CERT

DME MAC OUTREACH & EDUCATION

Task Force for Error-Free Medicare Claims

Positive Airway Pressure (PAP)

December 19, 2023

noridian Healthcare Solutions

CGS A CELERIAN GROUP COMPANY

Disclaimer

The DME MAC CERT Outreach and Education Task Force consists of representatives from each of the DME MACs and is independent from the CMS CERT Team and CERT Contractors, who are responsible for the calculation of the Medicare Fee-for-Service Improper Payment Rate.

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Webinar Moderators and Presenters

- Jurisdiction A and D – Noridian Healthcare Solutions
  - Kloe Roberts
- Jurisdiction B and C – CGS Administrators
  - Judie Roan

Agenda

- Comprehensive Error Rate Testing (CERT) Data
- Medical Necessity Requirements
  - Positive Airway Pressure (PAP)
- Documentation Requirements

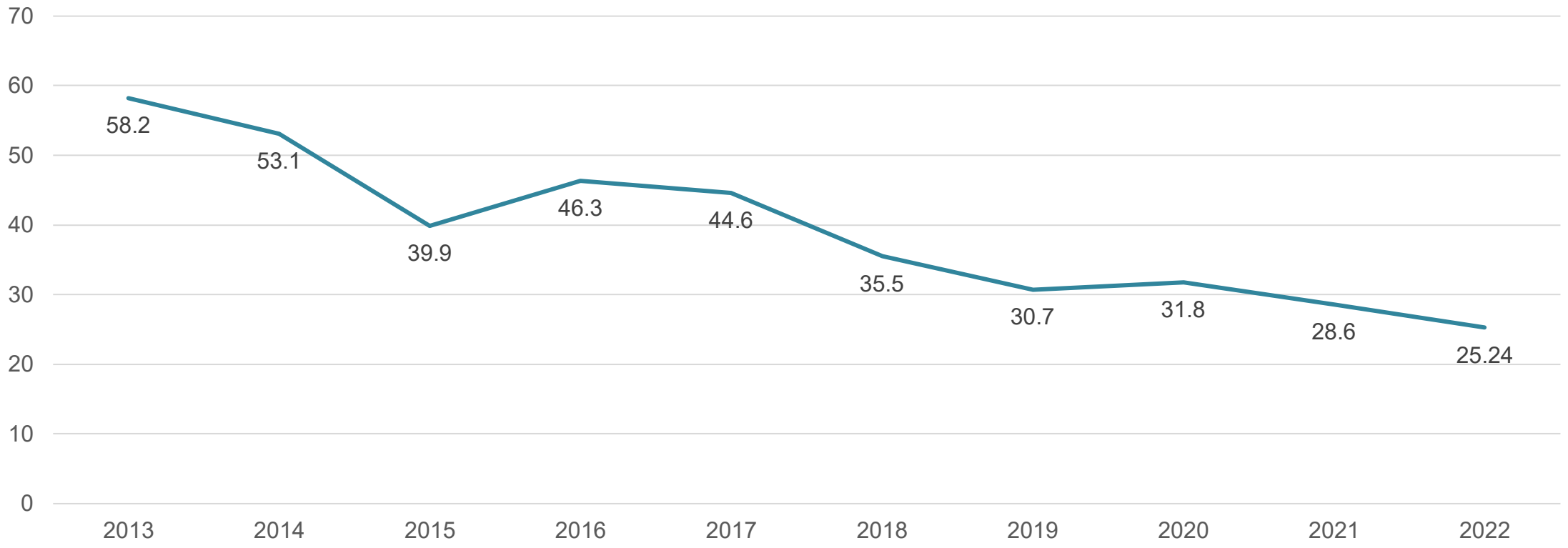
Comprehensive Error Rate Testing (CERT) Data

2022 Medicare Fee-for-Service Supplemental Improper Payment Data

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.46%	$31.46 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	**25.24%**	**$2.19 B**
Part B Providers	8.21%	$8.75 B
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	8.86%	$17.13 B
Hospital IPPS	2.99%	$4.12 B

Claims Submitted Dates: July 1, 2020 – June 30, 2021

DMEPOS Improper Payment Rate All DME MAC Trend



Top DMEPOS Improper Payment Rates by Service Type

Policy Group	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
CPAP	**928**	**$247 M**	**24.1%**
All Policy Groups with Less than 30 Claims	730	$211.8 M	31.2%
Lower Limb Orthoses	676	$187.8 M	57.5%
Infusion Pumps & Related Supplies	463	$118.4 M	18.3%
Surgical Dressings	428	$116.9 M	41.8%
Ventilators	362	$108.2 M	20.1%
Glucose Monitors	828	$105.8 M	118.5%
Lower Limb Prostheses	344	$96.4 M	25.1%
Oxygen Supplies/Equipment	525	$92.9 M	15.3%
Urological Supplies	352	$87.1 M	24.9%

