Home Health and HME Update

Charlotte Regional Healthcare Compliance Conference

January 18, 2019

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Current Audit Environment

- Medicare
  - UPIC (Unified Program Integrity Contractor)
  - RAC (Recovery Audit Contractor)
  - MAC (Medicare Administrative Contractor)
  - SMRC (Supplemental Medical Review Contractor)
  - CERT (Comprehensive Error Rate Testing)
- Medicaid
- Medicare Advantage
- Commercial Payors

CERT

- CMS calculates the Medicare Fee-for-Service (FFS) improper payment rate through the Comprehensive Error Rate Testing (CERT) program
- CERT evaluates a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules

CERT Errors - 2018 Improper Payment Rate

- 17.6% - Home Health*
  - 61.9% - Insufficient Documentation
  - 19.3% - Medical Necessity
  - 2.0% - No Documentation
  - 0.5% - Incorrect Coding
  - 16.2% - Other
- 35.5% - DMEPOS*
  - 62.9% - Insufficient Documentation
  - 9.0% - Medical Necessity
  - 0.0% - Incorrect Coding
  - 0.4% - No Documentation
  - 27.7% - Other

* 58.95% in 2015

*46.26% in 2016

Insufficient Documentation Errors (DMEPOS)

- Documentation to support medical necessity or to support the services were provided or were provided as billed was not submitted
- Valid order, or an element of an order, was not submitted
- POD, in its entirety or an element, was not submitted
- Documentation to support a F2F or prescription requirements prior to delivery was not submitted
- Documentation to support medical necessity of diabetic supplies or of high utilization was not submitted
- A signature log/attestation of medical personnel to support a clear identity of an illegible signature was not provided

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Insufficient Documentation Errors (HH)

- A valid provider's order, or an element of an order, was not submitted
- Documentation to support medical necessity was not submitted
- A valid provider's intent to order (for certain services) was not submitted
- Home health certification requirements, in entirety or an element, was not submitted

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Supplemental Medical Review Contractor

- SMRC performs a large volume of Medicare Part A, Part B, and DMEPOS claims nationally.
- Focus on lowering improper payments in Medicare Fee-For-Service programs and increasing efficiencies in medical review functions.
- Projects include issues identified by the OIG, CERT and CMS internal data analysis
- Focus on national claims data analysis versus MAC jurisdiction data
- Noridian Healthcare Solutions – www.noridiansmrc.com

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National DMEPOS and HHH RAC

- Performant Recovery
- Identified focused areas for new RACS and will be meeting monthly with CMS to identify audits
- Will be looking at post-payment claims than have been submitted within the previous 3 years from the date the claim was paid

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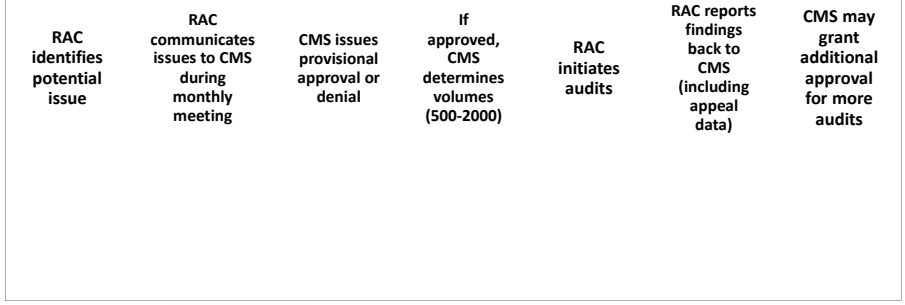
RAC Identified Issues Process



RAC Issues – Automated (DME)

DME While in Hospice	**9/20/2018**
CPAP without OSA Diagnosis	9/8/2017
Group 3 PWC Underpayments	5/17/2017
Multiple DME Rentals in one month	3/31/2017
DME while beneficiary is in an inpatient stay	2/16/2017
Nebulizers	2/2/2017
CPM Billed without Total Knee Replacement	2/2/2017
Glucose Monitor	1/5/2017
Spring Powered Devices Billed for >1 in a 6 Month Period	1/5/2017

RAC Issues – Complex (DME)

