Home Care /Hospice Financial Compliance Risks

Health Care Compliance Association
2004 Compliance Institute

Presented by
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Catholic Healthcare West,
April 28, 2004
### Home Health Medicare Reimbursement

- Originally at cost
- Cost per visit limits introduced in 1979
- Hospital add-on to visit limits eliminated 10/1/93
- No visit limit changes 7/1/94 to 7/1/96

### Changes to Home Health Reimbursement – BBA 1997

- Effective for CR periods on and after 10/1/97
- Payments for Home Health Services lower of:
  - Cost
  - Aggregate of Per Visit Limits
  - Aggregate of Per Bene Limit
  - Payment based on location of patient not home office

### Prospective Payment System (PPS)

- Effective for HHA services on & after 10/1/2000
- Full payments, including medical supplies
- OASIS used to determine patient acuity level
- 60-day episode PPS rates – 80 levels (case weights)
- 4 types of exception adjustments
Providers would submit “Request for Anticipated Payment” (RAP) to receive 60% if initial patient episode or 50% if subsequent episode.

Providers would submit final claim after episode is complete.

Cost reports cost finding methods and requirements did not change.

Compliance requirements changed with the reimbursement method change.

**Compliance in Finance**

FR 8/7/98, OIG voluntary compliance

Risk areas in finance:

- Billing for services not rendered
- Billing for unnecessary services
- Duplicate billing
- False cost reports
- Credit balances - failure to refund
- HHA incentives for referrals

**Compliance in Finance - cont**

- Joint ventures with referral sources
- Billing for patients not homebound
- Knowingly billing for inadequate or substandard care
- Insufficient documentation to support services and reimbursement
- Claiming unallowable costs of home health coordination
OIG 2004 Work Plan Financial Areas -
PPS

- Adequacy of controls
- Ensure services where needed
- Services coded properly
- Services inappropriately unbundled and paid by Medicare
- Overlapping episodes
- Appropriate payments for dually eligible beneficiaries
- Outlier Payments
- Therapy Threshold
- Arrangements with other facilities
- Physician care plan oversight

Billing

- HHAs and Hospices should have reasonable policies and procedures to ensure proper billing for services rendered
- Adequate training for clinical and billing staff
- Adequate billing/computer system to check
  - Proper orders
  - Physician signature and date
  - Duplicate billing
  - Adjustments and refunds

Billing Compliance

- HHA 15 Min Increments
- Significant Change in Condition (SCIC)
- OASIS Matching Key
- Therapy Threshold – M0825
- Hospitalization within 14 days of SOC – M0175
- Claim Adjustments M0825, M0175
- HIPAA compliant transactions
HHA 15 Minute Increments

- Defined as all time in the home, including
  - Completing OASIS assessments in the home
  - Updating medical records in the home
- Possible that CMS may use this info to influence reimbursement

Significant Change in Condition (SCIC)

- Determining whether a SCIC has occurred is a clinical decision
- Claiming a SCIC adjustment when the patient’s condition has improved is a compliance requirement
- Claiming a SCIC adjustment when the patient’s condition has deteriorated is a financial decision

Determining whether a SCIC has occurred is a clinical decision

- Change not anticipated in the Plan of Care
- OASIS Resumption of Care (RFA 3) or Other Follow-Up (RFA 5)
- Change in HIPPS code case mix weight
- Change in MD’s orders
SCIC Adjustment When Condition has Improved

- Where all clinical conditions are met and
- HIPPS code case weight has decreased**
- Must report SCIC adjustment on Claim

  - **Changes to the fourth position reflecting changed therapy needs only do not require adjustment

SCIC Adjustment When Condition has Deteriorated

- Where all clinical conditions are met and
- HIPPS code case weight has increased
- Submission of SCIC adjustment is optional
- Should test for best reimbursement
- Best reimbursement usually determined by number of days between billable visit dates

OASIS Matching Key Code

- UB-92 FL 63
- Must be associated with HIPPS code in FL 44 (last one used on claim)
- 18 digit code – consists of:
  - Start of Care date – M0030 (eight digits)
  - Date assessment was completed – M0090 (eight digits)
  - Reason for assessment – M0100 (two digits)
Therapy Threshold – M0825

