Today’s Agenda

- The Current Environment
- Compliance, Fraud and The False Claims Act
- Medicare Payment Systems
- Compliance Risk Areas
- Excluded Providers
- Auditing and Monitoring
- Questions and Answers
The Current Environment
Part I

John A. Beattie, CPA, CFE
Managing Director, Principal
Issues People Say Are Top Concerns in the Presidential Election

- Healthcare ranks second among Democrats (after Iraq) and third among Republicans and Independents (after Iraq and Economy).

- Source: USA Today/Gallup Poll of 1,006 adults nationwide. Margin of error 3 to 5 +/- percentage points
Doctors and their Relations to the Drug Industry

Ninety-four percent of doctors report some type of relationship with the drug industry.

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food or drinks in the workplace</td>
<td>83</td>
</tr>
<tr>
<td>Drug Samples</td>
<td>78</td>
</tr>
<tr>
<td>Payments for Consulting</td>
<td>18</td>
</tr>
<tr>
<td>Payments for Speaking</td>
<td>16</td>
</tr>
<tr>
<td>Reimbursement for Meeting Exp.</td>
<td>15</td>
</tr>
<tr>
<td>Tickets to Cultural or Sporting Event</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: The New England Journal of Medicine
Corporate Crime

- Should corporate officers and members of boards of directors who are convicted of practices harmful to employees, investors and the public be sent to jail:
  - Yes: 89 percent
  - No: 7 percent
  - Don’t Know: 4 percent

- Source: Pepperdine University Graduate School of Business and Management Corporate Board Survey Margin of Error 5 +/- percent.
The New World Order In Healthcare

- Competition
- Consumerism
- Performance
- Defensive Pricing
- Medical Tourism
- Consumer Driven Healthcare
- Transparency
- “Focused Factories”
Interested Parties

- Physicians
- Hospitals, Drug Companies and Other Providers
- Employers
- Insurers
- Government
- Patients (Insured and Uninsured)
- Academics (Call for an SEC-type Monitor)
Promote Integrity As Integral To a Successful Business Model

- Patient Centric = Consumerism
  - Pricing, etc.
  - But also,
    - Web Site
    - Patient Satisfaction Surveys
    - Availability
    - Open Booking (Physicians)
    - Inviting Office, Senses Oriented (Physicians)
    - Education
    - Research Participation
    - Demeanor, Bed Side Manner, Front Office, Reception
    - Location, Focus Group, Community Outreach

- Fundamentals - Evolution, The Campfire and The Hunt
Mapping, Monitoring and Analysis

- The basis of business intelligence.
- Example: Revenue Cycle (Tie to Patient Flow)
  - Scheduling
  - Pre-Authorization
  - Insurance Verification
  - Financial Counseling
Mapping, Monitoring and Analysis

- Charge/Code (CPT/DX) Input/Account Posting
- Billing/Follow-Up
- Cash Collection
- Denials Management
- Collections
- Accounting/Resolution
- Where data changes hands is highest potential for control point weakness.
Looking Ahead

Market Forces and the Need for Positioning Will Drive Compliance To Further Evolution:

Business Intelligence Officer
Watchdogs

- Department of Justice/USAO
- Federal Bureau of Investigations
- Postal Inspection Service
- Department of Labor, Office of Labor Racketeering and Inspector General’s Office
- Department of Health and Human Services, Office of Inspector General,
- HCFA - Program Integrity Units
- Office of Personnel Management (FEHP)
- Department of Defense, Defense Criminal Investigations Service (CHAMPUS/TRICARE)
- Drug Enforcement Administration
- States’ Medicaid Fraud Control Units
- States’ Auditors Offices
- Medicare Carriers
- Department of Veteran Affairs
- Commercial Insurers
Surrogate Agents

• Federal Civil False Claims Statute 31 U.S.C. 3729
  • Qui tam realtors can receive 15 to 30 percent of recoveries
  • Penalties: $5,500 to $11,000 per false claim in addition to treble damages and possible program exclusion.

• Medicare Integrity Program
• Beneficiary Integrity Program - “Who Pays, You Pay”
• Medicaid Integrity Program
• Recovery Audit Contractors - CA, Florida, NY...
• Program Safeguard Contractors
Whistleblower’s Motivations

1) Management indifference.
2) Moral, ethical and legal concern.
3) Money.
4) Unfair competition.

- “For the most part, my managers would ignore me...On one occasion, I recall being told that since I was only right half of the time, why should I be listened to?...No one in management that I dealt with seemed to be responsive to the fact that the superior performance of some of these labs was due to its improper billing patterns.”

