Leadership And The Interdisciplinary Group: Overcoming Organizational Challenges In A Time of Change

Alphabet Soup For The Hospice Soul: Understanding The Impact Of RHHI, MAC, RAC, CMS, OIG, FBI and DOJ Scrutiny

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Objectives

At the end of this pre-conference, participant will be able to:

• Articulate two national statistics and their impact on scrutiny-related activities.
• List four Federal entities and the type of hospice-related investigation each one conducts.
• Cite the five standards that comprise the Condition of participation entitled Interdisciplinary Group, Care Planning, and Coordination of Services (418.56).
• Describe two ways to empower a team.
• Convey the importance of sustainability to the leadership and interdisciplinary teams.

The Alphabet Soup Of Hospice Scrutiny

• CMS
• RHHIs/MACs
• RACs
• OIG
• ZPICs
• HEAT
• MICs
• MFCU
• FBI
• DOJ
Who Is Looking At You?

Hospices Always Need To Know

• Who is looking.
• What they are looking for.

Two Basic Types Of Scrutiny

1. Patient health and safety.
2. Payment.
Hospice Scrutiny

- State surveyors – Licensing / Certification / Complaints
- RHHIs / MACs
- ZPICs
- OIG
- FBI
- HEAT
- MCS
- RACs

Patient Health and Safety

CMS – CoPs

- Centers for Medicare and Medicaid Services (CMS) is the entity that deals with basic health and safety of patients.
- CMS – The Medicare Conditions of Participation.
Hospice Is Tier 4

• Tier 4 is the lowest priority for surveys unless there is an access to care issue and the provider is desperately needed.
• New hospices are not able to get certified unless they request an initial survey under deemed status through the Joint Commission or CHAP.

Tier 4 Is Good Because...

• Hospices are under so much scrutiny on the payment side it is a relief to not have to worry about random or regular recertification surveys.

Tier 4 Is Not Good Because...

• Providers can get lax with compliance with the regulations.
Why Does CMS Do Surveys?

- To protect hospice patients / Medicare beneficiaries.
- Assure that the Medicare-certified hospice is meeting minimum health and safety requirements.

Types Of Surveys...

- Initial Certification.
- Re-certification survey.
- Complaint survey.
- Re-Visit survey:
  - Follow-up survey after a re-certification or complaint survey that resulted in one or more condition level deficiencies.
  - Conducted within 90 days of 1st survey exit.
  - Can result in an additional Statement of Deficiencies.

Potential Survey Outcomes

- No deficiencies found.
- Condition Level deficiency.
- Standard Level deficiency.
- Finding of Immediate Jeopardy.
- Complaint substantiated.
- Complaint not substantiated.
Deficiencies

• Standard-level deficiency:
  – Hospice submits a plan of correction.
• Condition-level deficiency:
  – Hospice submits a plan of correction; and/or
  – Hospice on a termination track.

Immediate Jeopardy

• A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.
• Only one individual needs to be at risk.

Immediate Jeopardy, Cont’d.

• The hospice provider:
  – Knew or should have known about the situation.
  – Created the situation or allowed the situation to continue.
  – Had an opportunity to implement corrective measures.
Immediate Jeopardy, Cont’d.

- **Harm** – actual or potential.
- **Culpability** – did the hospice know or should have known.
- **Immediacy** – clear and present risk/danger.

Payment Scrutiny

Why All The Heightened Scrutiny On The Payment Side?

- Tremendous growth in Medicare payments to hospice.
- National focus on health care reform.
- Suspected fraud and abuse in the hospice industry.
Remember These Numbers?

