HomeCare Association of Arkansas

Home Health Compliance ABCs:
Avoiding (and Surviving) Compliance Audits
November 2013

Presented by:
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Fazzi Associates, Inc.
Objectives

- Discuss F2F requirements and other CMS audit activities.
- Discuss how to decrease your risk with documentation.
- Discuss how to make improvements happen in your Agency.

“In 2010, Medicare paid $19.5 billion to 11,203 home health agencies (HHA) for home health services provided to 3.4 million beneficiaries. HHAs are considered to be particularly vulnerable to fraud, waste, and abuse.”

-Department of Health and Human Services,
  Office of Inspector General
  CMS and Contractor Oversight of Home Health Agencies
  December 2012

CMS Contractors

- Medicare Administrative Contractors (MACs)
- Zone Program Integrity Contractors (ZPICs)
- Recovery Audit Contractors (RACs)
  - Medicare RACs & Medicaid RACs
- Medicaid Integrity Contractors (MICs)
National Health Projections

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<tbody>
<tr>
<td>Enrollment (in millions)</td>
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<tr>
<td>Medicare</td>
<td>47.9</td>
<td>49.3</td>
<td>50.9</td>
<td>52.4</td>
<td>53.9</td>
<td>55.4</td>
<td>57.1</td>
<td>58.8</td>
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<td>Medicaid</td>
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<td>56.2</td>
<td>56.3</td>
<td>75.6</td>
<td>77.8</td>
<td>80.6</td>
<td>81.4</td>
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<tr>
<td>Employer-Sponsored Private Health Insurance</td>
<td>163.8</td>
<td>165.5</td>
<td>167.3</td>
<td>170.3</td>
<td>171.3</td>
<td>168.9</td>
<td>167.1</td>
<td>166.1</td>
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<tr>
<td>Other Private Health Insurance</td>
<td>20.9</td>
<td>20.8</td>
<td>20.7</td>
<td>8.5</td>
<td>7.7</td>
<td>7.3</td>
<td>6.9</td>
<td>6.3</td>
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<tr>
<td>Uninsured</td>
<td>48.7</td>
<td>49.2</td>
<td>49.8</td>
<td>28.4</td>
<td>26.7</td>
<td>25.8</td>
<td>26.6</td>
<td>26.8</td>
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</tbody>
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By 2020, national health spending is expected to reach $4.6 trillion.

Source: CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Projections 2010-2020

Medicare Hospice Patients

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospice Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,223,551</td>
</tr>
<tr>
<td>2010</td>
<td>1,163,037</td>
</tr>
<tr>
<td>2009</td>
<td>1,094,005</td>
</tr>
<tr>
<td>2008</td>
<td>1,054,722</td>
</tr>
<tr>
<td>2007</td>
<td>999,803</td>
</tr>
<tr>
<td>2006</td>
<td>942,375</td>
</tr>
<tr>
<td>2005</td>
<td>873,909</td>
</tr>
<tr>
<td>2004</td>
<td>799,715</td>
</tr>
<tr>
<td>2003</td>
<td>739,469</td>
</tr>
<tr>
<td>2002</td>
<td>662,333</td>
</tr>
<tr>
<td>2001</td>
<td>594,665</td>
</tr>
<tr>
<td>2000</td>
<td>534,408</td>
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Source: Medicare & Medicaid Research Review, 2012 Statistical Supplement and HCIS, Office of Information Services, Data from the Standard Analytical Files, Table 8.1

Growth of Hospice Agencies

<table>
<thead>
<tr>
<th>Year</th>
<th>SNF</th>
<th>Hospital</th>
<th>Freestanding</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>23</td>
<td>597</td>
<td>480</td>
</tr>
<tr>
<td>2006</td>
<td>14</td>
<td>563</td>
<td>650</td>
</tr>
<tr>
<td>1996</td>
<td>22</td>
<td>526</td>
<td>815</td>
</tr>
<tr>
<td>1986</td>
<td>10</td>
<td>54</td>
<td>113</td>
</tr>
</tbody>
</table>

Heightened Monitoring

• 1997: Office of Inspector General (OIG) found 40% of total services in home health agency claims did not meet Medicare reimbursement requirements. (Four state review, CA, IL, NY, and TX) In 1999 review, found unallowable or highly questionable claims with charges totaling about $675.4 million.

