Medicare Audits & Compliance: Latest Developments & Emerging Issues Affecting Home Health Providers

Objectives

- Identify and explain the various audit contractors and key audit risk areas for home health providers
- Identify strategies to be used by home care agencies to manage audit contractor requests
- Discuss successful appeals strategies and effective defenses that can be employed if and when a home health provider faces an audit.
- Proactive clinical strategies that can be used as an effective defense to audits
THE CURRENT AUDIT LANDSCAPE

• CMS contractors in the current audit landscape
  – Medicare Administrative Contactors (MACs)
  – Zone Program Integrity Contractors (ZPICs)
  – Medicare Recovery Audit Contractors (RACs)

Zone Program Integrity Contractors (ZPICs)

• ZPICs are responsible for the identification of suspected fraud
  - Different from the Medical Review program which is primarily concerned with preventing and identifying errors
  - ZPICs request medical errors and conduct medical review to evaluate the identified potential fraud
  - ZPICs may also refer matters to the OIG and DOJ for further investigation

• Prepayment reviews
THE FOCUS OF CURRENT RAC AUDITS
Home Health RAC Approved Issues

Region A: No Skilled Service

States Affected: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT
To qualify for the home health benefit, a patient must need a skilled service. When a skilled service is needed, dependent services such as home health aide may also be covered. Dependent services are not covered for a patient who no longer needs a skilled service.

THE FOCUS OF CURRENT RAC AUDITS
Home Health RAC Approved Issues

Region B: Home Health Medical Necessity and Conditions To Qualify For Services

States Affected: MI, IL, OH
The medical record will be reviewed to validate that the Home Health services were both reasonable and medically necessary and that the patient met the conditions to qualify for home health services.
THE FOCUS OF CURRENT RAC AUDITS
Home Health RAC Approved Issues

Region C: Incorrect Billing of Home Health Partial Episode Payment Claims

States affected: AL, AK, CO, FL, GA, LA, MS, NM, NC, OK, Puerto Rico, SC, TN, TX, Virgin Islands, VA, WV

Description: Incorrect billing of Home Health Partial Episode Payment (PEP) claims identified with a discharge status 06 and another home health claim was not billed within 60 days of the claim from date. Additionally, MCO effective dates are not within 60 days of the PEP claim.

Compliance Policies on Government/Third Party Payor Investigations

• It is important for HHAs to have a policy on cooperation and coordination with government investigations.
• If an employee receives any inquiry, subpoena or other legal document relating to the employer’s business:
  - Notify the Compliance Officer immediately.
    o The Compliance Officer should contact legal counsel.
  - Do not provide false or inaccurate information to a government investigator.
Compliance Policies on Government/Third Party Payor Investigations

- Initial contact with a government investigator:
  - Obtain information specified in compliance program

- On-Site Inquiries
  - Obtain “initial contact” information
  - Contact Compliance Officer
  - Draft memorandum regarding information obtained from the investigator and provide to Compliance Officer

Compliance Policies on Government/Third Party Payor Investigations

- Search Warrants
  - Contact Compliance Officer immediately
  - Compliance Officer will immediately contact legal counsel

- Employees speaking with government investigators:
  - Cannot be prohibited from speaking with government investigators
  - May politely decline to speak with investigators
  - May request legal counsel to be present during an interview
Medicare & Medicaid Overpayments

77 Fed. Reg. 9179 (February 16, 2012)

• Requires providers to report and return an overpayment within 60 days after the date on which the overpayment is identified or the date any corresponding cost report is due. Failure to do so could result in False Claims Liability.

• “Overpayment” examples:
  - Medicare payments for non-covered services
  - Medicare payments in excess of the allowable amount for an identified covered service
  - Errors and non-reimbursable expenditures in cost reports
  - Duplicate payments
  - Receipt of Medicare payment when another payor had primary responsibility for payment

• Mistakes or routine errors = False Claims Act liability?

Medicare & Medicaid Overpayments

• Time limits
  - 1 year – reopening for any reason
  - 3 years – RAC look back period
  - 4 years – reopening for good cause
  - 6 years – False Claims Act allegations brought by individuals
  - 10 years – outer limit for False Claims Act
Medicare & Medicaid Overpayments

• “Identified” defined: a person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.