Improper Payment Rates for CPAP by Referring Provider

Referring Provider	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
Internal Medicine	454	$110.3 M	22.9%
Nurse Practitioner	142	$47.3 M	26.0%
Family Practice	138	$45.4 M	33.2%
Physician Assistant	59	$15 M	19.7%
Neurology	42	$9.1 M	15.3%
All Referring Providers	**928**	**$247 M**	**24.1%**

Top Root Causes of Improper Payments for CPAP

Root Cause Description – Insufficient Documentation/ Other	Sample Claim Count
Documentation to support coverage criteria - missing	144
Refill request - missing	57
Proof of delivery - inadequate	46
Order - missing	22
Proof of delivery - missing	21
Submitted order not written by provider listed on the claims as ordering/ referring provider	18
Order - inadequate	18
Refill request - inadequate	10
Provider orders are signed and dated after the claim was submitted	6
Documentation to support coverage criteria - inadequate	6

CERT Documentation Requests

- The CERT Review Contractor (CERT RC) requests and receives all medical records.
- Use the barcoded coversheet as your documentation coversheet
- Documentation may be submitted:
  - Mail or Fax
  - Electronic Submission of Medical Documentation (esMD)
    - Include a CID number or Claim number and the barcoded cover sheet in your file transmission.
  - CD or Email attachment
    - encrypted per HIPAA security rules
- Check the current status of a claim under CERT review by using the CERT C3HUB Claim Status Search
  - If CERT shows the review has been completed – refer to DME MAC CERT resources

CERT Contact Information

CERT Contractor Resources and Contacts

- Phone: 1.888.779.7477 or 1.443.663.2699
- E-mail: certprovider@empower.ai

Appeal Rights from CERT Audits

- If the CERT contractor finds errors with the claim in question, the supplier will receive an Overpayment Demand Letter and a revised Medicare Remittance Advice (MRA).
- If the supplier does not agree with the outcome of the CERT review, they should file an appeal to the Redeterminations department of their DME MAC within 120 days of the date on the demand letter or MRA.
  - If a Redetermination is filed to the appropriate DME MAC within 30 days of the letter/MRA, all recoupment activities will cease until the redetermination decision is made.

Medical Necessity Requirements

Positive Airway Pressure (PAP)

PAP Coverage Criteria

National Coverage Determination (240.4)
Local Coverage Determination (L33718)
Policy Article (A52467)
Standard Documentation Requirements Article
(A55426

Initial Coverage - 12 Week Trial

Face-to-face (F2F) clinical evaluation by treating physician prior to sleep test to assess patient for OSA

Medicare covered sleep test that meets either one of the following criteria

- AHI or RDI > 15 events per hour with minimum of 30 events or
- AHI or RDI > 5 – 14 events per hour with minimum of 10 events and documentation of:
  - > Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; OR
  - > Hypertension, ischemic heart disease, or history of stroke

Beneficiary or caregiver received instruction from supplier in proper use and care of PAP device

Treating Physician's Initial Evaluation

Physician F2F initial evaluation

- Written in same format used for other entries and may include:
  - History
    - Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
    - Duration of symptoms
    - Validated sleep hygiene inventory such as Epworth Sleepiness Scale (see Appendices)
  - Exam
    - Focused cardiopulmonary and upper airway system evaluation
    - Neck circumference
    - Body mass index (BMI)

Continued Coverage - Beyond 12 Weeks

F2F clinical re-evaluation between 31st and 91st day after initiating therapy

- Treating physician documents benefiting from therapy
  - Improvement in subjective symptoms of OSA
  - Objective data related to adherence
- Objective evidence of adherence reviewed by treating physician
  - Used > four hours per night 70% of nights during consecutive thirty-day period anytime during first three months of initial usage

Re-evaluations Occurring After 91st Day

Physician documents benefiting from therapy and objective evidence of adherence reviewed by treating physician

- Used > four hours per night 70% of nights during consecutive thirty-day period anytime during first three months of initial usage

Continue coverage begins with date of re-evaluation

Failing 12-Week Trial Period

May re-qualify

- New F2F re-evaluation by treating physician
  - Determine etiology of failure on PAP therapy
- Repeat sleep test
  - Facility-based setting only – Type I study
    - Diagnostic
    - Titration
    - Split – night
- Obtain documentation that beneficiary met new adherence to therapy
- Resume billing with fourth rental month by appending KXKJ modifier

Coverage for RAD Without Backup

Criteria D

E0470 covered for patients with OSA if:

- Patient meets initial coverage criteria A-C and
- Patient has had CPAP tried and proven ineffective in facility or home setting

Ineffective Scenarios with PAP

Based on therapeutic trial conducted in either:

- Facility
  - Failure may occur during titration portion of qualifying split night study
- Home setting
  - Failure may occur after beneficiary has been using PAP device at home
    - Despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure settings)

