

Medicare, Medicaid & Third Party Payer Audits: Latest Developments & Emerging Legal Issues Affecting Home Health and Hospice Providers

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Learning Objectives

- Overview of the Medicare audit appeals process and the various Medicare and Medicaid contractors
- Address specific audit issues that affect home health and hospice providers
- Identify key compliance areas facing home health and hospice providers as well as the processes to implement to prepare for a possible audit
- Discuss successful appeal strategies and effective defenses that can be employed if and when a home health or hospice provider is faced with an audit.

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THE CURRENT AUDIT LANDSCAPE: FOCUS ON HOME HEALTH & HOSPICE PROVIDERS

- In 2011, Medicare paid \$13.7 billion for hospice services on behalf of 1.2 million beneficiaries, and both of those numbers are expected to increase with the aging of the baby boomer generation.
- Also in recent years, the Federal government has focused on Medicare spending on home health and hospice services.
- As a result, home health and hospice providers can expect government audits from CMS contractors.

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Current Audit Landscape

- CMS contractors in the current audit landscape
 - Medicare Administrative Contractors (MACs)
 - Zone Program Integrity Contractors (ZPICs)
 - Recovery Audit Contractors (RACs)
 - Medicare RACs & Medicaid RACs
 - Medicaid Integrity Contractors (MICs)
 - Office of Inspector General (OIG) audits

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Medicare Administrative Contractors (MACs)

- Statistically Projected Audit
 - Statistical sampling is used to calculate and project (i.e., extrapolate) the amount of overpayment(s) made on claims.
 - Claims are reviewed from a statistical random sample, the results of which are then extrapolated to the universe of claims during a given time period to determine the overpayment amount.
- Focus/Target Review
 - Contractors conduct targeted reviews, focusing on specific program vulnerabilities inherent in the PPS, as well as provider/service specific problems. The reviews should be conducted based on data analysis and prioritization of vulnerabilities.
- Additional Document Requests (ADRs)
 - When a claim is selected for medical review, an ADR is generated requesting medical documentation be submitted to ensure payment is appropriate. Documentation must be submitted in a timely manner for review and payment determination.

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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 records and conduct medical review to evaluate the identified potential fraud
 - ZPICs may also refer to the OIG and DOJ for further investigation
- Prepayment reviews

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ZPICs Cont.

- Recent ZPIC Post-Payment Review Results Letter:

“The ZPIC has determined that it is likely you have been overpaid for the services provided from the end of the audit period through the current date based on the documentation submitted for the medical review. Section 1833(e) of the Social Security Act places the burden on the provider to furnish information necessary to determine the amount due to the provider.”

“The ZPIC is requesting that the provider conduct an internal audit of its claims to determine the accuracy of the claims billed. If research determines the claim/payment is incorrect, please process claim adjustments and arrange repayment with the claims processing contractor. Please provide the ZPIC with the results of this audit within 90 days.”

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The Medicaid Integrity Contractors (MICs)

- Medicaid Integrity Contractors (MICs) identify overpayments – Like Medicare RACs but for Medicaid.
- 3 types of MICs, but MICs are not tasked with collecting overpayments.
 - Review MICs
 - **Audit MICs**
 - Education MICs
- The Federal government collects its share directly from states (60 calendar days). The states are responsible for recovering overpayment from provider. Providers will be afforded appeal rights under state law.
- **Emerging Issues**
 - Recoupment from provider once overpayment is identified??
 - Specific appeal processes and procedures vary from state to state
- **Recent Policy Changes**
 - Uniform 5 year look-back period
 - Expanded time frame for responding to Audit MIC requests for records
 - Expanded from 10 days to 30 days
 - Option for 15 business day extension

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Looking Forward: UPICs In, MACs & ZPICs Out

- Unified Program Integrity Contractor (UPIC)
- CMS will be combining integrity responsibilities of ZPICs and MACs into one integrity contractor → UPIC
- MICs will be phased out
- Focus on both Medicare & Medicaid integrity issues
- CMS will be consolidating Medicare and Medicaid data into **one** unified database

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Recovery Audit Contractors (RACs)

- The RACs mission is to identify and correct Medicare improper payments through detection and collection of overpayments made on claims of health care

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Who are the RACs?

