Program Integrity Audits:

RACs, UPICs, & SMRC

Kelly Grahovac, General Manager, The van Halem Group

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RAC

- Performant Recovery – National HH&H and DMEPOS Recovery Audit Contractor (RAC) Region 5
- Goal: To recoup overpayments and pay underpayments
- As required by Section 1893(h) of the Act, RACs are paid on a contingency fee basis
  - The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to, providers.
  - The contingency fees range from 14.0 - 17.5 percent. The RAC must return the contingency fee if an improper payment determination is overturned at any level of appeal.

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RAC Audit Process

- The RAC reviews claims on a post payment basis
- Audit issues must be approved by CMS
- Two types of reviews:
  - Automated (no medical record needed)
  - Complex (medical record required)
- Providers have 45 days to respond, but can request extensions

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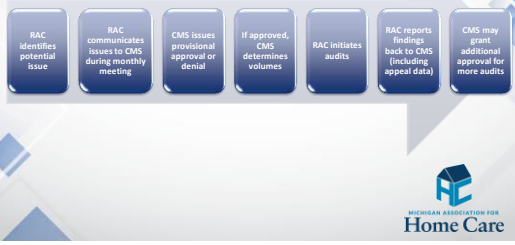
RAC Approved Issues Process



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Current RAC Audits: Automated

- There are currently no approved automated RAC audits related to home health or hospice.

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Current RAC Audits: Complex

- Home Health: Medical Necessity and Documentation Requirements
  - This review will determine if Home health services are supported by the medical record and meet the coverage and medical necessity requirements for Medicare payment. Claim lines that do not meet the indications for coverage and/or medical necessity will be denied.
  - Affected Codes: Revenue Codes: 027X, 042X, 043X, 044X, 023X, 055X, 056X, 057X

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Current RAC Audits: Complex

- Hospice Continuous Home Care: Medical Necessity and Documentation Requirements
  - This review will determine if hospice Continuous Home Care services were reasonable and necessary to achieve palliation and management of the patient's acute medical symptoms to maintain the terminally ill patient at home, based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment.
  - Affected codes:
    - REV Codes:
      - 0652 - Continuous Home Care
      - 0551- Skilled Nursing Visit
      - 0571- Home Health Aide Visit
    - HCPCS Codes:
      - G0299- Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
      - G0300- Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
      - G0156- Services of home health/hospice aide in home health or hospice settings, each 15 minutes

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Current RAC Audits: Complex

- Hospice General Inpatient Care: Medical Necessity and Documentation Requirements
  - This review will determine if Hospice General Inpatient Care (GIP) was reasonable and necessary to achieve pain control or acute or chronic symptom management which could not be managed in any other setting. Claims that do not meet the indications of coverage and/or medical necessity will be recoded to Routine Hospice Care 0651 and result in an overpayment.
  - Affected codes: REV Codes 0656 - GIP

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Supplemental Medical Review Contractor (SMRC)

- Conducts nationwide medical reviews, as directed by CMS
- Reviews are assigned through CMS and focus on analysis of national claims data issues identified by:
  - Federal agencies - Office of Inspector General (OIG), Government Accountability Office (GAO)
  - CMS internal data analysis
  - Comprehensive Error Rate Testing (CERT) program
- Three types of SMRC Reviews
  - Provider Compliance Group
  - Program Integrity Group
  - Healthcare Fraud Prevention Partnership

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SMRC Audit Process

- SMRC reviews claims on a post payment basis
- Affected providers receive an ADR letter
- Providers have 45 days to respond but can request extensions
- Supplier will receive Review Results Letters with detailed findings
  - Agree: Refund upon receipt of overpayment demand
  - Disagree:
    - Request a re-review - opportunity to submit additional documentation for review
    - Appeal upon receipt of overpayment demand

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SMRC Current Projects

- Issue 01-086 – Home Health
  - Post-payment review of claims for Medicare home health services billed on dates of service from January 1, 2020, through December 31, 2020.
  - Type of Bill: 032X, Home Health Services Under a Plan of Treatment

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SMRC Documentation Requirements

- Acute/post-acute care document to support home health eligibility
- Diagnostic tests, radiological reports, lab results, pathology reports, and other pertinent test results and interpretations
- History and Physical reports (include medical history and current list of medications)
- Documentation of all face-to-face (FTF) encounters and/or Signed Attestations from start of care
- Copy of physician's or authorized non-physician provider's order or referral for home health services if separate from plan of care
- Signed Consent Form
- Home Health start of care assessment

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SMRC Documentation Requirements