- Robert Merena, Qui Tam Relator
Compliance/Integrity, Fraud and The False Claims Act Part II
Compliance Elements

1. Standards and Procedures
2. Oversight Responsibility
3. Lines of Communication
4. Education
5. Auditing and Monitoring
6. Enforcement and Discipline
7. Response and Prevention
Best Compliance Model - Research

- Education
- Lines Of Communication
- Auditing and Monitoring
- Response and Prevention
Top Ten Effective Practices To Foster Values

- CEO Support
- Performance Appraisals
- Codified Corporate Statements
- Training
- Internal Communications
- Incentive Compensation
- Non-monetary Rewards
- Internal Monitoring/Audit
- Recruitment and Hiring
- External Review of Management

Source: strategy + business, Summer 2005, The Value of Corporate Values, Reggie Van Lee, Lisa Fabish and Nancy McGaw
Values and Compliance

• Values - A corporation’s institutional standards of behavior
• Movement and Action are not the same
• Words do not always reflect behavior.
• Values affect reputation and relationships.
• Values, compliance and risk management are linked.
• CEO Support for values and compliance is critical to effectiveness.
• Value Measures are difficult to quantify
Elements of a Compliance Plan Include:

- Written Standards and Procedures.
- Oversight Responsibilities (Compliance Committee, Corporate Compliance Officer, President, Board of Directors)
- Education and Training
- Monitoring and Auditing
- Delegating Substantial Discretionary Authority
- Enforcement and Discipline
- Corrective Action
- Derived from United States Federal Sentencing Guidelines
Benefits Of A Compliance Program

• United States Sentencing Guidelines Scoring
• Enhances Managerial, Control and Communication Processes - “Audit Effect”
• Protection from Corporate Liability, Reduces Potential for Qui Tam Actions
• Improves the Response to Lawsuits and Investigations
• Improves Business Value
• Good Corporate Citizenship
Elements Of A Compliance Program

- Standards and Procedures - Standards and procedures must be devised and implemented that are reasonably capable of reducing criminal conduct.
  - Code of Business Ethics and Conduct
  - Ownership Resolution
  - Compliance Program Manual
  - Acknowledgements of Training
  - Reporting Forms, Log and Incident Sheets
  - Exit or Post-Exit Interview Compliance Inquiry Form
  - Employment Application - Sanction Certification
  - Monitoring Reports
  - Corrective Action Documentation and Reports
  - Compliance Committee Responsibilities
  - Compliance Officer’s Duties and Responsibilities
Elements Of A Compliance Program

- Code of Business Ethics
  - Accuracy and Completeness of Medical and Financial Records
  - Confidential and Proprietary Information
  - Government and Regulatory Inquiries
  - Gifts and Entertainment Expenses
  - Reporting Violations Responsibilities
  - Political Contributions
  - Discrimination and Harassment
  - Workplace Safety, Environmental Laws
  - Conflicts of Interest
  - Use of Software and Property
  - Anti-Kickback Compliance
Elements Of A Compliance Program

- Oversight Responsibilities - A specific individual(s) within high-level personnel, i.e. compliance officer, responsible for operating and monitoring the compliance program.

- Education and Training - Standards and procedures must be effectively communicated to all affected employees through participation in training programs and distribution of compliance documents, policies and procedures.

- Monitoring and Auditing - The organization must have taken reasonable steps to achieve compliance with its standards through the use of auditing and monitoring systems reasonably designed to detect criminal conduct by its employees and other agents and by having in place and publicizing a reporting system so that employees and other agents can report criminal conduct by others within the organization without fear of retaliation.
Compliance/Integrity Committee Responsibilities

- Develop relevant and practical standards of conduct.
- Risk assessments, assess mhmc’s regulatory climate, legal requirements.
- Continual process improvement and monitoring.
- Review and incorporation of relevant existing policies into compliance plan.
- Reporting mechanisms.
- Educational agenda and documentation.
  - Promote compliance/integrity
Elements Of A Compliance Program

- Delegation of Substantial Discretionary Authority - The organization must use due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in illegal activities.

- Enforcement and Discipline - The standards must have been consistently enforced through appropriate disciplinary action against those who have violated internal compliance policies or applicable legal requirements. This includes discipline of those responsible for failure to detect an offense.

- Corrective Action - After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modifications to its program to prevent and detect violations of law.
Sanctions Checks

OIG
http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

Database is on-line and downloadable

The Downloadable Database File does not contain SSNs or EINs. Therefore, verification of specific individuals or businesses through the use of the SSN or EIN must be done with the Online Searchable Database.

GSA
http://www.epls.gov/
Active Listening
Exit And Post-exit Interviews

• Reason for Separation
• Completeness and Fairness of the Performance Evaluation Process.
• Retaliation: Did it ever occur?
• Solicit opinion for areas of improvement.
• Have you ever felt uncomfortable in performing any tasks?
• Did you ever decide against calling the hotline? Why?
• Are you aware of any improper conduct?
Communication

• Reporting mechanisms
  • Hotlines
  • E-mail
  • Written memorandum
  • Integrity boxes
  • Newsletters
  • Compliance officer
Hotline
Selected Developmental Considerations

- Name - Integrity, ethics, Values, Conduct. Think Mission, Aspirations, Ideals.
- Hours of Operation - 24/365, Normal Business Hours, Holidays, Weekends, Multiple Time Zones.
- Anonymous reporting - Unique Identifier.
- Non-Retaliation Policy
- Confidentiality Policy - to the fullest extent allowed by law. No blanket promise.
Hotline
Selected Developmental Considerations

• Logging - Including: Date, Time, Nature of Call and Disposition. Software.
• Advertising - Posters, Newsletters, Rolodex and Wallet Cards, Novelties.
• Define Users - Employees, Contractors, Vendors, Patients.
• Foreign Language Identification and Translation.
• Speech and Hearing Challenged Capabilities.
• Rewards - Monetary, Non-Monetary, Both, Neither.
Report Taking

