

**An Overview of Risk Areas and Compliance Strategies for**

**Hospice and Home Health**

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2016 AHLA Fraud and Compliance Forum

Baltimore, MD

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Medicare hospice care and home health agency providers have been subjected to increasing levels of claim audits and investigations, frequently encompassing as many as six years of claims. When the universe of claims being audited is so large, statistical sampling techniques are often used to generate an error rate from a relatively small sample which can then be applied to all claims in the universe to compute an overpayment. When statistical sampling is involved, any full or partial claim denial has a multiplier effect on the resultant overpayment, increasing the need to vigorously defend each and every claim in the sample. Further complicating these multi-year claim audits is the fact that there were numerous changes in regulatory, billing and payment requirements and guidelines issued by the Centers for Medicare and Medicaid Services (CMS). Recent settlements and government publications relating to home health and hospice, in combination with increasing pressure to reduce erroneous payments under the Medicare program, point to a likely continuation and increased intensity of these audits and investigations. These circumstances create significant challenges for home health and hospice providers, as well as their advisors, in defending billed services during post-payment audits and in prioritizing ongoing compliance efforts. Below is an outline of practical considerations to increase success in defending against denials, data sources to enable home health and hospice providers to effectively identify and manage the risk of improper payments, and evidence that the era of heightened scrutiny will likely continue in the foreseeable future.

### **Post-Payment Audits and Investigations**

During post-payment audits and investigations, providers are often faced with a difficult task in assembling complete medical records, including for example the following circumstances:

- Medical Record Maintenance: During the timeframe of many post-payment audits, medical record practices may have converted fully or partially from manually prepared paper documents to an electronic health record (EHR), sometimes changing software vendors to better meet the needs of the agency. Understanding when medical record documentation practices were modified, how EHR systems were phased in, and/or how to retrieve electronic health records from software systems no longer in use can complicate efforts to produce a complete medical record, especially when document requests span multiple years.
- Missing Documents: Paper charts may have been periodically “thinned” during the course of a beneficiary’s care in order to keep the medical record more current and user friendly, with older thinned documents maintained separately. Documents supporting a beneficiary’s medical status (such as hospital discharge summaries, nursing home records, diagnostic test results, consultations with medical specialists, etc.) may have been viewed by case managers at admission and/or during the course of covered care but not obtained in hard copy for the medical record. Physician certifications and recertifications may have been maintained separately in an effort to better manage compliance and may not

have made their way to the medical record at the time of a beneficiary's discharge.

All medical records copied in response to an audit should be carefully evaluated for completeness, with gaps in documentation and missing elements identified. Efforts to locate missing documents should be continued until all possible locations where records may have been stored have been thoroughly searched. Most hospice and home health providers have historically recognized the importance of ensuring compliance with Medicare requirements since the majority of their payments are derived from Medicare beneficiaries, with little non-Medicare revenue sufficient to cover losses that would otherwise occur. As a result, missing documents are often located when thorough searches are conducted.

The medical record should also be carefully reviewed to identify any clues to possible sources of contemporaneous documentation maintained in the medical records of other providers and/or practitioners. These should be investigated and additional documentation obtained when available to supplement the medical record in order to help paint a more comprehensive picture of each beneficiary's medical history and clinical status as known to the interdisciplinary team, both prior to and during service delivery.

### **Proper Application of Regulations to Specific Dates of Service**

Many revisions to the Medicare Manuals have been issued by CMS over time. Providers undergoing audits or investigations encompassing multiple years must be meticulous in identifying when and how critical criteria changed, to ensure the rules are applied properly by the government or third party claim auditors. Examples of such changes in the manual provisions abound; however, we have identified just two below:

Home Health Agencies: One of the requirements to be eligible for the Medicare home health benefit is that the beneficiary be considered to be confined to the home, commonly referred to as the “homebound requirement”. Prior to Change Request 8444, Transmittal 172, effective November 19, 2013<sup>1</sup>, Pub 100-02, Chapter 7, Section 30.1.1 – Patient Confined to the Home, included the following:

*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.*

When Transmittal 172 was issued, the above language was removed and replaced with the following, which was described by CMS as a “clarification”:

*For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:*

*1. Criteria-One: The patient must either:*

*- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence*

*OR*

*- Have a condition such that leaving his or her home is medically contraindicated.*

*If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet*

two additional requirements defined in Criteria-Two below.

2. *Criteria-Two: - There must exist a normal inability to leave home;*

AND

*- Leaving home must require a considerable and taxing effort. [Emphasis added.]*

A recent U.S. Court of Appeals decision in the Tenth Circuit acknowledged the challenges presented when attempting to properly apply Medicare rules (including the homebound status criteria) to the dates of service under audit. [*Caring Hearts v. Burwell*, No. 14-3243, 2016 BL 171256, (May 31, 2016)]. This decision notes that “Medicare is, to say the least, a complicated program” for which the CMS issues numerous revised guidelines every year to which providers must adhere. One problem noted in this case is that rules relating to homebound status not in force in 2008 were applied retroactively, although the provider could not have known of their existence at the time services were rendered. The decision notes, “*This case has taken us to a strange world where the government itself – the very ‘expert’ agency responsible for promulgating the ‘law’ no less – seems unable to keep pace with its own frenetic lawmaking*”.