Citation: NHPCO National Summary of Hospice Care

<table>
<thead>
<tr>
<th>DATA</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Profit</td>
<td>67.6%</td>
<td>49%</td>
<td>48.6%</td>
</tr>
<tr>
<td>For-Profit</td>
<td>27.2%</td>
<td>46%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Gov-Owned</td>
<td>5.2%</td>
<td>5.1%</td>
<td>&lt;5%</td>
</tr>
<tr>
<td>Total patients</td>
<td>1.2 Million</td>
<td>1.3 Million</td>
<td>1.4 Million</td>
</tr>
</tbody>
</table>

The Most Prevalent Types Of Payment Scrutiny

- MACs – Medicare Administrator Contractors
  - Replacing RHHIs
- RACs – Recovery Audit Contractors
- ZPICs – Zone Program Integrity Contractors
- OIG – Office of the Inspector General

The MACs
The MACs (Formerly RHHIs)

- The Centers for Medicare and Medicaid Services (CMS) contracts with Regional Home Health and Hospice Intermediaries (RHHIs) or Medicare Administrative Contractors (MACs) to administer hospice claims.

- CMS provides guidance to these contractors regarding medical review probes (probe edits) and progressive corrective action (PCA) activities.

MACs, Cont’d.

- Regional Home Health and Hospice Intermediaries (RHHIs) are transitioning to Medicare Administrative Contractors (MACs)

- All existing hospice providers with a Medicare claims history will remain in their current RHHI assignments until their workload is transferred to a MAC

- The workload currently being serviced by an RHHI will be absorbed by the MAC within the first 12 months

- In some situations the workload transition may be delayed by an award protest
MACs, Cont’d.

- National Heritage Insurance Corporation (NHIC)
  - http://www.medicarenhic.com
  - http://www.ngsmedicare.com (NGS)
- Highmark Medicare Services
  - http://www.highmarkmedicareservices.com
- Palmetto GBA
  - http://www.palmettogba.com
- Noridian Administrative Services
  - https://www.noridianmedicare.com

MACs, Cont’d.

- Pay claims.
- Provide education.
- Conduct both pre-payment and post-payment review of claims.
- Issue ADRs to review medical records.
- Etc.

Additional Development Requests

- ADRs:
  - Are initiated by the MAC (RHHI).
  - Can be pre-payment or post-payment.
  - Are usually related to a probe edit.
  - Basically involve technical and medical reviews of hospice claims.
Types Of Probe Edits

• Probes may include, but are not limited to:
  – Service-specific.
  – Provider-specific.
  – Beneficiary-specific.
  – Diagnosis-driven.
  – Length of stay (NCLOS).
  – Level of care.
  – Etc.

Technical Eligibility

• The following technical elements are required for hospice payment (and admission):
  – A valid and timely NOE; and
  – A valid and timely CTI.

Technical Denials

• Technical claim denials occur when the hospice:
  – Fails (or chooses not) to respond to an ADR.
  – Submits the clinical record after the due date.
  – Fails to submit all requested documents.
  – Utilizes and submits invalid or incomplete forms (NOE, CTI, etc.).
  – Submits documentation that is untimely, inaccurate, or incomplete.
**Medical Necessity “Test”**

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>ELIGIBILITY REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>DRGs.</td>
</tr>
<tr>
<td>SNF</td>
<td>Qualifying hospital stay &amp; skilled need.</td>
</tr>
<tr>
<td>Home Health</td>
<td>Homebound status &amp; skilled need.</td>
</tr>
<tr>
<td>Hospice</td>
<td>Terminal condition &amp; limited prognosis (certification – life expectancy of 6 months or less if the disease runs its normal course).</td>
</tr>
<tr>
<td></td>
<td>Level of care – Needed and provided.</td>
</tr>
</tbody>
</table>

**Medical Denials**

- A *not medically necessary* claim denial occurs when the hospice:
  - Submits documentation that does not clearly and consistently support hospice eligibility and limited prognosis (LCD not met).
  - Admits and/or recertifies non-terminal patients who require only custodial care (no decline).
  - Bills for a higher level of care than was needed by the patient and/or provided by the hospice.

**Claim Denials**

- Technical and medical denials are *not* mutually exclusive, for example:
  - A technical denial may occur at the ADR level and a medical denial may occur upon appeal.
  - Technical denials are difficult to overturn.
  - It is possible to request a “reopen” of the claim if a document was overlooked by the hospice or the reviewer.
  - If payment is denied, the hospice may appeal the decision.
The RACs

Recovery Audit Contractors

- Evolved from a three year demonstration project that recouped close to one billion dollars.
- CMS authorized to make the program permanent and nationwide by January 2010 because it was so successful in recouping money.
- RACs will work on a contingency basis—the more improper payments they identify, the more money the RAC will make.

