Trends, Challenges, and Best Practices for an Effective Home Health Compliance Program

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Agenda

- Recent Legal/Regulatory Developments in Home Health Compliance
- Home Health Compliance Challenges and Importance of Effective Compliance Programs
- Best Practices for Designing, Implementing, and Maintaining an Effective Compliance Program
  - Processes and Training for Compliance
    - Physician Signatures
    - Training/Education
  - Patient Safety and Quality of Care
  - Monitoring for Compliance
    - Utilization Review
    - Audits
  - Repayment
RECENT DEVELOPMENTS

Headlines, Headlines, Headlines

- 2/17/15. Owner of Miami-based Longcare Home Health pled guilty to conspiring to commit health care fraud by billing Medicare for services not medically necessary or not provided, and paying kickbacks and bribes.
- 2/10/15. ResCare Iowa paid $5.63 million to settle False Claims Act allegations related to its failure to document compliance with physician certification and face-to-face requirements between 2009 and 2014.
- 2/9/15. Kansas personal care attendant sentenced to 18 months prison and restitution of over $250,000 for submitting fraudulent bills to Medicaid.
- 1/30/15. Federal judge in Miami sentenced four people to prison terms of 2 to 10 years related to $6.2 million home health fraud scheme that ran from Dec. 2008 to Feb. 2014. Defendants were patient recruiters and/or management for Professional Medical Home Health, which billed Medicare for services that weren't medically necessary or weren't provided.
- 11/5/14. California home health agency’s provider agreement terminated when CMS determined facility was not compliant with conditions of Medicare participation during three CMS surveys.
Recent Legal Developments in Home Health Compliance – Regulatory Developments

- Changes to Medicare payment requirements effective Jan. 1, 2015
  - Elimination of face-to-face narrative requirement
  - Elimination of 13th and 19th visit therapy reassessment requirements
  - Increase in compliance threshold for OASIS assessments
- Proposed rule on home health Conditions of Participation (issued Oct. 6, 2014)
  - Focus on patient-centered, data driven, outcome-oriented process and on eliminating unnecessary procedural burdens
  - Would expand the current patient right CoP and create CoPs for care planning, coordination of services, and quality of care, quality assessment and performance improvement, and infection prevention and control

Recent Legal Developments in Home Health Compliance – Agency Activity

- Beginning April 1, 2015, Medicare will compare HIPPS code on home health claims with HIPPS code on corresponding OASIS assessment
- Details on standardized assessments for post-acute providers revealed during Open Door Forum on Feb. 25, 2015
- CMS authority to impose civil monetary penalties for non-compliance with CoPs (effective July 1, 2014)
- Second wave of temporary moratoria on enrollment in certain regions announced in Jan. 2014 (Fort Lauderdale, Detroit, Dallas, and Houston)
Recent Legal Developments in Home Health Compliance – Enforcement Focus

- CMS developing pilot program, to begin in South Florida, to determine how many Medicare fraud cases are taking place in home health agencies
- OIG has prioritized improved controls on improper Medicare billings by HHAs (March 2014)
- One of first OIG exclusions based on breach of a CIA since 2007 was of a home health provider (Kai Heart)
- Major target of False Claims Act activity in 2014 and generated some of the largest settlements
  - Amedisys - $150 million
  - Visiting Nurse Network - $34.9 million
  - CareAll Management - $25 million

COMPLIANCE CHALLENGES
Compliance Challenges and Importance of Effective Compliance Programs

- Evolving, complex federal regulatory and payment regimes
  - Medicaid is a major payor for home health – must contend with various state regimes, as well as Medicare regulations
  - Many states operate waiver programs covering home health services, adding to the regulatory complexity
  - Necessitates consistent processes, training, and monitoring to ensure compliance
- More difficult to supervise services and ensure quality of care where workforce is mobile and care is provided in patients’ homes
  - Must have processes in place to prioritize and protect patient safety and quality of care
- Challenges in appropriately screening and training employees, particularly in high turnover environment
  - Raises stakes on developing excellent processes for training and for monitoring safety and quality of care

Essential to design and implement an effective compliance program to address these challenges

- Implement and regularly update processes to ensure compliance with all applicable regulatory regimes – e.g., physician signature and documentation requirements
- Appropriately train staff to provide up-to-date information and promote culture of compliance
- Prioritize patient safety and quality of care by developing mechanisms for monitoring and responding to any issues
- Develop effective monitoring systems, including utilization review and audit functions
- Implement effective process for determining and making repayments when required
BEST PRACTICES FOR COMPLIANCE PROGRAMS

The Maxim Example

- Over 25 years of experience in home health care
- Operates more than 360 offices nationwide
- Entered into a DPA and CIA with the federal government and certain states in 2011
- Extensive internal reforms and restructuring since 2009 to ensure robust compliance
Physician Signatures

- Physician signature must be obtained on order (CMS 485, plan of care)
- Certain states require physician signature to be obtained within a time period and before billing
  - Time limits range between 30 and 60 days
- Maxim requires all physician orders to be scanned to a corporate database
  - All are reviewed for timeliness of signatures based on state regulations prior to being dropped to bill payer
Training/Education

- Dedicated training required under CIA
- Training includes the following:
  - Fraud and Abuse
  - HIPAA/Privacy
  - Sexual Harassment
  - Professional Boundaries
  - Billing
  - Policy training
  - Training provides clear examples
- Provided through online portal through Cornerstone software to caregivers
- Maxim received nationwide recognition 2014 Best Practice Award from Health Ethics Trust for their compliance and ethics education and training program.

