Beyond the ADR: Avoiding and Defending Against Increasing Numbers of Hospice Audits

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Goals

- Identify trends in hospice audits and learn who auditors are targeting
- Appreciate the potential consequences of audits, including worst case scenarios
- Be prepared to respond to government audits
- Understand keys to avoiding audits
- Takeaways – tips for your "right hand drawer"

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Preface

- This presentation is meant to provide a general overview of considerations in identifying and responding to government audits beyond Additional Development Requests (ADRs)
- This presentation does not constitute legal advice, and is not intended to take the place of legal advice

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So How Are These Audits Different Than ADRs?

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Audit Outcomes Can Be Scary

- The news is rarely good, and the results are frustrating
  - "We have determined that you have been overpaid by Medicare/Medicaid in the amount of $8,000,000.00"
  - Despite the size of the overpayments, the decisions lack detail and it may seem like the reviewer did not even read your documentation
    - Or worse, they reviewed your documentation using the wrong standards (*e.g.*, wrong LCD; clinical eligibility for nursing home room and board)

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Potential Outcomes: Individual Claim Denials

- Technical and clinical denials ranging from unsigned certifications to medical necessity
- If pre-payment review (less likely)
  - Can result in significant cash flow problems due to sequential billing
- If post-payment review (more likely)
  - Recoup from current billings (with interest accrual), unless full repayment, extended repayment plan or halt recoupment through expedited appeal

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Potential Outcomes: Statistical Extrapolation

- Statistical extrapolation of audit findings
  - "High" error rate in sampled patients (high percentage of denials or downcodes)
  - Sampled patients represent a "statistically valid" sample of a larger universe of patients/time
  - Contractor applies your error rate across larger universe of un-reviewed claims
  - Can lead to VERY high overpayment amount (*e.g.*, multi-million)

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Potential Outcomes: Other Actions

- Payment suspension
  - If "credible allegation of fraud" or "reliable information that an overpayment exists"
- Enrollment suspension
  - Hold on providers with existing overpayments
- Implementation of pre-payment review for future claims
- Referrals to federal Office of Inspector General (OIG) or Department of Justice (DOJ) for fraud investigation
  - Fraud prosecution; civil and criminal remedies

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So Who Are These Auditors?

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Overview of Auditors

- Many different auditors and new auditors being created
  - Federal
  - State
  - Often auditing same types of things, but often inconsistent
    - See Government Accountability Office Report (Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency, GAO-13-522, July 23, 2013)

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Federal Auditors

- Federal
  - Medicare Administrative Contractors (MACs)
  - Recovery Audit Contractors (RACs)
  - Medicaid Integrity Contractors (MICs)
  - Zone Program Integrity Contractors (ZPICs), Program Safeguard Contractors (PSCs), and Benefit Integrity Support Centers (BISCs)
  - Office of Inspector General (OIG)
  - Department of Justice (DOJ)

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State Auditors

- State
  - Medicaid RACs
  - State Medicaid integrity programs (*e.g.*, State Office of the Inspector General; Attorney General)

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The Auditor's Auditor

- Office of Inspector General (OIG) reviews appropriateness of program integrity activities and payment by Medicare and Medicaid
  - Recent reports on Rhode Island (Medicaid GIP) and Illinois (Medicaid hospice services and room and board)
- Comprehensive Error Rate Testing (CERT) Program
  - Randomly audits claims to calculate a national improper payment rate and contractor- and service-specific improper payment rates

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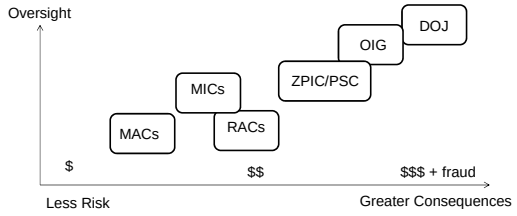
Be Aware: Risk Continuum of Auditors



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Potential Industry Newcomer

- Unified Program Integrity Contractors (UPICs) were introduced by CMS in its July 26, 2013 Request for Information (Federal Business Opportunities website)
  - Functions of ZPICs, PSCs, and MICs would be folded into UPICs, but may not be phased out separately
  - Focus on both Medicare and Medicaid integrity
  - CMS would consolidate all of its Medicare and Medicaid data into one unified database
  - MACs and RACs would remain in place and work collaboratively with UPICs
  - Focus on prepayment review and administrative actions instead of the "pay and chase" model

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How Active Are These Auditors?