• 2009: Suspicious billing patterns (particularly in Florida’s Miami-Dade county). More than 65% of the county’s claims were outliers, much higher than the national average.

Heightened Monitoring

• 2011: U.S. Senate Committee on Finance initiates inquiry into home health therapy practices at Amedisys, LHC Group, Gentiva, and Almost Family after a Wall Street Journal analysis of therapy utilization patterns.¹

• Obama Administration: elimination of fraud, waste and abuse a top priority.

• Health Care Fraud Prevention & Enforcement Action Team (HEAT).

¹Source: Committee on Finance United States Senate, Staff Report on Home Health and the Medicare Therapy Threshold, September 2011

Heightened Monitoring

• Affordable Care Act enhances screening and enrollment requirements, increased data sharing across government, expanded overpayment recovery, and greater oversight of private insurance abuses.

• In 2011, Medicare Fraud Strike Force Teams charge 323 defendants who allegedly billed Medicare more than $1 billion.

• Health care fraud prevention and enforcement efforts result in record-breaking recoveries totaling nearly $4.1 billion (largest sum ever recovered in a single year, 2011)

Source: HHS, News Release, February 14, 2012
Fraud in Home Health

- 2012: Texas doctor and the owners of five home health care agencies were charged with $375 million in Medicare and Medicaid fraud.
- 2012: Medicare Fraud Strike Force charges 107 individuals for participation in a Medicare billing fraud scheme involving approx. $452 million in false claims.

During 2011, OIG’s CMS oversight efforts resulted in approximately $5.1 billion in expected health care recoveries.

<table>
<thead>
<tr>
<th>Year</th>
<th>Audit Receivables</th>
<th>Investigative Recoveries</th>
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<tbody>
<tr>
<td>2007</td>
<td>$1.0</td>
<td>$1.0</td>
</tr>
<tr>
<td>2008</td>
<td>$1.3</td>
<td>$1.3</td>
</tr>
<tr>
<td>2009</td>
<td>$1.1</td>
<td>$1.1</td>
</tr>
<tr>
<td>2010</td>
<td>$1.1</td>
<td>$1.1</td>
</tr>
<tr>
<td>2011</td>
<td>$1.0</td>
<td>$1.0</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, Office of Inspector General, Narrative by Activity

**ROLES OF VARIOUS MEDICARE IMPROPER PAYMENT REVIEW ENTITIES**

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>Scope of Claims</th>
<th>Volume of Claims</th>
<th>Type of Review</th>
<th>Purpose of Review</th>
<th>Other Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT* All Medical Claims</td>
<td>Randomly Small</td>
<td>Prepay only - Automated</td>
<td>To measure improper payments</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>PERM* All Medical Claims</td>
<td>Randomly Small</td>
<td>Prepay only - Automated &amp; Complex</td>
<td>To measure improper payments</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Medical Review Audit* All Medical Claims</td>
<td>Targeted Depends on number of claims for this provider</td>
<td>Prepay &amp; Postpay - Automated &amp; Complex</td>
<td>To prevent future improper payments</td>
<td>Educate, Approve</td>
<td></td>
</tr>
<tr>
<td>Medicare Recovery Auditors* All Medicare FFS Claims</td>
<td>Targeted Depends on number of claims for this provider</td>
<td>Postpay - Automated &amp; Complex</td>
<td>To detect and correct past improper payments</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>PSC/ZPICS All Medicare FFS Claims</td>
<td>Targeted Depends on number of potentially fraudulent claims submitted by provider</td>
<td>Prepay, Postpay - Automated &amp; Complex</td>
<td>To identify potential fraud</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>OIG All Claims</td>
<td>Targeted Depends on number of potentially fraudulent claims submitted by provider</td>
<td>Postpay - Complex</td>
<td>To identify fraud</td>
<td>None</td>
<td></td>
</tr>
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</table>
COMPREHENSIVE ERROR RATE TESTING

Comprehensive Error Rate Testing (CERT) program is to measure improper payments in the Medicare fee-for-service (FFS) program. The CERT program cannot be considered a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. CERT is designed to comply with the Improper Payments Elimination and Recovery Act of 2010.