1) Independence - unbiased attitude, unprejudiced appearance, no conflicts of interest.
2) Objectivity - fact finding.
3) Active listening - notes, ask relevant questions, confirm understandings.
4) Professional skepticism - assess, test, evidence gathering. Cynicism is not skepticism.
5) Discretion, confidentiality - attorney/client privilege, defamation (slander, libel).
Training Needs Analysis
Organizational Work Group Needs

- HOW?
  - Three Phases:
    - Data gathering - Survey, Interviewing, Observation, Records.
    - Performance Analysis.
    - Cost/Benefit assessment.
  - Dissect and evaluate the task elements of performance
    - Frequency of performance
    - Subject complexity
    - Factorial analysis by importance.
    - Example: Auditors
  - Tasks
    - Research criteria.
    - Understanding internal controls.
    - Prepare workpapers.
    - Develop statistical sampling plan.
    - Perform substantive testing.
    - Report writing.
Frequency of Education and Training

- Annually: 88.6%
- Every Other Year: 3.8%
- Twice Annually: 3.8%
- Other: 3.8%
Effective Training And Education Documentation

- Names and unique identifier of attendees (attendance certifications, attendance logs),
- Instructor(s) name and bios,
- Date, times, and duration of training,
- Location,
- Course syllabus and seminar agenda,
- Materials distributed and
- Evaluations

LEAD AND DETAILED SCHEDULES
Training Analysis
Evaluate Training Effectiveness

- Four stages of measurement
  - Course and instructor evaluation
  - Comprehension of subject matter - Test
  - Job performance assessment - Is it being performed?
  - Results evaluation - Measure change test to claims review.
Effective Training and Education

- **Syllabus recommendations:**
  - Organizational values and commitments.
  - Compliance code of business ethics and compliance program.
  - Process for submission of accurate bills. (Claims submission and development processes and proper coding)
  - Applicable legal (federal and state) requirements, including billing, anti-kickback, etc. And policies of private payors and federally-funded program requirements.
  - Sanctions for improper billing.
  - Personal obligation of each individual involved in the billing process.
  - Examples of improper billing practices.
  - Entity policies, including discipline policy.
Compliance 101

• Fraud Defined
  • CMS - An intentional deception or misrepresentation that is made by an individual who knows it to be false and who receives an unauthorized benefit from that action.
  • HIPAA - Knowingly and willfully executing a scheme to defraud a health care benefit program or obtaining through false representation, money or other property owned by a health care benefit program.
  • Federal criminal law addresses fraud in private and public programs.
Examples of Fraud

- Upcoding (CPT/HCPCS, Sequencing of ICD-(, ICD-( in a DRG methodology)
- Fragmentation or unbundling
- Over or Under Utilization (Fee-for-service v. managed care)
- Kickbacks, Stark
- Enrollment Fraud
- Clustering
- Modifier Or Rev Code Misuse
- Product Substitution, Shorting
- Research Billing
- Off-Label Marketing
- Cost Reporting Fraud (Reverse False Claim)
- Unordered Services
- Unperformed Services (Sink Testing)
- Ping Ponging
Modifier 25 - What, When, Where?

• **What**: A "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."

• **When**: An E/M service was provided on the same date as a diagnostic medical/surgical (with the exception of pathology and laboratory) and/or therapeutic medical/surgical procedure(s) (CPT Code ranges 10040-69990, 70010-79999).
  
  • **NOTE**: Outpatient Code Editor (OCE) only requires the use of modifier -25 on an E/M code when it is reported with a procedure code that has a status indicator of "S" or "T. (PM A-01-80)

• **Where**: Modifier -25 should be appended only to E/M services codes 92002-92014, 99201-99499. It does not apply when non-diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) is performed.
Modifier -91

- Used to report a repeated lab test on the same day for the same patient to obtain subsequent (multiple) test results.
- May not be used when other CPT codes describe a series of test results, e.g. glucose tolerance test.
- Must not be used to report tests performed improperly due to inadequate specimens, personnel or equipment errors.
- Typically, is incorrectly reported during the performance of a manual differential to verify automated differential results or to verify/substantiate other automated testing results.
Medicare does not cover items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.
Medical Necessity

- Section 1862 (a) (1) of the Social Security Act is the basis for denying care, or specific items, services or procedures that are not excluded by any other statutory clause and meet all technical requirements for coverage.
- To be considered medically necessary, items and services must have been established as safe and effective. The items and service must be:
  - Consistent with the symptoms or diagnosis of the illness or injury under treatment
  - Necessary and consistent with generally accepted professional medical standards (e.g. not experimental or investigational or procedures where an assistant-at-surgery is ordinary not necessary)
  - Not furnished primarily for the convenience of the patient, the attending physician or other physician or supplier.
  - Furnished at the most appropriate level that can be provided safely and effectively to the patient.
- Medical documentation must support the medical necessity of the service
Compliance 101

- Regulatory Agencies will look at a variety of factors, including the following:
  - The clarity of the rule.
  - The complexity of the billing system at issue.
  - The guidance issued by CMS and/or its fiscal intermediaries.
  - The extent to which the provider has attempted to ascertain an understanding of the relevant rule.
  - The quality of the efforts of the provider to train personnel on the billing system.
  - Whether the provider has an effective compliance program in place.
Federal False Claims Act,
31 USC 3729, et seq (Civil), 18 U.S.C. 287 (Criminal)

