Health Care Compliance Association
2013 OIG Work Plan:
Priorities and Concerns for Post-Acute
Care Providers

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2013 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.
• On October 2, 2012, the OIG released its Work Plan for
2013.
• A significant portion of the 2013 Work Plan is devoted to
nursing facilities and home health and hospice providers.

2013 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.
2013 OIG Work Plan: Priorities and Concerns for Post-Acute Care Providers

- Increased focus on integrity and efficiency of the compliance function.
- The 2013 award for the provider type with the largest bull’s-eye target is .... NURSING FACILITIES.

2013 OIG Work Plan: Priorities and Concerns for Post-Acute Care Providers

The OIG has also been very busy in the last 12 months.
02-28-13 Spotlight On... Skilled Nursing Facilities
11-09-12 Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars in 2009
10-05-12 Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation
08-02-12 Inappropriate and Questionable Billing by Medicare Home Health Agencies
07-06-12 Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs

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
- 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
CMS Recovery Audit Program

- The Recovery Audit Program’s mission is to identify and reduce Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.
- Source: cms.hhs.gov

Zone Program Integrity Contractors (ZPICs)

- The primary goal of ZPICs is to investigate instances of suspected fraud, waste and abuse.
- ZIPCs:
  - Investigate potential fraud & abuse for CMS administrative action or referral to law enforcement
  - Conduct investigations in accordance with the priorities established by CMS
  - Perform medical review, as appropriate
  - Perform data analysis in coordination with CMS
  - Identify the need for administrative actions such as payment suspensions and prepayment or auto-denial edits
  - Refer cases to law enforcement for consideration and initiation of civil or criminal prosecution

What Can You Do To Get Ready?

- Learn From Past Experiences
  - Keep track of denied claims
  - Look for patterns
  - Determine what corrective actions you need to take to avoid improper payments
**Key Nursing Home OIG Initiatives For 2013**

- Quality of care
  - The OIG will focus on adverse events in post-acute care for Medicare beneficiaries.
  - The OIG will focus on national incidence of adverse and temporary harm events for Medicare beneficiaries in SNFs and inpatient rehabilitation facilities.

**Key Nursing Home OIG Initiatives For 2013**

- The OIG will focus on Medicare requirements for Quality of Care in SNFs.
- The OIG will focus on care planning, discharge planning and inappropriate payments based on upcoding and documentation issues.

**Key Nursing Home OIG Initiatives For 2013**

- On February 28, 2013, the OIG issued a report on the failure of skilled nursing facilities to meet care planning and discharge planning requirements.
- The OIG made the following findings:
Key Nursing Home OIG Initiatives For 2013

– For 37% of the states, SNFs did not meet care plan or service requirements representing Medicare payments of approximately $4.5 Billion.

Table 1: Percentage of Stays in Which SNFs Did Not Meet Care Plan or Service Requirements, 2009

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Percentage of Stays in Which SNFs Did Not Meet Requirements</th>
<th>Medicare Payments for Stays in Which SNFs Did Not Meet Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plan requirements</td>
<td>25.6%</td>
<td>$2.1 billion</td>
</tr>
<tr>
<td>Service requirements</td>
<td>16.4%</td>
<td>$1.2 billion</td>
</tr>
<tr>
<td>Total</td>
<td>38.7%</td>
<td>$4.6 billion</td>
</tr>
</tbody>
</table>

Note: The rows do not sum to the total because some stays met neither the care plan requirements nor the service requirements.

Key Nursing Home OIG Initiatives For 2013

– For 26% of the states, the nursing facilities did not develop care plans that met requirements.

Table 2: Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements, 2009

<table>
<thead>
<tr>
<th>Care Plan Requirements</th>
<th>Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plans address problem areas identified in the assessments</td>
<td>15.2%</td>
</tr>
<tr>
<td>Care plans have measurable objectives and defined timelines</td>
<td>6.6%</td>
</tr>
<tr>
<td>Care plans are developed by an interdisciplinary team</td>
<td>2.1%</td>
</tr>
<tr>
<td>Total</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

Note: The rows do not sum to the total because some stays did not meet two or more care plan requirements.
*The requirement states that both measurable objectives and timelines must be in the care plan. The 6.6 percent represents the stays in which either measurable objectives or timelines were missing.

Key Nursing Home OIG Initiatives For 2013

– For 15% of the states, the nursing facilities did not provide services in accordance with care plans.
– For 31% of the stays, the nursing facilities did not meet discharge planning requirements.