Comprehensive Error Rate Testing (CERT): Home Health Certification

"Most insufficient documentation errors for HH PPS result from claims in which the clinical findings from the face-to-face encounter, details about these findings supporting the beneficiary’s homebound status, or the need for skilled services are missing or inadequately documented."


Opportunities

- Plan of Care
- F2F
- OASIS and assessment notes supporting reasonable and necessary care
- LUPAs vulnerable to question of reasonable and necessary care
- Technical denial
- ICD-9 Coding errors
- PECOS compliance - future
Hospice Billing

Historically not the focus of targeted review, the landscape is changing. The hospice industry has been experiencing significant increase in pre and post payment review of claims.

Future Payment Reform Recommendations

MedPAC 1/2012 “U-shaped” Reimbursement:

• Increase payments per day at the beginning of the episode and reduce payments per day as the length of the episode increases.

• Provide an additional end-of-episode payment to reflect hospices’ higher level of effort at the end of life.

Face to Face
FACE TO FACE (F2F) ENCOUNTER

- Added January 1, 2011
- Purpose: Ensure the appropriate use of the Medicare home health and hospice benefits
- Places the patient in the presence of the physician to set the plan for care in motion and to determine/certify that the patient meets the eligibility criteria for home health services and continued eligibility for hospice care

QUALIFYING CRITERIA

- In need of skilled nursing care on an intermittent basis OR physical therapy OR speech language pathology; have a continuing need for occupational therapy.
- Confined to the home.
- Under the care of a physician.
- Receiving services under a plan of care established and periodically reviewed by a physician.
- Once the qualifying criteria are met, the patient may also receive the dependent services of an occupational therapist, medical social worker, registered dietician and/or home health aide.

HOSPICE CERTIFICATION

- Written certification of terminal illness for each period of hospice care
- Prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course
- Brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less
FACE-TO-FACE DOCUMENTATION

- Patient’s name
- Date of encounter
- How the clinical condition, as seen during the encounter, supports homebound status and the need for skilled services
- The physician’s signature (original, faxed, copy of original document with signature or electronic signature - but not stamped signature)
- Date of the physician’s signature

HOME HEALTH F2F CONTENT

- State what how and why the clinical findings at the time of the encounter support the patient’s primary need for home health care and the specific skilled services ordered
- State what clinical findings at the time of the encounter support the patient’s homebound status

DENIAL REASONS

- No F2F encounter documentation
- Insufficient F2F encounter documentation
- F2F encounter not obtained within the required time frame
- Issues related to the physician signature
  - No signature
  - Missing co-signature from the certifying physician
INSUFFICIENT DOCUMENTATION

• Brief narrative describing how the patient’s clinical condition, as seen during that encounter, supports the patient’s homebound status and need for skilled services.
• Encounter is related to the primary reason for home care

INSUFFICIENT DOCUMENTATION FOR SKILLED SERVICES

• Family is asking for help
• Continues to have problems
• List of tasks for nurse to do
• Patient unable to do wound care
• Diabetes

• Multiple medication changes. Patient with increased confusion. Monitor to ensure correct dosing and medications provide expected effects
• Finished course of antibiotics for bronchitis. Has COPD and current weather is humid. Monitor lungs. High risk for respiratory decompensation.
• Frequent lung infections. Still short of breath with very little movement/activity. Monitor lungs closely for changes to reduce risk of rehospitalization
HOMEBOUND CLARIFIED

ONE of these:
The individual has a condition due to an illness or injury that restricts his or her ability to leave their place of residence except with:
• the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or
• the assistance of another person; OR
• if leaving home is medically contraindicated.