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The Current Landscape: Auditing Pays

- Entire health care industry is being scrutinized
- For 2013, the OIG reported expected recoveries of over $5.8 billion in combined investigative and audit receivables (OIG Semiannual Report for Fall 2013)
  - Compare with approximately $4.2 billion recouped/collected in 2012
- Incentives
  - The return-on-investment for the Healthcare Fraud and Abuse Control Program over the last three years (2010-2012) is approximately $8.00 returned for every $1.00 expended

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The Current Landscape: Auditing Pays (cont.)

- Active whistleblowers
  - Whistleblowers can receive anywhere from 15-30% of the proceeds/settlement
  - Expanded whistleblower anti-retaliation protections
- Proposed changes to incentivize more fraud tips (*i.e.*, revising cap from $1,000 to $9.9 million)

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The Current Landscape: Automated Data Analysis Drives Audits

- CMS implemented a predictive analytics system to analyze claims and detect fraudulent activity
  - Similar to credit card protection – each claim streams through a predictive modeling system and receives a score with estimated risk for fraud
  - Results used to focus claim reviews
- Data analysis
  - Analyzing hospice data against national, regional and local averages (*e.g.*, PEPPER)
  - CMS collecting more hospice data in the near future (*e.g.*, cost report detail; claim form detail)

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The Current Landscape: Hospice on the Radar

- Significant growth in hospices and utilization (2013 MedPAC Report to Congress):
  - Between 2000 and 2011, hospice Medicare expenditures more than quadrupled to approximately $13.8 billion
  - In 2011, 45.2% of Medicare beneficiaries who died used hospice, up from 22.9% in 2000
  - Average lengths of stay increasing
- December 2013 *Washington Post* article

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The Current Landscape: Hospice on the Radar (cont.)

- Growth in high profile enforcement
  - In last 4 years, 15+ False Claims Act cases against hospices
    - Most cases were within the past 2 years; with several large cases in 2013
    - Often end in multi-million dollar settlements
  - Many cases starting with former employee, competitors

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The Current Landscape: Hospice on the Radar (cont.)

- Countless ZPIC and MIC audits
  - Long length of stay
  - GIP
- RACs
  - DME relatedness (Connolly; HealthDataInsights - HDI)
  - Face-to-face encounter for recertifications (HDI)
  - Acute care hospice relatedness (HDI)
  - Excessive units of physician services (HDI)

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How Do These Auditors Work?

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Ground Rules: How Far Back Can Auditors Look?

- Typically conducting post-payment review
- Reopening/look back periods vary, for example:
  - RACs
    - 1 year after the initial determination without cause
    - 3 years after initial determination with "good cause"
  - ZPICs and MACs
    - 1 year after the initial determination without cause
    - 4 years after the initial determination with "good cause"
- "Good cause" is a very broad standard, and providers cannot appeal whether there is good cause (42 C.F.R. 405.986)

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Ground Rules: What Records Can Be Requested and How Many?

- Relatively broad authority to request any records
  - Patient-specific records
  - Business records and related materials
- Some limits on number of patients that can be requested at one time:
  - RACs, for example:
    - 20 record minimum request
    - The ADR limit is equal to 2% of all claims submitted for the previous calendar year divided by 8
      - This is the limit per 45-day period

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Ground Rules: What Else Can Auditors Do?

- Responsible for making fraud referrals to OIG and DOJ
- Some auditors have the authority to extrapolate (*e.g.*, ZPICs)
- Can interview patients and families
- Are permitted to make on-site visits

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The Audit Process: A Glimpse From Start to Finish

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A Few Things to Remember...

