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Rockin' & Rollin With CMS

How to Avoid Doing the Jailhouse Rock

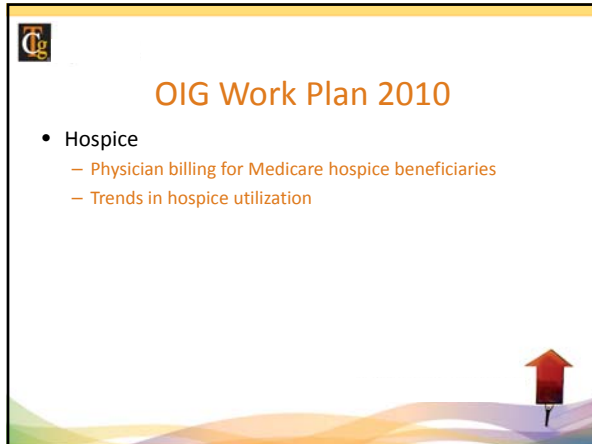
Professional. Responsive. Expert.

Dances to Learn

- 2010 Work Plan for Home Care & Hospice
- Recovery Audit Contractors (RACS)
- Medicare Audits
- False Claims & Stark III

OIG Work Plan 2010

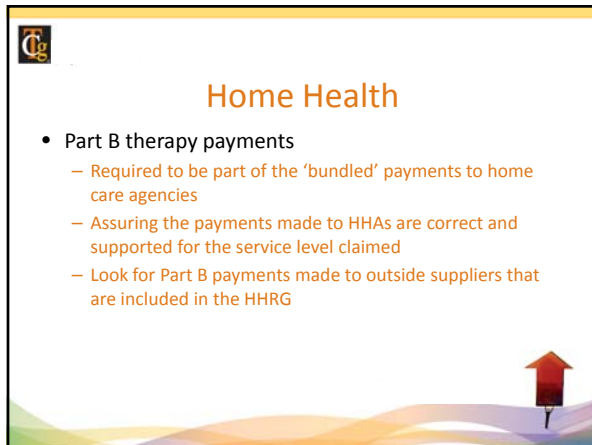
- Home Care
 - Part B therapy payments for Home Health Beneficiaries
 - Accuracy of coding of HHRGs
 - Medicare payments for insulin injections
 - Home Health Outlier Payments
 - Prospective Payment Controls
 - Agency Profitability
 - Diabetes Self-Management Training Services
 - CMS' Oversight of OASIS



OIG Work Plan 2010

- Hospice
 - Physician billing for Medicare hospice beneficiaries
 - Trends in hospice utilization

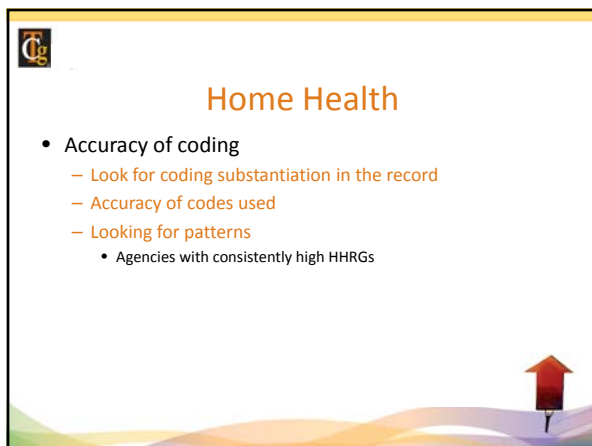
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Home Health

- Part B therapy payments
 - Required to be part of the 'bundled' payments to home care agencies
 - Assuring the payments made to HHAs are correct and supported for the service level claimed
 - Look for Part B payments made to outside suppliers that are included in the HHRG

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Home Health

- Accuracy of coding
 - Look for coding substantiation in the record
 - Accuracy of codes used
 - Looking for patterns
 - Agencies with consistently high HHRGs

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Home Health

- Home health payments for insulin injections
 - Outlier payments
 - Look at geographical billing patterns

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Home Health


- Home Health Outlier Payments
 - Look at CMS's methodology for calculating outlier payments
- Home Health PPS System Controls
 - Look at the geographical location for billings
 - Numbers of claims
 - Numbers of visits
 - Arrangements with other facilities and ownership info

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Home Health


- Home Health Profitability
 - Review trends
 - Not-for-profit vs. for-profit and trends between freestanding and hospital-based agencies