• Examples:
  - A provider or supplier performs an internal audit and discovers that and overpayment exists.
  - A provider or supplier is informed by a government agency of an audit that discovered a potential overpayment.

  • Failure to make a reasonable inquiry, including failure to conduct such inquiry with all deliberate speed after obtaining the information, could result in the provider or supplier knowingly retaining an overpayment because it acted in reckless disregard or deliberate ignorance of whether it received such an overpayment.

  • “Reasonable inquiry” is not defined

Important Aspects of Home Health Medicare Compliance: Face-to-Face Requirements

• The Patient Protection and Affordable Care Act (PPACA) implemented face-to-face requirements for home health providers as a condition of payment.

• Home Health: the certifying physician must document that s/he or a non-physician practitioner working with the physician has seen the patient within a reasonable timeframe as determined by the Secretary of the Department of Health and Human Services.
Important Aspects of Home Health Medicare Compliance: *Face-to-Face Requirements*

**Home Health Face-to-Face Encounter Documentation Requirements:**

1. Documentation must include the date when the physician or allowed NPP saw the patient
2. A brief narrative composed by the certifying physician who describes how the patient’s clinical condition as seen during that encounter supports the patient’s homebound status and need for skilled services
3. The certifying physician may dictate the documentation content or the documentation may be generated from a physician’s electronic health record
4. The certifying physician *may not* verbally communicate the encounter to the HHA where the HHA would then document the encounter as part of the certification for the physician to sign.

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April 2014: OIG Finds Limited Compliance with Face-to-Face Requirements

- 32% of home health claims between January 1, 2011 and December 31, 2012 failed to satisfy Medicare face-to-face encounter documentation requirements resulting in $2 billion in overpayments

- 10% of the claims had no documentation; the remaining 27% had deficient documentation

- The most-common (17%) missing element was the signature of the certifying physician

- Inconsistency with narrative content
Important Aspects of Home Health Medicare Compliance: **Face-to-Face Requirements**

- **OIG Report (continued)**
- **OIG recommended that CMS:**
  1. consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation
  2. develop a specific strategy to communicate directly with physicians about the face-to-face requirement
  3. develop other oversight mechanisms for the face-to-face requirement.
- **CMS concurred with the recommendations**

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**Important Aspects of Home Health Medicare Compliance: **Face-to-Face Requirements**

- **Proposed Rule**
  - Due to numerous industry concerns, in a Proposed Rule released on June 19, 2014, CMS proposed to eliminate the narrative requirement from the home health face-to-face encounter documentation requirement.

  - Under the proposed rule:
    - There should be sufficient evidence in the patient's medical record to demonstrate that the patient meets Medicare eligibility criteria for home health services.
Important Aspects of Home Health Medicare Compliance: **Face-to-Face Requirements**

- **Proposed Rule (continued)**
  - The certifying physician would still be required to certify that a face-to-face encounter occurred no more than 90 days prior to the start of care date for home health services or within 30 days of the start of the home health services, and that the face-to-face encounter was related to the primary reason the patient requires home health services.
  - In situations where skilled nursing visits for management and evaluation of the patient’s plan of care are ordered by the physician, the proposed rule provides that the physician must still include a brief narrative that describes the clinical justification for the management and evaluation service as part of the certification/recertification process.

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Important Aspects of Home Health Medicare Compliance: **Homebound Requirement**

- **2012 Home Health Prospective Payment System (HH PPS) rule, CMS finalized clarifications to the Benefit Policy Manual language definition for “confined to the home.”**
- **CMS Change Request 8444 (October 18, 2013) – Clarifies definition of “confined to the home” Benefit Policy Manual § 30.1.1**

1. The individual has a condition due to an illness or injury that restricts his or her ability to leave their place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated
2. The condition of the patient should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort.
Important Aspects of Home Health Medicare Compliance: **Homebound Requirement**

