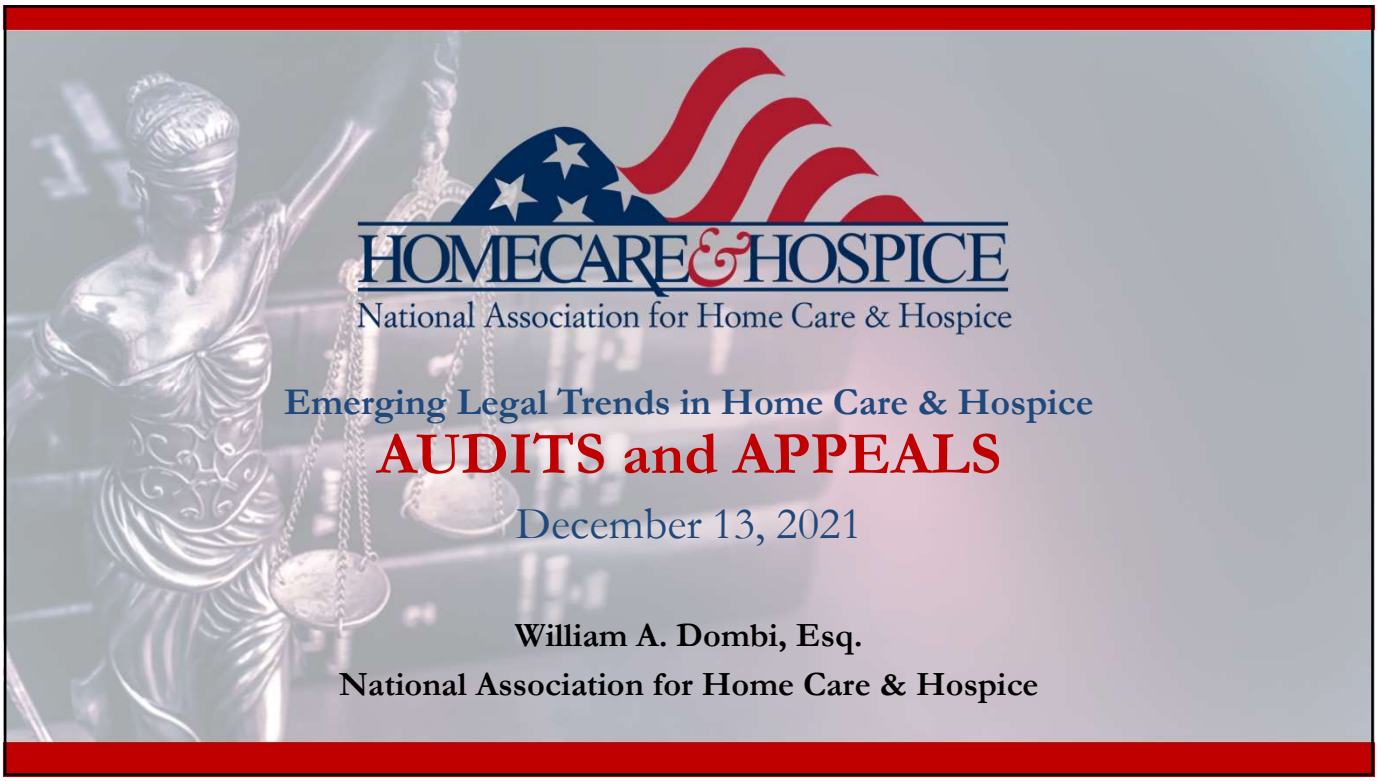

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PROGRAM FOCUS

- Nature and extent of oversight
  - Fraud prosecutions
  - Systemic oversight targets
  - Patient referral limitations
  - Claims compliance issues
  - Quality of care compliance
  - Provider enrollment
- Program focus here is on
  - Claims for payment (predominately Medicare-related)
  - Appeal rights

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Purposes of Audits

- Accountability of administrative agency to Congress and the people
- Overall program integrity
  - Proper payments
  - Deter fraud and abuse
- Save money!

