How To Determine Objectives, Priorities and Effectiveness: Post-Acute Care Compliance

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The cost of non-compliance is far greater than the cost of building an effective compliance program.
Using internal and external resources build both

Proactive and Responsive Pathways to Compliance

Proactive Pathway to Compliance

- Be efficient = do things right
- Follow government guidance
- Create clear communication lines between the compliance process and the entire organization and stakeholders
- Assess and manage risk areas
Responsive Pathway to Compliance

- Be effective = do the right things
- Surround yourself with strong legal and consulting resources
- Follow government guidance
- Develop and follow a plan
- Tone at the top mirrors response

3 Keys to Establishing Objectives and Priorities
#1
Apply the Government recommended compliance program components and applicable annual work plan elements to individual programs.

<table>
<thead>
<tr>
<th>Element number</th>
<th>OIG Fundamentals</th>
<th>Skills Needed</th>
<th>Compliance Target Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Policies, Procedures, Standards</td>
<td>Focus: a sharp eye</td>
<td>Where daily compliance lives- Code of Conduct</td>
</tr>
<tr>
<td>2</td>
<td>Compliance Officer &amp; Compliance roles</td>
<td>Oversight: plan the shot, utilize resources and manage the plan</td>
<td>Create accountability- who and what department</td>
</tr>
<tr>
<td>3</td>
<td>Education &amp; Training</td>
<td>Practice &amp; learn</td>
<td>Announce expectations and create understanding</td>
</tr>
<tr>
<td>4</td>
<td>Effective Communication</td>
<td>Gather strength, prepare and focus</td>
<td>Get the message out- establish trust</td>
</tr>
<tr>
<td>5</td>
<td>Enforcing via published guidelines</td>
<td>Understand limits and the cost of wasted efforts</td>
<td>Eliminate uncertainty about consequences of noncompliance</td>
</tr>
<tr>
<td>6</td>
<td>Monitor &amp; Audit</td>
<td>Measure and correct for demonstrated improvement</td>
<td>Data demonstrates the effectiveness of the program</td>
</tr>
<tr>
<td>7</td>
<td>Prompt response &amp; corrective action</td>
<td>Prepare and take the next best shot</td>
<td>Reaction and response mirrors program efforts</td>
</tr>
</tbody>
</table>
Work Plans - Projects and Priorities

- Annually, the OIG issues a work plan setting forth
  - New compliance and enforcement projects
  - Priorities they intend to pursue
  - Projects continued from the previous year
  - Legal activities
  - Investigative activities
- Providers are advised to use the OIG work plan to influence their own compliance priorities by
  - Reviewing the projects related to and affecting provider specific lines of business

#2
Utilize a high level and a specific approach
High Level Objectives

- Design a *sustainable* compliance program
- Defend against and continuously assess risk
- Focus on solutions rather than restrictions by building controls into process
- Provide easy access to understandable education
- Address tone at the middle and tone at the top

Specific Objectives

- Conduct an overall annual company assessment
  - Create a regulatory risk assessment tool
- Conduct a compliance program operational review for content and effectiveness
- Provide clear, current and accessible, education and training incorporating real life examples
- Create a response plan for Government audits/requests
- Create a consistent investigation process
#3 Prioritization

Methods to Prioritize Objectives

- Regulations
- Survey feedback from managers
- External and internal audit activity
- Compliance committee input
- Tracking misconduct trends
- Post training comprehension tests
Demonstrate Compliance Program Effectiveness

Compliance effectiveness directly impacts

- operations
- finance
- reputation
- risk
- company bottom line
Why Assess for effectiveness?

