office hours posted on first visit, a second attempt will not be made
  - NPE will be notified the site visit could not be completed
- If a site visit is refused or cannot be completed, the supplier is subject to the denial/revocation of Medicare billing privileges

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34

Site Inspections Tips

- Posted permanent signage must include supplier's business name and hours of operation
- Inventory is stored on site
- Documents are available upon request:
  - Licenses/certifications
  - Written complaint policy and procedure for logging complaints
- Warranty information to confirm equipment warranty was provided
- Proof of business records (rental/purchase agreements)

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35

Revalidation

- Suppliers are required to revalidate every three years
- CMS selects and establishes due dates by which providers and suppliers are required to revalidate
- Lookup tool (https://data.cms.gov/revalidation) for due dates
- The supplier will receive a revalidation letter prompting them to update information in PECOS
- Do not send in revalidation documentation until you are notified, or it will be rejected/returned

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36

FINAL THOUGHTS

37

Audits – Looking Ahead

- Audit volumes will continue to increase in Medicare FFS
- Managed care plans will continue increase audit functions
- CMS scrutiny on provider enrollment functions will expand further in both Medicare and Medicaid

38

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
- Licensing and credentialing is a component of compliance

39


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40


Questions and Contact
Kelly Grahovac
Kelly@vanHalemGroup.com
(404) 343-1815
www.vanHalemGroup.com
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41