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HOT TOPICS IN MEDICARE, RAC, ZPIC & MIC APPEALS

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I. RACS, MICS AND ZPICS

RACs – Recovery Audit Contractors

MICs – Medicaid Integrity Contractors

ZPICs – Zone Program Integrity Contractors

Recovery Audit Contractors

- Authorized by § 1893(h)(1) of the Social Security Act; 42 USC 1395 ddd(h)(1).
- HHS contracts with Recovery Audit Contractors (RACs).
- Purpose:

  Identify and recoup overpayments and identify underpayments of post-payment fee-for-service, Part A & B claims.

RAC Audit Implementation § 1893(h)(3)

- Tax Relief and Health Care Act of 2006, § 302, authorizes nationwide RAC contractors program implemented by January 1, 2010. RAC@cms.hhs.gov
- Four RAC Contractors awarded and Validator RAC.
- Websites:
  - www.dcsrac.com/providerportal.aspx
  - http://racb.cgi.com
  - www.connollyhealthcare.com/RAC
  - http://racinfo.healthdatainsights.com
  - www.provider-resources.com

The Four RACs

1. Region A – Performant Recovery (previously known as Diversified Collection Services, Inc. of Livermore, CA,) CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT.
2. Region B - CGI Technologies and Solutions, Inc. of Fairfax, VA, in IL, IN, KY, MI, MN, OH, WI.
3. Region C - Connolly Consulting Associates, Inc. of Wilton, CT, in AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands.
4. Region D – HealthDataInsights, Inc. of Las Vegas, NV, in AK, AZ, CA, HI, IA, ID, KS, MO, MT, NB, ND, NV, OR, SD, UT, WA, WY.

RAC Validator Contractor

- Provider Resources, Inc. of Erie, PA.
- RAC Validator works with CMS to approve new audit issues.
- CMS approves RAC audit issues and they are posted on RAC website.
- RAC Validator checks accuracy of overpayment collected by the four RACs by reviewing a sample of selected claims.

RAC Audit and Recovery Periods §1893(h)(4)

- RACs audit a percentage of claims based on volume criteria specific to provider/supplier type.
- RACs can audit claims paid by Part A & B during a fiscal year retroactive three years from the date the claim was paid.
- RAC Data Warehouse with claims data created by CMS.
- RAC paid a contingency fee of 9-12.5% from amounts recovered.
- As of 1/1/12, Demand Letter sent by MAC not RAC

Report to Congress § 1893(h)(8)

HHS must report annually to Congress on:

a. Use of RACs.
b. Overpayment amounts, identified and recouped.
c. Underpayment amounts, identified.
d. Evaluation of comparative performance of 4 RACs.
e. Savings to Medicare program.
f. Medicaid RAC.

Reported Collected Overpayments and Total Corrected Amounts

February 5, 2013 report to Congress for Fiscal year 2011 indicated that RACs:

1. Identified and corrected 887,291 claims
2. $939.3 million in improper payments corrected
   a. $799.4 million in overpayment
   b. $141.9 million in underpayments
   c. $488.2 million returned to Medicare Trust Fund

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/rac/

RAC Recoveries by Contractor

By amounts collected:

1. Region D – HealthDataInsights, Inc. (HDI)
2. Region C – Connolly Consulting Associates, Inc.
3. Region B – CGI Technologies & Solutions, Inc.
4. Region A – Performant Recovery, previously known as Diversified Collection Services, Inc. (DCS)

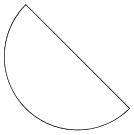
Automated Review Process

Automated Review Process:

- RAC reviews claims data – "data mining".
- Overpayment determination made without contacting provider.
- No review of medical record because
  a. there is a clear policy that is the basis for the denial. *"Clear Policy"* means a statute, regulation, National Coverage Determinations (NCD), Local Coverage Determinations (LCD) or CMS Manual, that specifies the circumstances under which payment for a service will ALWAYS be denied;
  b. the denial is based on a medically unbelievable service;
  c. failure to respond to medical record request letter within 45-day deadline, plus 10 calendar days mail time to submit.
- Claim Status Website.

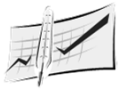
Semi-Automated Review Process

Similar to automated, reviews are made through data analysis, but there maybe documentation to support the claim, and providers will be permitted to provide the supporting documentation.



Complex Review Process

- Review of the medical chart.
- Send hard copy, CD or DVD.
- RNs or therapists must review medical record for coverage and medical necessity determinations.
- Certified Coders must review medical records for coding determinations.
- RACs have Medical Directors.



RAC Medicare Audit Criteria

RAC must comply with the following criteria:

- National Coverage Determinations (NCDs),
- Local Coverage Determinations (LCDs),
- CMS Manuals – coverage rules,
- CMS instructions and memoranda on interpretation of policy or regulation.

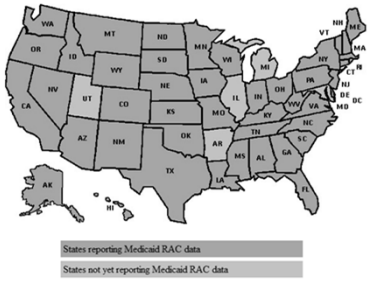
There's More

- RACs will not review medical records that are the basis of a voluntary disclosure accepted by Medicare. If claim was reviewed by OIG, or MAC, may be excluded.
- RACs can use statistical sampling and extrapolate findings to calculate overpayment.
- If the provider/supplier wins at any level of appeal, the RAC cannot keep the contingency fee it has been paid, and interest may be returned.
- MLN Matters MM6183, 9/29/08.
- MLN Matters MM7436 7/29/11

Medicaid RACS

- Implementation date was effective January 1, 2012.
- Review claims up to 3 years from date claim was filed (unless extension is received via state plan amendment).
- Subject matter is state dependent.
- Must coordinate with (1) U.S. Department of Justice; (2) Federal Bureau of Investigation; (3) Office of Inspector General of U.S. Department of Health and Human Services; (4) State Medicaid Fraud Control Units; and (5) CMS.
- Must afford providers appeal rights (State dependent).
- Paid based on contingency fee unless State law does not permit (must request exception from CMS).
- Medicaid RAC fees must be returned if overpayments are identified at any level of appeal.

States Reporting Medicaid RAC Data



http://w2.dehpg.net/RACSS/Map.aspx

RACs At A Glance Phase II Medicaid RAC Information

Contingency Fee Percentages - Overpayments: Data Table

State	Percentage	State	Percentage	State	Percentage
Alabama[1]	12.5	Mississippi	9.49	North Dakota	9.95
Arizona	12.5	Missouri	12.0	Ohio	10 .5
Colorado	11.0	MEAN	10.94	Oregon	9.4
Connecticut	9.3	Nevada	8.75	Pennsylvania5	11.57
Georgia	12.5	New Hampshire[4]	11.5	South Carolina	11.9
Indiana	10.5	New Jersey	11.5	Tennessee	12.0
Iowa[2]	12.5	New Mexico	10.5	Virginia	9.3
Kansas[3]	17.0	New York	5.25	Washington	9.9
Kentucky[1]	12.5	North Carolina	11.5		