- The Civil False Claims Act creates liability for false claims under seven circumstances:
  1) Knowing presentation of a false claim or fraudulent claim to the federal government for payment or approval (31 U.S.C. 3729(a)(1));
  2) Knowing use or creation of a false record or statement to get a false or fraudulent claim paid by the federal government (31 U.S.C. 3729(a)(2));
  3) Conspiring to defraud the federal government to get a false or fraudulent claim paid (31 U.S.C. 3729(a)(3));
  4) Intentional failure to return all federal government money or property (31 U.S.C. 3729(a)(4));
Federal False Claims Act,
31 USC 3729, et seq (Civil), 18 U.S.C. 287 (Criminal)

5) Intentional making and issuance of a receipt for more than what the federal government actually received (31 U.S.C. 3729(a)(5));

6) Knowing purchase or receipt of property from a federal official who is not authorized to sell or deliver the property (31 U.S.C. 3729(a)(6)); and

7) Knowing creation or use of a false record or statement to decrease a monetary obligation to the government (31 U.S.C. 3729(a)(7)).
Federal False Claims Act, 31 USC 3729(a) (Civil)

- Civil Penalties:
  - $5,500 to $11,000 per claim
  - Three times the amount of damages sustained by the government
  - Could be grounds for exclusion from participation in federal and state healthcare programs.
Legal Counsels Potential Liability

- Obstruction of audits/investigations
- Concealment of a felony
- Conspiracy
- Aiding and abetting
Medicare Payment Systems
Part III
Medicare Payment Systems

Varied Methodologies (DRG, APC, Fee Schedule) Understanding Critically Important For Compliance Officers
Medicare Payment Systems

- Different types of services:
  - Physician and Physician Extenders
  - Inpatient Acute - PPS, Inpatient Part B, Long Term Acute Care Hospitals
  - Outpatient - **Outpatient PPS**, Clinical Diagnostic Services, DMEPOS, Ambulance, ESRD, Hospital Outpatient Rehab and Therapy, etc.
  - Post Acute - Home Health Services, SNF, Hospice, Inpatient Rehab
  - Rural - Critical Access Hospitals, Rural Health Clinics and Sole Community Hospitals
  - Psychiatric - Inpatient and Partial Hospitalization
Outpatient Prospective Payment System

• Chronology
  • Hospital specific reasonable cost associated with Medicare beneficiaries
  • Payment Limit: < hospital’s reasonable costs to customary charges
  • Reductions of 5.8 and 10 percent for hospital costs and capital costs (1980s)
  • Fee Schedules implemented for clinical lab services, DMEPOS, blended rates of costs and rates paid for other delivery locations such as ASC
  • Balanced Budget Act of 1997 - development of OPPS mandated.
Outpatient Prospective Payment System

- DHHS Secretary mandated to designate applicable hospital outpatient services subject to OPPS.
- PT, OT, ST and ambulances excluded by law from the BBA.
- DHHS Secretary service exclusions included: Clinical diagnostic lab, DMEPOS, Physician and physician extenders professional services, Mammographies, Dx’ed ESRD services and
Outpatient Prospective Payment System

• Key Concepts.

• Services subject to OPPS include, but are not limited to:
  • Surgical procedures
  • Clinic and ED visits
  • Operating, Procedure or Recovery Room Usage
  • Observation Bed Usage
  • Anesthesia
  • Medical and Surgical Supplies
  • Radiology Services
  • Implantable DME and certain other implantable items and prosthetic devices
Outpatient Prospective Payment System

Key Concepts - Payment Status Indicators

Every HCPCS code has a status indicator that describes OPPS payment method. Some examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services paid under a different method, e.g. fee schedule</td>
</tr>
<tr>
<td>B</td>
<td>Non-Allowable under OPPS</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient services not payable under OPPS</td>
</tr>
<tr>
<td>S</td>
<td>Significant procedures, not discounted when multiple</td>
</tr>
<tr>
<td>T</td>
<td>Significant procedure, multiple procedure reduction applies</td>
</tr>
</tbody>
</table>
Outpatient Prospective Payment System

- Key Concepts - Ambulatory Payment Classifications ("APCs")
  - Payment Basis for OPPS is APCs
  - Factors Affecting APC Groupings
  - HCPCS remain important because hospitals submit HCPCS codes not APC codes
  - An outpatient encounters can generate multiple APCs
Outpatient Prospective Payment System

- Key Concepts - Payment Formula without Pass-Through
  - \((.40 \times \text{Relative Weight} \times \text{conversion factor}) + (.60 \times \text{Relative Weight} \times \text{conversion factor} \times \text{Wage Index})\) = Payment
Outpatient Prospective Payment System

- Key Concepts - Packaged Services
- Status Indicators:
  - **N** - Items and Services Packaged Into APC rates.
  - **Q** - Packaged Services - subject to separate payment under OPPS payment criteria.
Outpatient Prospective Payment System

- Key Concepts -
  - Outliers
  - New Technology
Hospital Outpatient Rehab and Therapy Services

