

Preparing for a DME Audit

These steps will help you through this process.

BY PAUL KESSELMAN, DPM

Since March of 2016 the number of DME audits has skyrocketed. This has caused a great deal of concern not just in the podiatric community but in the orthotic, prosthetic, and pedorthic professions. Similar concerns have been raised by the commercial DME suppliers and all medical professionals. Lectures and discussions about audits abound at meetings attended by all these professionals and focus primarily on which products are being targeted. Some have done well with audits while many remain frustrated. For orthotic professionals simply walking away from DME is not an option. The purpose of this article

is to allay the concerns of the reader and provide some useful tips for responding to an audit. Some of the tips provided are unique to DME but most will also be useful for non-DME audits as well.

continue to be the most problematic. Custom-fitted CAM Walkers (L4360 or L4386) and custom fabricated hinged ankle foot orthotics (L1970) are also now under a mandatory pre-payment probe. Pre-payment

**Since March of 2016
the number of DME audits has skyrocketed.**

The most obvious questions to answer are which DME products are being audited? From the Medicare perspective, Therapeutic Shoes and Inserts (A5500/A5512/A5513) con-

tinues to be the most problematic. Custom-fitted CAM Walkers (L4360 or L4386) and custom fabricated hinged ankle foot orthotics (L1970) are also now under a mandatory pre-payment probe. Pre-payment probes do not indicate that every claim you submit containing these codes will be audited. Rather it is an indication that CMS has mandated that the DME contractor conduct a pre-payment audit on a certain percentage of claims containing specific HCPCS codes.

Some Issues to Ponder about Audits:

- If one were to consider the law of averages, if you submit a lot of claims on a specific date for one specific HCPCS code, you are more likely to have multiple audits for the same type of claim than if you were to spread out those submissions over several days.

- It would be financially unsustainable for any Medicare carrier to audit every claim for a specific code. Thus the DME MAC (or any carrier) only targets a specific percentage (and number) of claims each day/week/month for specific codes.

- If you pass 10 pre-payment audits for a specific code, the DME MAC will no longer conduct a pre-payment review on any more of

Continued on page 50



Audit (from page 49)

your claims (for those HCPCS codes) for the remainder of the year.

- Even if you fail a small percentage of your audits on a specific code, your practice will still be profitable on the provision of that service.
- There has been no suggestion (to date) that failure of a small percentage of pre-payment probes will escalate into a larger post-payment audit with extrapolation.

From the Non-Medicare Carriers:

There are currently some large post-payment audits/investigations concerning L3000. The total amount being asked for recoupment would bankrupt even the largest of practices. Other recoupments are targeting the lack of a KX modifier on any orthotic/prosthetic claim or payments made to those who were not enrolled as DME suppliers and incorrectly paid, or were paid yet there was a lack of prior authorization for the HCPCS code provided.

So now the questions should begin with how does one begin to protect one's practice? As any football aficionado will tell you, a good offense starts with a good defense! Here are a dozen universal tips to use as part of a universal compliance plan, in order to be prepared for any pre-payment audit:

- 1) Assign someone in your practice to review the LCD associated with specific services, HCPCS or CPT codes. Be sure you are properly enrolled and have the requisite prior authorization, coding, pricing, etc.;
- 2) Develop an Excel spreadsheet with the appropriate columns and rows for each patient, code, and requirements as per the LCD;
- 3) Based on your LCD and Excel spreadsheet, be sure to obtain the requisite documentation prior to ordering and/or dispensing the materials;
- 4) Call the contractor if you have concerns. Medicare contractors are contractually obligated by CMS to provide providers with various types of outreach and assistance (most at no charge). Ask the contractor's education department to provide your practice with some form of educational forum. This can range from a

webinar to an in-personal visit. Ask the contractor to review a sample set of documents from a real claim prior to submission (educational review). Be mindful that the auditor who conducts an educational review (prior to claim submission) will not be the same one who is assigned to conduct a pre-payment review after claims submission. Thus the "All Clear" on an educational review is not an indication that you will pass the pre-payment review. Inconsistencies among auditors are

sary. Healthcare is a rapidly changing business and it's impossible to stay abreast of every nuance. Consultants are commonplace in other businesses. Why would you think your practice (solo or otherwise) would be any different? The time you save and the money you spend will likely be rewarded with increased revenue and decreased frustration!