- All Physician or authorized non-physician provider's orders, including medications and any DME prescribed for the beneficiary
- Initial certification and all re-certifications from start of care
- Homebound/not homebound status
- OASIS documentation (certifications, recertifications, follow-ups and significant change).
- Copy of the current medication list
- Signed and dated overall plan of care including, short- and long-term goals with any updates to the plan of care
- Home Health Plan of Care

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SMRC Documentation Requirements

- PT/OT/SLP – Initial evaluation, plan of care, progress reports, treatment encounter notes, therapy minute logs, and discharge summary
- Home Health skilled nursing, home health aide, or rehabilitation therapy notes including initial evaluations, re-evaluations, progress notes, and actual therapy minute grids
- Any other documentation supporting the beneficiary's need for the home health services being provided
- Documentation to support National Coverage Determination (NCD), Local Coverage Determination (LCD) and/or Policy Article
- If medical record documentation is submitted via esMD: Beneficiary identification, date of service, and provider of the service should be clearly identified on each page of the submitted documentation

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SMRC Documentation Requirements

- Advance Beneficiary Notice of Non-Coverage (ABN)/Notice of Medicare Non-Coverage (NOMNC)
- If an electronic health record is utilized, include your facility's process of how the electronic signature is created. Include an example of how the electronic signature displays once signed by the physician
- Signature log or signature attestation for any missing or illegible signatures within the medical record (all personnel providing services)

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SMRC Current Projects

- Issue 01-084 – Hospice General Inpatient (GIP) Level of Care
  - Post-payment review of claims for Medicare Hospice GIP Level of Care services billed on dates of service from January 1, 2020, through December 31, 2020.
  - Rev Code: 0656

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SMRC Documentation Requirements

1. Hospice Election Statement and Hospice Election Statement Addendum
   - If dates of service are on/after October 1, 2020, the election statement must include notification of the beneficiary's right to request an election statement addendum for conditions, items, drug, or services unrelated to the terminal illness and related conditions not covered by the hospice
2. Hospice Certification of Terminal Illness (Initial and subsequent to cover billed dates of service), from Certifying Physician/Attending Physician including written and oral/verbal certification and Physician's narrative
3. Face-to-Face Encounter and Face-to-Face Attestation statement(s) as applicable to the recertification period(s) during which the General Inpatient (GIP) level of care was provided for the dates of service under review

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SMRC Documentation Requirements

4. Documentation to support the medical necessity for the GIP level of care stay. This may include, but is not limited to, the following:
   - Hospice Plan of Care (POC) covering the GIP stay supporting the change in level of care including dates, reason for GIP, interventions, beneficiary's response and collaboration between the hospice and hospital teams
   - Clinical documentation to include, but not limited to, admission history and physical, progress notes, consultation notes, nursing assessments, treatment records (including medication administration records), wound care documentation, and discharge summary.
   - Hospice team documentation to include, but not limited to, visits, assessments, and discharge planning for the DOS under review

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SMRC Documentation Requirements

5. Signature log or signature attestation for any missing or illegible signatures within the medical record (all personnel providing services)
6. Advance Beneficiary Notice of Non-Coverage (ABN)/Notice of Medicare Non-Coverage (NOMNC)
7. Any other supporting documentation
8. If medical record documentation is submitted via esMD: Beneficiary identification, date of service, and provider of the service should be clearly identified on each page of the submitted documentation
9. PLEASE NOTE: It is the responsibility of the supplier or provider to obtain all documentation from the ordering/referring provider to ensure medical necessity criteria have been m

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SMRC Completed Projects

- Issue 01-301 – Home Health
  - Claim review on a sample of Home Health claims from January 1, 2020 through December 31, 2020. The SMRC will conduct medical record reviews in accordance with applicable statutory, regulatory, and sub-regulatory guidance. Applicable waivers and flexibilities established during the PHE will be utilized during claim review activities

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SMRC Completed Projects

- 01-009 - Hospice General Inpatient Care
- OIG report claimed that they found hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms and indicated over $250 million in overpayments.
- SMRC Common Denial Reasons
  - Medical Necessity
  - No response to ADR
  - Certification of terminal illness signature

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SMRC Completed Projects

- 01-103 - Hospice Portfolio – Phase 1
- OIG report OEI-02-16-00570, Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio, dated July 2018, found that hospices frequently bill Medicare for a higher level of care than the beneficiary needs.
- SMRC Common Denial Reasons
  - Medical necessity
  - No response to ADR
  - No documentation to support services as billed
  - Initial certification not signed by MD
  - Missing or invalid MD narrative on Certification of Terminal Illness