- Defined: Physical, Occupational and Speech Therapies
- Originally a cost based payment. Effective in January 1, 1999, paid per the physician fee schedule. The Medicare allowed charge is the lower of the actual charge or the Medicare fee schedule amount.
- Payment = 80 percent (allowed charge - Part B Deductible) Coinsurance is 20 percent of the actual charge or the fee schedule, whichever is lower.
- Requires a written Treatment Plan established by:
  - a physician after consultation with a PT, OT or ST
  - PT that will furnish the services
  - OT that will furnish the services
  - ST that will provide the services
Hospital Outpatient Rehab and Therapy Services

- Treatment Plan must be established before the Tx is initiated, promptly signed by the ordering physician, therapist or pathologist.
- “The signature and professional identity (SLP) of the person who established the plan, and the date it was established must be recorded with the plan.” (Pub 102 Chapter 15 MC Benefit Policy Manual 220.1.2)
- Reviewed by the attending physician and therapist at least 30 days or more depending on the severity of the patient’s condition. Continuing need, if applicable, must be recertified and estimate of duration.
Hospital Outpatient Rehab and Therapy Services

- Physician Certification Required - Services furnished while patient was under care of the physician, a plan was or is established by the physician or therapist and periodically reviewed by the physician and the services are or were required by the patient.

- Certification obtained concurrently with the plan of treatment.

- “Certification requires a dated signature on the POC or some other document that indicates approval of the POC. The certification should be retained in the clinical record and available if requested by the contractor.” (Pub 102 - CH 15 Sec 220.1.3 A)
Home Health Services

• Chronology and Key Concepts
  • Prior to 1998, Home Heath Services was paid under a cost based method.
  • Balanced Budget Act of 1997 required the development of a prospective payment system.
  • Payments made on a 60 day episode of care
  • Outcome and Assessment Information Set (“OASIS”) is conducted along with a plan of care established and the initial claim - Request for Anticipated Payment
  • Continuous Episode Recertifications where warranted
  • OASIS - groups the clinical severity, functional status, and service utilization severity levels of the beneficiary.
  • Payment is based on a Home Health Resource Group (“HHRG”) Each HHRG is assigned a a case mix weight that is then used to calculate the payment amount.
Payment Adjustments

- Low Utilization Payment Adjustment ("LUPA") - Wage adjusted national average payment per visit according to the type of service provided.
- Outlier Payment - Addition to the case mix and wage adjusted payment.
- Partial Episode Payment Adjustment - Example Significant Change of Condition
Home Health Services

- Key Concept - Home Health Resource Group ("HHRG")
- Derived from the OASIS assessment.
<table>
<thead>
<tr>
<th>Domain Level</th>
<th>Clinical Domain (HIPPS position 2)</th>
<th>Functional Domain (HIPPS position 3)</th>
<th>Service Domain (HIPPS position 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Severity</td>
<td>CO = A</td>
<td>FO = E</td>
<td>SO = J</td>
</tr>
<tr>
<td>Low Severity</td>
<td>C1 = B</td>
<td>F1 = F</td>
<td>S1 = K</td>
</tr>
<tr>
<td>Moderate Severity</td>
<td>C2 = C</td>
<td>F2 = G</td>
<td>S2 = L</td>
</tr>
<tr>
<td>High Severity</td>
<td>C3 = D</td>
<td>F3 = H</td>
<td>S3 = M</td>
</tr>
<tr>
<td>Maximum Severity</td>
<td></td>
<td>F4 = I</td>
<td></td>
</tr>
</tbody>
</table>
HIPPS Code

- **HIPPS Code**: Health Insurance Prospective Payment System Code generated from grouper software within HAVEN. This is a five-digit code as follows:
  - **First digit**: H
  - **Second, third, and fourth digits** crosswalk to the Home Health Resource Group (HHRG). Refer to the table above.
  - **Fifth digit** indicates which of the HHRG codes were computed based on valid data, or had to be derived because some of the data was missing or invalid. The fifth digit is assigned as follows:
<table>
<thead>
<tr>
<th>Position 5 of HIPSS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinical, Functional, and Service Domains computed</td>
</tr>
<tr>
<td>2</td>
<td>Clinical Domain derived</td>
</tr>
<tr>
<td>3</td>
<td>Functional Domain derived</td>
</tr>
<tr>
<td>4</td>
<td>Service Domain derived</td>
</tr>
<tr>
<td>5</td>
<td>Clinical and Functional Domains derived</td>
</tr>
<tr>
<td>6</td>
<td>Functional and Service Domains derived</td>
</tr>
<tr>
<td>7</td>
<td>Clinical and Service Domains derived</td>
</tr>
<tr>
<td>8</td>
<td>Clinical, Functional, and Service Domains derived</td>
</tr>
</tbody>
</table>
Home Health Documents Inspected

- Admission Service Agreement
- Plan of Care (POC)
- Interim Physician’s Orders/Verbal Orders
- Therapy evaluations
- Visit reports
- Service variation reports/Missed visit reports
- Discharge summaries for all treating disciplines
- General discharge summary
- OASIS assessments completed in the claim period being reviewed
- Clinical Coordinator Notes for home health aides
- Physician’s verbal/telephone orders
- Remittance Advice
- Master submission report
Generally speaking, a patient will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.
Homebound

...the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment...However, occasional absences from the home for nonmedical purposes...would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis, or of a relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.
Findings - Examples

- Documentation of homebound status was not substantiated following the SN visit that was performed on X/X. The note indicated homebound due to functional limitations and taxing effort - no documentation to support either.