- Collection of assessment data is vital to determining deficiencies and future risk / where are corrective measures necessary?
- Be prepared for future government intervention
- Become an attractive ACO partner
- Prepare for acquisition
- Focus on quality: quality data collection and reporting leads to improved outcomes/patient satisfaction

Culture and Ethics

- Be consistent with monitoring and enforcement
  - Consistently reinforce compliant behavior
- Define and discuss what compliant employees should do – not just what they can do based on the laws and regulations
- Provide motivating education by using real life examples
- Ensure the compliance program effectively articulates and demonstrates commitment to ethical conduct
Use Data to Demonstrate Effectiveness

- Audits / assessments and benchmarking results
- Hotline and misconduct statistics
- Program initiative status
- Trending - QAPI-governing body
- Policy management
- Education calendar & attestations for training initiatives
- Training event fliers
- Compliance, governance, ethics committee meetings
- Industry trends and best practice updates
- Cross reference OIG work plan and recommended program elements
What is an OIG Work Plan?

- Provides an indication of OIG enforcement activities for the coming year.
- Don't--

- What happened in the previous year???

2014 OIG Work Plan: Priorities and Concerns for Post-Acute Care Providers

- The OIG and the Department of Justice (“DOJ”) have been very busy in the last 12 months in the area of post-acute care.
- A significant portion of the 2014 Work Plan is devoted to post-acute care providers.
OIG Recoveries First Half FY 2014

- > $3.1 billion expected recoveries
  - ~ $295 million in audit receivables
  - ~$2.83 billion in investigative receivables

OIG First Half FY 2014 Actions

- 1,720 exclusions of individuals and entities
- 465 criminal actions of individuals and entities
- 266 civil actions
2014 OIG Work Plan: Priorities and Concerns for Post-Acute Care Providers

- The Plan’s list of post-acute related initiatives suggest that the OIG and the DOJ will focus on the following areas:
  - Increased focus on existence and integrity of documentation.
  - Increased focus on upcoding to obtain higher reimbursements.
  - Increased focus on quality of care.
  - Increased focus on integrity and efficiency of the compliance function.

Reducing Improper Payments

- Reducing incidence of improper payments - high priority for CMS
- Improper payment reduction goals include:
  - increased prepayment medical review
  - enhanced analytics
  - augmented education and outreach to the provider and supplier communities
  - expanded review of paid claims by the CMS Recovery Auditors
Reducing Improper Payments

- CMS will continue to assess improper payment rate measurement procedures and will make improvements and modifications as necessary to ensure the most accurate accounting of improper payments.

Source: Medicare Fee For Service 2011 Improper Payments Report – Executive Summary

2014 OIG Work Plan – Home Health Priorities

- Review compliance with home health prospective payment system requirements
  - OIG will focus on the sufficiency of claim documentation
  - In August 2012, the OIG issued a report on inappropriate and questionable billing by Medicare home health agencies. The OIG found certain areas in which home health agencies have received inappropriate Medicare payments. They include:
2014 OIG Home Health Priorities

- Claims that overlapped with inpatient hospital stays.
- Claims that overlapped with skilled nursing facility stays.
- Claims billed for services on dates after beneficiaries’ deaths.

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2014 OIG Home Health Priorities

**Table 1: Inappropriate Medicare Payments for Home Health Services, 2010**

<table>
<thead>
<tr>
<th>Error Type</th>
<th>Inappropriate Payment Amount</th>
<th>Number of Services</th>
<th>Number of Claims</th>
<th>Number of HHAs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlap between inpatient hospital stay and home health service</td>
<td>$3,506,429</td>
<td>1,722</td>
<td>1,309</td>
<td>956</td>
</tr>
<tr>
<td>Overlap between skilled nursing facility stay and home health service</td>
<td>$1,286,433</td>
<td>1,190</td>
<td>469</td>
<td>414</td>
</tr>
<tr>
<td>Home health service date after a beneficiary’s date of death</td>
<td>$200,311</td>
<td>1,007</td>
<td>82</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>$4,983,173</td>
<td>3,909</td>
<td>1,857</td>
<td>1,285</td>
</tr>
</tbody>
</table>

*Column sum exceeds total because some HHAs had multiple types of inappropriate payments.
Source: OIG analysis of Part A data for home health services, hospitals, and skilled nursing facilities, 2012.
**2014 OIG Home Health Priorities**

- The OIG also identified the following questionable billing patterns:
  1. HHAs that exceeded the OIG threshold for with outlier payments -- $403 per beneficiary;
  2. HHAs with total outlier payments that exceed 10% of the HHAs annual projected total Medicare home health payments.
  3. HHAs that exceeded the OIG threshold for an unusually high number of visits per beneficiary -- 91 visits per beneficiary.