1. **Alabama has two contracts that both pay a contingency fee of 12.5%.**
2. **Iowa uses a tiered contingency fee percentage structure.**
3. **In Kansas, a small number of vendors bid on the Medicaid Recovery Audit contract, so the State was granted an exception to the contingency fee percentage cap.**
4. **New Hampshire pays its RAC vendor different contingency fee percentage rates the first and second year.**
5. **Pennsylvania uses a tiered contingency fee percentage structure.**

http://w2.dehpg.net/RACSS/overpayments.aspx

RACs At A Glance Phase II
Medicaid RAC Information

Types of Underpayment Methodologies: Data Table

Underpayment Methodology Type	Number of Occurrences
Number of States paying contingency fees	15
Number of States paying a flat fee	5
Number of States paying tiered flat fees	1
Number of States paying other alternate arrangements	4

1. Alabama is not included because it has two contracts. Contract one has an alternate arrangement and contract two uses a contingency underpayment.
2. Washington is not included because it uses two types of payment methodology. It uses a flat fee as well as an alternate arrangement.

http://w2.dehpg.net/RACSS/Underpayments.aspx

Medicaid Integrity Contractors (MICs) of CMS

There are three types of MICs:

- Review 
- Audit 
- Education 

Review MIC

MICs review paid claims to ensure that:

- Services were provided and properly documented.
- Services were billed properly, using correct and appropriate procedure codes.
- The claims submitted were for covered services.
- The claims were paid according to Federal and State law, regulations and policies.
- Analyze Medicaid claims data to identify high-risk areas and potential vulnerabilities.
- Provide leads to the Audit MICs.
- Use data-driven approach to ensure focus on providers with truly aberrant billing practices.

Audit MICs

- Conduct both field and desk post-payment audits.
- Fee-for-service, cost report and managed care audits.
- The audits identify overpayments, and the individual State collects overpayments and adjudicates provider appeals.

Education MICs

- Use findings from Audit and Review MICs to identify areas for education.
- Work closely with Medicaid partners & stakeholders to provide education and training.
- Develop training materials, awareness campaigns and conduct provider training.
- Highlight value of education in preventing Medicaid fraud, waste, and abuse.

Current Audit MICs

Audit:

- Booz Allen Hamilton
- Cognosante
- IPRO
- Integriguard
- Health Integrity LLC

Audit MICs Task Orders Issued To:

1. Regions I / II - IPRO
2. Regions III / IV - Health Integrity LLC
3. Regions V / VI - Health Integrity LLC
4. Regions VII / VIII - Health Integrity LLC
5. Regions IX / X - Integriguard

Current Review MICs

- Review
  - Advance Med
  - ACS Healthcare
  - Thomson Reuters
  - IMS Government Solutions

Review MICs Task Orders Issued To:

1. Regions I / II - Thomson Reuters
2. Regions III/IV - Thomson Reuters
3. Regions V/VI - Advance Med
4. Regions VII/VIII - Advance Med
5. Regions IX/X - Advance Med

Current Education MICs

- Education
  - Information Experts
  - Strategic Health Solutions

ZPIC

Role is to prevent, detect and deter fraud, waste and abuse by:

1. Performing Data Analysis and Data Mining
2. Conducting Medical Reviews in Support of Benefit Integrity
3. Supporting Law Enforcement and Answering Complaints
4. Investigating Fraud and Abuse
5. Recommending Recovery of Federal Fund through Administrative Action
6. Referring Cases to Law Enforcement

ZPIC (cont'd)

The ZPIC:

- Prevents fraud by identifying program vulnerabilities.
- Proactively identifies incidents of potential fraud that exist within its service area and takes appropriate action on each case.
- Investigates (determines the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources.
- Explores all available sources of fraud leads in its jurisdiction, including the MFCU and its corporate anti-fraud unit.
- Initiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud.
- Refers cases to the Officer of the Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions.
- Refer any necessary provider the beneficiary outreach to the POE staff at the AC or MAC.

ZPIC Zones

Zone	ZPIC	States in Zone
1	Safeguard Services (SGS)	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
2	AdvanceMed	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
3	Cahaba	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
4	Health Integrity	Colorado, New Mexico, Texas, and Oklahoma
5	AdvanceMed	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
6	Under Protest	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
7	Safeguard Services (SGS)	Florida, Puerto Rico, Virgin Islands

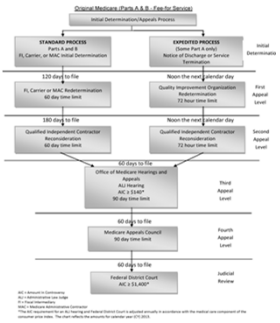
What To Do Once The Audit Is Done

THE GOVERNMENT ENTITY HAS FINISHED ITS AUDIT - NOW WHAT HAPPENS?

What are Providers' Options Following A Demand Letter?

- Pay any amount due by check
- Allow recoupment from future payments
- Request or apply for extended repayment plan
- Appeal/Stay Recoupment
- Interest may apply

Medicare Appeals Process



The Medicare Appeals Process

1. MACs must explain clinical and scientific basis for decision.
2. Providers may pursue appeals on behalf of patient
   a. Beneficiaries and providers, participating suppliers, and non-participating suppliers who accept assignment of claim have standing to appeal.
   b. Beneficiaries can assign their appeal rights to a provider or supplier.
   c. Must use form available at: www.cms.hhs.gov/forms or provide a letter with all required information
   d. With few exceptions, a party may appoint anyone to act as their representative
3. CMS AND MAC can participate in ALJ hearings.
4. OIG Report OEI -02-10-00340, November 2012 Recommended increased CMS Participation in ALJ Appeals
5. There is a process to expedite an appeal in certain circumstances.

The Medicare Appeals Process

The Initial Determination (ID):
42 C.F.R. § § 405.920-928

1. Contractor must review a "clean" claim within 30 days or interest runs to be paid to patient
2. 45 days to review non-clean claim. No interest.
3. A clean claim has no defect or impropriety requiring special treatment for payment.
4. Denied claim must explain reason, if LCD OR NCD used, and how to apply for Redetermination.

The Medicare Appeals Process

Redeterminations:
42 C.F.R. § § 405.940-958

1. Request within 120 days of receipt of ID plus 5 days for mailing if date of receipt not established.
2. No Amount in Controversy (AIC).
3. Request for Redetermination must contain:
   a. Summary of facts and clinical evidence supporting claims.
   b. Explain how laws, regulations, coverage rules and CMS policies apply.
   c. Explain why disagree with ID and include any new evidence.
4. Redetermination by same MAC, but not individual(s) involved in the ID.

The Medicare Appeals Process (cont'd)

5. MAC has 60 days to issue a redetermination. If evidence is submitted after request, extra 14 days.
6. Redetermination decision by MAC must contain:
   a. How to apply for Reconsideration.
   b. Statement that all evidence must be submitted with Request to QIC.

   c. At next level, ALJ will not accept additional evidence unless good cause shown, or beneficiary not represented.
   d. MAC can add new issues relevant to claim.

The Medicare Appeals Process (cont'd)

Reconsideration:
42 C.F.R. § § 405.960-978

1. 180 Days to request Reconsideration – 5–day mail rule.
2. Reconsideration is an independent, on-the-record review of an ID, redetermination, and all issues related to the claim made to Qualified Independent Contractor (QIC), on CMS Form, or in writing with certain required information.
3. Request should include all new evidence and explain why disagree.

The Medicare Appeals Process (cont'd)

Reconsideration (cont'd)

4. QIC reviews evidence already submitted and new evidence submitted with Reconsideration, as well as evidence the QIC develops on its own. QIC has 60 days to issue reconsideration decision, but if evidence presented after request, additional 14 days.
5. If issue is whether service or item is "reasonable and necessary" under § 1862(a)(1)(A) of SSA, the Reconsideration must consider recommendation from panel of physicians or appropriate health care professionals, and be based on clinical experience, the patient's medical, record, and medical, technical and scientific evidence of record.