- **Change Request 8444 and Temporary Absences**
  - Clarifies when temporary absences from the home are acceptable for homebound patients
    - Infrequent
    - For periods of relatively short duration, or
    - Attributable to the need to receive health care treatment
  - Nonmedical absences (e.g., funeral, graduation, etc.) are acceptable under limited circumstances as long as they are infrequent or of short duration

Important Aspects of Home Health Medicare Compliance: **Certification Requirement**

- **Verbal Orders – Medicare Benefit Policy Manual – Chapter 7, 30.2.5**
  - Services may be furnished pursuant to a physician’s oral orders
  - Must be signed and dated (date of receipt) by person responsible for furnishing or supervising ordered services
  - Supervising RN or Qualified Therapist may sign after services have been rendered as long as they are informed before services are rendered
  - Oral orders must be countersigned and dated by ordering physician before the final bill is submitted for payment.
  - Common Issue during Medicare audits
How Can You Survive

- Keep your “eyes” on the requests
- One of top reasons for all denials
- Review every record prior to sending
- Educate your staff
- Create a tracking tool
- Meet Every Deadline

Palmetto GBA HIPPS Code Edit Results

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<td>Claim Denial Rate</td>
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Gulf Coast (AL, FL, GA, MS) Midwest (including IL, IN OH) Southwest (KY, NC, SC, TN) Southeast (AR, LA, NM, OK, TX)
Summary of Care

- Review for completeness
- Define the skill per each discipline
- Homebound status
- Face to Face
- Orders

BENEFICIARY ADDENDUM

PATIENT: John Smith
HIC NUMBER: 012-34-5678A
DATE(S) OF SERVICE: 12/26/2010-8/17/2011

FACTUAL SUMMARY

Clinical Background/History:
[Include information from the record regarding the beneficiary's past and current clinical condition that is relevant to supporting the medical necessity and reasonableness of the skilled nursing and therapy services]

Face to Face Encounter:
Define the elements required as it relates to this patient. What is the clinical and homebound information documented by the physician. Include the date the encounter occurred and that it is signed and dated by the physician.

Skilled Nursing Services/Skilled Therapy Services:
This is a review of each visit validating the care was medically necessary. Describe the skill provided. (Chapter 7 of the Medicare Benefit Policy Manual)

Conclusion
As demonstrated by the information above, the home care services provided were reasonable and medical necessary for the care of the beneficiary, were ordered by the beneficiary's treating physician, and met the Medicaid criteria for coverage.
Clinical Record

- Review for completeness
- Be sure all the visits included
- Attestations
  - Physician
  - Clinician
    - On Hire
- Chart Order
- Number Pages

Chart Review

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<td>Face to Face complete- clinical/homebound</td>
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<td>485 signed and dated</td>
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<tr>
<td>Orders present, signed and dated by Physician</td>
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<tr>
<td>Teaching with patient response documented</td>
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<td>Homebound</td>
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<tr>
<td>Visit notes with complete documentation</td>
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<tr>
<td>SOC OASIS with homebound</td>
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<tr>
<td>DC OASIS with written notes</td>
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<td>Attestation- MD/Clinician</td>
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Tracking Every Request

- Monitor denials daily
- Spreadsheet
- Color Code
- Manage and monitor
- Weekly Review
- Deadlines! Deadlines!

Spread Sheet

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<th>ADR Line Date</th>
<th>ADR Outcome</th>
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<th>Denial Reason</th>
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Key:
1. Complete denial of episode if medically necessary. Renewal not ordered or claim not valid.
2. Partial denial of episode. Renewal made at different HCT# code if billed.
3. Partial denial of episode. Renewal not ordered or claim not valid.
4. Partial denial of episode. Renewal not ordered or claim not valid.
5. Complete denial of episode. No plan at time of denial, denial valid.
7. Complete Denial batch medical research reviewed.
8. Failed Payment - PEP Adjustment.
Submitting

- Letter from Intermediary
- Summary of Care
- Chart in Order
- Meet Deadline
- Update Tracking Sheet
- Portal/Fax/Mail