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**2014 OIG Home Health Priorities**

- HHAs that exceed the OIG threshold for an unusually high percentage of beneficiaries for whom HHAs billed Medicare – 61% of beneficiaries.
- HHAs that billed for unusually high numbers of late episodes exceeding the OIG’s threshold of two late episodes per beneficiary.
- HHAs that exceeded the OIG threshold of 24 therapy visits per beneficiary.
- HHAs that were paid above the OIG threshold for unusually high payments per beneficiary -- $11,653 per beneficiary.
2014 OIG Home Health Priorities

• The OIG will focus on the employment of home health aides with criminal convictions.
  • A previous OIG review found that 92% of nursing homes employed at least one individual with at least one criminal conviction
• The OIG will focus on states' survey and certification timeliness, outcomes, follow-up and Medicare oversight.

2014 OIG Home Health Priorities

• In December 2012, the OIG issued a report on CMS and contractor oversight of home health agencies.
• The OIG found that one in four home health agencies had questionable billing practices concentrated in Florida, Texas, Louisiana, California, Illinois, New York and Michigan resulting in $432 Million in improper Medicare payments.
• The OIG reviewed activities that CMS and its contractors performed to identify and prevent improper HHA payments from January to October 2011.
2014 OIG Home Health Priorities

• Home health face-to-face requirements
  • The OIG will determine the extent to which home health agencies are complying with a statutory requirement that physician or physician extenders who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries.
  • The encounters must occur within 120 days; either within the 90 days before the beneficiaries start home health care or up to 30 days after care begins.

2014 OIG Home Health Priorities

• In April 2014, the OIG issued a report titled “Limited Compliance With Medicare’s Home Health Face to Face Documentation Requirements”.
• CMS stated that the home health agency is financially accountable for ensuring that the documentation from the physician meets the applicable criteria.
• CMS allows physicians to use a standard form to document the face to face (“F2F”) visit. However, CMS does not permit a form that the HHA completes and the physician signs – THE PHYSICIAN MUST ACTUALLY COMPLETE THE DOCUMENTATION.
2014 OIG Home Health Priorities

- The F2F encounter must be conducted by the certifying physician, a physician who cared for the patient in an acute care or post-acute facility or a permitted non-physician practitioner. An acute care or post-acute care nurse practitioner can perform the F2F encounter in collaboration with or under the supervision of the acute or post-acute care physician. That physician must then inform the certifying physician.

2014 OIG Home Health Priorities

- The certifying physician must title, complete, date and sign the F2F document.
- The F2F documentation must be titled as such but CMS does not require a specific form.
- The date of the F2F encounter must be on the document.
- The F2F documentation must include a brief narrative that describes why the patient is homebound and why the skilled services are necessary to treat the patient’s illness or injury.
2014 OIG Home Health Priorities

- CMS looked at approximately 2.4 million claims dated on or after April 1, 2011 and selected a stratified random sample of 680 home health claims.
- CMS found that 32% of the home health claims did not have the required F2F documentation resulting in $2 Billion in payments that should not have been made.
- CMS also found that F2F documentation was missing in 10% of the claims and that 25% of the F2F documentation that was submitted was missing one of the required elements.