The Medicare Appeals Process (cont'd)

6. Reconsideration decision must include:
   a. Favorable or not.
   b. Summary of facts including clinical and scientific evidence.
   c. Explanation of how law, regulations, coverage rules and CMS policies apply to facts.
   d. If issue is reasonable and necessary, explain medical and scientific rationale.
   e. If missing documentation, explain how impacted decision.
   f. How to apply for ALJ hearing and $140 AIC – index for inflation.

The Medicare Appeals Process (cont'd)

ALJ Hearings:
42 C.F.R. §§ 405.1000-1064

1. Within 60 days, request ALJ hearing-usually via te or by video conferencing. Can request an in pers g, but must demonstrate good cause. Can also request a decision on-the-record (without hearing). AIC of $140 indexed for inflation. ALJ has 90 days to issue decision with certain exceptions.
2. If the QIC does not issue Reconsideration within 60 days, file request to escalate to ALJ hearing. QIC has 5 days to issue Reconsideration after escalation request.
3. Request for ALJ hearing must include:
   a. Reason disagree with QIC's Reconsideration
   b. Statement of additional evidence to be submitted, and when.
   c. Appellant must send copy of its request for ALJ hearing to all other parties.

The Medicare Appeals Process (cont'd)

ALJ Hearings:
42 C.F.R. §§ 405.1000-1064

4. CMS or MAC/RAC may be a "Party" and there may be "Participation" by CMS or MAC/RAC at its request or ALJ request. Appellant must be given notice within 10 days after receipt of Notice of Hearing.
   42 C.F.R. § 405.1010 and 42 C.F.R. § 405.1012.
   OIG REPORT OEI-02-10-00340
5. Evidence must be submitted with request for hearing or within 10 days after receipt of Notice of Hearing. Late submission tolls 90 days adjudication period. Must have a statement explaining why evidence was not previously submitted to QIC, but it is not applicable to oral testimony at hearing or for an unrepresented beneficiary. ALJ decides if there is good cause to admit evidence or exclude it or remand to QIC for consideration.

The Medicare Appeals Process (cont'd)

1. MACs are bound by the statute, regulations, CMS Rulings, NCDs, LCDs, CMS manuals, and other program guidance.

2. QICs, ALJs, and the Medical Appeals Council are bound by the statute, regulations, CMS Rulings, and NCDs.
3. QICs, ALJs, and the Medical Appeals Council must give substantial deference to LMRPs, LCDs, CMS manuals, and other program guidance if they are applicable to a particular case.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review:
42 C.F.R. §§ 405.1100-1134

1. Request Medicare Appeals Council review within 60 days from receipt of ALJ decision. No AIC. Medicare Appeals Council may decline review. Medicare Appeals Council has 90 days to issue decision.
2. Request for Medicare Appeals Council Review must:
   a. Be on CMS standard form or written with required information.
   b. Identify parts of ALJ decision, dismissal or other determination disagree with and explain why. Why ALJ inconsistent with statute, reg., CMS ruling, etc.
   c. MAC/RAC's review is limited to issues raised unless beneficiary is not represented.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review (cont'd)

3. Medicare Appeals Council conducts a de-novo review (on its own) motion or at request of CMS or MAC/RAC. The Medicare Appeals Council will only consider the evidence that was before the ALJ if it is reviewing an ALJ decision.
4. If hearing decision decides a new issue that the parties were not given an opportunity to address before ALJ, Medicare Appeals Council will consider evidence on that issue submitted with the request for Medicare Appeals Council review.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review (cont'd)

5. Medicare Appeals Council will accept case if there is an:
   a. error of law material to the outcome,
   b. an abuse of discretion by the ALJ,
   c. decision is not consistent with the preponderance of the evidence, or
   d. there is a broad policy or procedural issue that may effect the general public interest.
6. CMS or MAC referral to Medicare Appeals Council, parties notified.
7. Medicare Appeals Council will consider all documents, evidence and transcript of oral testimony before ALJ relevant to issues, briefs may be submitted, but oral argument only if there is an important question of law, policy or fact that cannot be resolved on the written record.

The Medicare Appeals Process (cont'd)

Judicial Review:
42 C.F.R. §§ 405.1136-1140

1. Appeal to Federal District Court where the beneficiary resides or where the provider has its principal place of business.
2. Complaint filed within 60 days. The AIC is $1,400 indexed for inflation.
3. No time limit within which the Court must issue a decision.
4. The standard of review is substantial evidence. The Court reviews the administrative record below and no new evidence is permitted.

The Medicare Appeals Process (cont'd)

Escalation:

1. Advance to the next level of appeal if an adjudicator fails to issue its decision within the time limits.
2. The appellant must request the escalation in writing, or the appeal remains at the current level until decided.
3. The adjudicator has an extra 5 days to issue its decision before the appeal is sent to the next level. Recoupment will begin when a request for escalation is made and favorable decision is not issued within 5 days.
4. Appellant waives right to obtain a decision within the specified number of days from the QIC or the ALJ. Also forgo benefit of level of review skipped.

The Medicare Appeals Process (cont'd)

Expedited Access to Judicial Review:
42 C.F.R. § 405.990

1. A party to the appeal may request expedited access to judicial review if there are no material issues of fact in dispute, and a review entity certifies that the MAC does not have the authority to decide the question of law.
2. A review entity consists of three reviewers who are ALJs or members of the Department Appeal Board (DAB) as determined by HHS.
3. The issue must be a challenge to a statute, or regulation as unconstitutional, or a NCD or CMS ruling is invalid.

Reopening

42 C.F.R. § 405.980

1. A reopening is a remedial action taken to change a final determination or decision. QIC, ALJ or MAC may reopen its decision.
2. Clerical errors include human and mechanical errors on the part of a party or contractor such as:
   a. Mathematical or computational mistakes;
   b. Inaccurate data entry; or
   c. Denials of claims as duplicates.

Reopening (con'td)

3. Within 1 year from date of initial determination or redetermination for any reason.
4. Within 4 years from date of initial determination or redetermination for good cause (defined in 42 C.F.R. 405.486)
5. At any time if there is reliable evidence that the initial determination was procured by fraud or similar fact.
6. At any time if the initial determination is at all unfavorable, but only to correct a clerical error on which the determination was based.
7. At any time to effectuate a determination under the coverage appeals process.

Rebuttal Statement and Discussion Period

42 C.F.R. §§ 405.374-375

1. Rebuttal – 15 days from the date of the demand letter to submit a rebuttal statement.
2. Rebuttal statement should explain why recoupment should not be put into effect.
3. MAC must consider rebuttal evidence to decide if overpayment should be reduced or reversed.
4. The MAC will advise you of its decision in writing within 15 days of receipt of your rebuttal request.
5. Discussion Period – Call MAC immediately for a discussion of why overpayment is wrong. Can request additional time for discussion period, but appeals deadlines are not stayed. Recoupment begins 41 days from date of denial letter.

Stay of Recoupment

"Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness."

42 C.F.R. § 405.370

- Recoupment is stayed during first two levels of appeal (if filed within appropriate time frames), redetermination and reconsideration, but interest continues to accrue.

Time Deadline for Stay of Recoupment

You Can Stay Recoupment of an Overpayment

- A provider has 120 days from receipt of the Demand Letter (5 days from mailing) to file a request for redetermination to the MAC.
- Recoupment begins on the 41st day after the date of the Demand Letter, unless the MAC receives a request for redetermination within 30 days from the date of the Demand Letter (not 30 days from the date of receipt).
- If the redetermination decision is not favorable, a provider has 180 days to file a request for reconsideration with the QIC.

