Significant Developments in Medicare and Medicaid Audits Affecting Hospices

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Learning Objectives

- Overview of CMS contractors in the current audit landscape
- Address key audit risk areas and regulatory issues impacting hospice and palliative providers
- Identify proactive compliance strategies to prepare for an audit
- Discuss successful appeal strategies when defending an audit

Current Audit Landscape

- CMS contractors in the current audit landscape
  - Medicare Administrative Contractors (MACs)
  - Zone Program Integrity Contractors (ZPICs)
  - Recovery Audit Contractors (RACs)
    - Medicare RACs & Medicaid RACs
  - Medicaid Integrity Contractors (MICs)
  - Office of Inspector General (OIG) audits

Medicare Administrative Contractors (MACs)

- Statistically Projected Audit
  - Statistical sampling is used to calculate and project (i.e., extrapolate the amount of overpayment(s) made on the claims.
  - Claims are reviewed from a statistical random sample, the results of which are then extrapolated to the universe of claims during a given time period to determine the overpayment amount.
- Focus/Target Review
  - Contractors conduct targeted reviews, focusing on specific program vulnerabilities inherent in the PPS, as well as provider/service specific problems. The reviews should be conducted based on data analysis and prioritization of vulnerabilities
- Additional Document Requests (ADRs)
  - When a claim is selected for medical review, an ADR is generated requesting medical documentation to be submitted to ensure payment is appropriate. Documentation must be submitted in a timely manner for review and payment determination.

Zone Program Integrity Contractors (ZPICs)

- ZPICs are responsible for the identification of suspected fraud
  - Different from the Medical Review program which is primarily concerned with preventing and identifying errors
  - ZPICs request medical errors and conduct medical review to evaluate the identified potential fraud
  - ZPICs may also refer matters to the OIG and DOJ for further investigation
- Prepayment reviews

ZPICs Cont.

- Recent ZPIC Post-Payment Review Results Letter:

"The ZPIC has determined that it is likely you have been overpaid for the services provided from the end of the audit period through the current date based on the documentation submitted for the medical review. Section 1833(e) of the Social Security Act places the burden on the provider to furnish information necessary to determine the amount due to the provider."

"The ZPIC is requesting that the provider conduct an internal audit of its claims to determine the accuracy of the claims billed. If research determines the claim/payment is incorrect, please process claim adjustments and arrange repayment with the claims processing contractor. Please provide the ZPIC with the results of this audit within 90 days."

The Medicaid Integrity Contactors (MICs)

- Medicaid Integrity Contractors (MICs) identify overpayments – Like Medicare RACs, but for Medicaid.
- 3 types of MICs, but MICs are not tasked with collecting overpayments.
  - Review MICs
  - Audit MICs
  - Education MICs
- The Federal government collects its share directly from the states (60 calendar days). The states are responsible for recovering overpayment from the providers. Providers will be afforded appeal rights under state law.
- **Emerging Issues**
  - Recoupment from provider once overpayment is identified??
  - Specific appeal processes and procedures vary from state to state
- **Recent Policy Changes**
  - Uniform 5 year look-back period
  - Expanded time frame for responding to Audit MIC requests for records
    - Expanded time from 10 days to 30 days
    - Option for 15 business day extension

Looking Forward: UPICs In, MACs and ZPICs Out

- Unified Program Integrity Contractor (UPIC)
- CMS will be combining integrity responsibilities of ZPICs and MACs into one integrity contractor → UPIC
- MICs will be phased out
- Focus on both Medicare and Medicaid integrity issues
- CMS will be consolidating Medicare and Medicaid data into **one** unified database

Recovery Audit Contractors (RACs)

- The RACs mission is to identify and correct Medicare improper payments through detection and collection of overpayments made on claims of healthcare

Who are the RACs?