RACs – Purpose

- To reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.
- The goal is to focus limited resources on where there will be the most return.
Current RACs

- **REGION A** – Diversified Collection Services, Inc.
  - CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, and VT.
- **REGION B** – CGI
  - IL, IN, KY, MI, MN, OH, and WI.
- **REGION C** – Connolly Healthcare
  - AL, AR, CO, FL, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV, Puerto Rico
  and the US Virgin Islands.
- **REGION D** – HealthDataInsights, Inc.
  - MT, WY, ND, SD, UT, AZ, AK, HI, ID, IA, KS, MO, NE, NV, OR and WA,
    and the territories of Guam, American Samoa and Northern Marianas.

Iowa’s RAC

www.racinfo.com

Current Status Of RACs

- RACs will be receiving Home Health and Hospice data in April and May 2009 but CMS does not anticipate any review of Home Health or Hospice claims until January 2010.
**RACs – Process**

- RACs have a prescribed number of records they can look at for hospices – 10% of average monthly Medicare claims (maximum 200) per 45 days.
- For example: 1200 Medicare claims paid in 2008 – divided by 12 + average of 100 claims/month X 10% = 10. Therefore, the RAC can review 10 medical records per 45 days.

**RACs – Process, Cont’d.**

- RACs will review post-pay claims either with the medical record (complex review) or without the medical record (automated review).
- In the review, the RACs will use the same Medicare policies as the MACs – LCDs, CMS Manual etc.
- If it determines there is an overpayment, a demand letter is sent.

**RACs – Process, Cont’d.**

- If an overpayment is identified, a demand letter will be sent.
- Hospice can pay the demand by check or by offset
- Hospice can appeal - same appeal process as currently used with MACs.
Challenge

• If the RAC loses at any level of the appeal, it must return its contingency fee.
• Clearly the incentive for the RACs will be to not lose any appeals.

What Is Particularly Scary About RACs

• They work on a contingency fee basis
• RAC contingency fees:
  • Region A - 12.45%
  • Region B - 12.50%
  • Region C - 9%
  • Region D 9.49%

www.racassistance.com
The Medicare Appeals Process

1st Level Of Appeal

<table>
<thead>
<tr>
<th>PARTY</th>
<th>HEARING APPEAL</th>
<th>FILING TIME FRAME</th>
<th>DECISION TIME FRAME</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination MAC / RHHI</td>
<td>120 days</td>
<td>60 days</td>
<td></td>
<td>This is a record review only; the hospice cannot discuss the patient with the reviewer.</td>
</tr>
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</table>
### 2nd Level Of Appeal

<table>
<thead>
<tr>
<th>PARTY HEARING APPEAL</th>
<th>FILING TIME FRAME</th>
<th>DECISION TIME FRAME</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconsideration Qualified Independent Contractor (QIC)</td>
<td>180 days</td>
<td>60 days</td>
<td>Typically, this is the last opportunity to introduce additional supportive evidence of eligibility. This is a record review only; the hospice cannot discuss the patient with the reviewer.</td>
</tr>
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</table>

### 3rd Level Of Appeal

<table>
<thead>
<tr>
<th>PARTY HEARING APPEAL</th>
<th>FILING TIME FRAME</th>
<th>DECISION TIME FRAME</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Law Judge (ALJ)</td>
<td>60 days</td>
<td>90 days</td>
<td>The ALJ hearing affords the hospice an opportunity to discuss the patient and review the details of the case (eligibility, care needs, etc.). Hearings are typically conducted via teleconference.</td>
</tr>
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</table>