Time Deadline for Stay of Recoupment (cont'd)

- The MAC can begin recoupment on the 61st day after the unfavorable redetermination notice, unless the provider files a request for reconsideration within 60 days.
- If the reconsideration decision is not favorable, a provider can appeal further, but recoupment cannot be stayed during the appeal.

II. HIGHLIGHTS OF KEY AUDIT ISSUES FOR HOME HEALTH AGENCIES AND HOSPICE

WHAT ARE THE ISSUES CURRENTLY BEING REVIEWED?

Medicare Home Health Coverage Criteria

- The beneficiary must be confined to the home.
- Under the care of a physician while the home health services are furnished.
- In need of skilled services (Nursing, PT, ST or continuing OT).
- On a part-time or intermittent basis (Maximum 8 hours/day totaling 28 and up to 35 hours per week).
- A plan of care has been established and is periodically reviewed by the patient's physician.

Home Health Issues Being Audited

- Eligibility Criteria (homebound, skilled service part-time or intermittent basis, care of physician)
- Plan of Care (verbal and written orders must be signed and dated by physician before billing)
- Face-to-Face (completed, technical requirements and timely)
- Lack of valid orders; no stamped signatures
- Physical Therapy Visits –LUPA plus 1 & 13/19
- Documentation does not support medical necessity
- Duplicate billing by 2 providers for same date of services
- Excluded individuals and providers

OIG Home Health Risk Areas

The OIG has identified 31 Risk Areas for home health agencies - footnotes

Department of Health & Human Services Office of the Inspector General Compliance Program Guidance for Home Health Agencies – 8/7/98

http://oig.hhs.gov/authorities/docs/cpghome.pdf

Home Health OIG Risk Areas

Risk:

1. Billing for services or items not actually rendered.

Strategy:

- Double-check time sheet and/or clinical documentation in the record prior to billing. This applies to clinical staff, as well as to HHAs and PCAs.
- Set up communication process between clinical and billing department to coordinate so that billing is done only after documentation exists and has been reviewed.

Home Health Risk Areas

Strategy (cont'd):

- If a provider does not respond timely to a request for documentation, the government can take the position that the documentation does not exist, and will recoup the money paid for those services.
  Meet deadline or obtain an extension.

Home Health OIG Risk Areas

Risk:

2. Billing for medically unnecessary services.

   OIG defines *"medically unnecessary services"* as *"services not warranted by the patient's current and documented medical condition."*

   The claim form includes a certification that the services billed are medically necessary for the health of the beneficiary and rendered pursuant to signed physician orders.

Home Health OIG Risk Areas

Strategy:

- OASIS, plan of care (485) and the clinical record documentation must agree as to the medical necessity of the services provided, as well as the patient's clinical status. Discrepancies between the three items above may lead to recoupment from either Medicare or Medicaid.
- Ongoing OASIS training for nurses conducting assessments.
- 24-hour home health aide live-in vs. 2/12-hour shifts.

Home Health OIG Risk Areas

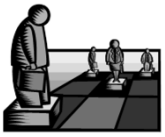
Risk:

3. Duplicate billing
   - Submitting the same claim twice
   - Submitting a claim for the same services to different payors at the same time
   - Mistake vs. systemic or repeated double billing
   - Computer issues

Home Health OIG Risk Areas

Strategy:

- Work with software vendors to ensure software prevents double billing.
- Training of billing department personnel.
- Must have a denial from primary payor source prior to billing secondary payor source.



Home Health OIG Risk Areas

Risk:

4. False Cost Reports

Issues to Consider:

- Related Party / Prudent Buyer
- Ghost Employees Salary and Benefits
- Home Office Allocations
- Shared Employees Among Different Entities
- Discharge Planning vs. Patient Coordination
- Public Relations (related to patient care) vs. Marketing (increase utilization)
- Shifting of costs due to reimbursement caps

Home Health OIG Risk Areas

Strategy:

- Check payroll roster against active employees.
- Make sure all costs are allowable costs.
- Audit allowable vs. non-allowable costs, for example public relations vs. marketing.
- Disclose related organizations and see if deminimis exception applies. If it does not, reduce costs on cost report.

Home Health OIG Risk Areas

Risk:

5. Failure to Refund Credit Balances to Medicare or Other Payor Sources
   - Provider is paid twice for the same service - either by the same payor or two different payors.
   - Billing based on a proposed schedule as opposed to an actual clinic note (services planned but not performed).

Home Health OIG Risk Areas

Strategy:

- Policies and procedures to identify credit balances and promptly return any overpayments to the appropriate payor source.
- Training of billing personnel.

Home Health OIG Risk Areas

Risk:

6. Incentives to Referral Sources.
   Home Health Agency incentives to actual or potential referral sources (*e.g.*, physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation.

Federal and State Anti-Kickback Law

Prohibits, among other things, remuneration in return for ordering, or for arranging for or recommending the purchase or order of, any item for which payment may be made in whole or in part under a Federal healthcare financing program.

42 U.S.C. 1320a-7B(b);

Federal and State Anti-Kickback Law

Strategy:

- Comply with Federal safe harbor for 25 different business relationships. For example, safe harbors for space rental, personal service and management contracts, equipment rental, referral services, discounts, employees, group purchasing organizations, investment interests, warranties, waiver of beneficiary co-insurance and deductibles, electronic and health records items and services, etc. All of the safe harbors can be found in 42 C.F.R. § 1001.952.

Compliance Strategies: Legal Considerations

Referral Issues:

- Providing staff, rental payments, meals and entertainment, training, or back-up staff to referral sources.
- Providing payments to entities or individuals to refer patients.
- Providing services for free or reduced rate to the patient, or potential patient/family.
- Providers agreeing to provide referrals to each other.

Compliance Strategies: Legal Considerations

- Aides referring patients in exchange for hiring/bonus.
- Aides changing agencies and bringing patients with them from one agency to another.

See OIG Special Fraud Alert Home Health Fraud at:
http://oig.hhs.gov/fraud/docs/alertsandbulletins/081095.html

Compliance Strategies: Legal Considerations

Marketing Practices Under Anti-Kickback Law:

- Free items or services contingent on purchases, or on access to referral base
- Grants
- Travel, entertainment, gifts
- Free consultants
- Continuing education

Compliance Strategies: Legal Considerations

Strategy: **Inducement or Gift?**

- Stark Law guidance for gifts to physicians
- *"Special Advisory Bulletin Regarding Provision of Gifts and Other Inducements to Medicare Beneficiaries,"* 8/30/02 available at: http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf
- Civil Money Penalties for inducements
  - "Remuneration"
  - $10 per item / $50 per year
  - Five exceptions

Compliance Strategies: Legal Considerations

Strategy: **Compensation for Marketers**

- OIG Safe Harbor for W-2 Equivalent Employees
- DOJ position in United States of America v. Goodwill Home Healthcare, Inc.
- Marketing as part of Employee Goals and basis for Annual Evaluations
- Policy Describes Bonus Criteria – Include Compliance with Admission Criteria

Compliance Strategies: Legal Considerations

Strategy: **Marketing Practices**

- Market what you do
- Have scripts for problematic situations
- Train staff to know kickback risks
- Don't exaggerate, and don't dump on the competition
- Back-up your quality measures
- Welcome compliance officer review
- Audit your marketers and their accounts

Home Health OIG Risk Areas

Risk:

7. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.
   - In the Compliance Guidance, OIG discusses joint ventures between physicians and entities providing health services.

