Session 603
Managing Compliance in the Revenue Cycle

November 2, 2013 8:00 a.m. – 9:30 a.m.

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OBJECTIVES
OBJECTIVES
// Identify various program integrity contractors focused on home care & hospice providers
// Describe known program integrity activity aimed at home health & hospice providers
// Express effective ways to manage key compliance risks

PROGRAM INTEGRITY CONTRACTORS
November 2, 2013

Managing Compliance in the Revenue Cycle

PROGRAM INTEGRITY CONTRACTORS

// Government Accountability Office

// Medicare program pays approximately $500 billion annually
// $48 billion improperly paid in 2010 due to fraud, waste & abuse

// Office of Inspector General

// August 2012 study of home health (HH) payments
// Identified approximately $5 million in 2010 inappropriate payments
// 2013 work plan
// “…home health benefit may be susceptible to fraud…”
// “…82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements…”

PROGRAM INTEGRITY CONTRACTORS

// Centers for Medicare & Medicaid Services (CMS)
Medicare Integrity Program

// Designed to identify & address improper payments resulting from fraud, waste & abuse
// Carried out through various contractors
// Medicare Administrative Contractors
// Comprehensive Error Rate Testing Program
// Recovery Auditors
// Zone Program Integrity Contractors
// Specialty Medical Review Contractors
// Medicaid Integrity Contractors
// Unified Program Integrity Contractor **coming soon**
// Comparative Billing Report contractors
PROGRAM INTEGRITY CONTRACTORS

// Medicare Administrative Contractors (MACs)

// CMS authorized contractors responsible for claims
processing & other administrative functions for designated
HH & hospice jurisdictions

// CGS
// National Government Services (NGS)
// Recent transition of all HH & hospice MAC duties from NHIC, Corp.
// Palmetto GBA (PGBA)

PROGRAM INTEGRITY CONTRACTORS

// Typically conduct program integrity activities through
medical review on pre-payment basis

// Additional Development Requests (ADRs)
// S 6001 claim status location code
// Providers have 30 days by which to respond to ADRs
// Claim automatically denied if record not received by MAC by day 45
// ADRs selected for various reasons
// Automated edits
// New provider/new benefit edits
// Provider-specific probe edits
// Provider-specific targeted review
// Referral edits
// Widespread probe edits
PROGRAM INTEGRITY CONTRACTORS

// Comprehensive Error Rate Testing (CERT)
Program contractors
  // Calculate paid claim error rates
  // Randomly select statistical sample of paid claims to determine whether claims were paid properly
  // Two CERT contractors
    // CERT Review Contractor
    // CERT Documentation Contractor

PROGRAM INTEGRITY CONTRACTORS

// CERT Documentation Contractor (CDC)
  // Responsible for requesting & receiving medical record documentation
    // Requests sent to providers via mail
    // Providers have up to 75 days to respond to CERT request

// CERT Review Contractor (CRC)
  // Responsible for reviewing selected claims & associated medical record documentation
PROGRAM INTEGRITY CONTRACTORS

// CDC notifies provider claim is selected for review
// CRC performs review & notifies MAC of determination
// Claim adjustment is then made by MAC
// Claim is reprocessed & ending type of bill character is changed to “H”
// Example: “329” is changed to “32H”

During the most recent reporting period, CGS has identified a significant increase in CERT errors related to the home health face-to-face encounter documentation. As a reminder, errors related to the F2F encounter are considered a full denial, and results in a full recoupment of Medicare payment. Errors include:

- Insufficient F2F documentation from the physician to support the patient’s homebound status;
- Insufficient F2F documentation from the physician to support the need for skilled services;
- F2F documentation is not signed and/or dated by the physician;
- F2F documentation is signed by the non-physician practitioner;
- F2F documentation does not include the date of the F2F encounter;

Source: CGS
http://www.cgsmedicare.com/hhh/education/materials/CERT_Errors_Summary.html

PROGRAM INTEGRITY CONTRACTORS

// Medicare A/B Contractor
CERT Task Force

// Joint effort of Part A/B MACs to communicate national issues of concern regarding improper payments
// Includes all HH & hospice MACs
// Fully supported by CMS
// Will select one to four national CERT ‘hot topics’ each year on which to publish educational activities
// Stay tuned…
PROGRAM INTEGRITY CONTRACTORS
// Medicare Recovery Auditors (RAs)
  // Formerly Recovery Audit Contractors (RACs)
  // Responsible for reviewing claims to identify improper payments
    // Post-payment review
    // 45 days to respond to record requests
    // All ‘issues’ published & approved by CMS
  // Specialized fifth RA expected in 2014
    // Dedicated to HH, hospice & durable medical equipment

