The OIG Report: Audits are Here!

Presented by:

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Harmony Healthcare International, (HHI)

About Kris

Kris Mastrangelo, OTR/L, LNHA, MBA

Kris Mastrangelo, President and CEO, owns and operates Harmony Healthcare International, (HHI) an industry leader in Long Term Care consulting.

- 14,000 Medical records reviewed per year
- Core Business Patient Centered

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OIG Audits

How We Got Here

Wall Street Journal, November 12, 2012

- Thomas Burton, November 2012
  - "More intensive services were done than actually performed"
  - "Patients could not benefit from it"
  - "Cutting fraud" Obama

Wall Street Journal

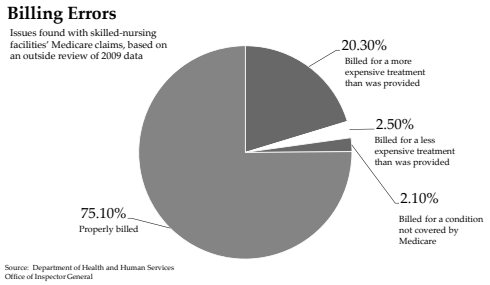
- Sample 499 claims by 245 (stays) nursing facilities
  - **1 home** reached a settlement agreement on allegations of fraudulent billing for "medically unnecessary" therapy
  - "More therapy during the period on which bills were based"
  - "Look-Back Period"

OIG Report: Claims in 2009

- 25% billed all claims in error 1.5 billion
- 26% claims <u>not supported in the medical record</u>
- 542 million in over payment
- "Majority" error "upcoded"*
- Many Ultra High

* Original RUG was a higher paying RUG than the revised RUG

OIG Report: Claims in 2009



OIG Report: Claims in 2009

- Remaining, "downcoded"*
  - Did not meet Medicare coverage requirements
- 47% claims, misreported information on the MDS
- "SNF's commonly misreported therapy"

* If the original RUG was a lower paying RUG than the revised RUG

OIG Report: Claims in 2009

- MedPac noted that the payment system "encourages SNF's to furnish therapy, even when it is of little or no benefit"
- 2006→2008 SNF's increasingly billed for higher paying categories even though beneficiary characteristics remained largely unchanged

OIG Report: Claims in 2009

- 3 RN Nurses reviewed the claims along with the PT/OT/ST
- Analysis
  - Upcoded
  - Downcoded
  - Both considered errors

OIG Report: Claims in 2009

- Paid **$1.5 billion** for these claims. This represents 5.6 percent of the $26.9 billion paid to SNFs in 2009
- See Table 1 for the percentage of SNF claims that were in error and Appendix D for the confidence intervals

OIG Report: Claims in 2009

Table 1: Percentage of SNF Claims That Were in Error - 2009

Type of Error	Percentage of SNF Claims
Inaccurate RUGs	22.8%
Upcoded	20.3%
Downcoded	2.5%
Did Not Meet Coverage Requirements	2.1%
Total Error Rate	24.9%

Source: OIG analysis of medical record review results, 2012

OIG Report: Claims in 2009

- SNFs billed **inaccurate RUGs** in **23 percent of claims**. Most of these claims were upcoded; far fewer were downcoded
- Claims with inaccurate RUGs amounted to a net **$1.2 billion** in inappropriate Medicare payments

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OIG Report: Claims in 2009

- Notably, **20 percent** of claims billed by SNFs had **higher paying RUGs** than were appropriate
- In these cases, the SNFs upcoded the RUGs on the claims. For approximately **half** of these claims, SNFs billed for **Ultra High Therapy RUGs** when they should have billed for lower levels of therapy or nontherapy RUGs

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OIG Report: Claims in 2009

- For **57 percent** of the **upcoded claims**, SNFs reported providing more therapy on the MDS than was indicated in the medical record

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OIG Report: Claims in 2009

- For a quarter of the upcoded claims, reviewers determined that the amount of therapy indicated in the beneficiaries' medical records was not reasonable and necessary

OIG Report: Claims in 2009

- For example, in one case, the SNF provided the highest level of therapy to the beneficiary even though the medical record indicated that the **physician refused to sign the order for therapy**
- In another example, the SNF provided an excessive amount of therapy to the beneficiary given her condition

OIG Report: Claims in 2009

- In another example, the SNF report on the MDS that **speech therapy** was provided even though the record contained an **evaluation** of the beneficiary concluding that no speech therapy was needed and that speech therapy had not been provided

OIG Report: Claims in 2009

- **Two percent** of SNF claims did not meet Medicare coverage requirements
  - For some of these claims, beneficiaries were not eligible for SNF care, either because they did not need skilled nursing or therapy on a daily basis or because there were no physician orders for these services

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OIG Report: Claims in 2009

- SNFs **misreported** information on the **MDS** for **47 percent** of claims.
  - SNFs reported inaccurate information, which was not supported or consistent with the medical record, on a **least one MDS item** for 47 percent of claims
  - For **30 percent of claims**, SNFs misreported the **amount of therapy** that the beneficiaries received or needed