Custom Fabricated Knee Orthosis: Medical Necessity	9/14/2018
Medical Necessity: Parenteral Nutrition	9/14/2018
Urological Supplies (Effective 8/1/2018)	07/11/2018
Home Use of Oxygen: Medical Necessity and Certification	07/11/2018
Group 3 Pressure Reducing Support Surfaces	5/15/2018
Ventilators submit to DWO Requirements prior to January 1, 2016	3/14/2018
Negative Pressure Wound Therapy Pumps – DWO	2/26/2018
Group 2 Support Surfaces without correct diagnosis of condition – DWO	2/20/2018
Ventilators submit to DWO Requirements on or after January 1, 2016	1/11/2018
Respiratory Assist Device	12/17/2017
PAP Devices for the treatment of OSA	9/19/2017
Spinal Orthoses	8/2/2017
AFO/KAFO	7/7/2017
PMDs not subject to PA Demonstration	6/6/2017
Blood Glucose Monitors with Integrated Voice Synthesizer	5/12/2017
Enteral Nutrition Therapy	5/11/2017
Negative Pressure Wound Therapy Pumps	4/28/2017
Nebulizers	4/14/2017
Group 2 Support Surfaces	2/15/2017
Osteogenesis stimulators	2/14/2017
Chest Wall Oscillation Devices	2/8/2017
Tracheotomy suction catheters, suction pumps, catheters and other supplies	2/8/2017

RAC Issues – Complex (Home Health)

- Issue: Complex Home Health Review: Documentation and Medical Necessity
- Posted: 1/10/2018
- States: All HHA MACs except for the following demonstration states: Delaware, District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia

Current RAC Situation

- They have sent a low volume of audits comparative to first round (less than 10,000)
- RAC isn't making a whole lot of money
- Audits likely to increase as appeals backlog declines, if the RAC chooses to continue under the current environment

OIG Work Plan

- Beginning June 15, 2017, OIG will update their Work Plan continuously, with the website being updated monthly.
- This change allows the OIG to enhance transparency around their work planning efforts.
- The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond.

OIG Work Plan

Project Description	Date Posted
Review of Home Health Claims for Services with 5 to 10 Skilled Visits	June 2018
Noninvasive Home Ventilators – Compliance with Medicare Requirements	May 2018
Questionable Billing for Off-the-Shelf Orthotic Devices	January 2018
Power Mobility Devices Equipment Portfolio Report on Medicare Part B Payments	December 2017
Home Health Compliance with Medicare Requirements	October 2017
Osteogenesis Stimulators - Lump-Sum Purchase Versus Rental	October 2017
Medicaid Health Home Services for Beneficiaries with Chronic Conditions	September 2017
Ventilation Devices: Reasonableness of Medicare Payments Compared to Amounts Paid in the Open Market	August 2017
High-Risk, Error-Prone HHA Providers Using HHA Historical Data	July 2017
Medicare Payments for Unallowable Overlapping Home Health Claims and Part B Claims	July 2017

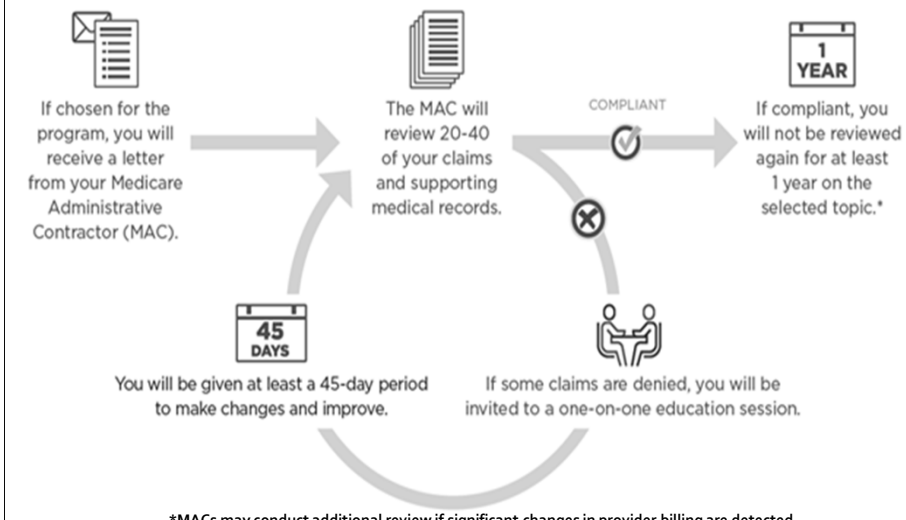
Targeted Probe and Educate (TPE)

- MACs will no longer perform widespread reviews
- Help providers reduce claim denials and appeals through one-on-one help
- Providers whose claims are compliant with Medicare policy won't be chosen for TPE
- Lessons learned from Home Health Prospective Payment System Final Rule (CMS-1611-F).
  - 5 prepayment claims reviewed to determine further level of oversight.