PROGRAM INTEGRITY CONTRACTORS
// Zone Program Integrity Contractors (ZPICs)
  // Responsible for reviewing claims, typically on post-payment basis, to identify improper payments
    // Primarily focused on identifying potential fraud, waste & abuse
  // Audits performed on targeted basis according to data analysis
  // May refer provider to law enforcement
  // May refer pre-payment or auto-denial edits to MACs for implementation
PROGRAM INTEGRITY CONTRACTORS

Specialty Medical Review Contractors (SMRCs)

Contract awarded by CMS in October 2012 to StrategicHealthSolutions

Contract covers specialty review for nation

Post-payment review determined based on data analysis

Medicare Part A, Part B & Durable Medical Equipment (DME)
PROGRAM INTEGRITY CONTRACTORS

// Medicaid Integrity Contractors (MICs)

// Entities with which CMS has contracted to conduct post-payment audits of Medicaid providers

// Goal is to identify overpayments & decrease inappropriate payments

PROGRAM INTEGRITY CONTRACTORS

This is to inform you that your facility has been selected for an audit of claims billed to Medicaid with dates of services from November 1, 2007, through December 31, 2011. The objective of our audit is to determine whether the beneficiaries met eligibility for hospice care and if the payments were in accordance with applicable Federal and State Medicaid laws, regulations, and policies.

An auditor from Health Integrity, LLC will be contacting you in the near future to schedule an entrance conference and discuss the audit process, which will include an on-site visit. Upon arrival at the on-site visit, Health Integrity, LLC will conduct an entrance conference, and will need adequate workspace to conduct the audit. During the entrance conference, Health Integrity, LLC will request an overview of your organization, including your Medicaid claims submission process, any policies and procedures related to this process, and an organizational chart.
Program Integrity Contractors

// Unified Program Integrity Contractor (UPIC)

// New consolidated program integrity contractor...coming soon
// Focus on identifying and reducing fraud, waste & abuse
// Consolidation of duties currently held by ZPICs & program integrity responsibilities of MACs

Program Integrity Contractors

// Comparative Billing Reports (CBRs) contractor

// National contract currently held by SafeGuard Services, LLC
// Data analysis reports that evaluate & compare individual provider billing trends
// “...not intended to be punitive or sent as an indication of fraud. ...it is intended to be a proactive statement that will help the provider identify potential errors in their billing practice.”
// Resulting in providers being selected for targeted pre-payment medical review
You have been selected for a prepayment review of 20 – 40 claims due to a high number of late episodes per beneficiary. Data analysis performed includes a comparison and evaluation of claims data. The analysis includes claim activity from October 1, 2012 through March 31, 2013. Please see the attached Comparative Billing Report. We have compared your billing to other providers during this time frame. The Comparative Billing Report depicts the average length of stay per beneficiary and percentage of beneficiaries with length of stay over 120 days as compared to all the providers claims processed during October 1, 2012 through March 31, 2013. The average length of stay of all CGS home health providers is included for comparison purposes. Your facility has been selected for review based on claims with length of stay greater than 180 days.

<table>
<thead>
<tr>
<th>Claims</th>
<th>Length of Stay (Days)</th>
<th>Avg LOS / Claim</th>
<th>Bvens LOS &gt; 120</th>
<th>% Bvens LOS &gt; 120 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>178086</td>
<td>186</td>
<td>43,663</td>
<td>192.71</td>
<td>32</td>
</tr>
<tr>
<td>CGS</td>
<td>133,198</td>
<td>13,094,245</td>
<td>315.55</td>
<td>41,777</td>
</tr>
</tbody>
</table>

![Bar chart comparing average LOS and percentage of beneficiaries with LOS > 120 days for 178086 and CGS providers.]
THE RA/RAC REVIEW PROCESS

RA/RACs review claims on a post-payment basis
RA/RACs use the same Medicare policies as Carriers and MACs:
NCDs, LCDs and CMS Manuals
Two types of review:
Automated (no medical record needed)
Complex (medical record required)
THE RA/RAC REVIEW PROCESS

RA/RACs will be able to look back three years from the date the claim was paid.

RA/RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician – Contractor Medical Director (CMD).