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Home Health


- Payments for Diabetes Self-Management Training Services (DSMT)
 - Examine billing patterns in geographical areas with high utilization of DSMT services
- Oversight of OASIS
 - Review CMS' process for ensuring HHA's submit accurate and complete OASIS data






Hospice


- Hospice is not separated into it's own heading
- Included in 'Other Part A and Part B Providers Payments'






Hospice



- Physician billing for hospice beneficiaries
 - Look at Part B billing
 - Look at the frequency and total expenditures under Part A and Part B for hospice beneficiaries (double dipping)






Hospice




- Trends in utilization
 - Lengths of stay
 - Geographical differences
 - Non-profit vs. for-profit






Strategies to Assure Compliance



- Home care
 - Auditing for signatures
 - Review of all recertifications
 - Ongoing coding review
 - Consider adding a trained coder or contracting for third party coding






Strategies for Home Care (cont'd)



- Homebound
 - Adding to audit activities
- Benchmarking
 - Do not want to be 'out standing in your field'






Strategies for Hospice



- Work with your referral sources and make sure they use the GW modifier appropriately
- Benchmark length of stay and diagnoses





Recovery Audit Contractors

- RACs
 - Purpose is to identify, correct and recoup Medicare overpayments/underpayments
 - Started as a demonstration project in 2005
 - Expanded to Home Care and Hospice no later than 2010
 - Missouri, Kansas, Nebraska and Iowa are among the last states for RAC implementation
 - First RAC letters have gone out to infusion & DME late 2009





Recovery Audit Contractors

- Contractors awarded
 - Diversified Collection Services – Region A
 - CGI Technologies & Solutions – Region B
 - Connelly Consulting – Region C
 - HealthDataInsights – Region D (includes MO)






Recovery Audit Contractors


- What will they look at
 - Incorrect payment amounts
 - Non-covered services
 - Incorrectly coded services – HHRGs
 - Medical necessity
 - Certification deficiencies – signatures (technical)
 - Duplicate services






Recovery Audit Contractors


- What won't be considered
 - Non fee-for-service Medicare Programs
 - Cost report settlements
 - Claims more than 3 years past the initial determination date
 - Claims paid prior to October 1, 2007

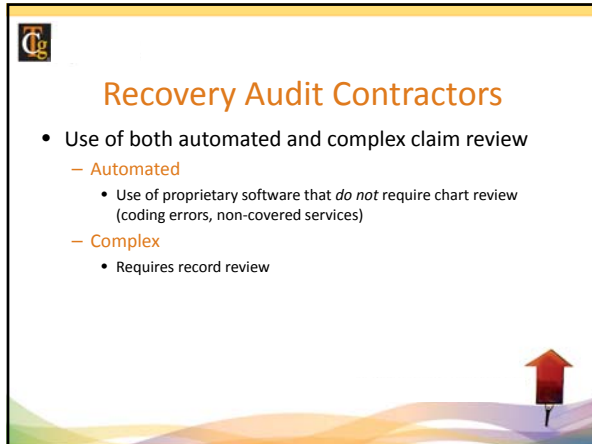




Recovery Audit Contractors

- What won't be considered (cont'd)
 - Claims where the provider is without fault
 - Random selection of claims
 - Medicare demonstration project
 - Pre-payment review

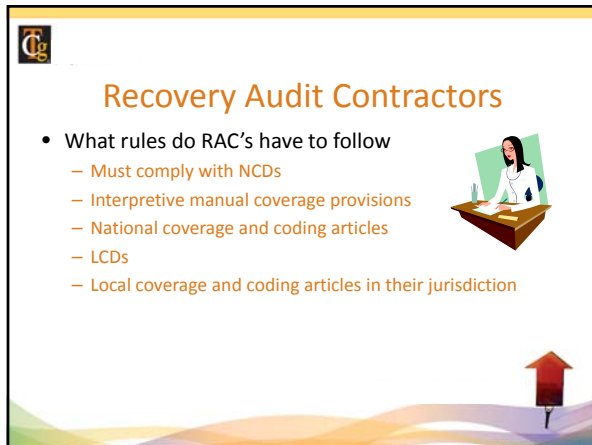




Recovery Audit Contractors

- Use of both automated and complex claim review
 - Automated
 - Use of proprietary software that *do not* require chart review (coding errors, non-covered services)
 - Complex
 - Requires record review

