CQRC COUNCIL FOR QUALITY RESPIRATORY CARE

The Documentation and Audit Process for Home Respiratory Therapy Remains Broken and Needs To Be Fixed

Fraud and abuse should be eliminated in the Medicare program in a manner that is responsible and balanced. The CQRC strongly supports eliminating fraud and abuse in the Medicare program. These efforts should be rational, balanced, and targeted to ensure that limited Medicare funds are directed at activities that appropriately need to be curtailed, rather than focused on technical errors.

- **The current documentation requirements and audit process inappropriately focus on documentation errors rather than whether the equipment and services are medically necessary.**

  - CMS data shows that the vast majority of home respiratory therapy equipment and services are medically necessary.
    - According to the 2016 CERT report, the improper payment rate for home oxygen therapy was 45 percent. Of that, 91.2 percent was due to missing documentation only 0.3 percent was due to the beneficiary not meeting the medical necessity requirements.
    - For CPAP (Continuous Positive Airway Pressure) equipment, the improper payment rate was 59.6 percent. Of this percentage, 85.2 percent was due to missing documentation, but only 0.6 percent was due to an actual lack of medical necessity.
    - If CMS's own contractor acknowledges that nearly 100 percent of beneficiaries who are prescribed home respiratory therapy actually meet the medical necessity requirements, it is not clear why claims should be denied. The current overly technical and burdensome documentation requirements serve no purpose.

  - Yet the government and suppliers remain engaged in an expensive and time-consuming appeals process because of the focus on prescriber medical records.

- **Common sense reform is needed to bring balance to the system. Specifically, CMS should:**

  - Use its discretionary authority to remove home respiratory therapy equipment from the face-to-face examination (returning to the physician visit requirements in the original Local Coverage Determination (LCD)) and the written order prior to delivery requirements (returning to previous requirements related to written orders), which is from where the burdensome and costly documentation requirements stem. If this change cannot be implemented quickly, CMS should:
    - For home oxygen therapy, rely upon the Certificate of Medical Necessity (CMN) to establish that a face-to-face visit occurred, rather than requiring patients' medical records, and to allow the CMN to constitute a valid written order for purposes of dispensing home respiratory therapy equipment so long as it include the detailed written order elements and the date of the physician visit.
    - For home sleep therapy, rely upon the required prescriptions and sleep test results to constitute a valid written order for the purpose of dispensing home respiratory therapy equipment so long as these documents include the detailed written order elements and the date of the physician visit.

  - Modify the proof of delivery requirement to allow for alternative documentation options;

  - Streamline the audit process to avoid duplicative audits of the same patient with a different date of service