HOSPICE RELATED SERVICES

Issue Name: Hospice related services billed with Condition code 07- Home Health: C000802012

Description: Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

Provider Type Affected: Home Health
Date of Service: Within Three Years prior to demand date
States Affected: Region C
Additional Information: 1) CMS Pub 100-04, Chapter 11, section 50 2) Medicare Benefit Policy 100-02, Chapter 9, sections 10 and 40.1.9
INCORRECT BILLING OF HH PEP

**Issue Name:** Incorrect billing of Home Health Partial Episode Payment claims
**CMS Issue Number:** C002022011

**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.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Multiple States

**Additional Information:** Additional information can be found in the following manuals/publications:

MEDICAL NECESSITY

**Issue Name:** Home Health Agency - Medical Necessity and Conditions to Qualify for Services
**Issue Number:** C002222011

**Description:** Medical record will be reviewed to validate that the Home Health Services provided were both reasonable and medically necessary, and that the patient met the conditions to qualify for Home Health Services.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Multiple States

**Additional Information:** Additional information can be found in the following manuals/publications: Medicare Benefit Policy Manual Publication 100-02 Chapter 7
RAP WITHOUT FINAL

**Issue Name:** RAP claim without corresponding home health claim CMS
**Issue Number:** C000682011

**Description:** Home health billing requires that the home health agency (HHA) submit a Request for Anticipated Payment (RAP), for determination of home health PPS payment, in addition to a home health final claim. Payment was made in response of the RAP claim bill, with expectation that a home health claim was billed. After data research of Medicare claims database, RAP claims were identified without a corresponding home health final claim.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Numerous

**Additional Information:** Additional information can be found in the following manuals/publications: 1) Medicare Claims Processing Manual Publication 100-04 Chapter 10 Home Health Agency Billing 2) Medicare Benefit Policy Manual Chapter 7 - Home Health Services

POSSIBLE LUPAS

**Issue Name:** Home Health Services for 5 to 9 Visits: D0004220103
**Description:** Medical documentation will be reviewed to determine that services for only 5 to 9 services within a 60-day episode were medically reasonable and necessary and not subject to the LUPA adjustment.

**Provider Type Affected:** HHA
**Date of Service:** Within Three Years prior to demand date
**States Affected:** Numerous

**Additional Information:** CMS Publication 100-02 Medicare Benefit Policy Manual: Chapter 7, Section 10.7 - Low Utilization Payment Adjustment (LUPA) Chapter 7, Section 20 - Conditions To Be Met for Coverage of Home Health Services Chapter 7, Section 20.1 - Reasonable and Necessary Services Chapter 7, Section 40.1 - Skilled Nursing Care CMS Publication 100-04 Medicare Claims Processing Manual: Chapter 10, Section 10.1.17 - Low Utilization Payment Adjustment (LUPA) Social Security Act: 1862A(1)a and 1862A(1)i - Exclusions from Coverage and Medicare as Secondary Payer (42 U.S.C. 1395y)
OUTPATIENT THERAPY IN HOME

**Issue Name:** Manual Review of Outpatient therapy claims in the home. D000542013

**Description:** "In accordance with The American Taxpayer Relief Act of 2012 (ATRA) signed into law by President Obama on January 2, 2013, reviews will be conducted on outpatient therapy claims in Home Health 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.

**Provider Type Affected:** HHA

**Date of Service:** 01/01/13 - current

**States Affected:** Numerous

**Additional Information:** The American Taxpayer Relief Act of 2012 (ATRA)

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KNOWN RA ISSUES

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>CMS Approved Issues</th>
<th>RA</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td>Post-pay review of outpatient therapy claims above $3,700 threshold</td>
<td>CGI, Connolly, HDI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>Pre-pay review of outpatient therapy claims above $3,700 threshold</td>
<td>CGI</td>
</tr>
<tr>
<td>HH</td>
<td>Skilled nurse episodes beyond third episode</td>
<td>CGI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>No skilled service</td>
<td>CGI, Performant</td>
</tr>
<tr>
<td>HH</td>
<td>Medical necessity</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Request for Anticipated Payment (RAP) without corresponding final claim</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Incorrect billing of partial episode payment (PEP) adjustment</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Hospice related services billed by HH</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Outcome &amp; Assessment Information Set (OASIS) assessment not completed timely</td>
<td>Connolly</td>
</tr>
<tr>
<td>HH</td>
<td>Episodes with five to nine visits</td>
<td>HDI</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice claims for more than 20 contiguous months</td>
<td>Performant</td>
</tr>
<tr>
<td>Hospice</td>
<td>Excessive units of physician services; face-to-face (FTF) encounter documentation</td>
<td>HDI</td>
</tr>
</tbody>
</table>
ADR EDITS – CGS

// 5023T This edit selects home health claims for diagnosis 401.9 (Hypertension) and a length of stay greater than 120 days.