And BOTH of these:
The individual does not have to be bedridden to be considered “confined to the home.” However, the condition of the patient should be such that:
• There exists a normal inability to leave home and, consequently; AND
• Leaving home would require a considerable and taxing effort.

Contractor’s Example

“The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new COPD medical regimen.”

HOMEBOUND STATUS

• Using O2?
  .....becomes short of breath while using O2 and walking more than 5 feet across the room.

• What causes the taxing effort?
  .....Significant gait impairment. Requires walker/cane and another person to ambulate short distances.

• Gait?
  .....status post hip replacement and currently walker dependent with pain 8/10 with ambulation today.
F2F CERTIFICATION

- Certifying physician OR
- Physician who cared for the patient in the acute or post acute setting OR
- Non-physician practitioner (NPP)
  - Nurse practitioner or clinical nurse specialist in collaboration with the certifying physician
  - Certified nurse-midwife
  - PA under the supervision of the certifying physician

No more than 90 days prior to the SOC or within 30 days after the SOC

ALERT!

In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after admission.

FLEXIBILITY

- A physician (e.g. hospitalist) or an allowed NPP and who attends to a patient in an acute or post acute setting can collaborate with and inform the community certifying physician regarding his/her contact with the patient. The community physician could document the encounter and certify based on this information.

- A face-to-face encounter can occur via telehealth, in rural areas, in an approved originating site.
**MAY CERTIFY**

A physician who attended to the patient in an acute or post-acute setting, but does not follow patient in the community (such as a hospitalist) may certify the need for home health care based on their contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then “hand off” the patient’s care to his or her community-based physician.

**MAY INITIATE HOME CARE**

- A physician who attended to the patient in an acute or post-acute setting can certify the need for home health care based on their contact with the patient, initiate the orders for home health services (verbal order for home care) and “hand off” the patient to his or her community-based physician to review and sign off on the plan of care

Source: CMS F2F Q&A Revised Feb 2013, Q 25 and 26

**FORM AND SIGNATURES**

- A separate and distinct clearly titled section of the certification/recertification form OR
- A clearly titled addendum to the certification/recertification form
- A legible dated signature
- Electronic signatures are permissible.
- Alert! If the F2F is attached as an addendum, both the certification and the F2F documentation require a signature by the certifying physician.
**ATTESTATION REQUIREMENT**

- A practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.
- The attestation, its accompanying signature, and the date signed, must be on a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
- When a NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.

**ALERT!**

- Physician documentation of their findings or those of the qualified non-physician practitioner acting on their behalf...in his/her own words.
- Agency providers may not dictate/write or otherwise prepare the F2F text or alter/change what the physician has written.
- May provide examples and training but not directed to a specific patient.

**ELIGIBILITY CRITERIA**

A Physician’s Guide to Medicare’s Home Health Certification, including the Face-to-Face Encounter, CMS MLN Matters

F2F - HOSPICE

- Required prior to the beginning of the patient’s 3rd benefit period, and prior to each subsequent benefit period.
- Hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care and attest that such a visit took place.

HOSPICE CARE

- Physician who is employed, contracted or a volunteer of the hospice
- Hospice Nurse Practitioner who is employed by the hospice
- No more than 30 calendar days prior to the 3rd benefit period recertification and
- No more than 30 days prior to each subsequent recertification

HOSPICE CONTENT

State the clinical findings of the visit used to determine whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.
QC CHECK LIST

✓ Is the encounter related to the primary reason for home care?
✓ How does the patient’s current clinical condition support homebound status?
✓ How does the patient’s current clinical condition support the need for skilled services?
✓ Is the encounter timely?
✓ Is the documentation signed and dated?

Fraud or Error?