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OIG Report: Claims in 2009

MDS Category With Misreported Information	Percentage of Claims
Therapy (i.e., physical, occupational, speech)	30.3%
Special Care (e.g., intravenous medication, tracheostomy care)	16.8%
Activities of Daily Living (e.g., bed mobility, eating)	6.5%
Oral/Nutritional Status (e.g., parenteral feeding)	4.8%
Skin Conditions and Treatments (e.g., ulcers, wound dressings)	2.4%

Source: OIG analysis of medical record review results, 2012
Note: The rows do not sum to 47 percent because some claims had more than on problem

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Look Back Period

- In addition, reviewers found several instances in which SNFs provided **more therapy** during the **look-back** period than they did during periods that did not determine payment rates

Therapy Minutes

- In one example, the SNF provided **90** to **110 minutes** of therapy a day to the beneficiary during the **look-back** period; however, **after that period**, the SNF provided only about **half that amount** of therapy to the beneficiary

Therapy Minutes

- In another example, the SNF provided **50 to 55 minutes** of therapy a day to the beneficiary during the **look-back period**. It lowered the amount to **30 to 40** minutes a day during the **rest of the coverage** period but then raised it back to 50 to 55 minutes during the next look- back period.

MDS

- For **17 percent** of claims, SNFs **misreported** whether the beneficiaries received **special care**. The inaccuracies came primarily from one MDS item in this category – **intravenous medication**. At the time of our review, SNFs were allowed to report intravenous medication if the beneficiary received it in the hospital prior to or during the SNF stay.

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MDS

- For these claims, the **medical records** either **did not indicate** that intravenous medication was provided during the hospital or SNF stay or clearly contradicted that these services were provided

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MDS

- For **7 percent of claims**, SNFs misreported the amount of **assistance** beneficiaries needed with **activities of daily living** (e.g., bed mobility, transfers, eating, and toilet use)
- SNFs also misreported MDS items related to **oral and nutritional** status and items related to skin conditions and treatments

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Skin

- SNFs did not always report the correct **number of stage of skin ulcers** or they reported the presence of burns or open lesions inaccurately. They also did not always correctly report skin treatments, such as surgical wound care or ulcer care.

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OIG Recommendations

- Increase and **expand reviews** of SNF claims
  - CMS should instruct its contractors to conduct more medical reviews of SNF claims

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OIG Recommendations

- Use its **Fraud Prevention System** to Identify SNFs that are Billing for Higher Paying RUGs
  - CMS should use its Fraud Prevention System to identify and target these SNFs

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OIG Recommendations

- Monitor **Compliance** with the **New Therapy Assessments**
  - As of October 2011, SNFs must complete a **"change of therapy"** assessment when the amount of therapy provided no longer reflects the RUG and an "end of therapy" assessment when therapy is discontinued for 3 days

OIG Recommendations

- CMS should instruct its MACs and RACs to closely monitor SNFs utilization of these assessments through **analyses** of **claims data**. Such analyses will identify SNFs that are using the assessments infrequently or not at all.

OIG Recommendations

- **Change** the **Current Method** for Determining How Much Therapy is Needed to Ensure Appropriate Payments

OIG Recommendations

- CMS should instruct the MACs to provide **education** to all SNFs, as well as specific training to selected SNFs, to improve the accuracy of their MDS reporting

OIG Recommendations

- **Follow up** on the SNFs That Billed in Error
  - In a separate memorandum, we will refer to CMS for appropriate action the SNFs with claims in our sample that had inaccurate RUGs or that did not meet coverage requirements

Appendix D: Sample Sizes, Point Estimates, and 95 Percent Confidence Intervals for Estimates Presented in the Report

Characteristic	Sample Size	Point Estimate	95 Percent Confidence Interval
SNF claims in error in 2009	499	24.8%	18.9%-30.4%
SNF claims with inaccurate RUGs	499	22.8%	18.0%-28.2%
SNF claims with higher paying RUGs than were appropriate (upcoded)	499	20.3%	15.6%-25.6%
Upcoded SNF claims that had an Ultra High RUG	101	48.2%	34.9%-61.7%
Upcoded SNF claims in which SNFs reported providing more therapy on the MDS than was indicated in the medical record	101	56.8%	42.8%-70.2%
Upcoded SNF claims in which reviewers determined that the amount of therapy was not reasonable and necessary	101	25.6%	14.6%-39.4%
SNF claims with lower paying RUGs than were appropriate (downcoded)	499	2.5%	1.3%-4.5%
SNF claims that did not meet Medicare coverage requirements	499	2.1%	0.7%-4.7%
Total inappropriate Medicare payments for SNF claims	499	$1.5 billion	$988 million-$2.0 billion
Inappropriate Medicare payments in proportion to total payments to SNFs in 2009	499	5.6%	3.7%-7.6%
Medicare payments for SNF claims with inaccurate RUGs	499	$1.2 billion	$736 million-$1.6 billion
SNF claims that had inaccurate information on the MDS	487	47.3%	41.2%-53.5%