- Three samples (#X, #XA, and #XB) reflected care provided to patients not homebound or with questionable homebound status based on documentation in the clinical record. In each of the situations, documentation of homebound was reflected in the initial OASIS assessment. Subsequent visit notes documented either a lack of confirmation of activity being a ‘taxing” effort, or that the patient’s status had improved significantly during the episode to render the last several visits in the episode as not reflective of the patient’s homebound status.
OIG Work Plan

“Among the things that OIG considers in setting its work priorities are findings from previous OIG and external reviews (e.g., Government Accountability Office (GAO) and Medicare Payment Advisory Commission), size of the program (i.e., expenditures, number of beneficiaries served), specific requests from Congress and the Department, and the need to review program areas that warrant revisiting”.

Source: House Committee on Ways and Means Subcommittees on Health and Oversight Hearing: March 8, 2007
High Risk DRGs

- Stroke and Acute Ischemic Attack, 14 and 559
- Respiratory Infections, 79
- COPD, 89
- Medical Back Problems (243)
- Septicemia, 575 and 576
- Archeology - Complications and Co-morbidities
Stark and Anti-Kickback

- Physician Arrangements
  - FMV of Services, Unrelated to Referrals
  - Contract Administration
  - Written Agreements and Compliance with agreement provisions
    - Time reporting
    - Employee v. independent contractor typing
Stark and Anti-Kickback

- Equipment Leases
  - Written Agreement
  - FMV
  - Loans - FMV, Payment Schedule
- Space Leases
  - Written agreement
  - FMV unrelated to referrals
  - Trace Payment
  - Tenants
Tax

- Executive Compensation
- Intermediate Sanctions
- Community Benefit Reporting
- Pension Protection Act
- Bond Proceeds (Private Use Issue)
- Reporting on Forms 1023 and 990
- IRS Enforcement Activities
Clinical Trials

- Clarity of Informed Consent
- Medicare Billing
Physicians

- Evaluation and Management Services
- Wound Care
- Polysomnography
- Cardiology
- Physician Extenders
Pepper Focus Areas

- Seven Day Readmissions
- One Day Stays - High number of admission denials relate to one day stays
  - Top 20 One Day Stay DRGs - possible errors
- Three day SNF qualifying admissions
Excluded Providers
Part V
Exclusions

- Exclusions based on authority located at 1128 and 1156 of the Social Security Act.
- When exclusion is imposed:
  - No payment may be made to anyone for any items or services (other than an emergency item or service not provided in a hospital emergency room)
  - furnished, ordered or prescribed by an excluded party
  - Under the Medicare, Medicaid, or other federal or state programs.
  - In addition, no payment may be made to any business or facility (Hospital, etc.) that submits bills for payment of items or services provided by an excluded party.
Example Hospital Policy

• Physicians and Allied Health Professionals
  • As part of the credentialing or re-credentialing process:
    • Check OIG, GSA, National Practitioners Data Bank
    • Employment Application
    • Perform Criminal Background Check
    • Require on-going disclosure
Some State Exclusion Databases

- Maryland -
  http://www.dhmh.state.md.us/mma/program_integrity/html/sanction_report.htm

- Pennsylvania -
  http://www/dpw.state.pa.us/Business/Fraud_Abuse/003673510.aspx
Some State Exclusion Databases

- Texas -
  http://www.hhsc.state.tx.us/OIE/Exclusionlist/ado/exclusion.asp

- New York -
  http://www.health.state.ny.us/health_care/medicaid/fraud/listing.htm
Example Policy

- Confirmation of an Offense, Exclusion or Sanction
  - Treat as Confidential
  - If internal investigation is inconclusive, send inquiry to federal agency for confirmation.
  - Proposed for Exclusion or Suspension - remove from involvement with or responsibility for Federally funded programs business operations pending resolution
  - Exclusion, sanctioned debarred or conviction equals termination
  - Address need for repayment and self-disclosure
Auditing and Monitoring
Part VI
The COSO Framework’s Three Dimensions

- Requires an entity level focus and an activity level focus
- Consists of three objectives:
  - Effectiveness and efficiency of operations (including safeguarding of assets)
  - Reliability of financial reporting
  - Compliance with applicable laws and regulations
- Consists of five components:
  - Control environment
  - Risk assessment
  - Control activities
  - Information/Communication
  - Monitoring

MONITORING
INFORMATION AND COMMUNICATION
CONTROL ACTIVITIES
RISK ASSESSMENT
CONTROL ENVIRONMENT

OPERATIONS
FINANCIAL REPORTING
COMPLIANCE
COSO And Compliance

Processes that involve compliance with state and federal regulations
Structured Approach

Components of Internal Control Reporting

Approach

Technology

PHASE I
- Set Foundation
- Assess Current State and Identify Relevant Processes

PHASE II
- Document Design and Evaluate Critical Processes and Controls
- Design Solutions for Control Gaps