- **Region A: Performant Recovery**
  - Working in CT, DE, D.C., MA, MD, MA, NH, NJ, NY, PA, RI and VT
  - www.dcsrac.com
- **Region B: CGI Federal**
  - Working in KY, IL, IN, MI, MN, OH and WI
  - http://racb.cgi.com
- **Region C: Connolly, LLC**
  - Working in AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA and WV
  - http://www.connolly.com/healthcare/Pages/CMSRACProgram.aspx
- **Region D: HealthDataInsights, Inc.**
  - Working in AK, AZ, CA, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas
  - http://racinfo.healthdatainsights.com/home.aspx

THE FOCUS OF CURRENT RAC AUDITS Hospice-Related RAC Approved Issues

- **Region A: Hospice Care, Extensive Length of Stay – Jurisdiction A**
  - **States affected:** CT, DE, DC, MA, MD, ME, NH, PA, RI, VT
  - **Description:** The potential for overpayment exists when hospice care rendered contiguously beyond a 20 month period lacks medical necessity and it is determined that the condition has improved and/or the beneficiary is no longer considered terminally ill.
- **Region C: Hospice: Medicare Coverage Requirement Review**
  - **States affected:** AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands.
  - **Description:** Hospice documentation will be reviewed to determine the appropriateness of payments for hospice care services for Medicare beneficiaries
- **Region C: Hospice related services billed with Condition code 07**
  - **States affected:** AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV
  - **Description:** Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.
- **Region D: Hospice Related Services – Part B and Part A**
  - **States affected**: AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, WY, SD, UT, WA, Guam, American Samoa, Northern Marianas
  - **Description**: Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

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THE FOCUS OF CURRENT RAC AUDITS Hospice-Related RAC Approved Issues

- **Region D: Hospice Date of Death**
  - **States affected**: AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, WY, SD, UT, WA, Guam, American Samoa, Northern Marianas
  - **Description**: Medicare does not pay for services rendered after the Beneficiary's date of death.
- **Region D: Excessive Units of Physician Services**
  - **States affected**: AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, WY, SD, UT, WA, Guam, American Samoa, Northern Marianas
  - **Description**: Each attending physician service should be dated separately indicating the date that each HCPCS code billed was delivered. Per diem physician codes can be billed once per day.
- **Region D: Face to Face Evaluation for Re-Certification of Hospice Care**
  - **States affected**: AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, WY, SD, UT, WA, Guam, American Samoa, Northern Marianas
  - **Description**: Recertification's on or after January 1, 2011, require the hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period.

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Recent RAC Updates

- CMS is in the procurement process for the next round of RAC contracts
- February 21, 2014: last day RACs could request medical records from providers for post-payment audits
- February 28, 2014: last day MACs could send medical record requests for prepayment audits under RAC Prepayment Review Demonstration
- June 1, 2014: last day RACs may send improper payment files to MACs for adjustment

Future RAC Program Changes

Concern	Program Change
Upon notification of an appeal by a provider, the RAC is required to stop the discussion period.	RACs must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
Providers do not receive confirmation that their discussion request has been received.	RACs must confirm receipt of a discussion request within three days.
RACs are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	RACs must wait until the second level of appeal is exhausted before they receive their contingency fee.
ADR limits are based on the entire facility, without regard to the differences in department within the facility.	The CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).
ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will require RACs to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.

Medicaid RACs

- **January 1, 2012**: States required to have implemented their Medicaid RAC programs.
- CMS will not issue oversight provisions regarding medical necessity reviews for the Medicaid RAC program.
- Medicaid RAC medical necessity reviews will be performed within the scope of state laws and regulations.
- The Medicaid RAC Final Rule does not require Medicaid RACs to receive prior approval for medical necessity reviews.