RIGHTS OF APPEAL

- SOURCE
  - U.S. Constitution
  - Statutory
  - Administrative rules
- Operation
  - Technical application
  - Exhaustion of remedies
  - Scope of review
  - Standard of review

AUDITS: FOCUS ON HOME HEALTH CARE & HOSPICE

- Growth in oversight activities in home care and hospice
  - Medicare and Medicaid
  - High level fraud/False Claims Act investigations
    - Referrals
    - Wholesale unnecessary care
    - Failure to provide any service
  - Day-to-day compliance oversight
    - Claims
    - Coverage
    - Quality of care
- Multiple oversight bodies
  - Medicare/Medicaid contractors (MAC, RAC, SMRC, UPIC)
  - Managed Care Organizations
  - OIG
  - FBI, DOJ, Etc.
  - Whistleblowers/Complaints
  - CERT reviews

Home Care Compliance vs. Fraud

- Fraud= Jail, Fines, and Repayments
- Noncompliance=Administrative headaches and Refunding Overpayments
- Compliance Areas
  - Claims and Conditions for Payment
  - Quality of care (CoPs)
  - Provider enrollment

CLAIMS RISK AREAS

- UTILIZATION LEVELS
- AUTHORIZATION OF CARE
- COMPLIANCE/CONSISTENCY WITH APPROVED PLAN OF TREATMENT
- DOCUMENTATION
- TECHNICAL REQUIREMENTS FOR PAYMENT

CLAIMS COMPLIANCE: Oversight Methods

- MACs, UPICs, SMRC, RACs, and States routinely looking
- OIG and FBI/DOJ highly targeted focus
- Hospice and home health care targeted
- Audits are data driven based on benchmark aberrancies
  - Automated and complex claims reviews
  - Technical compliance the first target
  - Coverage standards the second stop
  - Extrapolation through sampling audits
  - Payment suspensions a risk

Targeting Triggers

- PEPPER reports
- Probe and Educate audits
- OIG studies
- OIG audits
- CERT annual analyses

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CERT Drivers in Audits: Nonhospital Based Hospice

Report YEAR	Improper Payment Rate	Insufficient Doc	Medical Necessity
2015	10.7%	51.3%	44.9%
2016	14.6%	74.2%	23.2%
2017	15.0%	57.2%	31.8%
2020	5.6%	64.3%	13.2%
2021	6.5%	61.1%	13.2%

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CERT Drivers in Audits: Hospital Based Hospice

Report YEAR	Improper Payment Rate	Insufficient Doc	Medical Necessity
2015	18.9%	79.6%	16.6%
2016	31.0%	72.7%	27.3%
2017	10.5%	93.3%	0.0%
2020	20.4%	90.9%	4.8%
2021	22.3%	80.2%	10.3%

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CERT Drivers in Audits: Home Health

Report YEAR	Improper Payment Rate	Insufficient Doc	Medical Necessity
2015	59.9%	94.8%	4.1%
2016	42.0%	96.4%	2.3%
2017	32.3%	89.0%	4.3%
2020	9.3%	68.7%	16.0%
2021	10.3&	59.1%	27.1%

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Medicare Hospice Claims Risk Areas

- Technical compliance
  - Election
  - Attending physician
- Related to terminal illness
  - drugs
- Hospice face-to-face rule
- Terminal illness documentation
- Hospice and the nursing facility resident
- Continuous care
- Inpatient days

HOSPICE: CLAIMS COMPLIANCE

- Hospice election
  - Benefit waiver
  - Timeliness in relation to Start of Care
  - Competency/Surrogate Authority
- Terminal illness
  - Clinical support
  - Compliant process, i.e. attending physician/medical director certification
- Level of care
  - Focus on increases of continuous care days and appropriateness of inpatient days
- Unbundling of services/non-terminal illness related care
- Face-to-Face Encounter
  - Timing and documentation

HOSPICE ELECTION

- Issues
  - Completed prior to the start of hospice care
  - Compliant waiver of benefits notice
  - Evidence of individual's competency
  - Documentation of surrogate's authority
    - Health Power of Attorney (state law compliant)
    - Where no POA, state law standards met