- Answered in conjunction with POC
- Where there is 10 or more therapy visits planned MO825 s/b answered Yes
- Compliance issue where answered Yes and POC has less than 10 planned therapy visits
- On OIG 2004 Work Plan

OIG Therapy Threshold Audit

- Test compliance of therapy services
- Analysis of therapy visits provided vs. duration of therapy visits (time)
- Audit started in Massachusetts, January 2004
- Results to be published in late 2004

Hospitalization Within 14 days of SOC – M0175

- OIG identified payment system vulnerability where inpatient stay occurred during 14 days prior to SOC
- Pub 100-04, Trans 13, 10/24/03, effective 4/1/04
- Automated payment system will check for inpatient hospital claims on both a pre-payment and post-payment basis
Pre-Payment Basis
- Payment system compares incoming RAPS and Claims with HIPPS codes for no hospital discharge within 14 days of the start of care of the episode
- If discharge is found, system will take action:
  - RAPs returned to provider to correct HIPPS code
  - Claims will be down-coded and paid at the correct level

Post-Payment Basis
- CMS will annually analyze National Claims History for those hospital claims received after HHA claims
- Identified claims will be adjusted by down-coding paid claims
- Providers will note down-coding on RAs
- Expected annual review to begin summer of 2004, partially retroactive

CMS Up-coding ???
- Tom Scully, previous CMS Administrator, mentioned possible up-coding on M0175 issue
- CMS now says they will not up-code to preserve Medicare payments
Claim Adjustments Regarding M0825 / M0175, SCIC

- CMW allows and encourages for proper reimbursement
- Should only be done where documentation supports billing adjustment
- Cancel Claim and RAP if necessary
- Correct OASIS assessment if necessary and submit, run through grouper software
- Submit corrected RAP, Claim with new HIPPS codes and OASIS Matching Key code

CMS Clarification

- Instructions to RHHIs: refrain from denying payment based on failure of providers to comply with Medicare COPs...i.e. billing for visits when:
  - Therapists perform SOC assessments in cases where nursing was ordered,
  - Assessments not completed in 5-day window

Home Health Billing RAPS

- Requirements for Requests for Anticipated Payment (RAP) submission
  - OASIS locked assessment & resulting HIPPS code
  - Physician verbal orders received & documented by authorized personnel
  - Plan of care established
  - 1st visit (billable) delivered
### Home Health Billing Claims

- Claim must contain all ordered (within time frame) and provided services including non-routine medical supplies
- Plan of Care and any subsequent verbal orders must be signed by ordering physician prior to submission
- Includes diagnosis code(s) consistent with last OASIS assessment (M0230 & M0240) & POC

### Known Partial Episode Payment (PEP) Adjustments

- Where the HHA is aware the episode will be paid as a partial episode payment adjustment a patient status code of 06 is to be used on the claim
- Where a patient was discharged with goals met then readmitted with an exacerbation of the same diagnosis there needs to be a clinical decision over whether the discharge was premature to avoid a PEP adjustment

### General Compliant Billing

- Patient transfers to other HHAs must be properly coded on claims
- Any discovered billing errors must be corrected through the claims adjustment / cancellation processes unless claims timeframe has expired
- RAPs may only be cancelled
- Claims may be adjusted or cancelled
- Maintain refund log to document all corrected claims resulting from overpayments
**HHABN**

- Home Health Advance Beneficiary Notices and Demand Bills are required
- Triggering events:
  - Where an HHA will not accept the beneficiary as a Medicare patient because it expects the services are not covered
  - Where an HHA proposes to reduce or stop the beneficiary's services because it expects some or all of the services are not or no longer covered

**Hospice Billing**

- Admission date must be same date as the effective date of the hospice election or change of election and may not precede the physician's certification by more than 2 calendar days
- Care levels of hospice services (including physician services) billed must match medical record documentation

**Credit Balance Reporting**

- Credit Balance Defined: An improper or excess payment made to a provider as a result of patient billing or claims processing errors
- Claim paid twice for the same service either by Medicare or by Medicare and another insurer
- Claim paid for services planned but not performed or for non-covered services
- Claim overpaid because of billing errors on the part of the provider or FI
### Credit Balance Reporting - PPS