How do the identify targets?

- Widespread review error rates
- Claims that are at high financial risk
- Claims that have a high national error rate
- MACs will then focus on those with high error rates or whose billing practices designate them as outliers
- Determination made by “detailed data analysis”

TPE - How does it work?



*MACs may conduct additional review if significant changes in provider billing are detected

TPE Results

- If error rate is low (compliant):
  - Pass Round 1 = No new audits for 1 year
- If error rate high (noncompliant):
  - Education
  - Corrective Actions (Performance Improvement Plan aka PIP)
  - 45 days to make changes and improve
  - Begin Round 2
- If noncompliant after 3 Rounds:
  - Referral to CMS

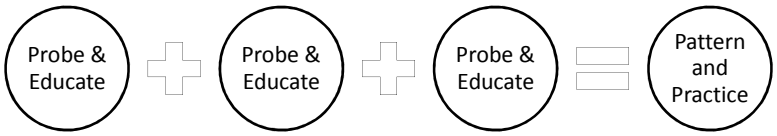
Referrals to CMS

- CMS may refer to UPIC for a more aggressive audit, which sometimes results in:
  - Payment Suspensions
  - Extrapolated Overpayment
  - 100% Prepayment Review
- CMS may recommend review by RAC
- CMS could exercise their revocation authority

Revocations

- Under authority of the ACA, CMS can and will deny or revoke enrollment of entities and individuals that pose a program integrity risk to Medicare for the following:
  - "… providers and suppliers that have a **pattern and practice of billing for services that do not meet Medicare requirements**. This is intended to address providers and suppliers that regularly submit improper claims in such a way that it poses a risk to the Medicare program."

Proving a pattern or practice



Language from results letters

- "Should you continue to fail to meet these requirements as described in this letter, your billing privileges may be revoked on this basis or any of the bases articulated in Per 42 CFR §424.535(a)."

Payment Suspensions

- 42 CFR 405.371(a)(1) affords contractors the authority to implement a payment suspension based on "reliable evidence that an overpayment exists or that the payments to be made may not be correct.

TPE - Additional Information

- If selected for review, providers are not excluded from other Medical Review activities, such as, automated reviews, other pilot review programs, prior authorization, etc., as directed by CMS or other contractor reviews.
- Additionally, the MAC will continue to work with other CMS contractors and collaborate with referrals back and forth to the UPIC for concerns related to potential fraud/abuse and Recovery Auditor (RA) for collaboration of vulnerability and to prevent duplication of reviews.

TPE Compliance

- HHH MACs compliance criteria:
  - Minor: 0-25% error rate (Minor: 0-20%, JM)
  - Moderate: 26-50% error rate
  - Significant: 51-100% error rate (Major: 21-100%, JM)
- DME MACs have not defined compliance

TPE – Top Denial Reasons (HH)

- Face-to-Face missing/incomplete/untimely
- Initial certification invalid
- Medical records were not received
- Recertification estimate missing/invalid
- Plan of care missing/invalid

TPE – Top Denial Reasons (DMEPOS)

- Records not mentioning need for specific equipment
- Other equipment being tried and ruled out
  - Oxygen
  - Manual Wheelchairs
  - Vents
- Documentation provided does not support medical necessity as referenced in the LCD
- Continued need/use not established
- Illegible or missing signatures