### 4th Level Of Appeal

<table>
<thead>
<tr>
<th>PARTY HEARING APPEAL</th>
<th>FILING TIME FRAME</th>
<th>DECISION TIME FRAME</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Appeals Council</td>
<td>60 days</td>
<td>90 days</td>
<td>Hospices should only appeal to the Medicare Appeals Council in cases where the ALJ has misapplied the law or misunderstood the facts of the case. This is typically not a formal hearing (record review only).</td>
</tr>
</tbody>
</table>
**5th Level Of Appeal**

<table>
<thead>
<tr>
<th>PARTY HEARING APPEAL</th>
<th>FILING TIME FRAME</th>
<th>DECISION TIME FRAME</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal District Court</td>
<td>60 days</td>
<td>N/A</td>
<td>Uncommon for hospices to appeal to this level.</td>
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</tbody>
</table>

**Charge Denial Rate**

- The CDR is expressed as a percentage.
- It is calculated by taking the **total dollar amount** of the charges denied, divided by the total dollar amount of the charges of all reviewed claims, multiplied by 100.
  - If a hospice had $2,000 in claim denials, and the total of the claims reviewed equaled $10,000, a 20% CDR would result ($2,000 ÷ $10,000 x 100).

**Targeted Medical Review**

- CMS requires RHHIs to “target” medical review activities on providers or services that place Medicare funds at the greatest risk.
- Based on probe edits results, the RHHI may place a provider on TMR (CDR >10-15%).
- Once the CDR reaches an acceptable level for a quarter, TMR activities typically cease.
Corrective Action Plan

• If a provider has a very high CDR, or an unacceptable CDR for several quarters, the RHHI may request a written CAP.
• A CAP outlines all actions the provider will take to correct the problems identified during the medical review process.
• The CAP is either accepted by the RHHI or sent back to the provider with suggested changes.

ZPICS

Zone Integrity Program Contractors

GOALS:
To investigate Medicare fraud and abuse through sophisticated data analysis and audits that lead to referrals for investigations.

To ensure the integrity of all Medicare claims under Parts A and B.
ZPIC – Background

- Seven zones have been created based on MAC jurisdictions.
- New entities have been created in each of the seven zones to perform program integrity for Medicare.
- ZPICs are expected to perform program integrity functions for Medicare A-D, DME, home health, hospice and the Medi-Medi program.

What They Will Do

- Look at billing trends and patterns across Medicare and focusing on companies and individuals whose billings are higher than the majority of providers and suppliers in the community.
- Consolidate the work of previous Program Safeguard Contractors (PSCs) and Medicare Drug Integrity Contractors (MEDICs).

Some Of The Things A ZPIC May Investigate

- Potential criminal, civil, or administrative law violations.
- Allegations extending beyond one provider, involving multiple providers, multiple states, or widespread schemes.
- Allegations involving known patterns of fraud.
- Pattern of fraud or abuse threatening the life or well being of beneficiaries.
- Scheme with large financial risk to the Medicare Program or beneficiaries.
The OIG

Office Of The Inspector General

- The mission of the Office of Inspector General (OIG) is to protect the integrity of Department of Health and Human Services programs, as well as the health and welfare of the beneficiaries of those programs.
- OIG reports program and management problems and recommendations to correct them.
- OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

OIG, Cont’d.

- Issues annual work plans.
- Is always looking at the provision of hospice care in nursing homes.
- Issued the Compliance Program Guidance for Hospices in 1999.
Recent OIG Reports

- Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements (report #OEI-02-06-00221) September 8, 2009.

- Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (report #OEI-02-06-00223) September 8, 2009.

Hospice Headlines

FEDS PURSUING CASE AGAINST ARKANSAS HOSPICE

- The hospice was accused of charging Medicare for GIP care in situations where only routine home care was provided.
- The US attorney’s office said that, in many cases, patients only needed routine care.
- The initial action was brought in 2004 by a neighboring hospice who said they were not trying to harm their competitor but rather needed to report false billing.
- The hospice declined comment.
SIX CHARGED IN CALIFORNIA HOSPICE SCAM

• The state attorney general has filed criminal charges against 6 individuals who allegedly paid healthy senior citizens to be admitted to a hospice and then billed state and federal healthcare programs for millions of dollars worth of care that was never performed.

Questions

Thank You!

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