Table 3: Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirements, 2009

<table>
<thead>
<tr>
<th>Discharge Planning Requirement</th>
<th>Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of beneficiary’s stay and status at discharge</td>
<td>15.2%</td>
</tr>
<tr>
<td>Post-discharge plan of care</td>
<td>23.3%</td>
</tr>
<tr>
<td>Total</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

Note: The rows do not sum to the total because some stays did not meet other requirement.
The OIG medical reviewers also found examples of poor quality care related to wound care, medication management and therapy.

In response to the OIG report, CMS agreed to strengthen the regulations for care planning and discharge planning.

- CMS agreed to provide guidance to nursing facilities to improve care planning and discharge planning including having Quality Improvement Organizations enroll nursing homes in the Nursing Home Quality Care Collaborative ("NHQCC").

CMS agreed to increase surveyor efforts to identify nursing facilities that do not meet care planning and discharge planning requirements.

- CMS agreed to link payments to nursing facilities that meet quality of care requirements in future nursing home demonstrations.

- CMS agreed to prioritize those facilities for review that were identified as having failed to meet care planning and discharge planning requirements or which provided poor quality care.

The OIG will also focus on accuracy of resource utilization groups ("RUGs") classifications.

- In November 2012, the OIG completed a study titled "Inappropriate Payments To Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars in 2009".
Key Nursing Home OIG Initiatives For 2013

- The OIG made the following findings:
  - SNFs billed one-quarter of claims in error in 2009 resulting in $1.5 Billion in inappropriate Medicare payments

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Percentage of SNF Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect Burds</td>
<td>31.3%</td>
</tr>
<tr>
<td>Upcoded</td>
<td>20.2%</td>
</tr>
<tr>
<td>Don’t need</td>
<td>2.5%</td>
</tr>
<tr>
<td>Did Not Meet Coverage Requirements</td>
<td>3.1%</td>
</tr>
<tr>
<td>Total error rate</td>
<td>24.0%</td>
</tr>
</tbody>
</table>


Key Nursing Home OIG Initiatives For 2013

- Nursing facilities misreported information on the Minimum Data Set (MDS) for 47% of the claims.

<table>
<thead>
<tr>
<th>MDS Category With Misreported Information</th>
<th>Percentage of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy (i.e., physical, occupational, speech)</td>
<td>30.3%</td>
</tr>
<tr>
<td>Special Care (e.g., intravenous medication, tracheotomy care)</td>
<td>16.8%</td>
</tr>
<tr>
<td>Activities of Daily Living (e.g., bed mobility, eating)</td>
<td>6.5%</td>
</tr>
<tr>
<td>Nasoenteral Feeding (i.e., gastrostomy tube feeding)</td>
<td>4.6%</td>
</tr>
<tr>
<td>Skin Conditions and Treatments (i.e., ulcers, round dressings)</td>
<td>2.4%</td>
</tr>
</tbody>
</table>


Key Nursing Home OIG Initiatives For 2013

- The OIG found several instances in which nursing facilities provided more therapy during the look-back period than they did during periods that did not determine payment rates.
- As a result of the report, the OIG made the following recommendations to CMS that were adopted by CMS:
Key Nursing Home OIG Initiatives For 2013

- CMS agreed to increase and expand reviews of SNF claims by MACs, RACs and ZPICs.
- CMS agreed to use its Fraud Prevention System to identify and target nursing facilities that have a high percentage of claims for ultra-high therapy and for high levels of assistance with activities of daily living.

Key Nursing Home OIG Initiatives For 2013

- CMS agreed to monitor compliance with the requirement to complete a “change of therapy” assessment when the amount of therapy provided no longer reflects the applicable RUG and an “end of therapy” assessment when therapy is discontinued for three (3) days.
- CMS agreed to analyze other possible changes in connection with the payment for therapy services, including group and concurrent therapy.

Key Nursing Home OIG Initiatives For 2013

- The OIG will focus on the use of atypical antipsychotic drugs.
- In July 2012, the OIG issued a report on nursing facility assessments in care plans for residents receiving atypical antipsychotic drugs.
Key Nursing Home OIG Initiatives For 2013

- The OIG reviewed records of elderly nursing facility residents with Medicare claims for atypical antipsychotic drugs during the first six (6) months of 2007.
- The OIG reviewed 375 records that were randomly selected.