Home Health OIG Risk Areas

Risk:

8. Stark physician self-referral law.
   - Physician ownership of home health agency (designated health services - DHS).
   - DHS include clinical laboratory services, physical, occupational and speech therapy, radiology services, DME and supplies, home health services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, and prosthetic devices and supplies, outpatient prescription drugs, and inpatient and outpatient hospital services.

Home Health OIG Risk Areas

Stark Three-Step Analysis:

- Is there a referral from a physician for a DHS?
- Does the physician (or an immediate family member) have a financial relationship with the entity providing the DHS?
- Does the financial relationship satisfy an exception?

Home Health OIG Risk Areas

Strategy: Sanctions Under Stark

- Denial. CMS will not pay claims for improperly referred DHS.
- Refund. Entity has duty to refund to individual.
- Civil Monetary Penalties.
  - $15,000 for knowingly presenting or causing another to present improper claim, plus an assessment of 3x the amount claimed.
  - $100,000 for *"scheme"* to circumvent.
- Exclusion.
- Potential False Claims Act Liability.

Home Health OIG Risk Areas

Risk:

9. Billing for services provided to patients who are not homebound.

Strategy:

- Ensure appropriate training of clinical personnel to evaluate homebound status, and correctly document homebound status.
- Surprise home visit if suspect an issue.

Home Health OIG Risk Areas

Risk:

10. Billing for visits to patients who do not require a qualifying service.

Strategy:

- Policies and procedures must address billing for dependent services after qualifying services have ended.
- Do not bill Medicare – Utilize other payment sources for which patient qualifies.

Home Health OIG Risk Areas

Risk:

11. Overutilization and Underutilization.
    - Under PPS, Medicare overutilization has been addressed. However, physician involvement in determining the need, type and frequency of services is significant.
    - Underutilization: *"knowing denial of needed care in order to keep costs low."*

Home Health OIG Risk Areas

Risk:

12. Knowingly billing for inadequate or substandard care.

Strategy:

- Training, training, training.
- Supervision, supervision, supervision.

Home Health OIG Risk Areas

Risk:

13. Insufficient documentation to evidence that services were performed and to support reimbursement.

Strategy:

- Make sure all personnel are trained to properly document the services rendered.
- Make sure all documentation, clinical and ancillary, are reviewed prior to billing.
- Make sure all documentation is timely filed in the appropriate chart to avoid misfiling and misplacement.
- Random internal audits as part of QA process to determine compliance.

Home Health OIG Risk Areas

Risk:

14. Billing for unallowable costs of home health intake coordination.

Strategy:

- SNF & Hospital COPs and State Law.
- SNF Rate and DRG reimburse for discharge planning (D/P).
- Discharge Planning vs. Intake Coordination
- How can marketing activities become D/P?
- Free D/P activities are kickbacks.
- Safe harbor if state law permits delegation.
- Also cost report issue.

Home Health OIG Risk Areas

Risk:

15. Billing for services provided by unqualified or unlicensed clinical personnel.

Strategy:

- Check databases for current licensure, at a minimum, on an annual basis.
- Criminal History Record Check (if applicable in state).
- Check OIG and OMIG exclusion lists, if applicable in your state.
- Obtain copies of all licenses and certificates.

Home Health OIG Risk Areas

Risk:

16. False dating of amendments to nursing notes.

Strategy:

- Written policy as to who can amend notes, as well as how it should be done.
- Security measures to prevent improper changes to medical and billing records.
- Discussion with software company to determine how to amend clinical note so original and amendment, with dates of entry, exist in electronic record.

Home Health OIG Risk Areas

Risk:

17. Falsified Plans of Care.
    - Plan of care must be dated and signed by a qualified physician prior to billing.
    - A qualified physician is a physician who is properly licensed and not excluded.
    - The physician must certify all the elements of a beneficiary's eligibility for home health services, as well as the establishment of the plan of care and its periodic review.
    - Lack of physician involvement as noted above could result in non-covered services.

Home Health OIG Risk Areas

Risk:

18. Untimely and/or forged physician certifications on plan of care.

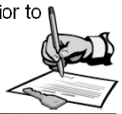
Issues:

- Physician signature obtained after the certification period ends.
- Physician orders not signed prior to billing.

Home Health OIG Risk Areas

Strategy:

- If known pool of physicians refer to CHHA, obtain a sample of the physicians' signature and periodically conduct random checks to ensure the signatures match.
- Policies and procedures for obtaining timely physician signatures.
- Mechanism to track orders and physician signatures.
- Software mechanism to prevent billing prior to obtaining signature.



Home Health OIG Risk Areas

Risk:

19. Forged beneficiary signatures on visit slips/logs that verify services were performed.

Strategy:

- Random audits, home visits by a supervisor.

Home Health OIG Risk Areas

Risk:

20. Improper patient solicitation activities and high pressure marketing of uncovered or unnecessary services.

Strategy:

- No prohibited conduct (*i.e.*, free gifts or services).

  "*Marketing should be clear, correct, non-deceptive and fully informative.*"

Home Health OIG Risk Areas

Risk:

21. Inadequate management and oversight of subcontracted services which results in improper billing.

Strategy:

- Random audits and supervisory visits.
- Reviewing vendor operations.
- Contracts with vendors should contain compliance assurances and clauses to require cooperation if documentation is requested from the provider.

Home Health OIG Risk Areas

Risk:

22. Discriminatory admission and discharge of patients.
23. Billing for unallowable costs associated with the acquisition and sale of home health agencies.

Strategy:

- Reimbursable costs on a cost report must be related to patient care, and transaction costs are not considered to be related to patient care.

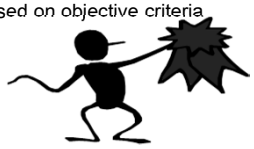
Home Health OIG Risk Areas

Risk:

24. Compensation programs that offer incentives for number of visits performed and revenue generated.

Strategy:

- Bonuses should be based on objective criteria set forth in a policy.



Home Health OIG Risk Areas

Risk:

25. Improper influence over referrals by hospitals that own home health agencies.

Strategy:

- Federal law requires that hospitals provide patients with a list of post-hospital service providers to ensure patient choice.

Home Health OIG Risk Areas

Risk:

26. Patient abandonment in violation of applicable statutes, regulations and Federal health care program requirements.

Strategy:

- State rules regarding patient discharge HHAABN.

Home Health OIG Risk Areas

Risk:

27. Knowing misuse of provider certification numbers resulting in improper billing.

Strategy:

- **Don't do this.**

Home Health OIG Risk Areas

Risk:

28. Duplication of services by assisted living facilities, hospitals, clinics, physicians, and other home health agencies.

Strategy:

- Compare ALF regulations – avoid overlap of services.
- Liaison resolve overlap aide issues.
- Clinical Form document activities – avoid overlap.
- Potential for inducement and kickbacks.
- Safe harbor protections – lease, shared employees, etc.

Home Health OIG Risk Areas

Risk:

29. Knowing or reckless disregard of willing and able caregivers when providing home health services.

Strategy:

- When a patient has a willing and able family member available to take care of the patient, or if the patient refuses services, home health services are not considered to be reasonable and necessary.

Home Health OIG Risk Areas

Risk:

30. Failure to adhere to home health agency licensing requirements and Medicare Conditions of Participation.

Strategy:

- Compliance with Federal and state laws (compliance plans).