- **Region A: Performant Recovery**
 - Working in CT, DE, D.C., MA, MD, MA, NH, NJ, NY, PA, RI and VT
 - www.dcsrac.com
- **Region B: CGI Technologies and Solutions, Inc.**
 - Working in KY, IL, IN, MI, MN, OH and WI
 - <http://racb.cgi.com>
- **Region C: Connolly Consulting, Inc.**
 - Working in AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA and WV
 - www.connollyhealthcare.com/RAC
- **Region D: HealthDataInsights, Inc.**
 - Working in AK, AZ, CA, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas
 - <http://racinfo.healthdatainsights.com/home.aspx>

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FOCUS OF CURRENT RAC AUDITS

RAC Approved Issues: Home Health

- Home Health Post-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the \$3,700 Threshold
 - **Description:** Clinically inappropriate modalities, patient’s clinical therapy needs do not match what was reported, excessive or inappropriate therapy was furnished, lack of physician/NPP certified therapy plan of care.
- Home Health Pre-Payment Review – Manual Medical Review of Outpatient Therapy Claims above the \$3,700 Threshold
 - **Description:** Reviews will be conducted on outpatient therapy claims in certain settings reaching the \$3,700 threshold for PT and SLP services combined and/or \$3,700 for OT services. When one or more lines of a claim have reached a therapy threshold, all lines of therapy services on that claim are subject to review
- Skilled Nurse Length of Stay
 - **Description:** Late episodes (third and later) receive increased payments, therefore payment incentives exist for extended home health care. Medicare covers skilled nursing services when they are reasonable and necessary. Extended nursing care for observation and assessment may not be covered. Claims for nursing services into the third episode and after will be reviewed to determine if all Medicare coverage criteria is met.

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FOCUS OF CURRENT RAC AUDITS

Recent Home Health Risk Areas

- “Homebound” requirement determination
- Documentation requirements
- Skilled Observation and Assessment coverage
- Coverage Criteria for Physical Therapy and Maintenance Therapy
- Medical Necessity and Coverage of Skilled Nursing Care
- Plan of Care requirements

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THE FOCUS OF CURRENT RAC AUDITS

RAC Approved Issues: Hospice

- Hospice Care, Extensive Length of Stay - Jurisdiction A
 - Description: The potential for overpayment exists when hospice care rendered contiguously beyond a 20 month period lacks medical necessity and it is determined that the condition has improved and/or the beneficiary is no longer considered terminally ill.
- Excessive Units of Physician Services – Hospice
 - Description: Each attending physician service should be dated separately indicating the date that each HCPCS code billed was delivered. Per diem physician codes can be billed once per day.
- Region C: Hospice Related Services – Part B
 - Description: Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

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THE FOCUS OF CURRENT RAC AUDITS

Hospice Recent Risk Areas

- Face to Face Certifications
- Hospice Recertification Requirements
- Respite Care
- Hospital Hospice Care
- Inpatient Admissions for Hospices with Inpatient facilities
- Clinical Status Determinations
- Conditions of Coverage
- Length of Stay and other non-technical medical necessity requirements

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Medicaid RACs

- **January 1, 2012:** States required to have implemented their Medicaid RAC programs
- CMS will not issue oversight provisions regarding medical necessity reviews for the Medicaid RAC program.
- Medicaid RAC medical necessity reviews will be performed within the scope of state laws and regulations.
- The Medicaid RAC Final Rule does not require Medicaid RACs to receive prior approval for medical necessity reviews.

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Latest Developments in Home Health

- CMS to cut payments to HHA by 1.5% in CY 2014
 - On June 27, 2013, CMS issued a proposed rule which would cut payments to HHA by \$290 million
 - The proposed rule is mandated by the ACA, which proposes a 4-year phase-in adjustment to HH PPS rates starting in CY 2014
 - The rule also proposes home health quality reporting requirements for CY 2014 and subsequent years

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Latest Developments in Home Health

- Potential fifth contractor for HHA & DME
 - The CMS plans to make significant changes to the RAC program. In doing so, CMS hopes to address providers' complaints and improve the RAC program through new Recovery Auditor contracts that will be awarded next year.
 - The most significant change is the creation of a fifth, nationwide RAC that is solely responsible for the identification and correction of improper payments for home health and hospice claims and payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The change leaves the existing four regional RACs in place to identify overpayments for all other Medicare A/B claims and provider types.