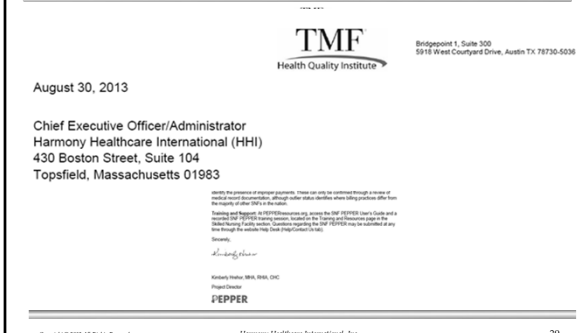
Source: Office of Inspector General medical record review, 2012

Program for Evaluating Payment Patterns Electronic Reports (PEPPER)

PEPPER

- Compare SNF to other SNFs nationally
- Received via mail on or about August 30, 2013
- Envelope with red print on the outside containing your facility specific PEPPER

Where is My PEPPER



TMF Health Quality Institute

Bridgepoint 1, Suite 300
5918 West Courtyard Drive, Austin TX 78730-5036

August 30, 2013

Chief Executive Officer/Administrator
Harmony Healthcare International (HHI)
430 Boston Street, Suite 104
Topsfield, Massachusetts 01983

identify the presence of improper payments. These can only be confirmed through a review of medical record documentation, although outlier status identifies where billing practices differ from the majority of other SNFs in the nation.

Training and Support: At PEPPERresources.org, access the SNF PEPPER User's Guide and a recorded SNF PEPPER training session, located on the Training and Resources page in the Skilled Nursing Facility section. Questions regarding the SNF PEPPER may be submitted at any time through the website Help Desk (Help/Contact Us tab).

Sincerely,

Kimberly Hefner, MHA, RHIA, CHC
Project Director
PEPPER

Where is My Pepper?

- From TMF Health Quality Institute
- Junk mail
- PEPPERResources.org from the PEPPER HELP Desk
- (http://pepperresources.org/HelpContactUs.aspx).

Where is My Pepper?

- Effective January 1, 2014 TMF will no longer resend copies of SNF PEPPERs (version Q4FY12) which were initially mailed to all SNFs on August 30, 2013.
- The next SNF PEPPER (version Q4FY13) will be distributed in late April-early May 2014 and will be available for access in electronic format by the SNF's CEO/administrator/president. TMF will send an email notification when the Q4FY13 SNF PEPPERs are available.
- TMF encourages you to sign up to receive this email by visiting the Home page of PEPPERresources.org and click on the gray box in the upper right area of the page to "Join the email list…."; fill out the requested information and select the "Skilled Nursing Facility". This will ensure that you receive any future information/updates pertaining to the SNF PEPPER.

PEPPER

- P**rovider-specific** Medicare data stat**istics** for services vulnerable to improper payments
- Compares to all other SNFs across the state, nation or Medicare Audit Contractors(MAC) jurisdiction
- Shared with both Medicare Audit Contractors (MACs) and the Medicare Recovery Auditor Contractors (RACs)

PEPPER

- Targeted areas were derived from two recent Office of Inspector General (OIG) Reports:
  - "Inappropriate Payments to skilled Nursing Facilities Cost Medicare than a Billion Dollars in 2009" (November 2012)
  - "Questionable Billing by Skilled Nursing Facilities" (December 2010).

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Claims Data

- The SNF PEPPER provides SNFs with their jurisdiction, state and national percentile values for each target area with reportable data for the most recent three fiscal years
  - FY 2012 (October 1, 2011 through September 30th) is displayed on the first table
  - When the target (numerator) count is less than 11 for a target area for a time period, statistics are not displayed

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Target Areas

- Therapy RUGs with High ADLs
- Non-therapy RUGs with High ADLs
- Change of Therapy Assessment
- Ultra High RUGs
- Therapy RUGs
- 90+ Day Episodes of Care

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Compare Target Report

- Page 1 (after introduction)
- FY2012 only
- When the SNF's percent is at or **above the national 80th percentile** for a target area, the SNF's percent is printed in red bold
- When the SNF's percent is at or **below the national 20th percentile** for a target area the SNF percent is printed in green italics
- When the SNF is not an outlier, the SNF's percent is printed in black
- Blank if Less than 11 SNFs or episodes in group

Target Count

- Number of Episodes of Care
  - Shows Volume of Care
  - The "Target Count" can also be used to help prioritize areas for review
  - Areas in which a provider is at/above the 80th percentile that have a large target count may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a smaller target count

Therapy RUGs with High ADLs

- **Numerator:** Rehabilitation and Rehabilitation Extensive RUGs
  - All Rehab "C" or "X" Days
  - Also includes RLB
- **Denominator**: All Rehabilitation RUGs

Non Therapy RUGs with High ADLs

- **Numerator:** Nursing RUGs
  - All Non Therapy "E" Days
  - Also includes BB1 and BB2 (Low ADL)
- **Denominator**: All Nursing RUGs