// 52xxT (‘xx’ denotes various numbers) This edit selects start of care home health claims from among all HHAs billing to CGS.

// 59BY9 This edit selects home health claims due to previous denials for selected beneficiary.

THERAPY AUTO EDIT - PGBA

// Home Health Insurance Prospective Payment System (HIPPS) Codes 2CGK* and 1BGP* in Four Regions Medical Review Results

// The J11 Medical Review Department performed a service-specific prepay targeted medical review on claims for 2CGK* and 1BGP* (variable last digit of HIPPS codes).

2CGK* - Midwest Results

<table>
<thead>
<tr>
<th>Percent of Total Denials</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.2%</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
<tr>
<td>25.2%</td>
<td>5A041</td>
<td>Info Provided Does Not Support Medical Necessity for This Service</td>
</tr>
<tr>
<td>25.2%</td>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>22.2%</td>
<td>5FNOA</td>
<td>Appropriate OASIS Not Submitted</td>
</tr>
</tbody>
</table>
**THERAPY AUTO EDIT - PGBA**

**1BGP* - Southwest Results**
Of the 404 claims reviewed, 119 were either completely or partially denied, resulting in a claim denial rate of 29.5 percent. A total of $1,297,204.64 charges was reviewed with $322,719.47 denied, resulting in a charge denial rate of 24.9 percent. The major denial reasons identified were:

<table>
<thead>
<tr>
<th>Percent of Total Denials</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.1%</td>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely Services Not Documented</td>
</tr>
<tr>
<td>31.6%</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
<tr>
<td>9.3%</td>
<td>5F012</td>
<td>Physician’s Plan of Care and/or Certification Present – Signed but Not Dated</td>
</tr>
<tr>
<td>4.7%</td>
<td>5F011</td>
<td>Physician’s Plan of Care and/or Certification Present – No Signature</td>
</tr>
</tbody>
</table>

**THERAPY AUTO EDITS**

**1BGP* - Southeast Results**
Of the 311 claims reviewed, 85 were either completely or partially denied, resulting in a claim denial rate of 27.3 percent. A total of $962,671.01 was reviewed with $240,519.89 denied, resulting in a charge denial rate of 25 percent. The major denial reasons identified were:

<table>
<thead>
<tr>
<th>Percent of Total Denials</th>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.2%</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
<tr>
<td>20.5%</td>
<td>56900</td>
<td>Requested Medical Records Not Submitted Timely</td>
</tr>
<tr>
<td>8.2%</td>
<td>5FNOA</td>
<td>Appropriate OASIS Not Submitted</td>
</tr>
<tr>
<td>6.7%</td>
<td>5F011</td>
<td>Physician’s Plan of Care and/or Certification Present – No Signature</td>
</tr>
<tr>
<td>5.8%</td>
<td>5F012</td>
<td>Physician’s Plan of Care and/or Certification Present – Signed but Not Dated</td>
</tr>
</tbody>
</table>
## TOP 10 ADR DENIALS - PGBA

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># Claims</th>
<th>% Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5FF2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>997</td>
<td>49.9</td>
</tr>
<tr>
<td>2</td>
<td>56900</td>
<td>Auto Deny - Requested Records not Submitted</td>
<td>413</td>
<td>20.7</td>
</tr>
<tr>
<td>3</td>
<td>5F041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>159</td>
<td>8.0</td>
</tr>
<tr>
<td>4</td>
<td>5A041</td>
<td>Info Provided Does Not Support the M/N for This Service</td>
<td>122</td>
<td>6.1</td>
</tr>
<tr>
<td>5</td>
<td>5F012</td>
<td>Physician’s Plan of Care and/or Certification Present - Signed but Not Dated</td>
<td>73</td>
<td>3.7</td>
</tr>
<tr>
<td>6</td>
<td>5FNOA</td>
<td>Unable to Determine Med Nec of HIPPS Code Billed as App Oasis Not Submitted</td>
<td>67</td>
<td>3.4</td>
</tr>
<tr>
<td>7</td>
<td>5F011</td>
<td>Physician’s Plan of Care and/or Certification Present - No Signature</td>
<td>49</td>
<td>2.5</td>
</tr>
<tr>
<td>8</td>
<td>5CHG3</td>
<td>MR HIPPS Code Change Due to Partial Denial of Therapy</td>
<td>48</td>
<td>2.4</td>
</tr>
<tr>
<td>9</td>
<td>5CHG1</td>
<td>MR HIPPS Code Change/Doc Contradicts MO Item(s)</td>
<td>47</td>
<td>2.4</td>
</tr>
<tr>
<td>10</td>
<td>5F023</td>
<td>No Plan of Care or Certification</td>
<td>25</td>
<td>1.3</td>
</tr>
</tbody>
</table>