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SMRC Completed Projects

- 01-036 – Hospice Portfolio – Phase 2 ALF setting
- OIG report OEI-02-16-00570 also found that Medicare beneficiaries receiving hospice services in the ALF setting had a higher prevalence of ill-defined diagnoses and an increased length of stay compared with beneficiaries receiving hospice services in other settings.
- SMRC Common Denials
  - No response to ADRs
  - Invalid F2F
  - Continuous Home Care (CHC) not reasonable and necessary

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SMRC Completed Projects

- 01-036 – Hospice Portfolio Phase 3 – Hospices that only provide routine home care
- OIG report OEI-02-16-00570 also found there are hospices that do not provide all levels of care, but instead are billing only for providing Routine Home Care (RHC) for all Medicare beneficiaries they serve.
- SMRC Common Denial Reasons
  - No response to ADR
  - Invalid Notice of Election/Hospice Election
  - Certification not submitted

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Unified Program Integrity Contractors

- Perform program integrity functions
- Primary goal is to investigate suspected fraud, waste, and abuse
- Share information (leads, vulnerabilities, concepts, approaches) with other UPICs
- Are often very aggressive although CMS oversight has increased in recent years
- Now, UPIC investigations must be approved by CMS Program Integrity Group

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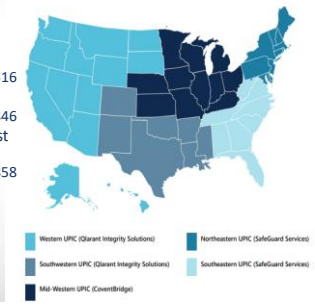
UPIC Contracts

- Qlarant Western and Southwest
  - Total Funding = $115,325,516
- CoventBridge Midwest
  - Total Funding = $155,389,846
- Safeguard Services Southeast and Northeast
  - Total Funding = $257,936,858



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UPICs

- UPIC auditors were conducting telephone interviews with beneficiaries during the pandemic and could see an uptick in UPIC audits based on those results
  - In one case we are aware of, a payment suspension was implemented based on the interviews
- UPICs actions include:
  - Referrals to law enforcement
  - Payment suspensions
  - Revocations
  - Extrapolated overpayments
  - Pre and Post-payment reviews

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UPIC Audit Response Strategy

- UPICs should be treated very differently and carefully
- Requests from UPIC should be escalated to upper management/ compliance officer immediately
- Review request and respond with required documentation to support services were provided and medically necessary
- Conduct a risk assessment to determine potential financial risk so you can prepare, if necessary
- Prepare "cover letter" that summarizes the medical record and pertinent policy requirements when necessary
- Consider engaging counsel and/or audit experts

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General Audit Response Strategies

- Prepare intake staff for incoming ADR requests and establish response process: Non-response adds to error rate
- Review ADR request and corresponding coverage policies to ensure documentation meets criteria
- Consider drafting a "cover letter" that summarizes the records and pertinent policy requirements when the opportunity allows
- If documentation is lacking and an addendum would be sufficient, work to obtain this for submission during the appeals process
  - Addendums are sometimes accepted upon appeal, but not during audit
- Request extensions when needed – only on post-payment reviews

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Audit Response Strategies

- Review audit results and utilize discussion periods if possible
  - Allows providers to provide additional information to support the original payment of a claim
  - 30 days to submit request
- Review records for valid signatures and obtain attestations where applicable

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Proactive Audit Strategies

- A provider without a compliance program is considered negligent and uncovered compliance issues could result in more severe penalties for providers without a compliance program
- Most important elements:
  - Education and Training
  - Internal Auditing
  - Risk Analysis
  - Policies and Procedures
- Have staff regularly review audit contractor web-sites

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Audits – Looking Ahead

- The Fiscal Year (FY) 2023 President's Budget provides $2.5 billion in total mandatory and discretionary investments for the Health Care Fraud and Abuse Control (HCFAC) Program and Medicaid Integrity Programs
- TPE started fresh, so providers that were in a TPE before may not get one right away and vice versa.
- Providers previously referred to CMS after failing round 3 and were in a round 4 have been picked up right away again.