Change of Therapy Assessment

- **Numerator:** AI second digit equal to "D" within episodes of care ending in the report period
  - "D" is a Change in Therapy Assessment (COT)
- **Denominator:** All assessments within episodes of care ending in the report period
  - COT initiated October 1st 2011 (FY2012)

Ultra High Therapy RUGs

- **Numerator:** RUG equal Rehabilitation Ultra High or Ultra High Extensive (RUC, RUB, RUA, RUX, RUL)
- **Denominator: ALL Rehabilitation RUGs**
  - Not Total RUGs

Therapy RUGs

- **Numerator:** Rehabilitation RUGs
- **Denominator: All** RUGs

Episode of Care

- Based on episodes of care
- Defined as a series of claims for a patient where the difference between the "Through Date" of one claim and the "From Date" of the subsequent claim is less than or equal to thirty days
  - Admission through Discharge
  - Considered same Episode of Care if readmission to SNF (billed again) within 30 Days of discharge
  - **Data includes episodes of care that end in period reported**

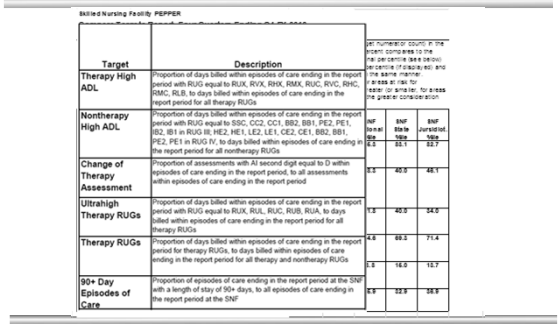
90+ Day Episodes of Care

- **Numerator:** A length of stay of 90+ days
- **Denominator:** All episodes of care ending in the report period

Target Area Reports

- **Comparative Data** for National, State and Jurisdiction
  - Some include 80th and 20th Percentile
  - Some only **include 80th percentile**

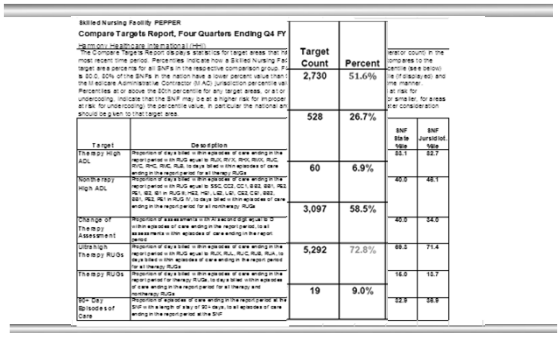
Target Areas



Skilled Nursing Facility PEPPER

Target	Description	SNF National Rate	SNF State Rate	SNF Jurisdict. Rate
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs	8.3	53.1	52.7
Nontherapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG IV, to days billed within episodes of care ending in the report period for all nontherapy RUGs	9.3	40.0	46.1
Change of Therapy Assessment	Proportion of assessments with A1 second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period	1.8	40.0	54.0
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs	4.6	69.3	71.4
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs	2.8	16.0	13.7
90+ Day Episodes of Care	Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF	8.9	52.9	56.9

Target Count and Percent



Skilled Nursing Facility PEPPER

Compare Targets Report, Four Quarters Ending Q4 FY

Target	Description	Target Count	Percent	SNF State Rate	SNF Jurisdict. Rate
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs	2,730	51.6%	53.1	52.7
Nontherapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG IV, to days billed within episodes of care ending in the report period for all nontherapy RUGs	528	26.7%	40.0	46.1
Change of Therapy Assessment	Proportion of assessments with A1 second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period	60	6.9%	40.0	54.0
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs	3,097	58.5%	69.3	71.4
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs	5,292	72.8%	16.0	13.7
90+ Day Episodes of Care	Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF	19	9.0%	52.9	56.9

Percentiles

SNF National %ile	SNF State %ile	SNF Jurisdict. %ile
85.3	83.1	82.7
58.3	40.0	46.1
21.8	40.0	34.0
64.6	69.3	71.4
8.8	15.0	13.7
25.9	32.9	36.9

A Closer Look at Target Areas

Target	Description
Therapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs
Nontherapy High ADL	Proportion of days billed within episodes of care ending in the report period with RUG equal to SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUG III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUG IV, to days billed within episodes of care ending in the report period for all nontherapy RUGs
Change of Therapy Assessment	Proportion of assessments with A1 second digit equal to D within episodes of care ending in the report period, to all assessments within episodes of care ending in the report period
Ultrahigh Therapy RUGs	Proportion of days billed within episodes of care ending in the report period with RUG equal to RUX, RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs
Therapy RUGs	Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs
90+ Day Episodes of Care	Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF

HHI Analysis

FY 2012 PEPPER ANALYSIS
Harmony Healthcare International (HHI)
430 Boston Street, Suite 104, Topsfield, MA 01983
MAC: NHIC

