Your Inpatient Rehabilitation Program in Shape?
Current Compliance Issues

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Agenda

1. Hospital Rehabilitation Claims: Standards for Reimbursement
   • Review of Standards
   • Identifying Risk Areas: Are you a target?
   • Voluntary Disclosure

2. Managing an Adverse Outcome of Probe Audits, OIG, MAC or RAC
   • Medical Necessity appeals
   • Challenging Statistical Extrapolations to Defeat False Claims Act and Financial Liability

3. Practical Suggestions for Implementing a Successful Compliance Program
   • Audit Focus
   • Managing "red flags"

4. Conclusion

5. Questions
Inpatient Rehabilitation – Standards for Reimbursement

- Since 1/1/2002, inpatient rehabilitation has been under a Prospective Payment System for reimbursement
  - Reimbursement based on the accurate assignment of the Case Mix Group (CMG)
    - Impairment Category for admission to inpatient rehabilitation
    - Functional status (as determined by the clinical staff) within the initial assessment period (first three days of admission)
    - Age
    - Co-morbidities
  - While only the CMG appears on the UB, all factors contributing to an accurate assignment of the CMG must be accurate
- All claims for inpatient rehabilitation assume that the exempt inpatient rehabilitation unit/hospital meets the “75% Rule” and all of the “Conditions of Participation”

Inpatient Rehabilitation – Standards for Reimbursement

- Attestation (CMS form 437A) completed annually
  - 75% rule
  - Written admission criteria
  - Separate medical records, readily available for review
  - UR applicable standards
  - Beds physically separate
  - Unit staffed and ready first day of cost reporting period
  - Pre-admission screening process
  - Close medical supervision and furnish rehabilitation nursing, PT, OT, SLP, social services or Psychological services, P&O
  - POC
  - Coordinated, multidisciplinary team approach
  - Director of Rehabilitation (20 hours/40 hours)
- 75% Rule
Inpatient Rehabilitation – Standards for Reimbursement

• Conditions of Participation
  – The patient has to “require” an inpatient rehabilitation stay vs. any other level of care
  – Intensity of rehabilitation (3 hours of therapy for a minimum of five days/week)
  – Rehabilitation nursing

• Implications if standards are not met
  – Organization discovers
    • Conduct an in-depth analysis to determine extent of issues
      ~ Determine cause
      ~ Frequency of issues
      ~ Length of time of issues
  – Example:
    • 200 bed rural hospital 20 bed rehabilitation unit (ADC of 5 – 7)
    • A staff member reported their concern to the compliance officer, who reported to the FI. (Soon afterward another staff member reported the issue to the FI)
    • Internal audit determined that nursing consistently coded two functional areas incorrectly on the initial PAI
    • The extent of the “inaccurate” coding was estimated to be all patients admitted for a three year period
    • Due to the inability to extrapolate to the entire population, the organization negotiated a payback of $275,000
Inpatient Rehabilitation – Standards for Reimbursement

- FI, MAC, RAC discovers
  - The organization may have been paid inaccurately (by Medicare) and be expected to “pay back”
    - May conduct indepth audit to determine frequency and length of time
    - Opens all records
  - Provider status may be lost
    - Potential (going forward) or actual reimbursement may be denied (and the organization expected to “pay back”)

- Example:
  - RAC requests 60 records for review for medical necessity
    - Determines that the medical necessity for the admission for all joint replacement and hip fracture was not demonstrated in the medical record.
    - Denies payment retroactively for all joint replacement and hip fracture admissions for the previous three years.
    - The organization appealed all the denials; one year later the cases were just reaching the ALJ level
    - The organization significantly decreased the admission of joint replacement and hip fracture patients

Rehabilitation Services

- Medical Necessity
  - Is the service reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part?

- Focus
  - Treatment
  - Setting
Medical Necessity Review

“Standards”

- Local Coverage Determinations (LCDs)
- Local medical review
- Provider input critical
  - LCDs can be changed
  - MAC consolidation
- National Coverage Determinations (NCDs)

* Caveat: Standards are not the law!
Medical Necessity Review

**Inpatient Rehabilitation**
- HCFA Ruling 85-2
  - Longstanding clinical reasoning/deference to physician judgment
- California LCD
  - LCD set precondition for hospitalization that SNF cannot provide care
  - How to prove?