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Latest Developments in Hospice

- CMS requires written contracts between LTC facilities & Hospice
 - Recently, CMS issued a final rule mandating that long term care (LTC) facilities and hospice providers enter into written agreements if the facility chooses to arrange hospice services through a Medicare-certified hospice provider.
 - The rule became effective on August 26, 2013.
- OIG report on General Inpatient Care
 - On May 3, 2013, the OIG released a memorandum describing hospice general inpatient care (GIP) provided to Medicare patients in 2011, for which Medicare paid \$1.1 billion.
 - The memorandum states that the OIG will begin a new study which will use actual beneficiary medical records to determine the accuracy of reimbursement.

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Compliance Policies on Government/Third Party Payor Investigations

- It is important for HHAs and Hospices 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.
 - The Compliance Officer should contact legal counsel.
 - Do not provide false or inaccurate information to a government investigator.

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Compliance Policy 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

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Compliance Policy 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

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Medicare and Medicaid Overpayments

- PPACA Section 6402(d)
 - Requires providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of (1) the date which is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable.
- Proposed Rule (77 Fed. Reg. 9179)
 - 10-year look-back period
- Recent case law: *United States and State of Wisconsin ex rel. Keltner v. Lakeshore Medical Clinic, LTD*

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

- The Patient Protection and Affordable Care Act (PPACA) implemented face-to-face requirements for **home health** and **hospice** providers.
- **Home Health**: the certifying physician must document that s/he or a non-physician practitioner working with the physician has seen the patient within 90 days prior to the start of care or within 30 days after the start of care.
- **Hospice**: A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each patient prior to the beginning of the patient's third benefit period and prior to each subsequent benefit period.

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Important Aspects of Home Health and Hospice 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 must document the encounter on the certification, which the physician signs and dates, or a signed addendum to the certification.
 4. The certifying physician may dictate the documentation content or the documentation may be generated from a physician's electronic health record;
 5. 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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Important Aspects of Home Health and Hospice Medicare Compliance: Face-to-Face Requirements

- **Requirements for a hospice face-to-face encounter:**
 - **Timeframe of the encounter:** must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter;
 - **Attestation requirement:** a hospice physician or nurse practitioner who performs the encounter must attest in writing that s/he had a face-to-face, including the date of the encounter.
 - Attestation must be: (1) signed; (2) dated; (3) a separate and distinct section of, or addendum to, the recertification form and (4) must be clearly titled.
- **Practitioners:** A hospice physician or a hospice nurse practitioner can perform the encounter.
 - **Hospice physician:** physician who is employed by the hospice or working under contract with the hospice.
 - **Hospice nurse practitioner:** must be employed by the hospice (i.e. receives a W-2 from the hospice or volunteers for the hospice).
- The hospice must retain the certification statements.
- Requirements also apply to individuals who had been previously discharge during a benefit period and are being recertified for hospice care.

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Important Aspects of Home Health and Hospice Medicare Compliance: Hospice Terminality Certification

- For the first 90-day period of hospice coverage, by the end of the third day the hospice must obtain oral or written certification of the terminal illness by:
 - The medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) **and** the individual's attending physician, if s/he has one.
 - The attending physician is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) or a nurse practitioner and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.
- Terminally Ill: medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.
- **The written certification must include:**
 - Statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;
 - Specific findings and other documentation supporting a life expectancy of 6 months or less; and
 - The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers.
 - The **physician's brief narrative explanation** of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

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Important Aspects of Home Health and Hospice Medicare Compliance: Terminality Certification

- **Local Coverage Determinations:** Addressing Terminal Status with similar requirements
 - **National Government Services, Inc.: L25678** (AK, American Samoa, AZ, CA, Guam, HI, ID, NV, OR, WA, North Mariana Islands)
 - **CGS Administrators, LLC: L32015** (CO, D.C., DE, IA, KS, MD, MO, MT, ND, NE, SD, UT, WV, WY)
 - **NHIC, Corp.: L29881** (Maine)
 - Patients will be considered to have a life expectancy of six months or less if there is documented evidence of a decline in clinical status;
 - Base guidelines for determining terminal status include:
 - Decline in clinical status guidelines
 - Non-disease specific baseline guidelines
 - Co-morbidities
- There has also been a decline in Clinical Status Guidelines for Terminality Certification.