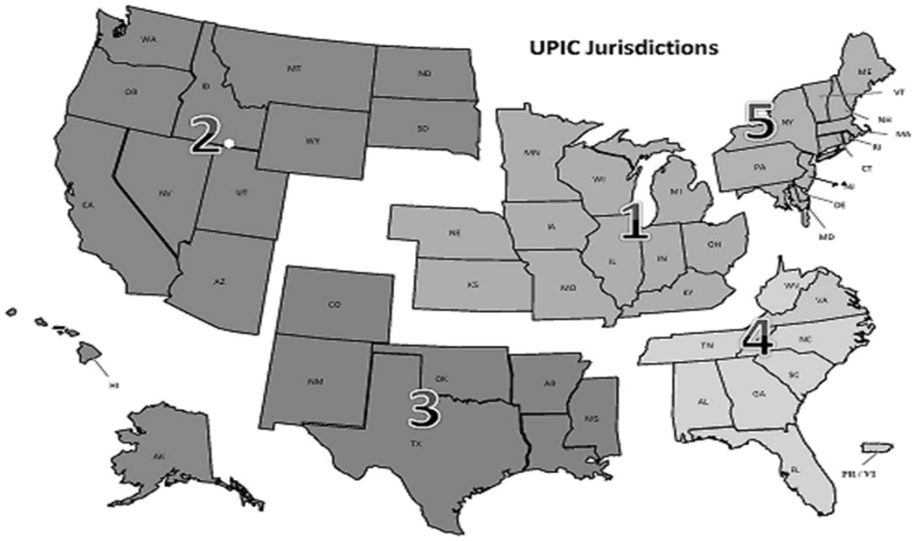
Unified Program Integrity Contractors

- Implementation of the UPIC initiative began in 2016
  - Combines the audit and investigation work currently conducted by the ZPICs (and their responsibilities) with the Audit Medicaid Integrity Contractors (Audit MICs) to form the UPIC
- Contracts with ZPICs/PSCs and MICs will end as the UPIC is implemented in specific geographic regions
- Implementation of the UPICs will be over a multi-year period in order to allow current contractors to transition out
- Goal: Streamline audit structure

UPICs

- AdvanceMed was awarded UPIC Jurisdiction 1 (Midwest)
  - Contract amount = $76,874,623.22
- Qlarant was awarded UPIC Jurisdiction 2 (Western)
  - Contract amount = $85,341,745.00
- Qlarant was awarded UPIC Jurisdiction 3 (Southwest)
  - Contract amount = $86,965,604.00
- Safeguard Services was awarded contracts for Jurisdiction 4 (Southeast) and Jurisdiction 5 (Northeast)
  - Contract amount Jurisdiction 4 = $129,729,617
  - Contract amount Jurisdiction 5 = $92,063,226

UPIC Jurisdictions



*Other territories of Zone 2 include American Samoa, Northern Marianas Islands and Guam

UPIC Actions against Providers

- Prepayment Audits
- Postpayment Audits
- Patient/Physician interviews
- On-site visits
- Extrapolated Overpayments
- Payment Suspensions
- Recommend revocations

HH Review Choice Demonstration

- HHAs that operate in and render services to Medicare fee-for-service beneficiaries in:
  - Illinois, Ohio, North Carolina, Florida, and Texas **AND**
  - Submit claims to Palmetto GBA, Jurisdiction M MAC
- Claims are excluded from MAC targeted probe and educate review, but may be selected for RAC, UPIC or CERT review

APPEAL ENVIRONMENT

Provider Friendly CMS?

- CMS and its contractors have indicated a more "provider-friendly" approach to DMEPOS claims
- "Provider-friendly" equates to reducing appeal backlog
- DMEPOS is the largest contributor to the appeal backlog
  - DMEPOS Account for 57% of all appeals pending for 2018
  - 7 of the top 10 appellants at OMHA are DME suppliers

ALJ Hearings Update

- On November 1, 2018 District Court ordered HHS to clear the Medicare Appeals backlog by 2022
- Average processing time 1,142 days (3Q 2018)
- 426,594 total pending appeals
- OMHA has hired more judges
- Opened up new offices in Seattle, WA and Kansas City, MO (from 4 to 6)
- Funding nearly doubled for 2019

Impact of "Provider-Friendly" Approach

- New, friendlier appeal processes
- Patients Over Paperwork

QIC Telephone Discussion

- Telephone discussion at the Reconsideration level
- Selected providers will have the opportunity to participate in a formal recorded telephone discussion with the QIC and offer verbal testimony.
- Providers will be able to discuss the facts of the case and provide any additional documentation that would assist in reaching a favorable determination.
- The Reopening process allows potential cases to be remanded back from the ALJ

QIC Reopening Process

- Previously completed unfavorable reconsideration decisions dated on, or after, January 1, 2013 and includes:
  - Cases that have been closed by the QIC, but yet to be appealed to the Administrative Law Judge (ALJ), or
  - Cases that have been appealed to the ALJ and are currently pending an ALJ decision.
- C2C will request additional documentation, if needed, to support a favorable outcome through the reopenings process
- C2C the QIC will review the materials received to confirm all requested documentation was submitted, and will determine if a reopening is warranted.
- C2C will work with the ALJ to remand the case back to the QIC for processing of the reopening for cases pending at the ALJ.