- Take a breath
- You are not alone
- Just because you are being audited does not mean you did something wrong
- It is a long and winding road
- There are happier endings

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From Letter to Final Decision: Overview

- From start to finish, the process of receiving, responding, and appealing an audit is long – think years, not months
- Four main "steps"
  - Request for Records
  - Response to Request
  - Audit Findings
  - Appeal (often multiple levels)
- Delays, for example:
  - Not receiving findings within regulatory timeframe
  - Federal ALJ hearing assignments are delayed by more than two years due to sheer volume of appeals

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The Request

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The Request: What To Expect?

- Notification methods
  - Receive letter in the mail
    - Informed of audit and records requested
  - Phone call
    - Advance notice that you will be getting a letter
    - Typically done when there will be an on-site visit
  - Grapevine
    - You hear that they are talking to your patients and families

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The Request: What To Expect? (cont.)

- Will I know why I am being audited?
  - Typically only vague reasoning provided in letter
    - Data analysis
    - Complaint
    - "The reopening is based on credible evidence regarding your billing practices"
  - No further information may ever be provided

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The Request: What To Expect? (cont.)

- What records will be requested?
  - Patient-specific
    - Typically for a long period; not just a month
    - Patients may be discharged or still on service
    - Want all records that support services billed
  - Business related
    - Contracts, employee information, policies, etc.
  - Can provide records electronically or in paper form

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The Request: Tips

- Keep on the look out for mail
  - Educate your staff so it gets to the right person fast
- Identify the "threat"
  - Who is the reviewer?
  - Keep in mind the risk continuum
- Calculate and calendar your deadline
- Notify relevant parties and start to build a team
  - Attorney, compliance officer, medical director, etc.
  - Assign tasks with due dates
- Stay focused
  - Avoid getting sidetracked with the "why"

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The Response

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The Response: What Does This Entail?

- Typically a quick turn around (*e.g.*, 30 days)
  - Sometimes an extension can be obtained
- Preparing records for either hard copy or electronic submission by mail
  - What kind of review should be done before sending in the records?
  - When is the right time to involve a consultant?
- What to provide:
  - All requested records and documentation from the time period
  - Cover letter
    - Explain what is included with submission and any assumptions made

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The Response: Tips for Preparing Records

- Identify any records that may be located offsite or with other providers
  - Are there inpatient records, physician notes, etc.
  - Do not forget any archived or hard copy documentation
- Prepare for scanning if submitting electronically
- Spend your time organizing the record
  - What will be most effective for a third party reviewer who will not see the patient
  - Don't put the end first; chronological order (admission to discharge)
  - Consider how you want to divide the record (separate folders if electronic or with title pages if on paper)

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The Response: Tips for Preparing Records (cont.)

- The record is what it is; do not alter records
- Page numbering
  - Sequentially page number all documents submitted
  - Can help you prove what records were submitted
- Password protect CDs
- Keep file copy of entire submission, including cover letter and delivery receipt
- Track submission to destination
  - Note the auditor's address and plan accordingly (*e.g.*, USPS Express for P.O. boxes)

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The Response: Tips for Preparing a Cover Letter

- Should patient clinical summaries be prepared?
  - Pros v. Cons
- Advisable to include cover letter
  - Explaining the submission and any assumptions made with regard to the records or requested time frame
  - Language to preserve right to supplement with additional information

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The Response: Tips On Other Things To Do

- Consider preparing a spreadsheet with key data points for patients requested
  - Examples: Length of stay, diagnosis, place of residence, levels of care received, reimbursement received for request period
  - Spreadsheet can help you see trends and provide insight into what the auditors may be targeting (*e.g.*, length of stay, GIP, nursing home patients)
  - Spreadsheet can be supplemented later with findings (*e.g.*, denials, downcodes)

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Interlude: The Waiting Game

- The waiting game
  - Generally, auditors are taking nearly a year or more to review requested records and provide findings
  - Unlikely to hear from reviewer until they provide findings
- In some cases, may never hear anything