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Audits – Looking Ahead

- Audit volumes will likely continue to increase as PHE winds down
- Industry stakeholders are still calling for transparency in CMS audit plans and clarity on unresolved issues
- There is a potential for a significant uptick in RAC audit volume

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UPICs – Recent OIG Report

- UPICs conducted substantially more program integrity activities for Medicare than for Medicaid
- Although most people with Medicaid are enrolled in managed care, UPICs conducted minimal activities for Managed Care
- Substantial disparities existed in the number of activities conducted across UPICs
- Strategies to improve program integrity by unifying Medicare and Medicaid data did not produce significant results

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UPICs – OIG Report

- The introduction of new collaborative processes, systems, and analytical tools has laid the foundation for improvement.
- Despite challenges caused by the COVID-19 pandemic, UPICs were able to identify vulnerabilities related to the pandemic and—with some limitations—continue program integrity activities
- Overall, UPICs face challenges in conducting Medicaid program integrity activities
- CONCLUSION – IMPLEMENT A PLAN TO INCREASE MEDICAID PROGRAM INTEGRITY ACTIVITES, PARTICULARLY RELATED TO MANAGED CARE

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OIG Audit – Hospice claims

- OIG Report, "Medicare Improperly Paid Suppliers an Estimated $117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries"
- Audited two samples of claims (with/without GW modifier) – 200 claims total
- OIG found 121/200 claims were improperly paid
  - Suppliers were unaware that they had provided items to hospice patients
  - System edits were not effective or did not exist
  - Suppliers inappropriately used the GW modifier
- Expect audit activity of hospice claims to increase

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SIX-YEAR LOOKBACK AUDITS

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Six-Year Lookback Audits

- February 12, 2016, CMS issues its final rule that implemented Section 6402 of the Affordable Care Act.
- These rules were effective March 14, 2016.
- 1128J(d) of the Social Security Act.
- 42 CFR Section 401.305 – Requirements for reporting and returning of overpayments.

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Key Provisions

- Identification of overpayments through the exercise of reasonable due diligence, such as proactive compliance activities.
- Investigative activities in response to credible information about potential overpayments.
  - This includes, per CMS, overpayments identified by contractors, including RACs and UPICs.
- 6 months is a benchmark for investigation
- 60 days to refund
- Six-year lookback period
- No minimum monetary threshold

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Concern

- We are now seeing language in all OIG reports as well as post-payment audit letters, such as the UPIC
- An overpayment implicates the six-year lookback rule
- A provider who does not "exercise reasonable due diligence" to comply with this rule could be subject to False Claims Act violations
- Significant concerns associated with this rule and how the federal government intends to enforce it
- Is a significant burden for providers who are attempting to comply

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REDUCE THE RISK OF BEING SUBJECTED TO AN ENFORCEMENT ACTION OR SIX-YEAR LOOKBACK

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Effective Corporate Compliance Program

- The OIG stresses the importance of compliance programs by issuing guidance to various provider and supplier types concerning the implementation of compliance programs.

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Reasons to Implement a Compliance Program

- Adopting a compliance program concretely demonstrates to the community at large that a provider or supplier has a strong commitment to honesty and responsible corporate citizenship.
- Compliance programs reinforce employees' innate sense of right and wrong.
- An effective compliance program helps a provider or supplier fulfill its legal duty to government and private payors.

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Reasons to Implement a Compliance Program

- Compliance programs are cost effective.
- A compliance program provides a more accurate view of employee and contractor behavior relating to fraud and abuse.
- The quality of care provided to patients is enhanced by an effective compliance program.
- A compliance program provides procedures to promptly correct misconduct.
- An effective compliance program may mitigate any sanction imposed by the government.
- Voluntarily implementing a compliance program is preferable to waiting for the OIG to impose a corporate integrity agreement.
- Effective corporate compliance programs may protect corporate directors from personal liability.

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Obstacles in Implementing a Compliance Program

Ten obstacles that providers may face in implementing effective compliance programs

1. Creating buy-in and enthusiasm
2. Changing past behavior
3. Lack of or poor communication
4. Too many roles for compliance officer
5. Not enough financial support
6. Integrating with other systems
7. Overcoming fear of retaliation/retribution
8. Finding qualified people
9. Lack of procedures
10. Education and training

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Elements of an Effective Compliance Plan

- The OIG's compliance guidelines for providers lists seven required elements of an effective compliance program.
  - Written policies and procedures
  - Designation of a compliance officer and compliance committee
  - Conducting effective training and education
  - Developing effective lines of communication
  - Enforcement of disciplinary standards
  - Auditing and monitoring
  - Response to offenses and corrective action

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Identifying Risk Areas

- It is not enough for providers to implement policies and procedures generally geared at educating staff and identifying potential regulatory and statutory violations.
- The provider is required to implement policies and procedures targeted at specific risk areas of concern.

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Compliance Program Follow Up

- Once the corporate compliance program is implemented, the provider must continue to take steps on an ongoing basis to ensure that the plan remains effective.

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Questions?

Kelly Grahovac
Kelly@vanHalemGroup.com

(404) 343-1815
www.vanHalemGroup.com

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