TERMINAL ILLNESS

- Compliance with hospice LCDs
- Supporting documentation
- Non-cancer diagnoses get extra attention
- Technical compliance crucial in terms of proper physicians involved, consistency with interdisciplinary team findings, timing, and signing/dating

Level of Care

- Inpatient care
  - Audits focus on nursing facility patients
  - Unstated suspicion of some hospices providing inpatient days to the max to maximize revenue share between NF and hospice
  - As always, it is documentation that makes or breaks it
- Continuous care
  - Audits focus on nursing facility patients
  - Gaming is suspected
  - Need to show skilled care needs with precise documentation

Hospice F2F Oversight

- Face-to-Face physician encounter: 42 CFR 418.22
- Enforcement is underway
- Failure to sign F2F certification
  - Narrative absent
  - Narrative insufficient

HOSPICE PEPPER

TARGET AREAS (examples)

- Live Discharges/No Longer Terminally Ill
  (excludes transfer, revocation, discharge for cause, move out of service area)
- Live Discharges/ Revocations (NEW)
- Live Discharges/LOS 61-179 days
- Long Length of Stay
  (greater than 180 days)
- CHC in ALF
- RHC in ALF
- RHC in NF
- RHC in SNF
- Claims with Single Dx Code (NEW)
- No GIP or CHC (NEW)

OIG REPORT

- HOSPICES INAPPROPRIATELY BILLED MEDICARE OVER $250 MILLION FOR GENERAL INPATIENT CARE: http://oig.hhs.gov/oei/reports/oei-02-10-00491.asp (March 2016)
  - OIG found that hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012.
  - Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms.

OIG Report

- **MEDICARE HOSPICES HAVE FINANCIAL INCENTIVES TO PROVIDE CARE IN ASSISTED LIVING FACILITIES, http://oig.hhs.gov/oei/reports/oei-02-14-00070.asp (January 2015)**
  - **Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling $2.1 billion in 2012.**
  - **Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings.**
  - **OIG has concerns about the financial incentives created by the current payment system**
  - **OIG suggests payment reform and more accountability are needed to reduce incentives for hospices to focus solely on certain types of diagnoses or settings.**

Current OIG Hospice Audits

- 2019 NONE

- 2020 2
- 12-16-2020
  - Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Tullahoma, Tennessee *A-02-16-01024*
- 11-19-2020
  - Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Payson, Arizona. *A-02-16-01023*

Current OIG Hospice Audits

- 2021 11
- 11-16-2021
  - Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries *A-09-20-03026*
  - *A-07-17-01173*
- 10-25-2021
  - Office of Inspector General's Partnership With the Commonwealth of Massachusetts Office of the State Auditor: Office of Medicaid (MassHealth) - Payments for Hospice-Related Services for Dual-Eligible Members *A-01-20-00001*
  - *A-07-17-06075*
- 07-12-2021
  - Medicare Hospice Provider Compliance Audit: Partners In Care, Inc. *A-09-18-03024*
- 07-08-2021
  - Medicare Hospice Provider Compliance Audit: Mission Hospice & Home Care, Inc. *A-09-18-03009*
- 06-23-2021
  - Medicare Hospice Provider Compliance Audit: Northwest Hospice, LLC *A-09-20-03035*

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Current OIG Hospice Audits

- 06-10-2021
  - Medicare Hospice Provider Compliance Audit: Professional Healthcare at Home, LLC *A-09-18-03028*
- 05-18-2021
  - Medicare Hospice Provider Compliance Audit: Franciscan Hospice *A-09-20-03034*
- 05-14-2021
  - Medicare Hospice Provider Compliance Audit: Alive Hospice, Inc. *A-09-18-03016*
  - Medicare Hospice Provider Compliance Audit: Ambercare Hospice, Inc. *A-09-18-03017*
- 05-07-2021
  - Medicare Hospice Provider Compliance Audit: Suncoast Hospice *A-02-18-01001*
- 04-21-2021
  - Office of Inspector General's Partnership with the Office of the New York State Comptroller: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare *A-02-21-01008*
- 02-22-2021
  - Medicare Hospice Provider Compliance Audit: Tidewell Hospice, Inc. *A-02-18-01024*

