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Billing Compliance Challenges in Changing Health Care Environment

HCCA Philadelphia Regional
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Disclaimer

- Opinions expressed are my own and do not represent any guarantees, warranties or endorsements by the University of Pennsylvania or its Trustees

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Course Objectives

- Emerging issues in the field of Billing Compliance
  - Government Audits
  - Home Health Care Services
  - Telemedicine

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- Penn Medicine offers comprehensive clinical services throughout the greater Philadelphia region
- Practice Plans
  - Clinical Practices of the University of Pennsylvania
  - Clinical Care Associates
- Hospitals
  - Chester County Hospital
  - Hospital of the University of Pennsylvania *(the nation's first teaching hospital)*
  - PENN Presbyterian Medical Center
  - Pennsylvania Hospital *(the nation's first hospital)*
  - Lancaster General Health
- Home Care & Hospice Services
  - PENN Care at Home / PENN Home Infusion Therapy
  - Wissahickon Hospice

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Federal & State Authorities
- **Office of the Inspector General**
- **Department of Justice**
- **Centers for Medicare & Medicaid Services**
- **Office of the State Attorney General**

Anti-Kickback Statute	**Pennsylvania False Claims Act**	**Federal False Claims Act**
Beneficiary Inducement Law	**"Stark" law: Physician self-referral law**	**Mail Fraud**

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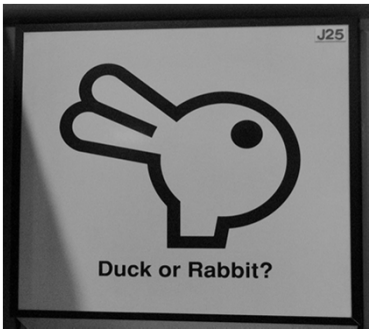

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JL CERT Error Rates

Claims Sampled between 7/2014 and 6/2015

NOVITAS SOLUTIONS

State	Part A	Part B
NJ	10.1%	11.4%
PA	6.5%	14.1%
MD	4.9%	9.7%
DE	6.9%	10.9%
DC	27.5%	10.0%
National Error Rate	10.0%	11.7%
Total Error Rate for JL	**7.6%**	**12.3%**

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Part B - Key Points

NOVITAS SOLUTIONS

- **Evaluation & Management Services**
  - Documentation is not supporting the level of service billed on the claim
    - One or more of key components required are not documented to the appropriate level
    - Non-physician practitioner and physician shared visits are not appropriately documented
  - Signatures
    - Illegible signatures with no attestation statement
    - Missing signatures on documentation
- **Lab Tests**
  - No documentation submitted to support medical necessity or intent to order test billed

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External Audit Appeals

- Lengthy process and success is not guaranteed
  - Can take years to recover payment
- Expenditure of resources

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RAC Program Update

- **CMS awarded new contracts on October 31, 2016**
- 5 total RAC's
  - 4 Regions for all provider types other than listed below
  - 1 National auditor reviewing Home Health/Hospice (New)
- Pennsylvania part of Region 4
  - Contract awarded to HMS Federal Solutions (HeathDataInsights or HDI)
- Region 5 (Home Health) was awarded to Performant Recovery (old Pa RAC)
  - ADR limits not known at this time

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Updated RAC Regions

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Change In Audit Scope

- Material increase in ***prepayment*** reviews
  - Not considered audits under CMS guidelines
  - Triggered off of "system edits"
  - No formal report of findings
  - Provider appeal rights the same as audits (5 levels)
- Request include significantly more inforantion

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Sample of Pre-payment Audit Activity

Infusion

- Physician Orders
- Pertinent H&P (including weight if it is a weight based drug)
- Lab Results (drug dependent—some ask for specific results like calcium)
- MN documentation support (why does the patient need this drug)
- Clinical trial participation?
- Name, dosage, time, route, and injection site (must be signed)
- Wastage documentation (if applicable)

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Pa Introduces Medicaid RAC

- Auditor - HMS Federal Services (same as Medicare)
- 1st letters received January 2017
- Per DPW conference call, maximum 6 audits per calendar year (every other month)
  - Limits: (size not defined by state)
    - Small: 10-15 records
    - Medium: 20-25 records
    - Large: 50 records

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Medicaid RAC (continued)

- No Statement of Work
- Only Fee-for-Service cases
- Beginning with Hospitals
  - Will introduce other provider types in the future
- All retrospective reviews
  - Look back period is 3 years from date of service
- Current issue under audit: Inpatient admissions with length of stay less than 7 days

Home Healthcare

Conditions of Participation 42 CFR 424.22; Medicare Benefits Policy Manual Chapter 7

CMS Improper Payment Report

- Medicare national home health care audit activity

Risk Area	2016
Projected improper payments	$7.7 billion
•Insufficient documentation	$7.4 billion
•Medical necessity	$200 million
Projected improper payment rate	42%
•Insufficient documentation	96%
•Medical necessity	2%

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf

2016 Improper Payments by State

- For home health and hospice areas only *(Pennsylvania ranks **3rd** for improper payment rate)*

State	Projected Improper Payments	Improper Payment Rate	Claim Reviewed
VA	$ 332.3	52.5%	37
TX	$ 1,552.5	47%	209
PA	**$ 697.6**	**47%**	**76**
IL	$ 783.0	46%	102
LA	$ 547.8	44%	85
IN	$ 224.1	42%	32
GA	$ 538.2	38%	77
FL	$ 1,135.3	33%	161
OK	$ 237.4	32%	49
NC	$ 360.2	30%	61

(dollars in *millions*)