Due Dates

- ADR’s due 30 days
- 1st Level of Appeal due 120 days
  - Date on ADR denial letter
- 2nd Level of Appeal due 180 days
  - Date on Redetermination letter
- Intermediary Website Calendars/Charts

Do Not Miss Deadline
SUCCESSFUL APPEAL STRATEGIES

The Medicare Appeals Process

OVERVIEW

- **Rebuttal Discussion period**
- Redetermination
  - Appeal Deadline: 120 days (30 days to avoid recoupment)
- Reconsideration
  - Appeal Deadline: 180 days (60 days to avoid recoupment)
- Administrative Law Judge Hearing
  - Appeal Deadline: 60 days
  - Recoupment
  - Newly Unveiled Settlement Conference Facilitation Pilot Program and Statistical Sampling Pilot Program
- Medicare Appeals Council (MAC)
  - Appeal Deadline: 60 days
- Federal District Court
  - Appeal Deadline: 60 days
Administrative Law Judge (ALJ) Hearing

- Backlog of appeals at the ALJ
- July 15, 2013: OMHA temporarily suspended the assignment of most new ALJ hearing requests
- Estimated delay of 28 months until assignment to an ALJ
- Post-assignment, expect over 6 months until a hearing is held
- ALJ Request Requirements 42 C.F.R. 405.1014

Best Practices for Appealing to ALJ

- Prominently list Medicare Appeal Number on your request
- Ensure beneficiary information matches Medicare Appeal Number
- List beneficiary’s full HICN
- Include first page of QIC decision or prominently list full name of QIC
- Document Proof of Service to other parties
Best Practices for Appealing to ALJ

- Do not submit courtesy copy to QIC
- Submit only one request per Medicare Appeal Number
- Mail request via tracked mail to OMHA Central Operations
- Do not send evidence already submitted to lower level
- Do not attach evidentiary submissions or submit additional filings to OMHA Central Operations
  - Wait until an ALJ is assigned and submit directly to ALJ
- Beneficiary Notice

SUCCESSFUL APPEAL STRATEGIES
The Medicare Appeals Process

Medicare Appeals Council (MAC)
A provider dissatisfied with the ALJ decision has 60 days to file an appeal to the Medicare Appeals Council (MAC)

- Use of past MAC cases is a key strategic component for presenting your case. The MAC is more likely to find in your favor if there is precedent.

- Previous MAC decisions can be found at:
  - http://www.hhs.gov/dab/macdecision/
Review of Recent Home Health MAC Decisions

*In the Case of Northwest Home Health Services, January 17, 2012*

Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

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New OMHA Initiatives – The Wave of the Future

**OMHA is considering alternative adjudication models and initiatives**

- Statistical sampling to adjudicate appeals
- Mediation of claims
- Attorney case reviews
- IT initiatives
  - Website for viewing appeals status online
  - Electronic Case Adjudication and Processing Environment (ECAPE)
New OMHA Initiatives – The Wave of the Future

Settlement Conference Facilitation (SCF) Pilot Program
- Designed to bring CMS and Appellant together to discuss the potential of a mutually agreeable resolution for claims appealed to the ALJ
- Current Eligibility Requirements
  - Part B providers
  - The request for hearing must have been filed in 2013 and not be currently assigned to an ALJ
  - At least 20 claims must be at issue, or at least $10,000 must be in controversy if less than 20 claims are involved
  - The amount of each individual claim must be less than $100,000 (for an extrapolated statistical sample, the extrapolated amount must be less than $100,000).
  - SCF request must include all of the appellant’s eligible claims for the same item or service (i.e., cannot pick and choose which claims are included in the SFC process)
- If a settlement cannot be reached, claims return to ALJ appeal level
- If past trends are any indication, this program could see expansion to Part A providers if it proves to be successful.