<table>
<thead>
<tr>
<th>Medicare Requirement</th>
<th>Percentage Missing From Document</th>
<th>Claim Amount (in Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face Documentation</td>
<td>10%</td>
<td>$605.3</td>
</tr>
<tr>
<td>Elements Required for Face-to-Face Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature of Certifying Physician</td>
<td>17%</td>
<td>$641.1</td>
</tr>
<tr>
<td>Date of Encounter Within the Required Timeframe</td>
<td>4%</td>
<td>$310.7</td>
</tr>
<tr>
<td>Appropriate Title</td>
<td>3%</td>
<td>$150.2</td>
</tr>
<tr>
<td>Print of Encounter</td>
<td>3%</td>
<td>$113.4</td>
</tr>
<tr>
<td>Date When Physician Signed Document</td>
<td>2%</td>
<td>$100.7</td>
</tr>
<tr>
<td>Physician Signature**</td>
<td>1%</td>
<td>$42.3</td>
</tr>
<tr>
<td>Total Claims Missing the Face-to-Face Documentation or Elements of the Face-to-Face Document***</td>
<td>22%</td>
<td>$2,027.6</td>
</tr>
</tbody>
</table>

Source: OIG analysis of face-to-face documents, 2013.
**Not significant at the p<.05 level.
**Physician signature left blank.
***Does not add because of overlapping errors
### 2014 OIG Home Health Priorities

#### Table 2: CMS Contractors' Examples of Text That Is Insufficient To Support Home Health Claims

<table>
<thead>
<tr>
<th>Text Insufficient To Support Homebound Status</th>
<th>Text Insufficient To Support Need for Skilled Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weak</td>
<td>Family is asking for help</td>
</tr>
<tr>
<td>Unable to drive</td>
<td>Continues to have problems</td>
</tr>
<tr>
<td>Unable to leave home</td>
<td>List of tasks for nurse to do</td>
</tr>
<tr>
<td>Dementia or confusion</td>
<td>Patient unable to do wound care</td>
</tr>
<tr>
<td>Functional decline</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>


#### Table 3: Most Commonly Used Narrative Text Supporting Homebound Status

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage of Narrative Texts That Code Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiring effort to leave home</td>
<td>17%</td>
</tr>
<tr>
<td>Weakness/fatigue</td>
<td>16%</td>
</tr>
<tr>
<td>Unable to leave home unassisted</td>
<td>14%</td>
</tr>
<tr>
<td>Unsteady gait or falls</td>
<td>13%</td>
</tr>
<tr>
<td>Decreased mobility</td>
<td>10%</td>
</tr>
<tr>
<td>Shortness of breath/dyspnea</td>
<td>6%</td>
</tr>
<tr>
<td>Poor endurance</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Source: OIG analysis of face-to-face documents, 2013.*
2014 OIG Home Health Priorities

- There is inconsistent treatment of check boxes on F2F documentation among the Home Health Medicare Administrative Contractors.
- Some of the F2F documentation contained elements that were not required by Medicare but were determined by CMS to be useful.
  - NPI
  - Printed name of physician
  - Name of non-physician practitioner
  - Letter of home health agency or hospital
  - List of home health services needed
2014 OIG Home Health Priorities
The OIG will review HHA claims to State Medicaid agencies to determine if the billing providers met the standards and conditions of participation.

In May, 2014, the OIG issued a memorandum dealing with state requirements for conducting background checks on home health agency employees.

- The Patient Protection and Affordable Care Act ("PPACA") established the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers.
2014 OIG Home Health Priorities

- The program awards grant funds to states that volunteer to conduct background checks on prospective long term care employees, including HHAs.
- CMS found that 41 states require HHAs to conduct background checks on prospective employees.