Target Areas	Target Count	Percent	Percentile Ranking: National	Percentile Ranking: State	Percentile Ranking: Jurisdiction (MAC)
Therapy High ADL Days	2,730	51.6%	85.3	83.1	82.7
Non-Therapy High ADL Days	528	26.7%	58.3	40.0	46.1
Change of Therapy Assessments	60	6.9%	21.8	40.0	34.0
Ultra High RUG Days	3,097	58.5%	64.6	69.3	71.4
Therapy RUG Days	5,292	72.8%	8.8	15.0	13.7
90+ Day Episode of Care	19	9.0%	25.9	32.9	36.9

≥ 80th Percentile
≤ 20th Percentile

HHI Comparative Data

National Comparative Data-Actual Percentages				
Actual SNF	Target Area	20th Percentile	50th Percentile	80th Percentile
72.8%	Therapy RUG Days	83.3%	92.1%	96.7%
58.5%	Ultra High RUG Days	21.6%	47.9%	69.2%
51.6%	Therapy High ADL Days	19.2%	32.3%	47.6%
26.7%	Non-Therapy High ADL Days	11.2%	22.9%	40.7%
9.0%	90+ Day Episode of Care	7.7%	14.5%	25.4%
6.9%	Change of Therapy Assessments	6.6%	11.2%	17.0%

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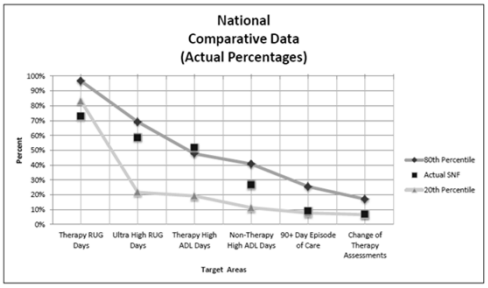
HHI Comparative Data



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HHI State and Jurisdiction Data

State Comparative Data-Actual Percentages			
Actual SNF	Target Area	20th Percentile	80th Percentile
72.8%	Therapy RUG Days	-	93.4%
58.5%	Ultra High RUG Days	-	66.6%
51.6%	Therapy High ADL Days	23.3%	49.3%
26.7%	Non-Therapy High ADL Days	16.5%	50.8%
9.0%	90+ Day Episode of Care	-	21.9%
6.9%	Change of Therapy Assessments	-	13.4%

MAC Jurisdiction Comparative Data-Actual Percentages			
Actual SNF	Target Area	20th Percentile	80th Percentile
72.8%	Therapy RUG Days	-	93.5%
58.5%	Ultra High RUG Days	-	65.4%
51.6%	Therapy High ADL Days	22.8%	49.3%
26.7%	Non-Therapy High ADL Days	14.8%	46.5%
9.0%	90+ Day Episode of Care	-	21.3%
6.9%	Change of Therapy Assessments	-	14.3%

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Closing Thoughts on PEPPER

- There is no "Good" or "Bad" PEPPER
- Compliance chart auditing at regular intervals for outlier areas
- Analyze PEPPER data
- Develop a Compliance Program

Compliance

Audit Process

Audit Process

- Significant increase in frequency of Medical Review
  - Office of Inspector General (OIG) Reports
  - Department of Justice (DOJ) Review
  - Zone Program Integrity Contractor (ZPIC)
  - Recovery Audit Contractor (RAC)
  - Budget cuts
- Expect to be Reviewed

Denial Reasons

- Services provided were likely clinically appropriate but the documentation did not support:
  - Technical requirements
  - Medical necessity
  - The skills of a therapist were required
  - Functional outcome
  - Need to receive an inpatient level of care

Technical Denial Reasons

- Response to Additional Documentation Request (ADR) did contain documentation requested
- Documentation not received within requested time frame
- Physician Certification not signed or missing
- Therapy Billing logs do not support billing
  - Part A – MDS Assessment
  - Part B - 8 Minute Rule
- Illegible documentation
- Hospital documentation was not submitted

Clinical Denial Reasons

- Documentation did not support **medical necessity**
- Documentation does not support **daily skilled intervention by a qualified therapist**
- Documentation in the medical records **must support continued progress**

Denial Reasons
Reasonable and Necessary

- The amount, frequency and duration of services were not reasonable, **given the patient's current status**
- ST documentation demonstrates that the therapist worked **long enough with the beneficiary to develop a restorative program**

Denial Reasons
Inpatient Level of Care

- Documentation did not support the need for inpatient level of care
- No daily skilled care requiring a stay in the SNF
- Supervised level of care

Denial Reasons
Medical Record Conflicts

- Nursing notes mostly dependent ADLs/functional tasks throughout the SNF stay. **Nursing note indicated there was no improvement and fluctuation of progress with self-care tasks.**
- MDS assessments indicate that the beneficiary's ability to perform functional tasks/**ADLs did not** improve from the 5-day to the 90-day assessment

Audit Process

On-site Medical Record Audits

On-site Medical Record Audits

- AdvanceMed
- Request for 160-170 medical records
- 14 days to submit
- Requesting ONLY therapy documentation
- Therapy staffing levels were requested
- AdvanceMed interviews with staff

On-site Medical Record Audits

- Rehab and MDS Questions
- Sample therapy staff interview questions:
  1. Do you feel pressure to meet your RUG levels?
  2. Who has the say on discharge from therapy?