CPAP Failure Documentation

Interface fit and comfort

- Appropriate interface properly fit and beneficiary using it without difficulty
  - Beneficiary properly fit for mask initially
    - Successful on E0601 and not need to move to E0470
- Properly fit interface will continue to be used with E0470

CPAP Failure Documentation 2

E0601 pressure settings:

- Prevented beneficiary from tolerating therapy and;
- Lower settings of E0601 were tried but failed to:
  - Control symptoms of OSA; or
  - Improve sleep quality; or
  - Reduce AHI/RDI to acceptable levels

Ineffective Therapy – Switching From E0601 to E0470

During initial three-month trial of E0601

- More than 30 days remain:
  - Trial length remains same
  - Re-evaluation between 31st and 91st day
  - Adherence to therapy on RAD prior to 91st day
- Less than 30 days remain:
  - Re-evaluation must occur before 120th day
  - Adherence to therapy on RAD before 120th day

Ineffective Therapy – Switching From E0601 to E0470 2

After initial three-month trial of E0601

- New evaluation
- New three-month trial with RAD
  - Clinical re-evaluation between 31st and 91st day with RAD
  - Adherence to therapy with RAD

Discontinuation of Usage

Supplier expected to know if beneficiary is using device

- Stop billing for equipment and supplies if not in use
- Recommend continuous follow-up with beneficiary through 13th month

Replacement PAP

PAP initially provided and covered through Medicare

- Inside of reasonable useful lifetime (RUL) due to loss, theft, or irreparable damage
  - No new clinical evaluation, sleep test, or trial
- After RUL requires F2F evaluation
  - Beneficiary continues to use and benefit from device
  - No requirement for new sleep study or trial period

Repairs PAP

Included in 13-month rental period

After 13 months – repairs are billable to Medicare

Beneficiaries Entering Medicare

Beneficiary seeking rental or replacement PAP and/or accessories must meet specified requirements:

- Sleep test prior to Medicare Fee-for-Service (FFS) that meets AHI/RDI criteria in effect at time replacement PAP and/or accessories are needed, and
- In-person evaluation following enrollment in FFS Medicare by treating physician that documents
  - Diagnosis of OSA; and
  - Beneficiary continues to use PAP device

If above not met, claim denies

- Not reasonable and necessary

Concurrent Use of Oxygen with PAP Therapy

- Both oxygen Local Coverage Determination (LCD) and PAP LCD must be followed
- OSA sufficiently treated
- Overnight oximetry during home sleep test not eligible to be used for oxygen qualification
- Testing may only occur during titration study and
  - Minimum two hours
  - During titration specific reduction in AHI/RDI criteria met
  - Only performed after optimal PAP settings determined
  - Nocturnal oximetry conducted during PSG shows <88%

Documentation Requirements

Signature Requirements

- Services provided/ordered/certified must be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies
- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received)
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry
- CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.4

Signature Attestation Statement

- Must be signed and dated by the author of the medical record entry
- Must contain sufficient information to identify the beneficiary
- CMS currently neither requires nor instructs providers to use a certain form or format
- Only considered when there is an associated medical record entry
- Attestation statements from someone other than the author of the medical record entry in question are not considered

Standard Written Order (SWO) Elements

SWO must be communicated to the supplier prior to claim submission and must contain:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of item
  - Description can be either general description (e.g., CPAP), HCPCS code, HCPCS code narrative, or brand name/model number
- Quantity to be dispensed, if applicable
- Treating practitioner name or National Provider Identifier (NPI)
- Treating practitioner's signature

Medical Records

- Detailed documentation in treating practitioner's records
  - Medical necessity of item billed
  - Focused history and examination of impacted body part
    - Critical to establishing medical necessity
  - Diagnosis code billed on claim
- Templates and forms
  - Corroborated with medical record

Direct Delivery (Method 1)

- Beneficiary's name
- Delivery address
- Description of item(s) being delivered
  - Narrative description; or
  - HCPCS code; or
  - Long description of HCPCS code; or
  - Brand name/model number
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature
- Date of Service = Date received

Shipping Service (Method 2)

- Supplier Shipping Invoice:
  - Beneficiary's name
  - Quantity delivered
  - Description of item(s) being delivered
  - Package identification number
- Delivery service tracking slip:
  - Each beneficiary's package
  - Delivery address
  - Package identification number (tracking number)
  - Date delivered
  - Evidence of delivery
- Date of Service = Shipping date or date of delivery

Delivery to Nursing Facility on Behalf of a Beneficiary (Method 3)

- Can be delivered via methods 1 or 2
- Documentation demonstrating delivery; and
- Documentation from nursing facility demonstrating receipt and usage
  - Quantities delivered and used
    - Justify quantity billed

Thank You!