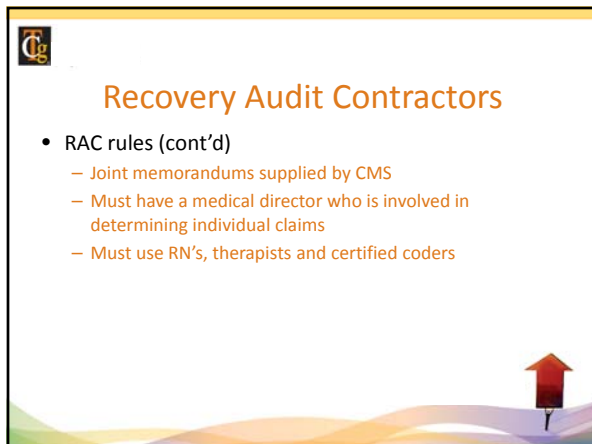
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Recovery Audit Contractors

- What rules do RAC's have to follow
 - Must comply with NCDs
 - Interpretive manual coverage provisions
 - National coverage and coding articles
 - LCDs
 - Local coverage and coding articles in their jurisdiction


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Recovery Audit Contractors


- RAC rules (cont'd)
 - Joint memorandums supplied by CMS
 - Must have a medical director who is involved in determining individual claims
 - Must use RN's, therapists and certified coders


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Recovery Audit Contractors



- How will we know what the 'hot spots' are
 - RACs will post on their websites what issues they intend to review
 - This isn't guaranteed
 - Will be using 'probe' reviews to determine if wider review is necessary






Recovery Audit Contractors


- How long do we have to respond
 - Providers have **45 CALENDAR** days to respond with copies of the medical record(s)
 - They will be *permitted* to pay – but only required to pay acute inpatient and long term care hospital claim copying charges
 - If no response – deemed to be overpayment






Recovery Audit Contractors


- RACs will be required to let providers know of their findings only if overpayment determination is made for automated reviews
- Must notify provider of ALL complex review findings






Recovery Audit Contractors


- Timelines
 - RACs will have up to 60 days to complete complex reviews and send letter to provider with results
 - RACs may request extension from CMS
 - If they do this, must notify the provider






Recovery Audit Contractors


- Underpayments
 - The Medicare contractor (RHHI/MAC) will make claim adjustments
 - Providers cannot request review from RAC for suspected underpayment
 - Providers may not have 'official appeal rights' for underpayments, but can use the RAC rebuttal process to discuss

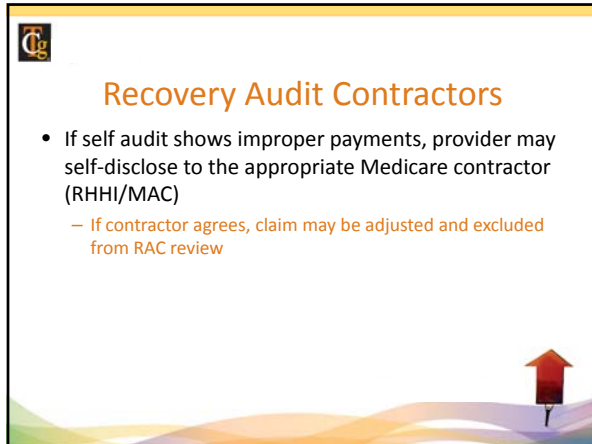





Recovery Audit Contractors


- RACs will have access to the CMS data warehouse
 - Includes excluded and suppressed claims – not available for RAC review (fraud investigations, etc.)
 - RAC must query to determine if claim has already been reviewed by another entity






 **Recovery Audit Contractors**


- If self audit shows improper payments, provider may self-disclose to the appropriate Medicare contractor (RHHI/MAC)
 - If contractor agrees, claim may be adjusted and excluded from RAC review

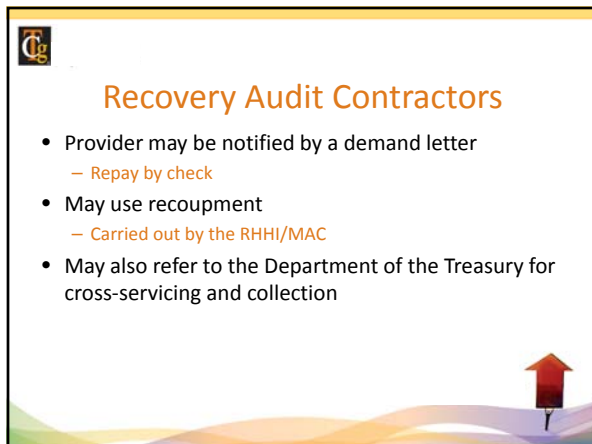





 **Recovery Audit Contractors**


- Overpayment process
 - RACs must follow CMS regulations, as well as Federal debt collection standards
 - The Medicare contractor (RHHI/MAC) will do the actual claim adjustment