PHASE III
- Control Operation
- Implement Solutions for Control Gaps

PHASE IV
- Control Improvements
- Internal Control Report

Project Management
Knowledge Sharing
Communication
Continuous Improvement

Process Management
Assessment Management
Knowledge Management

Structured Approach
Structured Approach

**PHASE 1: Assess Current State and Identify Relevant Processes**
1.1 Identify and prioritize financial statement elements
1.2 Review entity-level controls
1.3 Define business processes for the organization
1.4 Identify/prioritize relevant processes for further analysis
1.5 Identify process owners and other key contacts
1.6 Inventory available internal controls documentation
1.7 Document pilot process -- Process, information, ownership -- Risk, controls and disclosures
1.8 Review specific documentation of executive certification process
1.9 Validate with external auditors
1.10 Develop action plan for Phase 2

**PHASE 2: Document Design and Evaluate Critical Processes and Controls**
2.1 Identify risks and assertions for key financial statement elements -- Convert to control objectives -- Document objectives for each process
2.2 Document targeted processes -- Identify inputs, activities and outputs -- Source where risks are -- Indicate control points -- Obtain process owner sign-off
2.3 Assess key performance indicators
2.4 Assess effectiveness of control design (achieve objectives)
2.5 Assess effectiveness of control operation (operate as designed)
2.6 Document roles and responsibilities for employees
2.7 Summarize results and develop action plan for improvements for Phase 3

**PHASE 3: Design Solutions for Control Gaps**
3.1 Develop revised process maps
3.2 Design process to identify changes that impact controls
3.3 Document revised policies and procedures
3.4 Design unit and process owner monitoring reports
3.5 Design summary and issues management reports to facilitate certification
3.6 Align roles and responsibilities with other objectives
3.7 Align compensation with performance objectives
3.8 Develop implementation plan and timeline for Phase 4

**PHASE 4: Implement Solutions for Control Gaps**
4.1 Develop training guidelines and documentation
4.2 Provide training
4.3 Develop, test and roll-out improvements
4.4 Apply continuous process improvement methodology
4.5 Establish sustainable assessment process
OIG - The Audit Process

- Preliminary Planning
- Pre-Survey
- Survey
- Data Collection and Analysis
- Reporting
- Postaudit Evaluation
Work Plan Development

- OIG Work Plan
- New Regulations, Billing Requirements
- Brainstorming
- Employee Complaints
- Unsealed Qui Tam Actions
- Patient Satisfaction Surveys
- Media
- Process Analysis, Analytical Review
- Spin-off Audit/Investigative Issues
- Threshold Triggers, Unusual Fluctuations
Work Plan Development
Organizational Risks To Consider

- New Personnel (Human Resources)
- Changed Information System (IT)
- New Technology (IT and Departments)
- New Services (Departments)
- Regulation Changes (Patient Accounting, Reimbursement)
Risk Categorization and Related Documentation Considerations

Importance to business

Low               High

Low

High

Purchasing, AP and Cash Disbursements
Amortize Pre-paids and Intangibles
Assess Assets for Impairment

Sales, AR, Credit & Collections
Inventory Costing and Cost of Sales
Payroll

Close Process

Est. Commitments & Cont.
Key IT Processes

Inventory Obsolescence Reserves

Benefits Liability

Inventory

Physical Inventory

Calculate Income Taxes
Budgeting / Forecasting
Interco. Transactions
Capital Asset Acq.

Depreciate PP&E

AR Reserves

Foreign Currency

Risk

Low

High
Auditing And Monitoring Analysis And Communication Tools

- Histograms
- Document Flow Chart
- Pareto Chart
- Flow Charts
- Horizontal and Vertical Analysis (Comparative)
- Spider Charts
Pareto Chart

99215 Expressed as a Percentage of Code Grouping 99211 - 99215
**Spider Analysis**

- **DRG 372**
  - Vaginal Delivery with Complicating Diagnoses
  - DRG Pmt $3,219.56
  - RW 0.5027

- **DRG 374**
  - Vaginal Delivery with Sterilization &/or D&C
  - DRG Pmt $4,298.72
  - RW 0.6712

- **DRG 375**
  - Vaginal Delivery with O.R. Procedures Except Sterilization &/or D&C
  - DRG Pmt $3,738.32
  - RW 0.5837

*No Potential DRGs per the 2006 Desk Reference*
Work Plan Buy-In

- Illustrate analytics through Pareto charts and histograms
- Coordinated communication
- Prioritize - inspire - coach - lead
Tasks Plan Development

- Why is one engagement effective and another ineffective?
  - Planning, Criteria Research, Analysis, Compiling Documentation
  - Staffing - Interpersonal skills, Technical ability of personnel and team
  - Independent, Objective and Unbiased
  - Statistical Methods***
  - Evidential Matter/Working Papers
  - Quality Controls and Management Review
  - Corrective Action
Task Plan Development
Elements of a Finding

- Condition
- Criteria
- Cause
- Effect
- Recommendation (for corrective action and follow-up)
Tasks Plan Development

- Criteria - Laws, regulations, billing policies
- Condition - Routines to test for compliance with criteria
- Cause - IT programming errors, misinterpretation or lack of criteria. Inaccurate training - Fishbone.
- Effect - Monetary - Statistical Appraisal, Non-Monetary - Quality of Care
Tasks Plan Development
Condition Analysis