On-site Medical Record Audits

- Sample MDS staff interview questions:
  1. Who decides the ARD?
  2. Do they provide group and concurrent treatments?

Examine Your Program

- Effective Programs Consist of:
  - Policies and Procedures
  - Staff Training and education
  - Audit functions
  - Keep apprised of Regulatory Updates
- Is your plan effective?

Zone Program Integrity Contractors [ZPICs]

- Newest contractors in the CMS arsenal
- Broad mandate and, unlike the RACs are tasked with ferreting out fraud in addition to recovering overpayments
- Unlike RACs, they have specific investigative powers and do not need to have approval for types of issues they may investigate

ZPICs

- Auditors are designed to replace the more fragmented program safeguard contractors (PSCs), which had more limited jurisdiction as to types of providers they were permitted to evaluate
- ZPIC contractors are broken down into seven specific geographic zones

ZPICs - Responsibilities

- ZPIC responsibilities are extensive and they are charged with investigating numerous issues.
  - Preventing fraud by identifying program vulnerabilities
  - Proactively identifying incidents of potential fraud that exist within its service area and taking appropriate action on each case

ZPICs - Responsibilities

- Investigating factual allegations of fraud made by beneficiaries, providers, CMS, OIG and other sources
- Exploring all available sources of fraud leads in its jurisdiction
- Initiating appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud

ZPICs - Responsibilities

- Referring cases to the Office of Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions
- Referring any necessary provider and beneficiary outreach to the POE staff at the AC or MAC

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PSC and ZPIC

- Investigations have priority over RAC investigations
- Program Integrity Manual specifically notes that data being utilized for ZPIC reviews will be inaccessible to RAC auditors so as to prevent conflicts in investigations

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ZPICs Compensation

- Incentives are set forth in specific ZPIC contract with CMS
  - Compensation based on a fixed fee plus an award fee that is determined based on performance
  - Performance award factors:
    - Quality of services
    - Administrative actions

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ZPICs Auditing

- ZPICS have a wide discretion over the types of issues they may investigate
- Data analysis will play a key role in such investigations

ZPIC Auditing: Program Integrity Manual

- Types of issues ZPICs will be auditing
  - Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis should include simple identification of aberrancies in billing patters with a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment.

ZPIC Auditing: Program Integrity Manual

- Data analysis itself shall be undertaken as part of general surveillance and review of submitted claims, or shall be conducted in response to information about specific problems stemming from complaints, provider or beneficiary input, fraud alerts, reports from CMS, other ACs, MACs or independent government and non-governmental agencies

ZPIC Investigations

- ZPICs examine:
  - Incorrect reporting of **diagnoses** or procedures to maximize payments
  - Billing for **services not furnished** and/or supplies not provided
  - Billing that appears to be a deliberate application for **duplicate payment** for the same services or supplies, billing both Medicare and the beneficiary for the same service, or billing both Medicare and another insurer in an attempt to get paid twice

ZPIC Investigations

- **Altering claim forms**, electronic claim records, medical documentation, etc., to obtain a higher payment amount
- Soliciting, offering or receiving a **kickback, bribe or rebate**
  - Paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment
- **Unbundling** or "exploding" charges

ZPIC Investigations

- Completing **Certificate of Medical Necessity** (CMNs) for patients not personally and professionally known by the provider
- Participating in schemes that involve **collusion between a provider and a beneficiary,** or between a supplier and a provider, and result in higher costs or charges to the Medicare program

ZPIC Investigations

- Participating in schemes that involve c**ollusion between a provider and a contractor** where the claim is assigned
  - The provider deliberately overbills for services, and the AC or MAC employee then generates adjustments with little or no awareness on the part of the beneficiary
- Billing based on "**gang visits**"
  - Physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients

ZPIC Investigations

- **Misrepresentations of dates and descriptions of services** furnished or the identity of the beneficiary or the individual who furnished the services
- Billing **non-covered or non-chargeable services** as covered items
- Repeatedly **violating the participation agreement,** assignment agreement and the limitation amount

ZPIC Investigations

- Using another person's Medicare card to obtain Medicare care
- Giving **false information** about provider ownership in a clinical laboratory
- Using the adjustment payment process to generate fraudulent payments

ZPICs Authority

- ZPICs have considerable latitude regarding fraud investigations and have the authority to refer cases of fraud to OIG and DOJ for civil or criminal sanctions, including the potential filing of a false claims complaint

Strategies for Providers

- Critical that providers take any audit request seriously
  - Potential for referral to the OIG or DOJ for civil monetary penalties or criminal prosecution
- It is important to have **knowledgeable counsel** to assist in reviewing the information to determine whether there is potential for serious issues
  - Regardless if the request for information seems routine

Strategies for Providers

- **Be Cautious:** If the audit is requesting contractual information that may implicate either **Stark or the Anti-Kickback Act**
  - Such claims can give rise to an FCA complaint
- Consult an appropriate Billing or Financial Consultant if indicated
  - Determine whether the claims have been submitted appropriately

Strategies for Providers

- If inappropriate submissions are suspected, counsel should retain the Financial Consultant to assist in the investigation
  - Protected by the attorney-client privilege and/or work product doctrine
- Often self investigation into one area exposes issues in another area.