 **Recovery Audit Contractors**


- Provider may be notified by a demand letter
 - Repay by check
- May use recoupment
 - Carried out by the RHHI/MAC
- May also refer to the Department of the Treasury for cross-servicing and collection



 Recovery Audit Contractors


- Interest **will** accrue from the date of final determination and charged on an overpayment balance OR an underpayment balance for each 30 day period of delay



 Recovery Audit Contractors


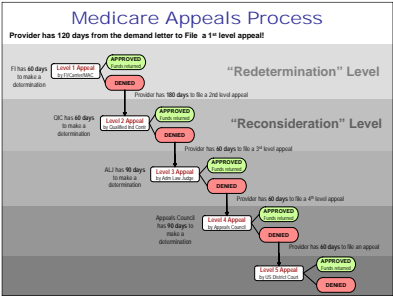
- Due process
 - May appeal according to Medicare’s appeal process
 - If overpayment is identified – have 120 days to request first level appeal
 - If do not respond, the dollars are recouped
 - If request appeal, funds not taken until after second level appeal




 Recovery Audit Contractors

Medicare Appeals Process



Provider has 120 days from the demand letter to file a 1st level appeal!






Recovery Audit Contractors



- What do we need to do to prepare
 - Look at current processes for dealing with ADR's, CERT requests, etc.
 - Review information on the CMS website
 - Review current programs to identify potential risk areas
 - Define a process (including roles) to handle RAC requests





Current RAC Focus' For Missouri Home Care and Hospice Providers

- DME while in hospice
- Hospice related services (services that should be part of the per diem)
- Medical supplies and home health bundling

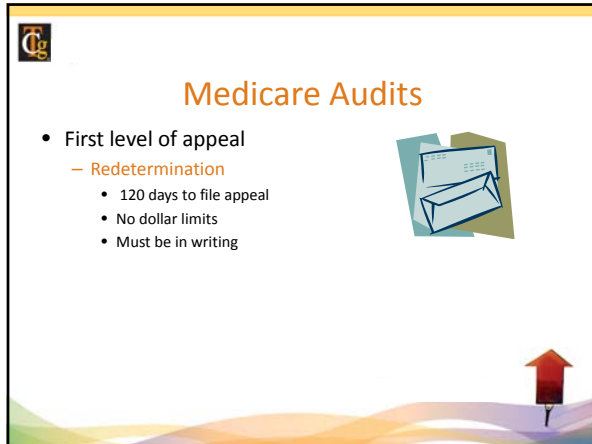




Medicare Audits

- Progressive Corrective Action
 - Modified in 2005 to allow Part A providers to directly appeal a denial
 - Added a second level of appeal for Part A providers (Qualified Independent Contractors)

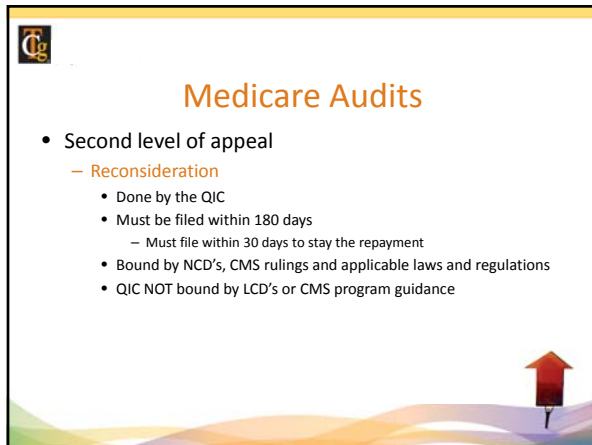




Medicare Audits

- First level of appeal
 - Redetermination
 - 120 days to file appeal
 - No dollar limits
 - Must be in writing

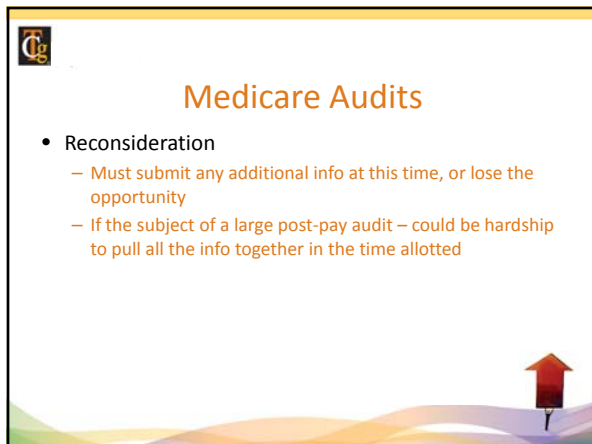
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Medicare Audits