It is important to note the error rate is not a “fraud rate,” but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

CMS CONTRACTORS

• Medicare Administrative Contractors (MACs)
• Zone Program Integrity Contractors (ZPICs)
• Recovery Audit Contractors (RACs)
  • Medicare RACs & Medicaid RACs
  • Medicaid Integrity Contractors (MICs)
**MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)**

Medicare Administrative Contractor is a contractor that performs Medicare fee-for-service claims administration services

The MACs enroll providers and educate them on Medicare billing requirements. They process Medicare claims, disburse or deny payments, and handle claim appeals

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**MEDICARE ADMINISTRATIVE CONTRACTOR**

15 Medicare Administrative Contractors (MAC) handling different geographic regions/jurisdictions. Within these, Home Health and Hospice providers handled by one of four specific MACs.

Moving from 15 A/B MAC jurisdictions to 10 A/B MAC jurisdictions. Four MACs servicing the Home Health and Hospice (HH+H) providers

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**ARKANSAS MAC**

- **Palmetto GBA**, LLC was awarded MAC Contract for this jurisdiction. Contract end date is in August 2015.
- Jurisdiction 11. Will be renamed Jurisdiction M in the future.
- Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas

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ARKANSAS MAC

- Total number of HHAs in Jurisdiction 11 as of December 2012: 7,571.
- Total number of hospices in Jurisdiction 11 as of December 2012: 1,807.
- Total number of fee-for-service beneficiaries as of 12/12: 16,272,814.
- Total annual claims volume: 50% of national HH&H workload.

MAC’S FUNCTION

- The MAC itself is measured on its performance, motivating it to do its job as accurately and efficiently as possible. Compliance audits are an important part of how your MAC achieves this.
- The MAC’s function is related to compliance with claims and billing rules and regulations. Therefore, the audits performed by MACs are focused accordingly.
-Types of MAC audits faced in the home health and hospice industry include: Recovery Audits.

TOP REASONS FOR MEDICARE DENIALS: JULY 1 AND DECEMBER 31, 2012

- Skilled observation was not reasonable and necessary. 56%
- No physician certification. This could indicate the face-to-face encounter did not meet the guidelines or the certification statement was not signed or dated by the physician. 15%
- Documentation not supporting the homebound status. 14%
- The physician orders were not signed timely. 5%
- OASIS is not found. Therapy services were determined to not require a therapist. Insufficient documentation was submitted for review. >5% combined.

Source: [CMS website](http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Jurisdiction_11_HHH_Fact-Sheet.html) for HHAs and hospices data.
TOP HOME HEALTH ISSUES: MEDICAL REVIEW
UNITS AT THE MACS

Common Denial Reasons:
- Documentation did not support that therapy was reasonable and necessary
- Documentation did not support that nursing was reasonable and necessary
- Documentation did not support the entries on the OASIS leading to coding
- Physician orders are incomplete, inadequate, or untimely
- Dependent services denied due to skilled services not meeting guidelines

RECOVERY AUDIT PROGRAM

Mission - The Recovery Audit Program’s mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

THE RECOVERY AUDITOR IN ARKANSAS/REGION C:
- Region C: Connolly, Inc.
- www.connollyhealthcare.com/RAC
TYPES OF DETERMINATIONS A RECOVERY AUDITOR MAY MAKE

- Coverage Determinations: included in the benefit, reasonable & necessary
- Coding Determinations: incorrectly coded
- Other Determinations: duplicate claim, incorrect payment

AUTOMATED REVIEW VS. COMPLEX REVIEW

- Automated review occurs when a Recovery Auditor makes a claim determination at the system level without a human review of the medical record.
- Complex review occurs when a Recovery Auditor makes a claim determination utilizing human review of the medical record.
  and
- Referrals: CMS often gets referrals of potential improper payments from claim processing contractors, program integrity contractors, external entities and OIG.