Home Health OIG Risk Areas

Risk:

31. Knowing failure to return overpayments made by Federal health care programs.

Strategy:

- Check billing to ensure that billing matches documentation.
- Documentation prior to billing
  - MD orders, patient consents, signed POC.
- Random billing audits.
- If discover that provider is not entitled to money, contact health care attorney to investigate and return reimbursement.
- Frequent open communication between billing, clinical and QA.

OIG Hospice Risk Areas

The OIG has identified 28 risk areas for hospices. These risk areas are explained in great detail in the footnotes to the OIG Model Compliance Program Guidelines for Hospices issued 1999 and found at:

www.oig.hhs.gov/authorities/docs/hospicx.pdf

Hospice Risk Areas

1. **Uninformed consent to elect the Medicare Hospice Benefit**
2. **Admitting patients to hospice care who are not terminally ill.**

   Certification of Terminal Illness 42 CFR § 418.22
   - Within 2 calendar days of start of hospice benefit need written certification, or oral certification and written before billing Medicare – or up to 15 calendar days prior to the date of election.
   - Initial certification need both MD and attending, if any.
   - Re-certification just MD - up to 15 calendar days prior to the subsequent benefit period.
   - Oral certification from MD within 2 days and documented; don't wait for IDT meeting.

Hospice Risk Areas

Face-to-Face Encounter – 42 C.F.R. § 418.22 (a)(4)

- Required for any hospice patient entering their third or later benefit period.
- Visit may be completed up to 30 calendar days prior to the recertification date.
- Visit may be done by hospice physician or hospice NP.
- Face-to-Face visit is not a billable visit unless there are other services rendered to justify billing.

Hospice Risk Areas

"*Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the certification.*" 418.22(b)(2)

- oral certification must include oral recitation of clinical information
- Reason - "*needed for the hospice IDG to develop the initial plan of care for new patient"*

Certification form must list "to" and "from " dates of certification periods as of 1/1/11, delayed implementation to 5/12/11 as per Transmittal 69, Change Request 7377 issued 4/22/11.

Hospice Risk Areas

Suggested Actions:

- Process to document who received MD verbal certification, date, confirming signature of hospice employee.
- Create computer based tickler system to ensure verbal/written certification are completed timely.
- Revise certification form to include required clinical information, such as history, test results, labs, attending notes and hospital records or discharge note.
- Ensure that the narrative has been completed – if the narrative is located on the certification form, the narrative must be located immediately above the physician's signature; if on another form, must be signed separately.
- Check Medicare database for patient benefit periods to determine whether a face-to-face visit is required.
- Audit medical records for compliance.

Hospice Risk Areas

Admission to Hospice 42 C.F.R. § 418.25

- When determining whether to certify, Medical Director must consider, at a minimum:
  a. diagnosis of the patient's terminal condition
  b. other health conditions, related or not to TI
  c. current clinically relevant information supporting all diagnoses
- Direct consultation between MD and attending not required, only review of patient information obtained directly or indirectly.

Hospice Risk Areas

Suggested Actions:

- Establish procedure for obtaining § 418.25 clinical information from attending physician.
- Create a process by which § 418.25 information is communicated to Medical Director prior to the certification.
- Document.

Hospice Risk Areas

3. **Arrangement with another health care provider who a hospice knows is submitting claims for services already covered by the Medicare Hospice Benefit**
4. **Underutilization.**

Covered Services 42 C.F.R. § 418.202:

Amended to reflect 1998 Program Memorandum.

- Hospice includes not only services listed in SSA § 1861(dd)(1) – definition, but also any service covered by Medicare that is needed for palliation and management of TI.
- Radiation, if used for palliative care, and part of hospice plan of care.

Hospice Risk Areas

5. Falsified medical records or plans of care.
6. Untimely and/or forged physician certifications on plans of care.
7. Inadequate or incomplete services rendered by the Interdisciplinary Group (IDG).
8. Insufficient oversights of patients receiving more than six consecutive months of hospice care.

Hospice Risk Areas

9. Hospice incentives to actual or potential referral sources (*e.g.,* physicians, nursing homes, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar Federal or State statute or regulation, including improper arrangements with nursing homes.
10. Overlap in the services that a nursing home provides, which results in insufficient care provided by a hospice to nursing home residents.

Hospice Risk Areas

11. Improper relinquishment of core services and professional management responsibilities to nursing homes, volunteers, and privately-paid professionals.
12. Providing hospice services in a nursing home before a written agreement has been finalized.
13. Billing for a higher level of services than was necessary.

Hospice Risk Areas

14. **Knowingly billing for inadequate or substandard care.**
15. **Pressure on a patient to revoke the Medicare Hospice Benefit when the patient is still eligible for and desire care, but the care has become to expensive for the hospice to deliver.**

Hospice Election & Discharge From Hospice

Election of Hospice Care 42 C.F.R. § 418.24:

- Only revocation by beneficiary or discharge by hospice can terminate election.
- 90-90-60-etc. periods effective as long as patient:
  - remains in care of hospice
  - does not revoke the election to receive hospice care
  - is not d/c by hospice pursuant to § 418.26

Discharge from Hospice Care 42 C.F.R. § 418.26

- Patient moves out of service area or transfer to another hospice
- Hospice determines that patient is not longer TI
- For cause
  - patient's behavior is *"disruptive, abusive or uncooperative"* so that hospice cannot provide care
  - threat from family
  - drug dealing by family

Hospice Election & Discharge From Hospice

Suggested actions:

- Develop policy on discharge for cause
- Regulations require:
  a. notice to patient of d/c for cause
  b. serious effort to resolve problem
  c. d/c not due to patient use of hospice services
  d. document all above in medical record
- Develop D/C Planning Process *if* patient stabilizes.

Hospice Risk Areas

16. **Billing for hospice care provided by unqualified or unlicensed clinical personnel.**
17. **False dating or amendments to medical records.**
18. **High-pressure marketing of hospice care to ineligible beneficiaries.**
19. **Improper patient solicitation activities, such as *"patient charting."***

Hospice Risk Areas

20. **Inadequate management and oversight of subcontracted services, which results in improper billing.**
21. **Sales commissions based upon length of stay in hospice.**

    Productivity bonus to bona fide employee based on written criteria for bonus and policy that admissions are on based on eligibility of patient and no nexus to LOS.

Hospice Risk Areas

22. **Deficient coordination of volunteers.**
23. **Improper indication of the location where hospice services were delivered.**
24. **Failure to comply with applicable requirements for verbal order for hospice services.**
25. **No-response to late hospice referrals by physicians.**

Hospice Risk Areas

26. **Knowing misuse of provider certification numbers, which results in improper billing.**
27. **Failure to adhere to hospice licensing requirements and Medicare conditions of participation.**
28. **Knowing failure to return overpayments made by Federal health care programs.**

OIG 2013 Home Health Work Plan

- OIG will review compliance with the Home Health Face-to-Face requirement.
- OIG will determine extent to which HHAs are complying with State requirements of criminal background checks of employees.
- OIG will review the timeliness of HHA recertification and complaint surveys conducted by State Survey Agencies and Accreditation Organizations, their outcomes and follow up to complaints.
- OIG will review Outcome and Assessment Information Set (OASIS) data to identify payments for episodes for which OASIS data were not submitted or the billing codes on the claims are inconsistent with OASIS data.

OIG 2013 Home Health Work Plan (cont'd)

- OIG will also identify the number of States that violate Federal regulations by inappropriately restricting eligibility for home health services to homebound recipients.
- OIG will review activities of CMS contractors to identify and prevent improper home health payments.
- OIG will review compliance with various aspects of PPS.
- OIG will review cost report data to analyze HHA revenue and expense trends under the home health PPS to determine whether the payment methodology should be adjusted.