OIG Audit Activity

- Three home health agencies cited:
  - Documentation lacking:
    - Support for medical necessity and/or homebound status
    - F2F missing or incomplete
  - Outcome:
    - Sea View Health Care Services, Inc.
      - Overpayments (refunds) of $185K
    - Excellent Home Care Services, LLC.
      - Overpayments (refunds) of $6.4 million
    - Home Health VNA
      - Overpayments (refunds) of $6.3 million

CMS definition of Homebound Status

A patient is considered homebound if:

- ✓ Their illness or injury requires the need of supportive devices (walker, cane, crutches, wheelchair) *or requires the assistance of another person in order to leave their place of residence*
- ✓ OR, their condition is such that leaving the home is medically contraindicated
- ✓ AND, there must be a normal inability to leave home which requires a considerable and taxing effort

CMS - Absence from Home

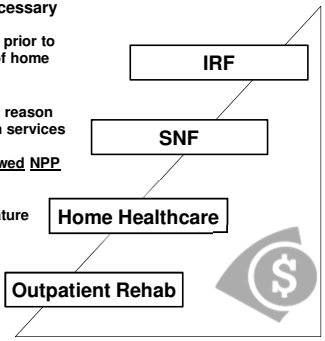
Patient may be considered homebound (that is, confined to the home) if absences from the home are:

- ✓ Infrequent
- ✓ Periods of relatively short duration
- ✓ Need to receive health care treatment
- ✓ Religious services
- ✓ Attend adult daycare programs
- ✓ Other unique or infrequent events (e.g., funeral, graduation, trip to the barber)

Face to Face Requirements

Timely Documentation Necessary

- ✓ **Must occur within 90 days prior to or 30 days after the start of home health services**
- ✓ **Must be related to primary reason patient needs home health services**
- ✓ **Date the physician or allowed NPP saw the patient**
- ✓ **Certifying physician signature and signature date**



Physician Responsibility

Certifying physicians **must**:

- ✓ Provide supporting documentation of the patient's eligibility for home health services to:
  - Home health agency, review entities, and/or CMS
- ✓ Review and sign off on any documentation incorporated into the patient's medical record utilized to support the certification of patient's eligibility
- ✓ ***Ensure the patient's medical record contains:***
  - ***Actual note for Face to Face encounter visit***
  - Documentation to support medical necessity and homebound status

Absence of results in 100% denial

Non-compliance or inadequate or incomplete patient medical records:

- ✓ Physician may be subject to increased reviews, such as provider-specific probe reviews

Form CMS-485


HOME HEALTH CERTIFICATION AND PLAN OF CARE

The physician treatment plan for care of the patient

Must include the following orders:

- ✓ Skilled and unskilled services (include amount, frequency and duration)
- ✓ Other types of treatments (wound care, etc.)
- ✓ Medications

And a signature by the certifying physician

- ✓ **Should align to the physician's signature on the Face to Face encounter**

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What is Telehealth?

- CMS regulations define telehealth services to include specific patient locations and limitations of Part B services

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Innovations In Medicine & Technology Versus Government Barriers

- Laws of supply & demand
  - Managing scarce resources & improving quality of life
- Significant government imposed billing obstacles associated with telemedicine restricts use and access
  - Geographical constraints;
  - Credentialing/Privileging; and,
  - Licensure

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Core Concepts – CMS Telehealth

- Originating site – location of eligible Medicare beneficiary
  - Physician or practitioners offices
  - Hospitals
  - Critical Access Hospitals (CAHs)
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Hospital-based or CAH-based Renal
  - Dialysis Centers (including satellites)

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Telehealth Services

- Condition of payment – must use interactive audio and video telecommunications systems permitting real time communication

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- Limited services
  - G codes for consultations in hospitals & SNFs
  - Office and hospital visits
  - No home visits
  - **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf**.

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Statutory Barriers to Telemedicine

- Geographical constraints
  - CMS restricts coverage to rural health professional shortage areas
  - Metropolitan statistical areas excluded
- Physicians must be credentialed and hold privileges to practice in the hospital where patient is located
  - Risk associated with delegated credentialing
- Physicians must be licensed to practice in the state
  - Professional liability exposure

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Other Considerations

- Informed consent
- Signed authorization for payment
- Medical record documentation
  - Originating site?
    - Information needed to treat patient
    - How would the note be retrived for post payemtn review?
  - Distant site?

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The doctor is ready to see you now

"Now inhale deeply Mrs Saunders"

- Might be telemedicne but not telehealth under CMS regulations

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AMC Audit Challenges

- "Cutting Edge" of medicine
  - Introduction of new procedures &/or techniques that do not agree with CPT code descriptions (e.g. approach using arthroscopy versus open fashion as described in CPT)
  - Use of unlisted codes
- Technological advances in medicine
  - Extended timeframe for development of new codes

Penn Medicine AMC Audit Challenges

- Tertiary/quaternary care institutes
  - Patient acuity
- Teaching Physician New Rules (TPNR)
  - Required attestation & tethering language
  - Service fully documented by resident but insufficient documentation by teaching physician (e.g. demonstrate participation & management)

Penn Medicine Summary

- Material increase in external audits by government and private payors
  - Change in scope with additional documents requested
- Audits expanding to post acute care
  - Home health care services
- Innovations in medicine and technology subject to government barriers such as telemedicine

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1. By the time he was admitted, his rapid heart had stopped, and he was feeling better
2. On the second day the knee was better and on the third day it had completely disappeared
3. Healthy appearing decrepit 69 year-old male, mentally alert but forgetful
4. The patient has no history of suicides
5. Patient has two teenage children, but no other abnormalities

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Medical Humor

6. The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days
7. Rectal exam revealed a normal size thyroid
8. While in the ER, she was examined, X-rated and sent home
9. The patient will need disposition, and therefore we will get Dr. Blank to dispose of him

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Medical Humor

10. The worst time to have a heart attack is during a game of "charades"