THE FOCUS OF CURRENT RAC AUDITS
Hospice Recent Risk Areas

- Face to Face Certifications
- Hospice Recertification Requirements
- Respite Care
- Hospital Hospice Care
- Inpatient Admissions for Hospices with Inpatient facilities
- Clinical Status Determinations
- Conditions of Coverage
- Length of Stay and other non-technical medical necessity requirements

Latest Developments in Hospice

- CMS requires written contracts between LTC facilities & Hospice
  - Recently, CMS issued a final rule mandating that long term care (LTC) facilities and hospice providers enter into written agreements if that facility chooses to arrange hospice services.
  - The rule became effective on August 26, 2013.
- OIG report on General Inpatient Care
  - On May 3, 2013, the OIG released a memorandum describing hospice general inpatient care (GIP) provided to Medicare patients in 2011, for which Medicare paid $1.1 billion.
  - The memorandum states that the OIG will begin a new study which will use actual beneficiary medical records to determine the accuracy of the reimbursement.
- Effective April 1, 2014, Medicare hospices shall report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in SNFs or in hospitals. *See* Change Request 8358 (Transmittal 2747).

Current Considerations in Hospice Medicare Compliance

- Hospice organizations should establish and maintain compliance policies.
- The OIG recommends that Hospice compliance programs include **seven** key components:
  1) Development and distribution of polices and procedures to promote compliance with specific requirements.
  2) Designation of a compliance officer and other appropriate bodies.
  3) The development and implementation of frequent effective education and training programs for employees.
  4) Creation and maintenance of a process to receive complaints and effectuate communication between the compliance officer and employees.

Current Considerations in Hospice Medicare Compliance

- Key components for compliance programs (continued)
  5) Use of audits and/or other evaluation techniques to monitor compliance and identify problem areas.
  6) Development of disciplinary mechanisms to enforce compliance standards.
  7) Development of polices that direct prompt and proper responses to detected offenses, including corrective action and preventative measures.

Compliance Policies on Government/Third Party Payor Investigations

- It is important for Hospices & Palliative Care facilities to have a policy on cooperation and coordination with government investigations.
- If an employee receives any inquiry, subpoena, or other legal document relating to the employer's business:
  - Notify the Compliance Officer immediately.
    - The Compliance Officer should contact legal counsel.
  - Do not provide false or inaccurate information to a government investigator.

Compliance Policies on Government/Third Party Payor Investigations

- Initial contact with a government investigator:
  - Obtain information specified in compliance program
- On-Site Inquiries
  - Obtain "initial contact" information
  - Contact Compliance Officer
  - Draft memorandum regarding information obtained from the investigator and provide to Compliance Officer

Compliance Policies on Government/Third Party Payor Investigations

- Search Warrants
  - Contact Compliance Officer immediately
  - Compliance Officer will immediately contact legal counsel
- Employees speaking with government investigators:
  - Cannot be prohibited from speaking with government investigators
  - May politely decline to speak with investigators
  - May request legal counsel to be present during an interview

Medicare and Medicaid Overpayments

- Patient Protection and Affordable Care Act Section 6402(d)
  - Requires providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of (1) the date which is 60 days after the date on which the overpayment was identified or (2) the date any corresponding cost report is due, if applicable.
- Proposed Rule (77 Fed. Reg. 9179)
  - 10-year look-back period
- Recent case law: *United States and State of Wisconsin ex rel. Keltner v. Lakeshore Medical Clinic, LTD*

Important Aspects of Hospice & Palliative Care Medicare Compliance: Face-to-Face Requirements

- The Patient Protection and Affordable Care Act (PPACA) requires that a hospice physician or nurse practitioner have a face-to-face encounter with every hospice patient prior to the beginning of the patient's third benefit period and prior to each subsequent benefit period in order to determine continued eligibility.
  - **Attestation Requirement**: the practitioner must attest in writing that the face-to-face occurred, including the date of the encounter.