## RISK MANAGEMENT STRATEGIES
RISK MANAGEMENT STRATEGIES

- Develop culture of compliance
- Identify current risk trends
- Establish concurrent compliance monitoring processes
- Maintain objective & accountable tracking system
- Periodically test compliance processes

• Communicate & reinforce clear message of compliance at all times
• Increase ease for maintaining compliance through training & ongoing monitoring
• Tie responsibility with authority for enforcement
RISK MANAGEMENT STRATEGIES

- Identify current program integrity initiatives & common billing/payment errors
- Assess your agency’s greatest areas of risk
- Identify source of data to monitor risk areas

Develop culture of compliance

Identify current risk trends

Establish concurrent compliance monitoring processes

Maintain objective & accountable tracking system

Periodically test compliance processes

Identify current program integrity initiatives & common billing/payment errors

Assess your agency’s greatest areas of risk

Identify source of data to monitor risk areas

June 7, 2013

Widespread Home Health Probe – Face-to-Face Encounter Documentation

In a result of numerous errors identified by both CGS and the Comprehensive Error Rate Testing (CERT) contractor related to home health face-to-face (FF) encounter documentation, CGS will be initiating a widespread edit for all home health providers. The topic code for this review will be 22393 (as indicated various numbers) and the edit will select start of care home health claims equally across the provider community. Once selected, the claims will be reviewed for valid FF encounter documentation, medical necessity compliance with all CMS coverage guidelines, correct billing and coding.

In addition, beginning July 8, 2013, CGS will begin requesting the initial certification face-to-face (FF) encounter documentation is submitted with all home health claims selected for Medical Reviews. The Centers for Medicare & Medicaid Services (CMS) clarified the “face-to-face encounter requirement is necessary for the initial certification, which is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes.” (CMS FAQ #44)

Source: CGS

Source: Palmetto GBA
### RISK MANAGEMENT STRATEGIES

**Home Health**
- 50% FTF encounter requirements not met
- 20% Auto deny, requested records not submitted
- 13% Lack of documentation to support medical necessity
- 4% Partial denial of therapy resulting in claim downcode
- 4% Plan of care not dated by physician
- 4% Applicable OASIS assessment not submitted with other medical record documentation

**Hospice**
- 32% Not hospice appropriate
- 22% No plan of care submitted with documentation
- 14% FTF encounter requirements not met
- 12% Auto deny, requested records not submitted
- 7% No certification for dates billed
- 4% No valid election statement submitted

Source: CGS  
RISK MANAGEMENT STRATEGIES

- Develop culture of compliance
- Identify current risk trends
- Establish concurrent compliance monitoring processes
- Maintain objective & accountable tracking system
- Periodically test compliance processes

• Establish concurrent documentation controls
• Assign compliance responsibilities to appropriate personnel & roles
• Align compliance with billing

RISK MANAGEMENT STRATEGIES

<table>
<thead>
<tr>
<th>Routine Pre-billing Compliance Activities</th>
<th>Home Health</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate physician signed &amp; dated FTF encounter documentation, per start of care</td>
<td>Validate physician signed FTF encounter documentation, if applicable</td>
<td></td>
</tr>
<tr>
<td>Confirm all physician orders are received signed &amp; dated</td>
<td>Validate clinician signed &amp; dated verbal physician certification(s), if applicable</td>
<td></td>
</tr>
<tr>
<td>Verify receipt of physician signed &amp; dated order for every visit</td>
<td>Validate physician signed &amp; dated written certification(s), per benefit period</td>
<td></td>
</tr>
<tr>
<td>Account for every visit according to physician ordered frequency</td>
<td>Confirm level of care against plan of care &amp; confirm timely updates to plan of care</td>
<td></td>
</tr>
<tr>
<td>Confirm therapy reassessment compliance</td>
<td>Confirm claim coding of patient location, diagnosis code(s) &amp; physician(s)</td>
<td></td>
</tr>
</tbody>
</table>
RISK MANAGEMENT STRATEGIES