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The Findings

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The Findings: Overview

- Findings are provided in a letter and typically comprised of the following:
  - Overpayment determination
    - "As a result of the findings contained herein, AdvanceMed has determined that you have been overpaid by Medicare in the amount of $7,425,032.00" (extrapolated from approx. $196,000)
  - Individual decisions
  - Statistical methodology, if overpayment extrapolated

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The Findings: Individual Decisions

- Individual decisions
  - Patient-specific denials (either technical or clinical)
  - Completed by a nurse; name or credentials rarely provided
  - Reasoning tends to be limited or includes unsupported conclusory statements
    - Single sentence to support months of denied claims
    - Generic citations followed by a key code

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The Findings: Statistical Decision

- Statistical decision
  - Lengthy, but generally boilerplate
  - Explains sampling methodology
  - Defines the larger claim population that error rate is being applied to
    - All patients who were on service for more than 180 days during the defined time frame

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The Findings: Tips for What to Do First

- Contact legal counsel
- Calendar deadline for appeal to be submitted (may have option of accelerated time frame to halt recoupment)
- Reconnect and provide findings to your team
  - Attorney, medical director, compliance officer, etc. – to determine tasks for appeal
- If extrapolated overpayment, get statistician involved under attorney-client privilege
- Update tracking spreadsheet with decisions and dollar values
- Stay organized – this is just the beginning

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The Appeal Process

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The Appeal Process: Overview

- State vs. federal appeal process
  - MIC and state program integrity audits will be governed by state appeal process
  - ZPIC, RAC will be governed by federal appeal process
    - 5 levels, including an ALJ hearing
    - Same process used for ADRs
- The rebuttal period
  - Federal and most states have rebuttal process
  - Is not an appeal
  - Should you use it?

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Federal Appeal Timeline (ZPICs, RACs, MACs)

Level of Appeal	Party that Hears the Appeal	Deadline for Filing the Appeal	Timeframe to File in Order to Halt Recoupment	Timeframe for Appeal Decision
Redetermination	RHHI / MAC	120 days	30 days	60 days
Reconsideration	QIC	180 days	60 days	60 days
ALJ Hearing	ALJ	60 days	n/a	90 days
Medicare Appeals Council	Appeals Council	60 days	n/a	60 days
Federal Court	Federal District Court	60 days	n/a	n/a

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The Appeal Process: Increased Utilization

- New OIG Report highlights the increased utilization of the Medicare appeals process (these numbers continue to increase)
  - Redeterminations increased 33 percent since 2008
  - Between 2008-2012, Part A redeterminations increased 148 percent
  - Delays in transferring case files for reconsideration

(OIG Report, The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness, OEI-01-12-00150 (Oct. 2013))

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The Appeal Process: Appeal Letter

- Lengthy letter that defines what is being appealed, the action requested and the support for the request
- Content
  - Facts
  - Governing law
  - Legal arguments; for example:
    - The role of the LCD
    - Treating Physician Rule
    - Prognostication
    - Waiver of liability

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The Appeal Process: Appeal Letter (cont.)

- Legal Arguments
  - Conditions of payment
    - Not all deficiencies implicate payment
    - Only those requirements set forth in 42 C.F.R. 418.200 are identified as conditions of payment
      - 1. Medical Necessity – Services must be "reasonable and necessary for the palliation and management of the terminal illness"
      - 2. Election – Patient must elect hospice in accordance with 418.24
      - 3. Certification – Certification of patient's terminal illness must be completed as set forth in 418.22

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The Appeal Process: Appeal Letter (cont.)

- Conditions of payment
  - 4. Care Plan – Plan of care must be established and reviewed by physicians and interdisciplinary team as set forth in 418.56
  - 5. Care plan must be established before hospice care is provided
  - 6. Services provided must be consistent with plan of care

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The Appeal Process: Appeal Letter (cont.)