ENSURING PATIENT SAFETY AND QUALITY OF CARE
Patient Safety and Quality of Care – Best Practice: Rapid Response Investigations

- Rapid Response – Privileged Investigation led by attorney
  - Identified pervasive process breakdown that may involve patient injury or death
    - Swat team approach to ensuring patient safety
    - Operation team leads are in the office within 48 hours and accounting for operational and clinical processes
    - High degree of a patient safety risk
- VP Compliance, Regional Compliance Officer involved
- Plan of Correction reporting and Root Cause Analysis
- Frequent meetings until issue is resolved

Patient Safety and Quality of Care

- Quality Committee – est. 2013
  - Quarterly meetings
  - Discuss any sentinel events
  - Review incident reports
    - Falls
    - Broken bones/injury
    - Patient deaths
    - Medication errors
    - Sleeping nurses
    - Competency
MONITORING COMPLIANCE

Auditing/Monitoring Activity Planning

- Understanding the scope and purpose of the audit request
  - On notice of pending investigation
  - State survey issue (e.g. Standard, Conditional, Immediate Jeopardy)
  - Repayment request
  - Pending acquisition
  - Incident follow up
  - Scheduled
Understanding the Risks

- Risks that should be considered:
  - Patient Safety
  - Billing/Coding
  - Licensure
  - Documentation
  - Education and training available
  - Employee honesty
  - Theft
  - Reputation

Availability of Resources

- Priority established
- Length and breadth of engagement
- Personnel available and skillset
- Opportunity costs
- Leadership support
- Cross departmental collaboration
- Subcontracting resources
Development of Audit Format

- Items to consider when constructing an audit format
  - Nature of the issue
  - What created the audit need (e.g., patient complaint, outside inquiry, hotline call, investigation interview)?
  - Are there patient safety issues?
  - Identifying potential payers involved
  - What policy, rule, law, regulation may have been violated?
  - Define a timeframe goal for the completion of the audit

Audit Performance

- Auditing/monitoring objective
- Where to start?
- When to start?
- How did the issue arise?
- Personnel involved
- Is there a deadline?
- Availability of audit grid/tool or ad hoc
- Technology available
- Audit team skill set
Audit Process

- Define audit lead
- Clarify information flow prior to beginning the engagement
- Provide clear direction and instruction to team assigned
- Discuss anticipated scenarios, if at all possible
- Provide direction on levels of concern that may be discovered
- Schedule routine communications based on nature of engagement

Audit Process

- Maintain an open mindset to ensure all known risks are addressed
- Report development
- Identify reporting requirements
- Identify process for high risk situations that require immediate attention
- Communicate need for plan of correction
- Establish expectation for root cause analysis
Audit Process

- Address all issues so that engagement can be closed
  - Patient Safety
  - Billing
  - Clinical
  - Administrative
  - Re-Education
  - Human Resources
  - Reporting
  - Legal
  - Licensure
  - Accreditation

Audit Teams and Approach

- On site review
  - Opportunity to review original documentation
  - Home Visits
  - Administrative process
  - HR Files
  - Interviews of Leadership
  - Escalation process
Audit Teams and Approach

- Claims Testing
  - Documentation – Shift Level, Authorizations/Orders
  - Documentation – Physician Orders
  - Clinical Quality
  - Claims Submission
  - Financial Review

- Flexibility
- Knowledge of Payer/Program Requirements
- Audit Tools Specific to a Program
  - Homecare Certified locations
  - Behavioral - state / program specific
  - State waiver programs
Utilization Review Processes – Utilization Review Committee

- Created in July 2013
- 4 clinicians including compliance and legal members
  - CMO
  - VP of Clinical
  - VP of Compliance
  - Regional Compliance Officer (rotating)
  - Senior Director of Compliance
  - Chief Counsel, Healthcare
  - Legal Assistant

- Meetings based on volume; every other month
- Peer Review Committee
- Medical necessity
- Homebound status
- Clinical documentation issue
- Repayments have been made
Utilization Review Processes

- In order to determine whether a repayment may be warranted, review the following documentation:
  - Diagnosis
  - Physician orders
  - Home visits
  - Assessments/Reassessments
  - Payer’s definition of medical necessity
  - Nursing or Aide notes
    - Repeated refusal of services
    - Goals met
    - Patient is independent

HANDLING REPAYMENTS
Repayment Process Best Practices – Process Flow

- Conduct internal compliance investigation
  - Gather facts
  - Conduct interviews
  - Scope of non-compliant issue
  - Determine credibility of witness to substantiate claims
- Review non-compliant issue for a repayment
  - Legal Billing Analysis Team
  - Review regulations to determine conditions of payment or conditions of participation
  - Conduct risk analysis

If repayment is warranted, dates of services are calculated for repayment by finance/accounting team
- Repayment database logged (tracking system)
- Accounts for days (30 days, 60 days in the system)
- All repayments are tracked to be paid back within 30 days of identification per Maxim’s CIA (stricter than federal law)
- Closed out when check is cashed or when electronic refund is processed
- Chief Compliance Officer is notified as to the number of days a repayment is open through share point system
Repayment Process Best Practices – Process Flow

- Discuss self-disclosure with Medicaid Fraud Control Unit, if applicable
- Top 15 Repayments/Audits are discussed on a monthly call with the Chief Financial Officer, Chief Compliance Officer, General Counsel, Finance and Accounts Payable
  - Need to determine probability of repayment if in appeal or litigation
  - Finance will need to accrue for large repayments

Questions?

THANK YOU!
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