Hospice Providers: When a beneficiary initially elects the hospice benefit, a hospice physician and the beneficiary’s attending physician must certify that the beneficiary has a terminal illness (i.e., a life expectancy of six months or less if the illness runs its usual course). For subsequent benefit periods, the hospice physician must recertify that the patient continues to have a terminal prognosis. The guidelines addressing the certification and recertification requirements have undergone many revisions, especially since 2008. For example, a brief outline of these changes follows:

- Prior to October 1, 2009: A written certification was to contain a statement that the medical prognosis was six months or less; specific clinical findings and

documentation supporting that prognosis; and a dated signature by the hospice physician.

- Effective October 1, 2009: New and specific requirements were implemented for the physician to include a brief narrative explanation of the clinical findings supporting the patient's terminal prognosis.<sup>2</sup>
- Effective January 1, 2011: Recertifications for a beneficiary's third and subsequent benefit periods required a Face to Face encounter be conducted by the hospice physician or hospice nurse practitioner and that the physician's narrative include findings from this encounter that support a six-month life expectancy.<sup>3</sup>
- Effective for the First Quarter of CY 2011: CMS announced that enforcement of the Face to Face requirements were be deferred for the first quarter of calendar year 2011, although this enforcement deferral was not manualized.<sup>4</sup>

### **Identifying Areas of Payment Vulnerabilities**

Many governmental agencies and other entities identify areas of payment vulnerability under Medicare and providers are expected to access and utilize this information in planning their own compliance program and related activities. CMS, Medicare Administrative Contractors (MACs), Recovery Auditors and other third party contracted claim auditors, General Accountability Office (GAO), Office of Inspector General (OIG), and Program for Evaluating Payment Patterns Electronic Report (PEPPER), among others, identify areas susceptible to payment errors and expect providers to use them in designing and carrying out compliance activities within their organizations. Unfortunately, it appears that many hospice and home health providers may not be fully utilizing these resources in their compliance efforts.

Highlighted below are a few of these resources of particular interest to hospice and home health providers.

### **PEPPER Data**

PEPPER provides hospice and home health specific Medicare data that identifies “target areas” that have been determined to be at high risk for improper payments. Each provider can access its own PEPPER and learn how its statistics in these target areas compare to those of home health or hospice providers in the same state, in their jurisdiction, and to their provider category nationwide.<sup>5</sup> PEPPER data for individual providers is not available to the general public and may only be accessed by an authorized provider representative.

Home Health Agencies: PEPPER for home health agencies is released annually in mid-July, beginning in July 2015. The data reflects trends for the previous three years in identified target areas. In July 2016, those target areas were:

1. Average Case Mix Rate;
2. Average Number of Episodes (per beneficiary);
3. Episodes with 5 or 6 Visits;
4. Non-LUPA Episodes;
5. High Therapy Utilization Episodes; and
6. Outlier Payments.

The PEPPER website contains instructive materials to help home health agencies download their PEPPER and interpret its results. However, as of September 20, 2016 (three months after the most recent PEPPER became available), only 21% of home health agencies in the country had accessed their July 2016 PEPPER.<sup>6</sup>

Hospice Care Providers: PEPPER for hospice providers is released annually in mid-April, beginning in April 2014. The data reflects trends for the previous three years in identified target areas. In April 2016, those target areas were:

1. Live Discharges – No Longer Terminally Ill;
2. Live Discharges – Revocations;
3. Live Discharges – With LOS 61-179 Days;
4. Long Length of Stay;
5. CHC Provided in ALF;
6. RHC Provided in ALF;
7. Claims with Single Diagnosis Coded; and
8. Claims with No GIP or CHC.

The PEPPER website contains instructive materials to help hospice providers download their PEPPER and interpret its results. As of September 20, 2016, (five months after the most recent PEPPER became available), only 55% of home health agencies in the country had accessed their July 2016 PEPPER.<sup>7</sup>

### **Office of Inspector General (OIG)**

The OIG is tasked with protecting the integrity of programs of the Department of Health & Human Services (HHS) and the health and welfare of program beneficiaries. The majority of the OIG's resources are using in combating fraud, waste and abuse, particularly relating to the Medicare and Medicaid programs. The OIG publishes an annual and semi-annual Work Plan that identifies its focus areas and planned reviews, including those for specific provider types such as home health agencies and hospices. The work plan can be useful to individual providers in helping to plan compliance endeavors for the coming year. Reports published by the OIG as a

result of completed reviews provide specific findings from their activities that can be used by home health and hospice providers to help focus compliance efforts. Examples of OIG reports of interest to home health agencies and hospice providers are noted below.