OIG 2012 Home Health Work Plan

- OIG will review the timeliness of surveys, outcomes of the surveys, and nature and follow-up of complaints.
- OIG will review oversight by CMS of OASIS data submitted.
- OIG will review OASIS data for episodes in which OASIS data were not submitted or for which claim billing codes are inconsistent with OASIS.
- OIG will review claims to identify home health agencies that exhibited questionable billing in 2010.
- OIG will review reduction in payment errors by MACs as well as fraud and abuse prevention and performance efforts by MACs.
- OIG will review home health payments to determine whether incorrect wage indexes were utilized to calculate the payments.

OIG 2012 Home Health Work Plan (cont'd)

- OIG will review compliance with PPS requirements.
- OIG will review cost report data trends to determine whether the home health PPS payment methodology should be adjusted.
- OIG will review the health screening records of home health workers who provide services to Medicaid beneficiaries.
- OIG will review HHA claims to determine whether beneficiaries have met eligibility criteria.
- OIG will review CMS policies and practices for reviewing the sections of Medicaid State plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements for home health services. OIG will also identify the number of States that violate Federal regulations by inappropriately restricting eligibility for home health services to homebound recipients.

OIG 2013 Hospice Work Plan

- **OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities.**

  - In a recent report, OIG found that 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.
  - OIG will focus their review on hospices with a high percentage of their beneficiaries in nursing facilities.
- **OIG will review the use of hospice general inpatient care in 2011, and will also assess the appropriateness of hospices' general inpatient care claims.**

OIG 2013 Hospice Work Plan (cont'd.)

- **OIG will review hospital discharges to hospice facilities – focusing on hospital DRG payments.**
- **OIG will review Medicaid payments to determine compliance with Federal reimbursement requirements.**

OIG 2012 Hospice Work Plan

- OIG will review claims for inpatient stays where the beneficiary was transferred to hospice care – OIG will review the relationship (financial or common ownership) between the acute care hospitals and hospices.
- OIG will review hospice marketing materials and practices and financial relationships between hospices and nursing facilities.
- OIG will review the appropriateness of the use of GIP.
- OIG will review drug claims under Part D.
- OIG will review Medicaid payments to determine if the hospice services complied with the Federal reimbursement requirements.

Medicare RAC – Performant Recovery Home Health Issues

(DME) services related to the terminal illness during a hospice benefit period

Medicare RAC – CGI Home Health Issues

1. No skilled service – review to determine whether skilled services were needed on an ongoing basis.
2. Claims for nursing services into the third episode will be reviewed to determine if all coverage criteria are met.

Medicare RAC Connolly – Home Health Issues

1. Services related to terminal diagnosis provided during a hospice period that are billed by HHA.
2. HHA Medical record review for coverage criteria and medical necessity.
3. Request for Anticipated Payment (RAP) for home health episode w/o final claim billed.
4. Incorrect billing of HH Partial Episode Payment claim with discharge status and another HH claim was not billed w/n 60 days of PEP.
5. DME bill for medical supplies provided to HH patient. HHA Prospective Payment System includes RN, PT, OT, ST, MSW, routine and non-medical supplies, & aides, but not DME.

Medicare RAC - HealthDataInsights Home Health Issues

1. (Therapists) Therapy services rendered by therapists in private practice during a home health episode.
2. (DME) Inclusion of medical supplies in home health PPS rate.

Medicare RAC – Performant Recovery Hospice Issues

None

Medicare RAC – CGI Hospice Issues

(DME) services related to the terminal illness during a hospice benefit period

Medicare RAC – Connolly Hospice Issues

1. Audits to assess whether hospice providers are billing with Core-Based Statistical Area (CBSA) codes that are invalid or no longer in use.
2. Hospice related services billed with Condition Code 07 (related to HH, outpatient or inpatient)
3. (DME) services related to the terminal diagnosis during a hospice benefit period
4. (Short-Term Acute Care Hospitals) services related to a hospital terminal diagnosis during a hospice period are included in the hospice payment
5. Physician/NPP who has an employment, contract or volunteer relationship with a hospice billing Medicare Part B for physician services provided to a hospice patient.

Medicare RAC – HealthDataInsights Hospice Issues

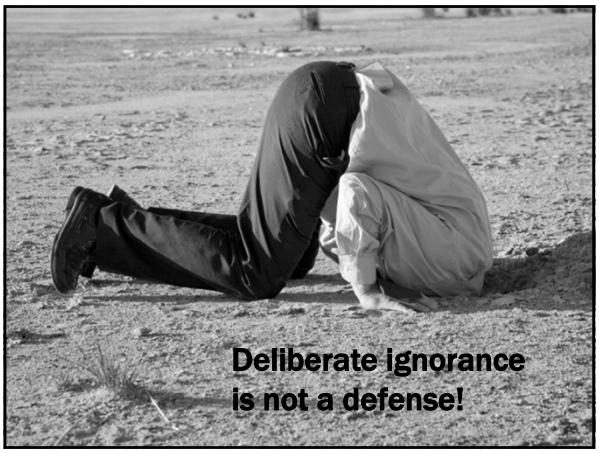
1. (DME) services related to the terminal diagnosis during a hospice benefit period
2. (Short-Term Acute Care Hospitals & Physician/NPP) services related to a hospital terminal diagnosis during a hospice period are included in the hospice payment

Hospice Issues Audited – "Low Hanging Fruit"

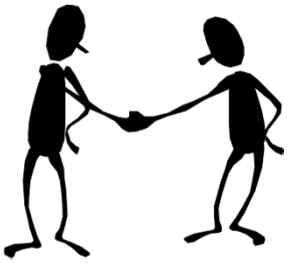
- Proper election
- Timely certifications (verbal, written and signed before billing)
- Narratives
- Face-to-Face (completed and timely)
- Lack of attending physician for initial certification
- Lack of signatures/stamped signatures
- Duplicate billing (two providers for same date of service, *i.e.*, hospice and hospital.)
- Physician Billing
- Medicare Part D billing

Complex Audit Hospice Issues

1. Lack of documentation in the record for hospice eligibility.
2. Non-Cancer Length of Stay (NCLOS).
3. Hospice services provided in the nursing home.
4. Lack of documentation in the record for level of hospice care provided.
5. Use of continuous care in a skilled nursing facility.
   MLN JA 6778



III. COMPLIANCE



What is Fraud, Waste and Abuse?

- Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist - includes obtaining a benefit through intentional misrepresentation or concealment of material facts.
- Waste includes incurring unnecessary costs as a result of deficient management, practices, or controls.
- Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally, includes excessively or improperly using government resources.

What the Government Expects

A provider has a duty to have knowledge of the statutes, regulations and guidelines regarding coverage for Medicare services including:

a. reasonable and necessary medical services furnished to beneficiaries. 42 U.S.C. § 1395y(a)(1)(A)

b. economical medical services and then, only when, and to the extent medically necessary. 42 U.S.C. § 1320c-5(a)(1)

c. clinical record must be *"legible, clear, complete, and appropriately authenticated and dated…"* in accordance with accepted professional standards.