Important Aspects of Hospice & Palliative Care Medicare Compliance: Face-to-Face Requirements

- **Requirements for a hospice face-to-face encounter:**
  - **Timeframe of the encounter:** must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter;
  - **Attestation requirement:** a hospice physician or nurse practitioner who performs the encounter must attest in writing that s/he had a face-to-face encounter, including the date of the encounter.
    - Attestation must be: (1) signed; (2) dated; (3) a separate and distinct section of, or addendum to, the recertification form and (4) must be clearly titled.
- **Practitioners:** A hospice physician or a hospice nurse practitioner can perform the encounter.
  - **Hospice physician:** physician who is employed by the hospice or working under contract with the hospice.
  - **Hospice nurse practitioner:** must be employed by the hospice (i.e. receives a W-2 from the hospice of volunteers for the hospice).
- The hospice must retain the certification statements.
- Requirements also apply to individuals who had been previously discharge during a benefit period and are being recertified for hospice care.

Important Aspects of Hospice & Palliative Care Medicare Compliance: Hospice Terminality Certification

- For the first 90-day period of hospice coverage, by the end of the third day the hospice must obtain oral or written certification of the terminal illness by:
  - The medical director of the hospice *or* the physician member of the hospice interdisciplinary group (IDG) **and** the individual's attending physician, if s/he has one.
  - The attending physician is a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) or a nurse practitioner and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.
- Terminally Ill: medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.
- **The written certification must include**:
  - Statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;
  - Specific findings and other documentation supporting a life expectancy of 6 months or less; and
  - The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers.
  - The ***physician's brief narrative explanation*** of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

Important Aspects of Hospice & Palliative Care Medicare Compliance: Terminality Certification

- **Local Coverage Determinations:** Addressing Terminal Status with similar requirements
  - **National Government Services, Inc.: L25678** (AK, American Samoa, AZ, CA, CT, Guam, HI, ID, MA, ME, MI, MN, NH, NJ, NV, NY, OR, Puerto Rico, RI, Virgin Islands, VT, WA, WI, North Mariana Islands)
  - **CGS Administrators, LLC: L32015** (CO, D.C., DE, IA, KS, MD, MO, MT, ND, NE, PA, SD, UT, VA, WV, WY)
  - Patients will be considered to have a life expectancy of six months or less if there is documented evidence of a decline in clinical status;
  - Base guidelines for determining terminal status include:
    - Decline in clinical status guidelines
    - Non-disease specific baseline guidelines
    - Co-morbidities

Effective Hospice & Palliative Care Compliance Measures

- Objectively review documentation practices to verify compliance with Face-to-Face Documentation and Terminal Illness Certification Requirements.
- Establish proactive protocols for reviewing cases:
  - Documentation enhancement
  - Periodically review policies
  - Implement monitoring protocols

Compliance Measures: CBRs

- Comparative Billing Reports (CBRs)
  - Snapshot of utilization data for an individual provider
  - Provider's billing pattern for a given code or group of codes is compared to the state and national average
  - Mailed to the top 5,000 billers
- Compliance Policy on Investigations
- Compliance and Organizational Tips to Prepare for an Audit
- Same CBR Comparisons
  - Hospice CBRs: Avg. # of days billed per beneficiary for routine home care, continuous home care and inpatient respite care

Overview of the Medicare Appeals Process

- *Rebuttal and Discussion Period*
- Redetermination
  - Appeal deadline: 120 days (30 days to avoid recoupment)
- Reconsideration
  - Appeal deadline: 180 days (60 days to avoid recoupment)
- Administrative Law Judge Hearing
  - Appeal deadline: 60 days
  - CMS will recoup the alleged overpayment during this and following stages of appeal
- Medicare Appeals Council (MAC)
  - Appeal deadline: 60 days
- Federal District Court
  - Appeal deadline: 60 days

Administrative Law Judge (ALJ) Appeals

- Backlog of appeals at the ALJ
  - 480,000 appeals awaiting assignment
- July 15, 2013: OMHA temporarily suspended the assignment of most new ALJ hearing requests
- Estimated delay of 28 months until assignment to an ALJ
- Post assignment, expect over 6 months until a hearing is held