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Strategies for Providers

- When information is protected, the provider can make an informed decision as to the nature of the problem and devise a strategy for correction
- May involve **self-disclosure or repayment** of the funds to Medicare

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Strategies for Providers

- If a provider can be deemed to have **voluntarily returned the funds**, as opposed to have the overpayment discovered by the government (in which case not credited for self-disclosing) they may be entitled to a **reduction in penalty** which self-disclosure may provide

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Strategies for Providers

- Counsel can assist if there is an inquiry from OIG or DOJ
  - Specifically if either issues a subpoena or investigative demand
- All inquiries must be escalated to the highest levels until the provider can be sure that no real problem exists

Vernacular

Triggering Audits

- State and Federal investigations
- ZPIC, OIG, DOJ and many other governmental entities
- Etiology of reviews vary
  - UB-04 edits
  - Diagnoses patterns
  - ICD-9 Coding
  - Whistleblowers

False Claims

Also known as qui tam or Whistleblower cases

False Claims

- **False Claims Act**

  Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval……

False Claims

……is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person

False Claims

- Example False Claims:
  - Billing for services of an unlicensed therapy professional
  - Receiving payment for therapy services to patients that were not reasonable or necessary given the patients condition
  - Corporate incentives for therapy staff to provide higher levels of care when not indicated

False Claims

- Example 1: Accused entity paid $1.5 Million for submitting claims to Medicare and Medicaid for services provided by an unlicensed speech therapist

False Claims

- Example 2: Accused entity paid $953,375 for providing services that were unnecessary, and submitting claims to Medicare.
  - For example, occupational therapy was provided to elderly Alzheimer's patients who could never expect to return to the workforce

False Claims

- Example 3: Accused entity charged with violating the False Claims Act by encouraging therapists to bill higher amounts and do more expensive therapy—even if patients didn't need therapy or could be harmed by it.
  - Billed nearly 68% of its Medicare Rehab days at Ultra High.

False Claims

- Example 4: Accused entity paid $675,000 for submitting claims for therapy (provided by contract therapy company) that did not match the residents' needs.
  - The provider is suing the therapy company for negligence and breach of contract.
  - Will the contract therapy company face government penalties - it is likely.

Allegations

- Medicare Upcoding
- Unnecessary Therapy Treatments
- Systematic Scheme
- Medicare Fraud

Allegations

- Corporate guidelines established by Operators or Directors
- Direct front line staff to follow internal guidelines to deliver expensive skilled therapy, OT, PT and ST that is not reasonable or necessary

Allegations

- Excessive Goals
  - Rehab Ultra High – regardless of clinical need
  - Length of stay targets paralleling allowable benefit coverage

Claim Submissions

Five important tips to defend allegations of improper claim submission.

1. **Review the Medical Records** prior to submission to the governmental entity and observe if there is in fact a pattern of misconduct or false claims (i.e., minutes on therapy logs match the MDS). Do not send the medical records without reviewing every claim. It is imperative to know what the auditors will unearth. Scrutinize the charts with a cynical eye.

Claim Submissions

2. **Identify the patient's functional level** prior to hospitalization, on admission and upon discharge from the SNF setting.

Claim Submissions

3. **Note whether or not the patient improved** functionally and clinically. If the patient's status declined or stayed the same, see if the record depicts a medical justification.

Claim Submissions

4. **Assess functional status versus the documentation**. In some instances, the documentation may be lacking content but the gist of the medical status is transparent. If this is the case, write a summary describing the care and status.
5. **Create a summary sheet** of all patients reviewed including: ICD-9 coding, hospital admission diagnoses, clinically anticipated stay at the facility, certification form completion, MDS ARDs, along with the rationale for skilled coverage.

Vernacular

- Providers and clinicians are reacting to the abundance of publicized investigations, with a potential negative impact on patient care
- Therapy professionals are questioning therapeutic interventions provided as a covered service and have adopted a **conservative approach** so as not to create a potential overpayment situation for the SNF

Knowledge is diluted

- CMS created a complex PPS reimbursement system that focuses on calculating and monitoring therapy minutes to ensure that SNFs are properly reimbursed for services provided.

Knowledge is diluted

- The system is so intricate that Rehabilitation Managers are consumed by minute management with attention drawn away from clinical management

Knowledge is diluted

- Due to the densities of the system, the Rehabilitation Manager is the only one who understands the system
- Hence Rehabilitation Departments focus on minutes, categories, EOTs, COTs and schedules versus patient care
- Question: Do frustrated therapists that do not understand the complexities of the system fueling the Whistleblower fire?