Seven Elements of Compliance Programs

1. Written policies, procedures and standards of conduct
2. Compliance Officer and Committee
3. Effective training and education
4. Effective lines of communication
5. Enforce standards through well publicized disciplinary guidelines
6. Conduct internal auditing and monitoring
7. Respond promptly to detected offenses and develop corrective actions

1. Written Policies, Procedures and Standards of Conduct

Code of Business Ethics and Conduct:

- Commitment to compliance with Federal and State health care program requirements.
- Expectation that associates will comply.
- Right and requirement to report to Compliance Officer or Committee suspected violations of any Federal/State law or regulation or company policies.
- Commitment to non-retaliation.
- Confidentiality of disclosing employee

Compliance as an Element of Employee Performance Plan

1. Written Policies, Procedures and Standards of Conduct (cont'd)

Written Policies and Procedures:

- Comprehensive and comprehensible
- Distributed /available to all employees
- Frequently updated
- OIG Risk Areas – (Eligibility, Anti-Kickback, Medical Necessity, Plans of Care, Stark)

Records and Documentation:

- Medical Record and Billing Process/Records
- Compliance Program Documentation:
- Training, Hotline calls, corrective action plans, self-disclosures, audit and monitoring results, program modifications

2. Compliance Officer and Compliance Committee

Integrity, Independence, Authority

- Oversee/monitor the compliance program
- Report to Governing Body, Board of Directors, CEO and Compliance Committee
- Updates changes in requirements
- Develops and participates in training
- Independent Contractors
- OIG/ZPIC/RAC/MIC checks
- Investigations

Compliance Committee:

- Senior management, drawn form all departments
- Assist and support the compliance officer
- Analyze and review legal requirements
- Review/revise existing policy
- Determine strategy
- Monitor internal and external reviews

3. Effective Training and Education

- All Company Associates:
  - corporate officers, senior management, nurses, other clinical staff, administrative, marketing and financial services
- Annual, mandatory, post-tests & employee attestations
- Business Ethics and Compliance
- HIPAA
- Regulations, statutes and COP's – Program Integrity
- Eligibility and Coverage Requirements
- Billing Requirements
- Patient rights
- Duty to comply and report misconduct
- Marketing

4. Develop Effective Lines of Communication

Access to the Compliance Officer

- Unfettered access to the compliance officer
- Non-retaliation
- Confidential and anonymous

Hotline and Other forms of Communication

- Confidential Hotline
  - Confidential and anonymous
  - Readily available
  - Distributed to all
  - Appropriate follow-up to calls: log, investigations, reports
- E-mail, suggestion box, newsletters, etc., can also be used

5. Enforce Standards through Well-Publicized Disciplinary Guidelines

Effective Disciplinary Policies and Actions

- Well disseminated
- Effective
- Fair and equitable
- Enforced

New Employee Policies

- Background checks
- OIG/GSA Exclusion Lists
- State Medicaid exclusion lists

6. Auditing and Monitoring

- Pre-bill Audits
- Internal Review
- Admission, Eligibility Audits
- Certification and Plan of Care Audits
- Plan of Care Audits
- Investigation of Hotline calls and other complaints
- Patient/family complaints
- Collate data – review trends – provide feedback
- Act on findings – education, plan of correction, discipline

7. Respond to Detected Offenses and Develop Corrective Action Initiatives

- Report misconduct within a reasonable period
  - Demonstrates good faith
  - Failure to do so might be construed as a deliberate attempt to conceal findings from the government
  - Provide evidence of the violation and estimate of the overpayment that resulted from it
  - Return the overpayment (See return of overpayments)
- Demand plan of correction
- Implement corrections to practices and required disciplinary action
- Evaluate effectiveness of corrective actions

What To Do When The Government Comes Knocking

TIPS FOR PROVIDERS WHEN RESPONDING TO AN AUDIT REQUEST

How To Respond To An Audit Request

- Make certain government has your correct mailing address – mail delay is not an excuse for an untimely response.
- Designate one person to whom all audit letters will be given when received by the provider and open immediately.
- If representatives of a government entity shows up at your door, take their cards and immediately contact the individual designated for such matters.
- Designate one person to coordinate a response.
- Contact health care counsel for guidance.

How To Respond To An Audit Request (cont'd)

- Make sure that all information requested is gathered If the document is missing, find it. If the document does not exist, DO NOT CREATE IT.
- Number each page of all documentation sent to the government (bates stamp).
- Respond by the deadline noted in the audit request.
- Send the response to the correct entity at the correct address.
- Timely respond to any requests for additional information.
- Submit a road map or clinical chronology of medical record.

Two Steps Ahead

If You're Not Two Steps Ahead...

Civil Money Penalties Amended by Affordable Care Act

- ACA § 6402 amends §1128A(a)(i)(6), definition of remuneration under CMP, to exclude *"certain charitable and other innocuous programs."*
  a. Remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs;
  b. The offer or transfer of items or services for free or less than FMV if:
     i. Coupons, rebates, or other rewards from retailer;
     ii. Items offered on equal terms to general public regardless of health insurance status; and
     iii. Offer or transfer is not tied to provision of care reimbursed by Medicare or Medicaid.

Civil Money Penalties Amended by ACA

c. Offer or transfer of items or services for free or less than FMV by a person to an individual in financial need if not part of an ad or solicitation; not tied to care paid for by Medicare or Medicaid; and there is a reasonable connection between the item or service and the medical care being provided.

d. Effective March 23, 2010.

e. Effective January 1, 2011, waiver of certain co-pays under Part D for first prescription under certain circumstances.

The Civil False Claims Act: 31 U.S.C. § 3729

- Fraud Enforcement and Recovery Act of 2009 (FERA) – effective May 20, 2009 – amends the FCA.
- False or fraudulent claim for government payment exists regardless of whether the claim was presented to the government for payment.
- Actual knowledge, deliberate ignorance, or reckless disregard used to be intent requirement. Amended to eliminate the intent requirement: *"require no proof of specific intent to defraud."*
- Sufficient that the false record or statement may be *"material to a false or fraudulent claim."*
- Penalty from $5,500 to $11,000 per claim, plus treble damages.
- Other penalties include criminal prosecution, exclusions, costs and attorneys fees.
- Qui tam provisions – whistleblower.

Return of Overpayments

ACA § 6402 defines overpayment as *"any funds that a person receives or retains under Medicare or Medicaid to which the person after applicable reconciliation is not entitled . . ."*

- "Person" includes provider of services, Medicaid managed care organization, Medicare Advantage Plan and Prescription Drug Plan.
- Report and return the overpayment to Medicare or Medicaid within 60 days after O/P is identified or date any corresponding cost report is due.

Return of Overpayments

- Failure to return money a provider is not entitled to is considered a violation of the FCA and subjects the provider to a penalty of $5,500-$11,000 per claim.
- Knowingly concealing or failing to disclose occurrence of event affecting right to payment – 42 U.S.C.1320a-7b(a)(3). Criminal Sanction.

Proposed Regulations Regarding Reporting and Returning of Overpayments

Proposed Rule Published 2/16/12 in the Federal Register:

http://federalregister.gov/a/2012-03642

- If an overpayment is identified, provider has 60 days from the date the overpayment is identified to return the money
- Time period is 10 years
- Must use the self-reported overpayment refund process as set forth by the MAC
- Written report with providers name, tax ID#, how discovered, reason for O/P, claim #, DOS, Medicare claim control #.

Proposed Regulations Regarding Reporting and Returning of Overpayments (cont'd)

- Medicare NPI.
- Description of corrective action plan to ensure error does not occur again.
- Whether the provider has a CIA with the OIG or is under the OIG self disclosure protocol.
- The timeframe and total amount of the refund.
- If a statistical sample was used to calculate the overpayment, a description of the statistically valid method used.
- The refund for the overpayment. A provider may request an extended repayment schedule.

THANK YOU

Questions?

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