**Outpatient Rehabilitation Services**

CMS Transmittal 88 (May 7, 2008): Medicare Benefit Policy (Pub 1002)

- "Active Participation" by physician
  - No set time tables
  - No Form
  - Review of notes show physician involvement
- Therapy every other/every day

Progress in patient is “factor” in medical necessity

**Documentation for records: can include correspondence**
### Medical Necessity Review

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**Medical Necessity Review**

- [www.hcca-info.org](http://www.hcca-info.org)
- 888-580-8373

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Electronic Medical Records

Legibility, but ...

Other considerations

• “Cut and paste”
• Auto-population not always ideal
• Billing/coding prompts with documentation
• Customize templates?

Outpatient Rehabilitation – Standards for Reimbursement

• Medical necessity
  – The services provided must be realistic for the diagnosis identified
    • There must be a documented reason for “skilled” therapy services
  – The patient has to be making (measureable) progress as a result of the service provided
    • Reaching “plateaus”
• The bill has to accurately reflect the services provided
  – Group vs. individual
  – Documented services reflect billed services
    • Time
    • Service
Outpatient Rehabilitation – Standards for Reimbursement

- Implications if standards are not met
  - Total or partial denial
  - If there are a significant number of questions, organization placed on “focused” review
- Example
  - A multi-system hospital had large outpatient therapy services at all five hospitals in the system
  - Based on “internal concern”, the organization reported their concerns to the FI
  - An indepth analysis revealed that inaccurate billing of individual therapy had occurred when in fact group therapy was provided
  - While it was uncertain how long the inaccurate billing had taken place, a payback of $700,000 was made to the fiscal intermediary

Identifying Risk Areas: Are you a target for review?

- Inpatient
  - The medical necessity for the admission is not supported in the medical record
    - The patient’s medical condition does not require admission to an inpatient/acute bed
    - The patient does not need the intensity of an inpatient rehabilitation program
  - Admitting diagnosis not documented as being treated
  - Clinical staff have not scored the patient accurately using the functional scoring methodology
    - Scores are not supported in the medical record
  - Diagnosis/condition does not require the treatment by a licensed staff member (skilled)
### Are you a target for review - Outpatient

- A high number of units of service billed on the same day
- A high volume of the same diagnosis for patients treated at same facility
- Admitting/treating diagnosis does not:
  - Support services of treating therapist/units of services billed
  - Require the services of a skilled therapist
- Length of treatment exceeds that which would be ‘normally accepted’
  - Patient has not made any noted progress for billing period (plateau’ed)
- Once record is pulled:
  - Medical necessity is not documented
  - Plan of care not current
  - Progress made does not support number of treatments provided/billed
  - Physician’s script not current
  - Billed services not supported in documentation

### OIG Focus

**Therapy Issues**

OIG has correlated various records to search for inconsistencies, e.g.:

- Compared therapist time sheets with patient billing records

OIG investigations of services that could have been rendered in a less intensive setting have focused on:

- Uncomplicated knee, hip and other single joint replacements, and
- Simple orthopedic injuries and medical or neurological conditions that required only general muscle strengthening and reconditioning
## Potential Liability

### False Claims Penalties - OIG

A provider’s potential liability when it provides services that are later found to be medically unnecessary is enormous.

- False claims provisions of the Federal fraud and abuse statute provide liability for:
  - Submitting a claim that the person knows or should have know was false or fraudulent; or
  - Submitting a claim for services that the person know or should have know were up-coded.
- CMP – up to $10,000.00 per claim.
- Assessment - up to 3 times the amount claimed for each item or services covered by the claim(s)
- Exclusion from Federal health care programs

### Knowledge of Falsity

The element of false claims liability that distinguishes it from routine overpayments is the person or entity must have knowledge of the falsity of the claim.

- But, willful ignorance of the situation will suffice for actual knowledge.
Potential Liability

Federal False Claims Act _ DOJ

• Provides for civil and criminal penalties
• Authorizes private person (termed a “Relator”) to bring action under the name of the government and share in recovery.

Voluntary Disclosure to OIG

Nature of the Process

A procedure for resolving civil money penalty liability under Stark and the Federal fraud and abuse law.