Knowledge is diluted

- Hours and hours of labor are focused on the investigation versus the normal daily tasks of patient care, company development and industry relevance
- Fear and chaos ensue as employees worry about losing jobs and providing for their families

Knowledge is diluted

- Anxiety and paranoia bleed out of staff as they replay the time frame under scrutiny and ponder whether or not "they did something wrong".
- Silent finger pointing manifest in management's brains, while direct care providers lose confidence in the accused organization's integrity

Vernacular

- The number one goal in post-acute care, as mandated by OBRA '87, is to bring the patient to his/her highest practicable state of wellbeing.

Compliance

Compliance Programs

Compliance Program

- Per Federal and State laws and Federal healthcare program requirements
- A system of policies and procedures
- Monitoring and Auditing tools
- Communication and reporting methods
- Enforcement
- Leadership

Compliance and Ethics Program

- **OIG Supplemental Guidance:**

"Compliance programs help nursing facilities fulfill their legal duty to provide quality care; to refrain from submitting false or inaccurate claims or cost information to the Federal health care programs; and to avoid engaging in other illegal practices".

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Be As Informed As Possible

- **OIG Guidance**

http://oig/hhs/gov/compliance/complianceguidance/index.asp

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Compliance Is Mandatory

- Medicare/Medicaid Condition of Participation
- March 23, 2013
- Patient Protection and Affordable Care Act

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HIPAA

- Privacy Rule
- Security Rule
- Breach Notification Rule

Penalties: HIPAA

- Civil penalties: up to $50,000 per violation ($1.5 Million annual maximum per type of violation)
- Criminal penalties: Up to $250,000 and 10 years imprisonment

Efficacy

- Criminal sanctions may be mitigated by a compliance program, but only if that program is **effective**
- Most SNFs lack the policies & procedures, staff training, audit functions, and regulatory updates to keep their compliance programs effective

Required Compliance Program Components

- Written Policies & Procedures, Code of Conduct
- Compliance Officer & Compliance Committee
- Training and Education
- Effective Lines of Communication
- Enforcement of Standards
- Responding Promptly to Detected Offenses and Taking Corrective Action
- Auditing and Monitoring

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Risk Areas

- Quality of Care
- Resident Rights
- Billing & Claims Submission
- Employee Screening
- Kickbacks, Inducements and Self-Referrals
- Cost Reporting
- HIPAA Privacy and Security
- Record Creation and Retention
- Anti-Supplementation
- Medicare Part D

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Baseline Audit:

- Identify risk areas
- Identify strengths and weaknesses
- Seek input from all departments
- Always be on the lookout for "new" risks

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Periodic Audits

- Quality of Care
- Resident Rights
- Billing & Cost Reporting
- Employee Screening
- Kickbacks, Inducements and Self-Referrals
- Submission of Accurate Claims
- HIPAA Privacy and Security
- Record Creation and Retention
- Anti-Supplementation
- Medicare Part D
- Additional risk areas identified in the baseline audit

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Annual Review

- Annual Review of the overall effectiveness of the compliance program

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Compliance Officer

- Develop a position description
- Essential duties
  - Oversee and monitor the implementation of a corporate compliance program
  - Help the organization, through policies and procedures, auditing, and training, minimize the risk of fraud and abuse

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Compliance Officer

- Reports to the Compliance Committee
  - Directs facility audits
  - Collect data
  - Develop responsive action plans
- Manages compliance hotline reports
- Compliance training for the organization

Compliance Officer

- Manage employee, officer, contractor, and volunteer screening
- Oversee HIPAA compliance activity
- Participate in the Quality Assurance program
- Conduct annual compliance program review and update
- Ensure contractors are aware of your compliance program and resident rights

Compliance Officer

- A Compliance Officer can hold another position within the organization at the same time, i.e., staff development coordinator, quality assurance nurse
- Requires a dynamic person will have to interact with Board members, CNAs, housekeepers, department leaders, contractors, volunteers, and regulators

Compliance Programs

- Train and educate
  - Provide compliance training to all employees, officers, directors, owners upon hire and annually
  - Create a training schedule for each risk area

Compliance Programs

- Audit and Monitor
  - Develop audit tools for each risk area
  - Schedule audits throughout the year
  - Assign responsibility for audits
  - Develop a reporting mechanism for audit results

Compliance Programs

- Review annually
  - Acknowledge progress
  - Identify areas to further advance compliance

Compliance Programs

- Stay current
  - Monitor and incorporate updates into the Compliance Program
    - New regulations
    - OIG updates
    - Recent enforcement actions

Compliance Programs

Compliance Officer is the key to a successful program

Conduct Baseline Audits

- Identify areas of exposure
- Identify areas of strength
- Highlight weak areas and prioritize solutions
- Seek interdisciplinary participation

Compliance

Care Centered Patient Advocates

Conclusion

- Educate, Discuss and Prepare
- Define Medicare Medical Review
- Communicate to all Staff Medicare Skilled Care Criteria
- Conduct internal/external Mock Audits to educate staff
- Refine Interdisciplinary Management of Medicare Appeals

Sources

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- Public Law 109-432, 120 STAT. 2922
- www.dcsrac.com/IssuesUnderReview.aspx
- Program Integrity Manual
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- Richardson v. Perales, 402 U.S. 389 (1971)

Questions/Answers

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