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Medicare Home Health Oversight Claims Target Areas

- Technical compliance
  - Signed and dated orders
- Homebound
  - Absences documented or reported by patient
  - Conflicting documentation
- Medical Necessity
  - Therapy is a big target
  - Improper "improvement" standard
  - Documentation weakness on skilled nature of care
- Coding
  - diagnoses
- Face-to-Face Encounter
- Therapy Assessments

Home Health PEPPER Targets

- Average Case Mix
- Average Number of Episodes
- Average Length of Stay
- Average Medicare Payment

Face-to- Face Physician Encounter Changes

- Effective 1/1/15
- Eliminates physician narrative requirement
- Requires certifying physician to have sufficient records to support certification
- Rejects physician payment claims for certification/recertification when home health claim denied for noncompliant certification/recertification
  - CMS began nationwide prepayment "probe and educate" on 10/1/15 (5 claims from each HHA)/ ends September 1
  - Limited pre-2015 claims review on F2F currently
- CR 9189; 9240 -- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2015-Transmittals.html

Medicare Advantage: Post Pay Audits

- MA plans have begun auditing home health claims on a post-pay basis, including MI
- Some using a contractor: SCIO
- Focus on technical compliance issues
  - Signed physician orders
  - F2F requirements
  - Pre-2015 therapy needs assessments
  - OASIS
- HHAs not aware that MA plans required compliance with technical Medicare FFS standards
- Significant back liabilities
- Costly appeals processes

Medicare Home Health OIG Oversight

- Audit of an MA-based HHA (2016) https://oig.hhs.gov/oas/reports/region1/11300518.pdf
- estimated overpayments of at least $15.5 million for the audit period.
- Alleged that agency incorrectly billed Medicare because beneficiaries were not homebound, beneficiaries did not require skilled services, documentation from the certifying physicians was missing or insufficient to support the services the Agency provided, or, in one instance, a claim contained an incorrect payment code.
- CMS settled for much less

Medicare Home Health OIG Oversight

- Audit of NY-based HHA (2016) https://oig.hhs.gov/oas/reports/region2/21401005.pdf
- Alleges that the agency incorrectly billed Medicare for some beneficiaries who were not homebound, some beneficiaries who did not require skilled services, and some services for which the documentation from the certifying physician was missing or insufficient to support the services.
- OIG estimated that the agency received net overpayments of at least $7.5 million for the audit period.

Medicare Home Health OIG Oversight

- **2019 6**

- 12-05-2019
  - Medicare Home Health Agency Provider Compliance Audit: Palos Community Hospital Home Health Agency *A-05-17-00022*
- 10-30-2019
  - Medicare Home Health Agency Provider Compliance Review: Angels Care Home Health *A-07-16-05093*
- 09-05-2019
  - The Centers for Medicare & Medicaid Services Could Use Comprehensive Error Rate Testing Data To Identify High-Risk Home Health Agencies *(A-05-17-00035)*
- 05-28-2019
  - Great Lakes Home Health Services, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements *(A-05-16-00057)*
- 05-13-2019
  - EHS Home Health Care Service, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements *(A-05-16-00055)*
- 05-08-2019
  - Excella HomeCare Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements *(A-01-16-00500)*

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Medicare Home Health OIG Oversight