Statistical Sampling Pilot Program
- A random sample of claims is selected from the universe of claims. The selected sample is reviewed at the ALJ hearing. Following the hearing, the ALJ will render a decision on the sample claims. The ALJ’s decision will then be extrapolated to the remaining claims in the universe.
- Eligibility Requirements
  - Minimum of 250 claims at issue
  - All claims must fall into one of the following categories: (1) pre-payment denials; (2) post-payment non-RAC denials; or (3) post-payment RAC denials from one RAC
  - Claims must be currently assigned to one or more ALJs or the ALJ request was filed between April 1, 2013 and June 30, 2013
  - No hearing on the claims have been scheduled or conducted
  - No outstanding SFC request for the same claims
- Enables providers to receive timely adjudication
- Risk: putting all of your eggs into one ALJ’s basket
SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

• Provider Without Fault
• Waiver of Liability
• Challenges to Statistics
• Merit-Based Arguments

• Provider Without Fault
  • Section 1870 of the Social Security Act
  • Once an overpayment is identified, payment will be made to a provider if the provider was without “fault” with regard to billing for and accepting payment for disputed services
    – Definition of fault
    – 3 Year Rule

• Waiver of Liability
  • Section 1879(a) of the Social Security Act
  • Under waiver of liability, even if a service is determined not to be reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

• Home Health application
SUCCESSFUL APPEALS STRATEGIES
Challenges to Statistics

• Section 935 of MMA:
  - Limitations on Use of Extrapolation – A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that –
    o There is a sustained or high level of payment error
    o Documented educational intervention has failed to correct the payment error.

• The guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual, Ch. 3, §§ 3.10.1 – 3.10.11.2

• MAC Case: In the case of Transyd Enterprises, LLC

SUCCESSFUL APPEALS STRATEGIES
Arguing the Merits

• Merit-based arguments include:
  - Medical Necessity of the services provided

• To effectively argue the merits of a claim:
  - Draft a position paper laying out the proper coverage criteria
  - Summarize submitted medical records and documentation
  - If relying on medical records in an ALJ hearing:
    o Organize using tables, exhibit labels, and color coding
SUCCESSFUL APPEALS STRATEGIES
Arguing the Merits

- Clinical Arm – Involvement of Experts
  - Involvement of Statistician Expert
  - Clinical component
    - Expert opinions (affidavits and in-person testimony)
    - Integration of high quality literature review
    - College, society standards
    - LCDs – locally and nationally

Effective Defenses

Proactive Approach
- Identification of high risk area’s
- Development of specialty carepaths
- EMR integration
- Outcome measurement
Proactive Approach

Identification of high risk area’s
• Chronic diseases
  - CHF
  - COPD
  - DM
• High utilization
  - Bid diabetics
  - High therapy utilization

Specialty Carepath’s
• Review of current practice
• Literature review
• Evidence based practice integration
• Research products to support concept
• Solicit internal experts for input
Proactive Approach

Specialty Carepath’s

<table>
<thead>
<tr>
<th>Program Components</th>
<th>Light</th>
<th>Intermediate</th>
<th>Extensive</th>
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<tr>
<td>Staff Education Tools</td>
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</tbody>
</table>

Specialty Carepath’s

- Internal development of all elements
- Internal development with supplementation of external products
- External product adaptation

_Solicit Medical Director involvement_
Proactive Approach

Specialty Carepath’s

- Organizational readiness assessment to determine timeline for integration
- Clearly communicated plan with dates and expectations
- Pre-determined plan for integration of end user changes

Proactive Approach

Specialty Carepath’s

- Program review (Timeline: within 7-10 days of initial launch and every 6-12 months)
  - What worked well?
  - Did timeline meet end-user educational needs?
  - What opportunities for improvement were identified?
  - How soon will the organization be ready for the next carepath?
  - Will the approach remain the same (internal, internal with external supplementation or external)?
Proactive Approach

EMR Integration
- Identification of patients in system for tracking
- Integration of key items on each visit
  - Vital signs
  - Pulse ox
  - Weight/BMI
  - BS
- Supply tracking for cost analysis

Proactive Approach

EMR Integration
- Tele-health or tele-monitoring results
- Supply cost integration
- Risk assessment
Proactive Approach

Outcome Measurement

• Improvement in functional scores
• Re-hospitalization rates
• Cost analysis
• Visit utilization

_Evaluate and re-adjust on a routine basis_
Questions?

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