// Routine post billing compliance activities

// Medical review monitoring
  // Pre-pay ADR by MAC
  // Post-pay review by program integrity contractor
  // Confirm all applicable documentation is included in response
    // Obtain additional documentation & late entry attestations, if needed

// Receivables managing & monitoring
  // Reconcile & investigate any payment differences at time of payment posting
    // Correct claim, if necessary
  // Manage accounts receivable aging reports
  // Monitor write-offs & adjustments

RISK MANAGEMENT STRATEGIES

• Establish tracking of individual personnel & process compliance
• Routinely review tracking to identify process & personnel compliance trends
• Target high risk areas: FTF encounter documentation, etc.
RISK MANAGEMENT STRATEGIES

- Establish timeframe for testing compliance: quarterly, annually, etc.
- Evaluate compliance resources: internal vs. external
- Test sample of paid claims compared to medical record documentation, including manual & electronic documentation
- Involve legal counsel, if necessary

COMMON RISKS & ERRORS
Failure of process, personnel or software?

Non-compliant documentation received

Documentation logged into software system

Documentation filed in medical record

Pre-billing compliance audit completed

Claim billed & paid

‘Compliance audit’ completed

Non-compliant documentation received

Verbal order received from Dr. Bradford (attending) & Dr. Broady (Medical Director) to admit to hospice. Prognosis 6 months or less if terminal illness runs its normal course.

DOB: 9-9-45

Disease Course Narrative: LC, YR was NSCLC

Terminal Diagnosis: LC

Secondary Conditions:

Co-morbidities:

Attending Physician Involvement:

Documentation of Hospice Appropriateness:

appropriate
“Full denial as FTF requirements not met. Insufficient clinical findings & homebound status addressed on FTF document.”
### Encounter Information and Certification

The following section is to be completed by the physician, nurse practitioner, or hospitalist who performed the face-to-face encounter.

I certify that the patient is under my care and that I, a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that was the physician face-to-face encounter requirement with this patient on.

**Date and Time:** 01/07/2013

This encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for the home health care (list medical condition) and my clinical findings support the need for the above services because:

**Right Ankle Fracture with a Torn Metatarsal Fracture**

I certify that, based on my findings, the following services are medically necessary home health services:

- **Speech-language Pathology**

To provide the following services to the patient (Required only when the physician completing the face-to-face encounter documentation in different than the physician completing the care of care):

- Services to improve patient mobility, function, and endurance, strength to improve patient ability

Documented below are my clinical findings that support that this patient is homebound (i.e., abides from home due to:

- **Homebound due to recent right ankle fracture**

  **Right Ankle Fracture with a Torn Metatarsal Fracture**
FACE TO FACE – WHAT DOESN’T WORK!

Used alone, the sample documentation statements listed below are considered as incomplete or insufficient to meet the Face-to-Face regulatory compliance in supporting the patient as homebound or in need of skilled home health services.

<table>
<thead>
<tr>
<th>Homebound Status:</th>
<th>Supporting the Need for Skilled Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Functional decline”</td>
<td>“Family request”</td>
</tr>
<tr>
<td>“Dementia”</td>
<td>“Continues to have problems”</td>
</tr>
<tr>
<td>“Confusion”</td>
<td>“Diabetes” or other diagnoses</td>
</tr>
<tr>
<td>“Difficult to travel to doctor’s office”</td>
<td>“Gait abnormality” without specific clinical findings</td>
</tr>
<tr>
<td>“Unable to leave home”</td>
<td>“Patient unable to do wound care”</td>
</tr>
<tr>
<td>“Weak”</td>
<td>A list of tasks for nurse to perform</td>
</tr>
<tr>
<td>“Unable to drive”</td>
<td>Visit frequency of SN or therapy service</td>
</tr>
</tbody>
</table>

DENIAL FROM RA/RAC REVIEW

The plan of care noted functional limitations of ambulation and endurance, and the activities permitted were exercises prescribed and use of cane and walker. In the April 13, 2011, Outcome & Assessment Information System it was noted that the patient had a healing surgical wound to left anterior knee, and required use of a two-handed device to walk alone on a level surface, and/or required human supervision or assistance to negotiate stairs or uneven surfaces. On 4/15/11 documentation no longer reflected that the patient was homebound. The patient was noted as able to ambulate without assistive device in the home and with modified independence and straight cane 200 feet on uneven surface. The patient denied pain.
SUMMARY

Develop culture of compliance

Identify current risk trends

Establish concurrent compliance monitoring processes

Maintain objective & accountable tracking system

Periodically test compliance processes