• Not an amnesty program
• OIG will impose penalties
• General pledge of leniency but no up-front commitment
  – Usually OIG will not impose exclusion
  – OIG will generally settle for an amount near the lower end of the possible range of CMP liability
  – Generally the less costly and onerous Certification of Compliance Agreement is imposed instead of a Corporate Integrity Agreement
Voluntary Disclosure

Pending Investigation
If the claims are already subject of an investigation the OIG will not accept a provider's request for treatment under the Self Disclosure Protocol, e.g.
- RAC has already requested medical records
- Relator has filed suite and initialed government inquiry.

Voluntary Disclosure

Initial Submission
The Initial submission to OIG must contain detailed information about the matter and the names of those involved, those who knew or should have known of the situation and those who detected and investigated the situation. The submission should include:
- A complete description of the conduct being disclosed;
  - Be as specific as possible to prevent any later audit by RAC from being considered outside scope of voluntary disclosure
- A description of the provider’s internal investigation or a commitment when it will be completed (within 3 months);
- An estimate of the damages to the Federal health care programs and the methodology used to calculate the figure;
- A statement of the laws potentially violated by the conduct
Voluntary Disclosure

Cooperation with OIG Investigation

OIG performs its own investigation to verify information submitted by Provider.

- OIG insists on full cooperation from the provider during its verification process (production of documents and interviews with employees)

Voluntary Disclosure

Decision to Voluntarily Disclose

Voluntary disclosure program is not appropriate for mere billing errors or overpayments.

- Disclosures of these matters should be submitted directly to the appropriate Medicare claims processing entity

Voluntary disclosure is intended for situations that involve fraud:

- examples of situations that may involve fraud:
  - Systematic upcoding;
  - Falsified records

Provider should conduct a thorough internal investigation before disclosing so that the decision to disclose is based on complete knowledge of the nature and extent of the problem.
Voluntary Disclosure

**Decision to Disclose – Additional Concerns**

- DoJ is not bound by OIG’s resolution of the Matter
- Voluntary disclosure entails providing substantial evidence to the Government which could prejudice the defense of later lawsuits and prosecutions

Appealing A Denial

Denial (“Initial Determination”)

- Redetermination
- Qualified Independent Contractor (QIC)
- Administrative Law Judge (ALJ)
- Medicare Appeals Council (MAC/[Departmental Appeals Board (DAB)])
- Federal Court

Note: After redetermination, can escalate to next level if reviewing entity fails to meet deadlines (60d) to decide case
**Appealing A Denial**

**Request for Redetermination**

- Reviewer informs you of denial
  - Must give specific reason for denial
- File with Fiscal Intermediary/MAC
  - 120 days to file, but recoupments start earlier
  - CMS form v. letterhead?

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**Appealing A Denial**

**MEDICARE REDETERMINATION REQUEST FORM**

- Beneficiary’s Name: 
- Medicare Number: 
- Description of item or service in question: 
- Date the service or item was received: 
- I do not agree with the determination of my claim. MY REASONS ARE: 

- Date of the initial determination notice: 
  (If you received your initial determination notice more than 120 days ago, include your reason for not mailing this request earlier)

- Additional Information Medicare Should Consider: 

- Requestor’s Name: 
- Requestor’s Relationship to the Beneficiary: 
- Requestor’s Address: 
- Requestor’s Telephone Number: 
- Requestor’s Signature: 
- Date Signed: 

**NOTICE:** Anyone who knowingly and willingly makes false statements may be subject to civil or criminal penalties under Federal Law.
### Appealing A Denial

**Practical Considerations in Filing Redetermination Requests**

- Space limitations on CMS forms
- Preference: Provider letterhead
- Ability to highlight stay of recoupment: Be sure to copy MAC/FI on appeals requests

### Recoupment

- Medicare Modernization Act of 2003
- CMS Transmittal 322
  - Issued March 5, 2008
  - Effective July 1, 2008
  - Recoupment 40 days from determination date “should be automated”
  - Stays only through first 2 levels of appeal
  - Interest accrues while appeal is pending
Stay of Recoupment