Key Nursing Home OIG Initiatives For 2013

- The OIG found that 99.5% of the records that were reviewed failed to meet one or more federal requirements for resident assessments and/or care plans.

<table>
<thead>
<tr>
<th>Federal Requirements Not Documented</th>
<th>Records Reviewed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Assessments</td>
<td>125</td>
<td>33.1%</td>
</tr>
<tr>
<td>(Evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Consideration or MDAP for antipsychotic drug use)</td>
<td>10</td>
<td>4.6%</td>
</tr>
<tr>
<td>Care Plan Development</td>
<td>371</td>
<td>99.9%</td>
</tr>
<tr>
<td>Care Plan Implementation</td>
<td>87</td>
<td>17.6%</td>
</tr>
<tr>
<td>Overlapping</td>
<td>80</td>
<td>21.2%</td>
</tr>
<tr>
<td>Total (per)</td>
<td>373</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of nursing facility records, 2011

Key Nursing Home OIG Initiatives For 2013

- As a result of the report, CMS agreed to improve the detection of non-compliance with federal requirements for resident assessments and care plans as it relates to anti-psychotic medication.
Key Nursing Home OIG Initiatives For 2013

- CMS also agreed to ensure that survey deficiencies with respect to atypical antipsychotic drug usage are significant enough to deter non-compliance.
- CMS also agreed to provide methods for nursing facilities to enhance the development and usefulness of resident assessments and care plans for residents receiving antipsychotic drugs.

Key Nursing Home OIG Initiatives For 2013

- The OIG will also focus on hospitalization of nursing home residents.
- The OIG will determine the extent to which hospitalizations were as a result of manageable or preventable conditions.

Key Nursing Home OIG Initiatives For 2013

- State Agency Verification of Deficiency Corrections
  - Prior review found that one State survey agency did not always verify that SNFs corrected deficiencies identified during recertification surveys
  - Determine whether States verified correction plans through onsite reviews or by obtaining other evidence of correction
  - Determine whether CMS and States oversee the accuracy and completeness of Minimum Data Set (MDS) data submitted by SNFs
Compliance Plans

- The ACA requires nursing facilities to implement compliance plans by 2013.
- CMS failed to issue the compliance plan regulations by the required deadline.
- Although nursing homes are not yet required to have nursing compliance plans, a prudent facility will have already prepared and implemented a compliance plan in accordance with the applicable OIG guidelines.

Key Home Health Initiatives

- 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.

Key Home Health Initiatives

- 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.
Key Home Health Initiatives

- The OIG will focus on inappropriate and questionable billing by Medicare home health agencies.
- 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:

Key Home Health Initiatives

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

Key Home Health Initiatives

<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 HOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlap between inpatient hospital stay and home health service</td>
<td>$3,054,420</td>
<td>1,722</td>
<td>1,300</td>
<td>566</td>
</tr>
<tr>
<td>Overlap between skilled nursing facility stay and home health service</td>
<td>$1,269,422</td>
<td>1,190</td>
<td>469</td>
<td>414</td>
</tr>
<tr>
<td>Home health service dates after a beneficiary’s date of death</td>
<td>$206,011</td>
<td>1,027</td>
<td>82</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>$4,529,455</td>
<td>3,989</td>
<td>1,857</td>
<td>1,385</td>
</tr>
</tbody>
</table>

Claims sum exceed total because some HOs had multiple types of inappropriate payments.

Key Home Health Initiatives

• 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.

Key Home Health Initiatives

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

Key Home Health Initiatives

• 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.
• The OIG will review activities that CMS and its contractors preformed to identify and prevent improper HHA payments from January to October 2011.
Key Home Health Initiatives

• The OIG will focus on the employment of home health aides with criminal convictions.
• The OIG will focus on states' survey and certification timeliness, outcomes, follow-up and Medicare oversight.

Key Hospice Initiatives

• The OIG will focus on marketing practices and financial relationships with nursing facilities. Contractual relationships between hospices and nursing facilities will receive extensive scrutiny.

Key Hospice Initiatives

• 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
Key Hospice Initiatives

- 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

Key Hospice Initiatives

- Medicaid Hospice Services
  - Evaluate Medicaid payments for hospice services to ensure compliance with federal Medicaid coverage requirements
  - Focus on coverage requirements concerning terminal illness and waiver of rights to otherwise covered Medicaid services

Questions?