Lessons from the CMS Program Integrity Manual

Learn how to prevent a pre-payment audit.

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At the recently concluded American Orthotic and Prosthetic Association (AOPA) 2016 National Assembly, a speaker presented a lecture entitled, "Documentation Changes that Work! Proof that Better Documentation Leads to Overturn of Denials."

This lecture was very well attended by a large number of the AOPA membership. Always looking to see what the experts in other professions are discussing was equally intriguing and as it turned out, it was chock-full of helpful tips for any provider billing Medicare or any third-party payer. There were many topics covered, but the most daunting were discussions referencing the Program Integrity Manual (PIM). This is a very long document, subdivided into many chapters, covering the many rules and regulations for supplier conduct and billing.

One section of the PIM contains a stipulation regarding suppliers showing a "pattern" of failing to comply with requests for additional documentation (ADR) or providing inadequate or incorrect information to substantiate payment(s) of claims. Upon questioning, the presenter also noted that CMS now considers a pattern of abuse to mean anything greater than two requests where either documentation is not provided or is incorrect or inadequate.

The consequence of being labeled as showing a pattern of abuse is the provider having all their claims being subject to a pre-payment review. The length of this type of punishment would be determined by the DME MAC audit review department.

Most healthcare providers could not economically survive if all their claims were subject to pre-payment review. Thus, it is very important that if you do receive a request for additional documentation (ADR), you respond prior to the deadline using traceable methods. It is equally important to be sure that you send complete, appropriate, and accurate documentation.

The second most important takehome message is the verbiage and documentation contained in the patient's medical record. Use of templated certificate of medical necessity (CMN) or checked box forms which simply replicate the LCD will most likely result in your claims being rejected. It appears that CMS auditors are using software which requires much more than the LCD information and also uses "Natural Language".

Natural language appears to be a system whereby the software reads the document as one might speak. Thus, if there are any boxes which are unchecked (which is often the case) or significant spaces and blanks, then the claim will be rejected.

Furthermore, when reviewing chart notes, the auditors are looking for a narrative story describing the patient's condition(s) and need for the device being provided. Replication of verbiage directly from the LCD is therefore not considered an accurate portrayal of the patient's condition and thus will be rejected. The above seems to fit very well with a significant number of articles written in this series which cautions providers not to rely on LCD language or CMN-type language or the use of check-off box templates.

The third most important message provided during this lecture was how Medicare determines your "Provider Error Rate". This is determined by The Dollar Amount of services paid in error/The dollar amount of services you provided.

One can easily see that your provider error rate can soar if you are found to have submitted only a few claims with a high dollar amount. The higher the "Provider Error Rate" as compared to other providers in your discipline, the more likely you are to be subjected to a pre-payment review on all of your claims. For more information on the Provider Error Rate and other information in this article, research Chapter 3 of the Supplier Provider Manual, which may be found on your DME MAC website. **PM**

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