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C2C – Reopenings by the Numbers

- Cases C2C has reopened/withdrawn from the ALJ:
  - Approximately 22,000 in 2016*
  - Approximately 81,000 in 2017
  - Approximately 129,000 thus far in 2018 (Jan-Nov)

*C2C's withdrawal process was approved at the beginning of April 2017

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Appeal Settlement Options

- Settlement Conference Facilitation Pilot
  - Pilot alternative dispute resolution process designed to bring the appellant and CMS together to discuss the potential of a mutually agreeable resolution for claims appealed to the ALJ
  - DMEPOS providers should keep in mind that claims will not be adjusted so subsequent supply or repair claims for that patient will not get paid
- Low Volume Claims Settlement
  - Administrative settlement process
  - Partial payment of 62% of the net Medicare approved amount
  - Completed in June 2018

Patients over Paperwork

- CMS Administrator Seema Verma launched this initiative, which is in accord with President Trump's Executive Order that directs federal agencies to "cut the red tape."
- CMS has established internal process to streamline regulations and reduce unnecessary burden
- ReducingProviderBurden@cms.hhs.gov

Patients over Paperwork

- (HHA) CMS eliminated the requirement that the certifying physician estimate how much longer skilled services are required when recertifying the need for continued home health care
- (DME) Simplified the requirements for preliminary/verbal DMEPOS orders
- (DME) Clarified DMEPOS written order prior to delivery date requirements
- (DME) Revised manual to allow bar codes to be added to CMNs and DIFs for tracking and efficiency

Settlement Discussions

- 80% verses 100% for part A
- Ongoing rentals
- Ongoing supplies

PROVIDERS FIGHT BACK

USA vs. HRC ManorCare

- A years-long investigation coupled with 3 years of litigation – the government and a qui tam relator fought a False Claims Act case against HRC ManorCare (a rehab facility) for medically unnecessary services
- The government relied upon the expert report of Rebecca Clearwater, of AdvanceMed, and her team of nurses, to analyze the sample and provide an expert report of testimony as to medical necessity
- Extrapolated overpayment of over $500 million from a sample of 180 claims

Pretrial Motion to exclude the expert

- Defendents claimed:
  - Although touted as a "medical review expert" she did not work in AdvanceMed's medical review department
  - Although a licensed PT, she has not practiced PT for over 24 years and had never worked in a rehab facility like ManorCare
  - She had never practiced under the current Medicare reimbursement system
  - She purports to make clinical decisions about OT and SLP despite lacking formal training in either profession

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Judge's ruling

- Case was a "huge waste of money…"
- "Clearwater's entire report must be stricken and that she must not be allowed to testify because of her utter lack of credibility."
- "The Government's case here was…[a] house of cards that was resting on Ms. Clearwater's testimony."
- Government was also admonished for failing to disclose 131 pages of handwritten notes by Clearwater, who said she couldn't remember taking the notes.

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Case outcome

- Judge awarded HRC ManorCare attorney's fees and costs for bringing its motion for sanction and suggested ManorCare could obtain attorney's fees and costs for the preparation for Ms. Clearwater's deposition.
- Although they initially intended to appeal the decision, the DOJ later decided to dismiss its case with prejudice after the court excluded the expert report of DOJ's key witness.
- HRC ManorCare was completely admonished.

Family Rehabilitation vs Azar

- Audit resulted in $7.6 million overpayment
- Family Rehab challenged the overpayment allegations at Redetermination and Reconsideration but due to backlog would not have an ALJ Hearing within 90 days as required by statute
- In the meantime, recoupment of the alleged overpayments was about to begin, so Family Rehab sued to enjoin the recoupment asserting that that the system violated their rights to procedural due process.

Outcome

- District court dismissed for lack of jurisdiction because they had not exhausted all four stages of the Medicare appeal process.
- The Fifth Circuit reversed the decision concluding that the claims were "collateral" to the underlying administrative dispute and these claims, coupled with the threat that Family Rehab would be forced to go out of business and disrupt services to Medicare beneficiaries, were sufficient to meet a "collateral-claim" exception.
- Gave Family Rehab the right to sue in federal court to suspend Medicare recoupment without first exhausting the backlogged appeal process.

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Tips

- Identify risk areas/audit targets
  - Develop checklists for required documentation
    - Support eligibility at admission and ongoing
  - Revisit coverage policies with staff and be sure you understand and are following coverage guidelines
- Working with beneficiaries to obtain documentation
- Proper transferring of liability
- Innovation
- Review certification process
  - Dates billed, valid signatures, narrative (patient specific)
- Compliance Programs with effective monitoring

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Questions???

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