SEMI-AUTOMATED REVIEW

Semi-Automated Review is a two-part review.
- The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has high indexes of suspicion to be an improper payment.
- The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that is identified. The provider has 45 days to submit documentation to support the original billing.
- RAC review within 60 days of receiving documentation or will not receive contingency.
FOCUS OF RAC AUDITS: RAC RECOMMENDED

• New Issue Review Process
  – CMS reviews and determines whether RAC may proceed or be reviewed by RAC Validation Center
  – RAC Validation Center provides recommendation to CMS

RAC APPEALS

• Redetermination
• Reconsideration
• Administration Law Judge (ALJ)
• Appeals Council Review
• Final Judicial Review (Federal District Court Review)

MEDICAID RACS: FUNDING

• States’ costs to carry out the Medicaid RAC program (establish, operate, and appeals process) will be shared by the federal government at the 50% administrative rate applied to all Medicaid expenditures
• States are required to determine the contingency fee rate to be paid to Medicaid RACs
  – Must not exceed the highest contingency rate set paid in the Medicare RAC program (currently 12.50%)
  – Anything in excess will be paid using state-only funds
MEDICAID RACs: Scope

- 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.
- CMS will encourage states to form review teams for Medicaid RACs similar to the Medicare RAC program’s "New Issue Review Board".
- Absent from the Final Rule: a requirement that states require advanced approval of medical necessity reviews.

MEDICAID INTEGRITY CONTRACTORS (MICs)

- The Deficit Reduction Act 2005 mandated the creation of the Medicaid Integrity Program (MIP).
  - Under MIP, CMS hires contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues.
  - CMS will support and assist the states in their efforts to combat Medicaid fraud and abuse.

HIGH RISK AREAS FOR HOSPICE

- Certification (timing and content)
- Covered services
- Physician certification
- Services provided are consistent with plan of care
- Inpatient
- Nursing Homes
ZONE PROGRAM INTEGRITY CONTRACTORS

• ZPIC: The primary goal of the Zone Program Integrity Contractors (ZPICs) is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped.

• There are seven ZPIC zones and the ZPICs for these zones are tasked with performing program integrity for Medicare Parts A, B, C, Durable Medical Equipment (DME), Home Health and Hospice (HH + H), and the Medicare-Medicaid data match program (Medi-Medi).

ZONE PROGRAM INTEGRITY CONTRACTORS (ZPICs)

• CMS is in the process of transitioning the functions of Program Safeguard Contractors (PSCs) to ZPICs
• PSCs and ZPICs are responsible for preventing, detecting, and deterring Medicare fraud
  – Different from the Medical Review program which is primarily concerned with preventing and identifying errors
  – ZPICs request medical records and conduct medical review to evaluate the identified potential fraud
  – PSCs and ZPICs may also refer to the OIG and DOJ for further investigation

ARKANSAS ZPIC

Zone 5, AdvanceMed Corporation
Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.
OFFICE OF THE INSPECTOR GENERAL

Major Causes of Improper Payments

- 98% Met the Homebound requirement
- 22% of the claims were submitted in error because the services were not medically necessary or the claims were coded inaccurately resulting in $432 Million in improper payments
  - Upcoded (Incorrectly Coded) (10.4%)
  - (Typically Diagnosis Coding)
  - Downcoded (Incorrectly Coded) (9.8%)
  - Medically Unnecessary services (2.1%)
  - Insufficient documentation (0.5%)

SYSTEMS, STRUCTURE & ACCOUNTABILITY

HOW DO WE MAKE CHANGES HAPPEN?

WHEN THINGS ARE CHANGING FAST

Not Paying Attention to the Changes and Not Responding to the Changes Can Lead to Your…

Demise
THE TRIPLE AIM

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of the populations
- Reducing the per capita cost of health care

Source: Institute for Healthcare Improvement

DEFENSIVE DOCUMENTATION

- Be specific and factual: avoid general statements
- Use objective, patient stated documentation: describe progress
- Be specific: who was called? Outcome?
- Individualize: care planning is specific
- Describe behaviors and events: paint a picture

*Adapted from Bureau of Home Care and Rehabilitative Standards Improvement

DEFENSIVE DOCUMENTATION PRACTICES

- Use only approved abbreviations
- Follow Agency policy/procedure: correcting documentation
- Document as close to the visit/call as possible
- Review previous visit notes/events: address issues in current visit