ALJ Request Requirements

- *42 C.F.R. 405.1014*
  1. Beneficiary name, address and HICN
  2. Name and address of appellant (if not beneficiary)
  3. Name and address of designated representatives (if appropriate)
  4. Medicare Appeal Number (assigned by QIC)
  5. Date(s) of service
  6. Reasons for disagreement with QIC's decision
  7. Statement of any additional evidence to be submitted and the date it will be submitted

Best Practices for Appealing to ALJ

- Prominently list Medicare Appeal Number on your request
- Ensure beneficiary information matches Medicare Appeal Number
- List beneficiary's full HICN
- Include first page of QIC decision or prominently list full name of QIC
- Document Proof of Service to other parties
- Do not submit courtesy copy to QIC
- Submit only one request per Medicare Appeal Number
- Mail request via tracked mail to OMHA Central Operations
- Do not submitted evidence already submitted to lower level
- Do not attach evidentiary submissions or submit additional filings to OMHA Central Operations
  - Wait until an ALJ is assigned and submit directly to ALJ

Medicare Appeals Council case: *Solari Hospice Care, LLC*

- 84-year-old patient entered hospice care in May 2008 after a prior hospitalization for septic shock, SNF care, and a move to a group home.
  - Admitting diagnosis: end-stage debility.
  - Additional diagnoses: CAD, COPD, chronic atrial fibrillation, dementia, anemia, myocardial infarction, HTN, and recent sepsis.
  - Patient's decline was slow and steady and she passed away in May 2010.

Medicare Appeals Council case: *Solari Hospice Care, LLC*

- Contractor denied hospice services for the first half of November 2009 because the appellant allegedly did not provide support of the patient's **terminal illness**.
- The MAC applied the clinical status guidelines in LCD L25678, Part I, "Decline in clinical status guidelines."
  - The ALJ erred in applying the LCD's requirements for Alzheimer's disease and related disorders because Alzheimer's disease was not the patient's primary diagnosis.
- The MAC specifically noted in its analysis that the LCD's clinical indications do not all have to be met.
  - The LCD requires sufficient "variables" to be shown to demonstrate a terminal illness with a life expectancy of six months or less.
- The case demonstrates the importance of a complete medical record that accurately paints the patient's terminal illness.

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

- Provider Without Fault
- Waiver of Liability
- Challenges to Statistics
- Merit-Based Arguments

SUCCESSFUL APPEALS STRATEGIES
Audit Defenses

Provider Without Fault

- Section 1870 of the Social Security Act
- Once an overpayment is identified, payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services
  - Definition of fault
  - 3 Year Rule

Waiver of Liability

- Section 1879(a) of the Social Security Act
- Under waiver of liability, even if a service is determined not to be reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

SUCCESSFUL APPEALS STRATEGIES
Challenges to Statistics

- Section 935 of MMA:
  - Limitations on Use of Extrapolation – A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that
    - There is a sustained or high level of payment error; or
    - Documented educational intervention has failed to correct the payment error.
  - Cannot challenge the substance of the finding of "sustained or high rate of error," but can challenge whether a finding was made
  - Guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08), Chapter 3, §§ 3.10.1 - 3.10.11.2
  - *See also* MAC case: *Transyd Enterprises, LLC d/b/a Transpro Medical Tra*nsport

SUCCESSFUL APPEALS STRATEGIES
Arguing the Merits

- **Merit-based arguments include**:
  - Medical necessity of the services provided
  - Terminal diagnosis
- **To effectively argue the merits of a claim**:
  - Draft a position paper laying out the proper coverage criteria
  - Summarize submitted medical records and documentation
  - If relying on medical records in an ALJ hearing:
    - Organize using tabs, exhibit labels and color coding
    - Use graphs and medical summaries to assist in the presentation of evidence
- **Clinical Arm – Involvement of Experts**
  - Clinical component
    - Expert opinions (affidavits and in-person testimony)
    - Integration of high quality literature review
    - College, society standards
    - LCDs – locally and nationally

Questions?

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