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Effective Home Health & Hospice Compliance Measures

- Objectively review documentation practices to verify compliance with Face-to-Face Documentation and Terminal Illness Certification Requirements.
- Establish proactive protocols for reviewing cases:
 - Documentation enhancement
 - Periodically review policies
 - Implement monitoring protocols

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Compliance Measures: CBRs

- Comparative Billing Reports (CBRs)
 - Snapshot of utilization data for an individual provider
 - Provider's billing pattern for a given code or group of codes is compared to the state average and the national average
 - Mailed to the top 5,000 billers
 - CBR examples:
 - E/M services
 - Podiatry: nail debridement
 - Cardiology services
- Compliance Policy on Investigations
- Compliance and Organizational Tips to Prepare for an Audit
- Sample CBR comparisons
 - Hospice CBRs: Avg. # of days billed per beneficiary for routine home care, continuous home care and inpatient respite care
 - Home Health CBRs: Avg. # of home health visits per beneficiary, avg. # of home health therapy visits per beneficiary, and the average Medicare payment per beneficiary

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Overview of the Medicare Appeals Process

- *Rebuttal and 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
 - CMS will recoup the alleged overpayment during this and following stages of appeal
- Medicare Appeals Council (MAC)
 - Appeal deadline: 60 days
- Federal District Court
 - Appeal deadline: 60 days

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Medicare Appeals Council case: Solari Hospice Care, LLC

- 84-year-old patient entered hospice care in May 2008 after a prior hospitalization for septic shock, SNF care, and a move to a group home.
 - Admitting diagnosis: end-stage debility.
 - Additional diagnoses: CAD, COPD, chronic atrial fibrillation, dementia, anemia, myocardial infarction, HTN, and recent sepsis.
 - Patient's decline was slow and steady and she passed away in May 2010.

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Solari Hospice Care, LLC

- Contractor denied hospice services for the first half of November 2009 because the appellant allegedly did not provide support of the patient's **terminal illness**.
- The MAC applied the clinical status guidelines in LCD L25678, Part I, "Decline in clinical status guidelines."
 - The ALJ erred in applying the LCD's requirements for Alzheimer's disease and related disorders because Alzheimer's disease was not the patient's primary diagnosis.
- The MAC specifically noted in its analysis that the LCD's clinical indications do not all have to be met.
 - The LCD requires sufficient "variables" to be shown to demonstrate a terminal illness with a life expectancy of six months or less.
- The case demonstrates the importance of a complete medical record that accurately paints the patient's terminal illness.

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SUCCESSFUL APPEALS STRATEGIES

Audit Defenses

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

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SUCCESSFUL APPEALS STRATEGIES

Audit Defenses

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.

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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
 - There is a sustained or high level of payment error; or
 - Documented educational intervention has failed to correct the payment error.
 - Cannot challenge the substance of the finding of “sustained or high rate of error,” but can challenge whether a finding was made
 - Guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08), Chapter 3, §§ 3.10.1 - 3.10.11.2
 - See also MAC case: *Transyd Enterprises, LLC d/b/a Transpro Medical Transport*

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SUCCESSFUL APPEALS STRATEGIES

Arguing the Merits

- **Merit-based arguments include:**
 - Medical necessity of the services provided
 - Terminal diagnosis
- **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:
 - Organize using tabs, exhibit labels and color coding
 - Use graphs and medical summaries to assist in the presentation of evidence
- **Clinical Arm – Involvement of Experts**
 - Clinical component
 - Expert opinions (affidavits and in-person testimony)
 - Integration of high quality literature review
 - College, society standards
 - LCDs – locally and nationally

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Questions?

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