- Specific HHA PPS examples:
  - Billed 5 visits on episode claim when it should be 4 visits
  - Billed 10 therapy visits when it should be 9 therapy visits
  - Billed claim without required SCIC adjustment
  - Billed claim without proper transfer code

### Cost Reporting in General

- Costs claimed on reports must:
  - Reasonable and necessary
  - Allocated properly
  - Associated with Medicare services
  - Comply with Medicare reimbursement regulations
  - Be supportable by verifiable and auditable data

### Home Health & Hospice Cost Reports in General

- Must segregate direct expenses by each cost center
- All general service cost center expenses aggregated then allocated to all direct cost center which they benefit
General Cost Reporting & Record Keeping Issues

- Organizational structure and relationship with hospital makes a difference
- Accurately record expenses in unique direct service cost center GL account
- Segregation of home health, hospice cost centers and other health care service lines i.e. vaccines, DME, etc

Non Allowable Costs

- Organizational dues and other expenses related to lobbying and political activities
- Related organizations, Home Offices
- Advertising, Public Relations
- Discharge planning vs home health coordination
- Fund raising, Lifeline

Non Allowable Costs

- Cellular phones & 800 phone numbers
- Brochures, calendars & give-a-ways
- Marketing
- Excess compensation for key employees
- Prior audit adjustments
**Reimbursement for Management Fees**

- Operational need
- Contract terms
  - Responsibilities
    - Punitive termination penalty
    - 5 years or less is reasonable
- Reasonable cost, documentation of services
  - If related, fee is limited to cost
  - Access clause if over $10,000 for 12 month period

**Documentation of Costs**

- If its not documented its not a cost to be claimed
- Financial statements and trial balance
- Continuous time records and time studies
- Transportation, IRS guidelines
- Costs must be actually paid within a certain period
- Accurate visit counts

**Like-Kind Visits**

- Must meet Medicare guidelines
  - Homebound
  - Under care of Physician
    - In need of intermittent skilled care
    - Under a plan of care
  - Aide services - not custodial nor personal care
Like-Kind Visits - cont.

- If not “Like-kind”:
  - Expenses must be segregated into different cost center
  - Visit counts must be excluded from the counts to determine average cost per visit

Cost Finding

- Direct and indirect costs
- Fragmenting Administrative and General costs
- Proper cost centers
- Allocation of hospital overhead – where A & G dept benefits home health / hospice
- Allocation statistics, sq ft, $, FTEs

Typical Hospital Department Exp to Allocate

<table>
<thead>
<tr>
<th>Building/Occupancy</th>
<th>Media</th>
<th>Admitting</th>
<th>Laundry &amp; Linen</th>
<th>Central Services</th>
<th>Therapy Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment</td>
<td>Communi.</td>
<td>Patient Accounting</td>
<td>Housekeeping</td>
<td>Pharmacy</td>
<td>Medical Supplies</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>Data Processing/inf.</td>
<td>Maintenance &amp; Repairs</td>
<td>Cafeteria</td>
<td>Medical Records</td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>Purchasing</td>
<td>Operation of Plant</td>
<td>Nursing Admin</td>
<td>Social Services</td>
<td></td>
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Cost Finding Problem Areas within Hospital Environment

- General Inpatient Hospice Services
- Inpatient Respite Hospice Services
- Other hospital departments serving Hospice patients:
  - Outpatient
  - Labs and Diagnostics
  - Radiation / Chemotherapy, etc.

Hospice Nonreimbursable Service Areas

- Bereavement Program
- Volunteer Program
- Fundraising
- Others

Reimbursement - Lower of Cost or Charges

- Community rates should be higher than cost and limits
- Record revenue at community rates in GL – consistency required
- Record contractual allowances
- Discounts - written contracts
- Clear policies on discounts and indigent care
<table>
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<th>Summary</th>
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<tr>
<td>- Home Health / Hospice regulations in billing and cost reporting is complex</td>
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<tr>
<td>- Regular Education and Training is necessary</td>
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<tr>
<td>- Periodic reviews and audits are necessary to ensure compliance</td>
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