- **2020 11**

- 12-22-2020
  - Medicare Home Health Agency Provider Compliance Audit: Tender Touch Health Care Services *A-04-18-07077*
  - New York Improved Its Monitoring of Its Personal Care Services Program But Still Made Improper Medicaid Payments of More Than $54 Million *A-02-19-01016*
- 12-07-2020
  - Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC *A-06-16-05005*
- 11-18-2020
  - Medicare Home Health Agency Provider Compliance Audit: The Palace at Home *A-04-17-07067*
- 10-29-2020
  - Medicare Home Health Agency Provider Compliance Audit: Visiting Nurse Association of Central Jersey Home Care and Hospice, Inc. *A-02-17-01025*
- 10-16-2020
  - Medicare Home Health Agency Provider Compliance Audit: Gem City Home Care, LLC *A-05-18-00011*
- 09-11-2020
  - Medicare Home Health Agency Provider Compliance Audit: Mercy Health Visiting Nurse Services *A-05-18-00035*
- 08-11-2020
  - Medicare Home Health Agency Provider Compliance Audit: Mission Home Health of San Diego, Inc. *A-09-18-03008*
- 08-10-2020
  - Medicare Home Health Agency Provider Compliance Audit: Condado Home Care Program, Inc. *A-02-17-01022*
- 08-05-2020
  - Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services *A-04-18-04067*
- 07-22-2020
  - CMS Could Have Saved $192 Million by Targeting Home Health Claims for Review With Visits Slightly Above the Threshold That Triggers a Higher Medicare Payment *A-09-18-03031*
- 04-09-2020
  - Medicare Home Health Agency Provider Compliance Audit: Residential Home Health *A-05-16-00063*

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Medicare Home Health OIG Oversight

- **2021 5**
- 08-18-2021
  - Medicare Home Health Agency Provider Compliance Audit: Catholic Home Care *A-02-19-01013*
- 05-28-2021
  - Medicare Home Health Agency Provider Compliance Audit: Caretenders of Jacksonville, LLC *A-04-16-06195*
- 04-27-2021
  - Medicare Home Health Agency Provider Compliance Audit: Visiting Nurse Association of Maryland *A-03-17-00009*
- 02-25-2021
  - Medicare Home Health Agency Provider Compliance Audit: Brookdale Home Health, LLC *A-04-18-06221*
- 01-13-2021
  - Medicare Home Health Agency Provider Compliance Audit: Southeastern Home Health Services *A-03-17-00004*

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EXTRAPOLATION

- **Oversight body utilizes a sample of claims following OIG RAT-STATS standards**
- **Extrapolation triggers exponentially increased alleged overpayment ($10k on actual claims reviewed increases to $2m**
- **Appeal rights include sampling methodology**
- **Reverse extrapolation for denials overturned**
- **Some success in challenging methodology**

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APPEAL RIGHTS

LEVEL	Filing Deadline	Decision Deadline
MAC Redetermination	120 days from initial determination	60 days
QIC Reconsideration	180 days from Redetermination Notice	60 days
ALJ hearing (or attorney adjudicator)	60 days after QIC notice	90 days if QIC decision appeal or 180 days if escalated
Medicare Appeals Council	60 days after ALJ decision or after expiration timeframe if no decision	90 days after ALJ decision or 180 days after expiration of review time with no ALJ decision
U.S. District Court	60 days after AC decision or expiration of AC decision timeframe	No limit n the law

APPEAL PROCESS NOTABLES

- "De Novo" vs. Appellate review
- Law vs. Guidelines
- Burden of Proof standard
- Documentation submission limitations
- Value of each step

APPEAL ISSUES

- Technical
  - Physician certification
  - Timely filing of claims
  - Face-to-Face encounter requirements
  - Hospice election
- Substantive
  - Home Health: homebound status; skilled care need; "intermittent"; and medical necessity
  - Hospice: terminal illness status; level of care
  - Points of eligibility/ineligibility
- Special issue: Waiver of liability rights

Claims: C-LEVEL SCREENING

- Has there been any change in utilization patterns, e.g. length of stay?
- What does the claims data tell you about changes in case mix, LUPA volume, outliers volume?
- How is "relatedness" to the hospice terminal diagnosis determined?
- Can you account for the actual hours worked by personal care staff?
- Is your number 2 pencil sharpened and ready for perfection on the technical requirements?
- Are your internal claims compliance systems right for the today risks?
- Is claims documentation consistently done?
- Did you forget about MA Plans?
- Have you checked the exclusions list lately?

CONCLUSIONS

- Oversight is on the rise
- ROI drives its expansion
- Technical compliance is essential
- Documentation is the savior
- All areas of compliance under scrutiny
- Culture combined with internal auditing is key
- Plan for the costs of compliance

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Questions

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