12) Check with your professional liability carrier to see if they can offer you direct assistance or referral to an expert on the area of concern. They

**Check with your professional liability carrier
to see if they can offer you direct assistance or referral
to an expert on the area of concern.**

less frequent, but nevertheless still problematic;

- 5) Use the APMA Resource Center and APMA Member Website which is full of useful information;
- 6) Speak with the compliance officer/consultant at your vendors. Most large vendors have employees who sole function is to provide their clientele with the information about documentation requirements for their specific products. Recent letters from a well-known nationwide laboratory have been circulated alerting that such a service is available for their customers;
- 7) Check your vendors' websites. Many have workflow guides and templates (which can be customized for your practice and individual patients' requirements);
- 8) Attend lectures, webinars, etc. on compliance provided by APMA, your state component, other O&P professionals, Codingline. and those sponsored by your vendor;
- 9) Do not fear something new. Every success is based on a previous failure. It's likely you will not succeed if you are afraid and succumb to failure;
- 10) If you are a new supplier, it would be wise to submit only a very few claims for any specific service. If you are audited on one of the new claims, it will be less financially painful should you fail;
- 11) Hire a consultant if neces-

may also provide audit assistance as part of your professional liability package.

Having completed all of the above, you should be in a good position to respond to a pre-payment audit.

Inevitably the day will come when you receive that dreaded pre-payment letter from your carrier. Your concerns should be:

- 1) How many charts are being requested? If it is one or a few (received over several days/weeks), from the carrier's general mailbox, this is something you can likely handle in-house without a major amount of assistance. You may want to check with your professional liability carrier anyway;
- 2) If the inquiry is certified and/or is from an investigator at the carrier (e.g. DME MAC, etc.), this should demand a much higher degree of attention from the physician and staff. One should immediately contact one's professional liability carrier or attorney for further assistance.

For most practices, scenario #1 is the most likely and here is my top ten list for responding to a pre-payment review and for appealing:

- 1) Make a copy of the letter you receive. Use the copy as a mark-up to

Continued on page 52

Audit (from page 50)

highlight the response deadline and the information they require you to provide.

2) Gather up copies of any of the requested information and annotate each page with a specific page number.

3) Place the corresponding page number of your documentation on the mark-up copy.

4) Make copies of the pertinent pages of the LCD and mark on the exact page number of your documentation where you believe your documentation has met that litmus test.

5) Write a very concise response letter which contains all of the above information in an outline form. For example, "You requested the Certification Statement from the MD/DO Physician Supervising DM Care. This was properly completed by Dr. Jones and dated within a three-month period of time prior to the date of service (DOS) for shoe dispensing and is located on page 3."

Do this for each documentation request. If the requested material(s) are not required (e.g., separate prescription from a supplier who is also the prescriber), provide that stipulation and the page number from the LCD and Internet Only Medicare Manual (IOM). Be sure to attach the pertinent marked-up sections from the LCD with references to your page number(s).

6) Create a Table of Contents and corresponding title for each page of documentation.

7) Send the cover letter along with all the requested materials, including a clean copy of their letter (within the time frame requested) and other documents noted above via traceable courier. Most Medicare carriers are contractually obligated to provide electronic means by which you can submit all your materials directly to the carrier (e.g., provider portal). This will also allow you

If you are not signed up for your MAC portal, do so today!

to obtain proof of timely submission of all the items you submitted.

8) If you are not signed up for your MAC portal, do so today! It is a free and easy way to keep track of your audit, claims submission, "Same and Similar", eligibility, and many other features. In particular, you will also be able to view the notes of the nurses who reviewed your claim.

9) If you believe you have been comprehensive in your response and have submitted all the required documentation and are still denied, appeal, appeal, and appeal. As was stated by a persistent colleague at the recently conducted APMA CAC-PIAC meeting, "You owe this not only to yourself, but to your patients and your colleagues."

10) First level appeals (re-determination) of unfavorable pre-payment review at the carrier level allow you to obtain and submit additional documentation not initially submitted. Keep appealing by repeating the process above as needed until you are successful!

A neurologist who recently became a DME provider fervently adopted all these action points. While he initially failed his first pre-payment audit, he appealed, viewed this as a learning experience, and eventually won on appeal. He has not looked back. His philosophy was that anything worthwhile is usually not easy. He was smart enough to hire a consultant who had him and his staff ready for whatever the carrier requested. He was prepared for a painful learning curve, which, as it turned out, was not as painful as he anticipated. Why? Because he was prepared! **PM**



Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory

Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.