### Home Health Agencies

1. *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases* (HHS OIG Data Brief, June 2016, OEI 05-16-00031): This publication noted that although home health fraud cases vary, they generally involve claims for services that were not medically necessary or were not provided. Five characteristics were identified as common in cases of home health fraud investigated by the OIG:
  - a. High percentage of episodes for which the beneficiary had no recent visits with the supervising physician.
  - b. High percentage of episodes that were not preceded by a hospital or nursing home stay.
  - c. High percentage of episodes with a primary diagnosis of diabetes or hypertension.
  - d. High percentage of beneficiaries with claims from multiple HHAs.
  - e. High percentage of beneficiaries with multiple home health readmissions in a short period of time.
2. *Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians* (June 22, 2016): This publication encourages home health agencies and physicians that enter into compensation arrangements to carefully evaluate them for compliance with the Federal anti-kickback statute. It also notes that the

Federal government has obtained criminal convictions and entered into civil settlements with home health agencies and physicians that were found to have defrauded Medicare. The following examples are provided:

- a. Making (or accepting) payments for patient referrals;
- b. Falsely certifying patients as homebound; and
- c. Billing for medically unnecessary services or for services that were not rendered.

### Hospices

- *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (March 2016, OEI-02-10-44491): This study analyzed a stratified random sample of all GIP stays billed by hospice providers in 2012, and estimated the percentage of GIP stays that were billed inappropriately. The OIG found that one-third of GIP stays totaling approximately \$268 million were billed improperly for beneficiaries who did not evidence uncontrolled pain or unmanaged symptoms. Some of the OIG recommendations for CMS included: (1) increase its oversight of hospice GIP claims; (2) ensure the physician is involved in the decision to use GIP; and (3) conduct prepayment reviews of lengthy GIP stays.

### **Why the Focus on Improper Payments Will Continue**

Some other factors contributing to a continued focus on home health and hospice payments include the following.

### **Comprehensive Error Rate Testing (CERT) Program**

The CERT Program annually evaluates a random sample of Medicare fee-for-service claims across all provider types to estimate a rate of improper payment. The *Medicare Fee-For-*

*Service 2015 Improper Payments Report*<sup>8</sup> notes that the improper payment rate was estimated to be 12.1 percent or \$43.3 billion based on an analysis of claims between July 2013 and July 2014. The largest contributors to this error rate were Part A services (excluding those billed by hospitals under the Inpatient Prospective Payment System - IPPS) for which the error rate was 14.7 percent. Home health and hospice services are both included in this category, although home health services alone were estimated to have an improper payment rate of 59 percent, comprising nearly 23 percent or \$10.1 billion of the overall error rate in this category. The improper payment rate for hospice was 3.2 percent or \$1.4 million of this category.

### **Legislative Mandate to Reduce the Rate of Improper Payments under Medicare FFS**

The OIG is required to report on various governmental agencies' (including the Department of Health and Human Services – HHS) annual improper payment information as reported in their Agency Financial Reports (AFRs). This requirement is in accordance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA) to determine compliance with the Improper Payments Information Act of 2002 (IPIA), which includes a provision that HHS achieve a goal of less than 10 percent improper payments in the Medicare Fee-For-Service program. As a result, the OIG published a report in May 2016 entitled *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Did not Fully Comply for Fiscal Year 2015* (A-17-16-5200). One element of this report of particular interest to providers who receive Medicare fee-for-service payments is that CMS did not achieve an improper payment rate of less than 10 percent as mandated by IPIA. HHS reported that insufficient documentation and mistakes in determining medical necessity were primary causes, especially with home health claims whose error rate HHS calculated had increased by 7.57 percent over FY 2014.

**Focus on Better Data and More Prepayment Reviews**

In April 2016, the General Accountability Office (GAO) published a report entitled *MEDICARE; Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data* (GAO-16-394), which evaluated the use of prepayment and post-payment reviews of Medicare fee-for-service claims at high risk for improper payments. It found that prepayment reviews are generally more cost-effective because they prevent improper payments and reduce the need to collect payments made in error (often referred to as “pay and chase”), which is more costly and not always successful.

## Footnotes

<sup>1</sup>Transmittal 172 to Pub 100-02, Medicare Benefit Policy, SUBJECT: Home Health – Clarification to Benefit Policy Manual Language on Confined to the Home Definition.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R172BP.pdf>

<sup>2</sup>August 6, 2009, Hospice Wage Index Final Rule (74 FR 39384). Incorporated in the Medicare Manual, Pub 100-02, Chapter 9 in Transmittal 141, Change Request 7337, Publication Date: March 2, 2011; Effective Date: January 1, 2011; Implementation Date: March 23, 2011.

<sup>3</sup>Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372).

<sup>4</sup>[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/f2f\\_listserv.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/f2f_listserv.pdf)

<sup>5</sup><https://pepperresources.org/>

<sup>6</sup><https://pepperresources.org/Training-Resources/Home-Health-Agencies/PEPPER-Portal-Retrieval-Map>

<sup>7</sup><https://pepperresources.org/Training-Resources/Hospices/PEPPER-Portal-Retrieval-Map>

<sup>8</sup>[https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2015\\_Improper\\_Payments\\_Report.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2015_Improper_Payments_Report.pdf)