AnMed et al v. Leavitt  /  Case No. 8:08-2453-HFF

• Filed July 3, 2008, U.S. District Court, S.C.
• Complaint for Declaratory Judgment, Injunction and Mandamus
• 32 Providers sued, asserting recoupment while appeals process pending violated § 935(a) of the Medicare Modernization Act of 2003 (MMA)
  – Recoupment by RACs almost immediately
  – Stay tuned …

Appeals Procedures

Practical Considerations

• Benefits to early filing
  – If technical defect, may refile
  – Stay in recoupment
    • Reserve right to supplement
    • To ensure stay in recoupment, communicate with FI/MAC
Appeals Procedures

Redetermination Decision
- Must decide in 60 days
  - Cannot escalate if FI is late
- If favorable, no letter!
  - Tracking is critical

* Providers are winning at this level

Appeals Procedures

Reconsiderations
- Conducted by Qualified Independent Contractors (QIC)
  - Panel of physicians or other “appropriate health professionals”
  - Use “clinical experience, and medical, technical and scientific evidence”
- On-the-Record review (!)
  * Submit all evidence to be considered
Reconsideration Decisions

- Informed of Decision in 60 days
  - Decision issued in all cases: fully favorable as well as for full or partial denials
  - Specific reason for denials
  - Can escalate if decision not timely issued
  - Notice given if fully, partially or unfavorable
- Only 60 days to file at next level – before the Administrative Law Judge
**Appeals Procedures**

**Administrative Law Judges**
- With new appeals process, HHS needed ALJs familiar with Medicare
  - Clinical progress notes closely scrutinized
- ALJ “Hearings”
  - On the record
  - Telephonic
  - In person
  - No New evidence submitted, absent “good cause”

- Note: Some ALJs relatively “new” to Medicare, so important to include legal standards for reimbursement in appeals.

**Statistical Review**
- Reviewer requests 20 records for period
  - Error rate based on review of 20 records
  - Extrapolation to entire universe
  - “Small” audits can have major consequences
    - Monetary recoupment
    - False Claims Act?

Tip: Consider Escalation?
Voluntary Disclosure to OIG

Nature of the Process

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• Not an amnesty program
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Practical Suggestions for Implementing a Successful Compliance Program

*Internal Controls can effectively detect, lessen or eliminate potential compliance failures*
Audit Focus

- Consider issues that are important to the compliance of rehabilitation and not issues that are important to a general hospital
- Inpatient rehabilitation
  - 75% Rule
    - Treatment of admitting diagnosis
  - Medical necessity
    - Medical need to be admitted to an acute care bed plus a necessity for an intensive inpatient rehabilitation program
  - Accurate scoring on the PAI
  - Conditions of participation
- Outpatient rehabilitation
  - The necessity for skilled services
  - The necessity for services related to the admitting/treating diagnosis
  - Billed services correlate with documented services
  - Billed services reflect treatment provided

Managing Red Flags

- Education and training for staff
  - Creating staff knowledge base of their responsibilities related to demonstration of compliance
- Inpatient
  - “Mentoring” of new staff, agency, pm staff
    - Functional scoring training (competence vs. certified)
    - Rehab vs. med/surg nursing
  - Interdisciplinary communication
    - Discussion among the treatment team about the reason the patient is admitted to inpatient rehabilitation and the diagnoses that will be “treated”
    - Correlate the nursing care hours/per patient day and the case weight of the patient population
    - Ensuring therapy coverage (including weekends) to provide an intensive rehabilitation program?
    - Ability of EMR to reflect “inpatient rehabilitation program” and “medical necessity”
Managing Red Flags

• Outpatient
  – Therapy expectations need to support the accurate provision/billing of outpatient treatment
  – Scheduling of patients should support accurate provision/billing of outpatient treatment
  – Review of diagnosis (upon admission) to support treatment and plan of care
  – Processes should allow for review of billed charges/date of service

Know when to involve counsel
References

- Code of Federal Regulations, 42 – CFR Ch. IV, 412.23, 412.25 and 412.29
- Federal Register, Part II, Department of Health and Human Services, 42 CFR Part 412, “Medicare Program: Inpatient Rehabilitation Facility Prospective Payment System for FY 2006; Final Rule”
- Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered Under Part A, “110 – Inpatient Hospital Stays for Rehabilitation Care”
- Appeal of Claims 42 C.F.R. § 405.900 et seq.