### Table 1: HHA Background Check Requirements by State

<table>
<thead>
<tr>
<th>Type of Check Required</th>
<th>States(s)</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBI and Statewide for All Individuals</td>
<td>DE, DC, FL, ID, IL, MI, MS, NV, NY, OK, UT</td>
<td>11</td>
</tr>
<tr>
<td>FBI and Statewide for Certain Individuals</td>
<td>AK, NE, NM, NC, OH, SC</td>
<td>6</td>
</tr>
<tr>
<td>Statewide for All Individuals</td>
<td>AZ, ME, MD, MA, MD, NH, OR, VA, WI</td>
<td>9</td>
</tr>
<tr>
<td>Statewide for All Individuals and FBI for Certain Individuals</td>
<td>AR, CO, IN, KY, MN, PA, WA</td>
<td>7</td>
</tr>
<tr>
<td>Statewide for Certain Individuals</td>
<td>CA, IA, KS, LA, RI, TX, VT</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td><strong>Ty</strong></td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>AL, CT, GA, HI**, MT, NJ, ND, SD, WV, WY</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: OIG analysis of State surveys, 2014.

*Note: Tennessee reported that it requires HHAs to perform checks of registries of sex offenses, adult abuse, and elder abuse.
**Note: The Hawaii legislation requires that the State agency adopt rules to mandate background checks on HHA employees; however, no implementing rules have been published.*
2014 OIG Home Health Priorities

- The OIG will review Medicaid payments for adult day care services
- The OIG will review Medicaid payment for continuing day treatment mental health services providers
- The OIG will target Medicaid-covered personal care services

Personal Care Services

  - Missing documentation
  - Services not in accordance with plan of care
  - No supervisory nursing visits
  - No verification caregiver qualifications
  - No physician order
Personal Care Services

  - No timesheets supporting daily services
  - Billed more hours than on timesheets
  - Training deficiencies

- Attendants whose qualifications were not documented, http://oig.hhs.gov/oei/reports/oei-07-08-00430.pdf - 10 State review: CA, FL, GA, IL, IA, NE, NY, OH, TN, WV
    - No medical professional exam of beneficiary before service
    - No nursing assessment
    - No nursing supervision
    - No physician's order
Personal Care Services

- N.Y. State, Audit (A-02-08-01005, October 2010),
  http://oig.hhs.gov/oas/reports/region2/20801005.pdf
- Same as above for New York City and
  - No in-service training for aide
  - Time with patient not documented

RAC Approved Home Health Issues

- Region C: Connolly, Inc.
- States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands
  - Home Health Agency – Medical Necessity and Conditions to Quality for Services: Complex
  - RAP claim without corresponding home health claim: Automated
  - Incorrect billing of Home Health Partial Episode Payment claims: Automated
RAC Approved Home Health Issues

- Validation of late episode timing: Automated
- Core-based statistical area: Automated
- Hospice related services billed with Condition code 07-Home Health: Automated
- Non-Routine Medical Supplies and Home Health Consolidated billing: Automated

Moratorium on New HHAs

- January 31, 2014 – 6 months
  - Miami-Dade, FL and Cook County (Chicago area) extended
  - Fort Lauderdale, Detroit, Dallas and Houston added
- New providers
  - Branches included
HIPAA Breach

- Home Health and Hospice agencies are particularly vulnerable to breaches due to the nature of the business
  - Stolen and lost laptops/records

2014 OIG Hospice Priorities

- The OIG will focus on marketing practices and financial relationships with nursing and assisted living facilities.
- Contractual relationships between hospices and nursing and assisted facilities will receive extensive scrutiny.
2014 OIG Hospice Priorities

- Hospice Marketing and Relationships with SNFs
  - Recent OIG Report concluded that 82% of hospice claims in nursing facilities did not meet Medicare coverage requirements
  - Concern with inappropriate enrollment and compensation relationships among nursing facilities and hospices
  - Review hospice providers with high percentage of their patients in SNFs
  - Review aggressive marketing by hospices to nursing facility patients

2014 OIG Hospice Priorities

- Hospice General Inpatient Care
  - Review the use of hospice general inpatient care
  - Assess the appropriateness of hospices' general inpatient care claim
  - Review hospice medical records to address concerns that this level of hospice care is being misused

- Hospice Eligibility
  - Can a patient with multiple benefit periods be eligible for hospice?
  - Physician designation on hospice election statement

- Hospice and Medicare Part D
Questions?