- Horizontal and Vertical analysis of dollar and volume trends (Analytical review)
- Ratio Analysis (Analytical Review)
- Claim review to verify analytics (Inspection)
- Talking Heads (Inquiry)
- Observation of Practices
- Confirmation
Statistical Plan Development

- Testing Objective
- Population
- Sampling Frame
- Sampling Unit
- Sampling Design
  - Unrestricted Random, Single Silo
  - Stratification
  - Network (Snowball) Sampling
  - Multi-stage
Statistical Plan Development

- Determination of Sample Size
- Method of Selecting Sample Items
- Treatment of Missing Sample Items
- Characteristics to be Measured
- Extrapolation Methodology
Logistical and Operational Mistakes

- Ineffective identification through inadequate analysis (Reckless disregard, deliberate ignorance)
- Taking too much time
- Failing to properly define statistical parameters, methods or the scope
- Creating distrust (rank and file/reporter)
- Failing to recognize complex issues, and to retain expert assistance, when necessary
- Failure to take timely corrective action, follow-through - Trust with verification
Compliance Effectiveness Validation Of Effort And Outcomes

- Regulatory Agencies will look at a variety of factors, including the following:
  - The clarity of the rule.
  - The complexity of the billing system at issue.
  - The guidance issued by CMS and/or its fiscal agents (intermediaries, carriers).
Compliance Effectiveness Validation Of Effort And Outcomes

- The extent to which the provider has attempted to ascertain an understanding of the relevant rule.
- The quality of the efforts of the provider to train personnel on the billing system.
- Whether the provider has an effective compliance program in place.
Auditing and Monitoring: Compliance Awareness

• Questions that may be asked include:
  • Do you know the compliance officer’s name?
  • Did you receive a copy of the Code of Conduct?
  • Do you know whether there is a compliance/security hotline?
  • If so, did you ever consider calling the hotline but decided against it? If so, why?
  • Where is the compliance manual located?
  • Is there an open/door policy with supervisors and management?
  • Does the compliance program assist with day to day job activities?
Engagement Administration

• Electronic Milestone Date Reporting
  • Activity
  • Estimated Duration
  • Person Accountable
  • Start Date
  • End Date
  • Status / Comments
Engagement Administration

• Population and sample selection
  • Activity: Prepare / send letter requesting population
  • Estimated Duration: 2 - 5 days after contract is signed #3

• Population Received
  • 2 to 3 Weeks after #5

• Validate Population
  • 1 - 3 days after #6

• If problems exist w/ population communicate with client to resolve issues
  • 2 days after #7
Engagement Administration

- Population and sample selection
  - Select Sample
    - 2 days after #8
  - Validate sample selection method & mechanics
    - 2 days after #9
  - Prepare letter regarding Sample Selection
    - 2 days after #10
  - Date Sample Sent by Parente Randolph to Client
    - 2 days after #10
 Documentation Request
Claims Inspection

• Order, Encounter Form
• Claim
• Medical Record, Reports (Lab, Imaging, Therapy Log, MAR, TAR, ER Record, Progress Notes, MDS, etc.)
• Fixed Asset Schedule
• Detailed Transactions AR
• Remittance Advice (Detailed)
• Inventory - Missing Documents Request - Inventory
Working Paper Organization

- Current file
  - Master Index
  - Report, Management Comments
  - Administrative - Staffing, Time Chart, Objectivity Statements, Conflict Search, Management Review
  - Communications (Letters, Memorandums, Specialists Reports)
- Task Plan
- Statistical Plan, Data and Data Processing
Working Paper Organization

- Current File
  - Criteria
  - Analytics
  - Entrance and Exit Conferences Memorandums
  - Findings
  - Records of Discussion (Inquiries)
  - Records of Observations
  - Lead Schedules
  - Detail Analysis Schedules
  - Detail Analysis, Documents Inspected
Working Paper Organization

- Permanent File
  - Organizational Chart (Employee and entity levels)
  - History
  - Financial Statements
  - Process Flowchart, Narrative
  - Other Relevant Quality, Compliance, Internal Audit Reports
  - Contracts
Reporting

- Report Format
  - Executive Summary
  - Procedures
  - Statistical Plan
  - Findings
  - Schedules
Reporting

- Descriptive Statistics-Variable (v. Attribute) Appraisal
  - Universe Size
  - Sample Size
  - Mean of Differences
  - Standard Deviation
  - Net Financial Error Rate
Reporting

- Number/Percentage of Sample Items with Findings, Overpayments, Underpayments and Zero Payment Errors
- Mid-Point Estimate
- High and Low Dollar Limits
- Precision Rate @ 90 percent confidence level
- Estimated Full Sample Size, as applicable
Corrective Action Plan

- Columnar Spreadsheet
  - Observation - Finding
  - Recommendations
  - Management Action Plan/Response
- Devise By Job, Department and Entity
- Follow-Up Work Plan - Completes the circle.
What Have We Discussed

- The Current Environment
- Compliance, Fraud and The False Claims Act
- Medicare Payment Systems
- Compliance Risk Areas
- Excluded Providers
- Auditing and Monitoring
Questions & Answers

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