- Statistical Arguments
  - Based on analysis of statistician, legal standard not satisfied
    - Secretary has not determined that there is a high or sustained error rate or educational efforts have failed
    - The sample is not a statistically valid sample from which to extrapolate
      - Cannot verify analysis
      - Methodology flawed
      - Lack sufficient oversight and review

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The Appeal Process: Responding to Individual Decisions

- Technical denials
  - Was documentation overlooked?
  - If something is missing, are there other documents or attestations that could help support the missing element?

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The Appeal Process: Responding to Individual Decisions (cont.)

- Clinical decisions
  - Denials vs. downcodes
  - Did the auditors use the right standard?
  - Evaluating strength of clinical record
  - Who will testify?
    - Medical director/treating physician
    - Clinical consultant

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The Appeal Process: Beyond the First Level

- If at first you don't succeed try again
  - Be prepared to go to an ALJ hearing
- Be aware of interest accrual and evaluate how you will fund repayment
- Ongoing evaluation of the claims to appeal

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Reminder: All Is Not Lost; Happier Endings

- $7.4 million – At redetermination, successfully overturned 84% of the ZPIC's claim denials and extrapolation removed resulting in $90,000 repayment
- $6 million – At redetermination secured removal of extrapolation reducing overpayment to approximately $100,000
- $4.6 million – Prevailed on all appealed beneficiary denials at ALJ reducing overpayment to under $40,000
- Overpayments based on nursing home room and board cases withdrawn on appeal

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How Do You Avoid These Audits?

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The Reality: You Cannot Hide

- Ultimately, audits cannot be avoided entirely
- If you have not been audited yet, it does not mean it will not happen
- If you have been audited recently, it does not mean it will not happen again
- "The best defense is a good offense"

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Best Defense is a Good Offense

- Compliance is key for identifying potential issues and preventing government investigations
- Generally better served by knowing your issues and being able to evaluate and, if necessary, voluntarily repay
  - Define issues
  - Correct issues to limit future exposure
  - Opportunity to potentially head off whistleblowers
    - Ignored internal complaints are the #1 driver of whistleblower actions and tips to the government
    - In recent case, whistleblower raised concerns more than 3 years before filing lawsuit

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Avoiding Audits: Know Your Data

- Track key data points
  - Examples: Length of stay (mean, median), GIP length of stay, patients in facilities
- Compare yourself – are you an outlier?
  - To yourself historically
  - To others in your region
  - To others nationally
  - PEPPER report or NHPCO data

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Avoiding Audits: Know Industry Risk Areas

- OIG Work Plan and Reports
  - Financial relationships between hospices and nursing homes, and marketing practices
  - Utilization of GIP level of care
  - Overlap of drugs with Part D payment
  - Hospice in assisted living facilities (NEW)
- 1999 OIG Compliance Guidance for Hospices
  - Overlap in services that a nursing home provides resulting in insufficient care by hospice
  - Hospice incentives to actual or potential referral sources

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Avoiding Audits: Focus on Conditions of Payment

- These are the elements that can add up quickly in audit denials
  - Incomplete initial certification – denial of entire benefit period or more
- Conduct internal monitoring and **pre-billing** audits focused on conditions of payment
  - For the most part, low hanging fruit
    - Unsigned elections
    - Incomplete certifications/recertifications
    - Incomplete plans of care
- Based on audit results, revise processes and re-educate personnel

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Avoiding Audits: Think and Review Like An Auditor

- Look at "snippets" of time just as an auditor would
- Remember the reviewer does not see the patient
  - Example: "Assistance with 5 ADLs"
  - Improvement: Compare to past, be more descriptive (how long does it take to complete ADLs)
- View and use physician narratives and face-to-face documentation as tools to support eligibility, not just "compliance"

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Avoiding Audits: Stay Alert to New Trends

- What is on the horizon for hospice audits?
  - Seeing pharmacy audits focused on whether certain drugs were related to the terminal illness
  - Scrutiny of relatedness determinations; ensuring that documentation supports decisions to cover or not cover drugs, supplies, etc.
  - Focus on eligibility of hospice patients in nursing homes and assisted living facilities

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Questions?

Thank you!

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