*Adapted from Bureau of Home Care and Rehabilitative Standards Improvement
RAC DENIALS

- "Was in hospital for bronchitis, had decline in function."
- Living situation "capable"
- "Pain: = 0"
- Posture: "Kyphotic"
- "Full weight bearing, with standby assistance."
- "Decreased endurance with ambulation"


OASIS COMPETENCY: AT ALL LEVELS

Source: Fazzi OASIS Testing

TOP 3 OASIS OPPORTUNITIES

- Ambulation/Falls: M1910 fall risk assessment has been one of the most frequently missed items on the exam.
- Medication Management: In the October 2013 exam, 89% of RNs and 86% of Therapists missed M2000 Drug Regimen Review. In addition, in the past three exams M2020 Management of Oral Medications has been a most missed item.
- Integumentary Assessment: 77% of RNs and Therapists missed M1308 Current Number of Unhealed Pressure Ulcers in the June 2013 test. Wound related questions are consistently an item with a high rate of error (more than 50%).

Fazzi OASIS Testing Results Oct 2012- October 2013
CODING COMPETENCY: Top Issues

- Related to Plan of Up coding risks for use of Diabetes, Neuro-1 and Skin-1 codes in primary position without supporting documentation
- Including CM diagnoses that do not impact the POC (such as GERD) or are not supported by documentation
- Coding acute/resolved conditions in M1020/22
- Manifestation codes used as the primary diagnosis, such as Dementia 294.10 instead of 294.20
- Trauma wound coding when wound is surgical or is a superficial injury
- Psychiatric diagnoses as primary when the care is not provided by a psyche qualified RN (except when the skill is an injection for a mental condition)
- Improper sequencing for etiology/manifestation codes in any position (primary/secondary)
- Incomplete codes – inadequate number of digits

Fazzi’s Care Management

A program to manage the care of home health patients that ensures the delivery of standardized, outcome based and cost efficient patient care.

Clinical Model Features

Interdisciplinary Teams, led by Clinical Manager

- OASIS assessment competence
- Competence in use of software/hardware
- Patient satisfying behaviors
- Time management and problem solving

- Scheduling – use clinician self scheduling and automated functions.
- Team Assistant to support scheduling – reports to Clinical Manager
- Clinical Manager leads to clinician accountability in updates of schedule and resultant productivity.
CLINICAL MODEL & CARE MANAGEMENT

• Care Management – integrating ongoing learning into best practice care provision.
• Regular Care Management Conferences - focus on utilization and best practice:
  • Grand rounds approach, multi-disciplinary team
  • Review adverse events
  • Platform for ongoing clinical education as practice advances
• Dynamic review of Care Plans – to meet standards of best practice and visit utilization.

QUALITY AND PERFORMANCE IMPROVEMENT RECOMMENDATIONS

• Develop formalized Care Management Program and position within PI.
• Clerical support may help track and trend competence and performance by staff member.
• Ensure competence and then reduce to 10% auditing per staff member.

ACCOUNTABILITY
F2F Resources

- CGS FAQ Re: F2F requirements for home care and hospice, [http://www.cgsmedicare.com/hhh/education/faqs/FTF_FAQs.html](http://www.cgsmedicare.com/hhh/education/faqs/FTF_FAQs.html)
- Medicare Benefits Policy Manual, Chapter 7
- Medicare Home Health Face to face requirement, [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/faceto-face-requirement-powerpoint.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/faceto-face-requirement-powerpoint.pdf), Retrieved 082813
- Face to Face Requirement Affecting Hospice Recertification, [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/HospiceFace-to-FaceGuidance.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/HospiceFace-to-FaceGuidance.pdf), Retrieved 082813

RAC Resources


Arkansas RAC

- www.connollyhealthcare.com/RAC
  Medicare Learning Network Quarterly Compliance Newsletter

OASIS/Coding Resources