- Second level of appeal
 - Reconsideration
 - Done by the QIC
 - Must be filed within 180 days
 - Must file within 30 days to stay the repayment
 - Bound by NCD's, CMS rulings and applicable laws and regulations
 - QIC NOT bound by LCD's or CMS program guidance

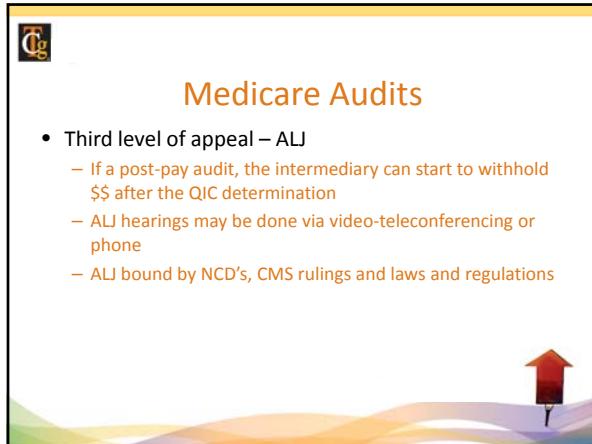
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Medicare Audits

- Reconsideration
 - Must submit any additional info at this time, or lose the opportunity
 - If the subject of a large post-pay audit – could be hardship to pull all the info together in the time allotted

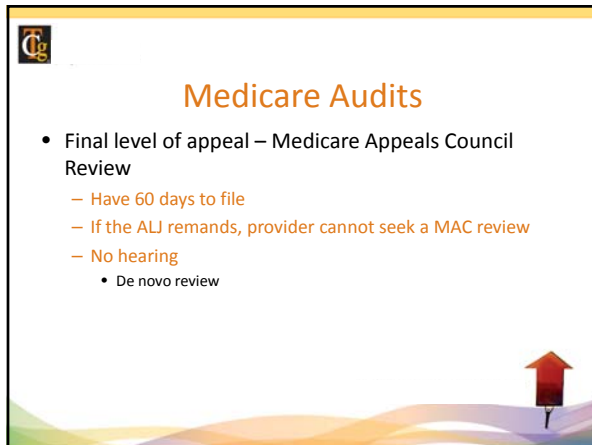
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Medicare Audits

- Third level of appeal – ALJ
 - If a post-pay audit, the intermediary can start to withhold \$\$ after the QIC determination
 - ALJ hearings may be done via video-teleconferencing or phone
 - ALJ bound by NCD's, CMS rulings and laws and regulations

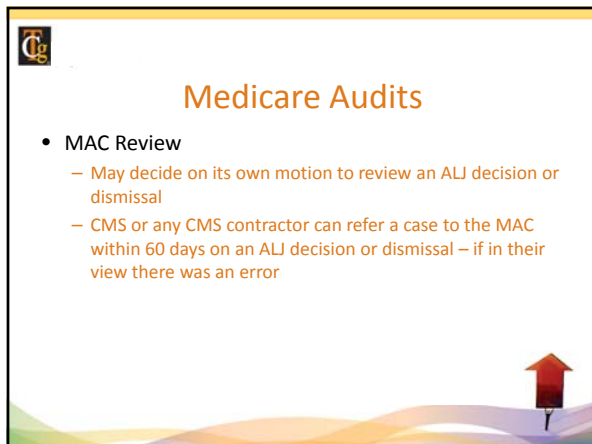
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Medicare Audits

- Final level of appeal – Medicare Appeals Council Review
 - Have 60 days to file
 - If the ALJ remands, provider cannot seek a MAC review
 - No hearing
 - De novo review

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Medicare Audits

- MAC Review
 - May decide on its own motion to review an ALJ decision or dismissal
 - CMS or any CMS contractor can refer a case to the MAC within 60 days on an ALJ decision or dismissal – if in their view there was an error

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Medicare Audits

- Strategies for appeals
 - Challenge the statistics
 - Physician letter/affidavit
 - Expert involvement
 - Review credentials

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Medicare - Audits

- Appeal experiences
 - QIO issues
 - QIO overturns decision to discharge, but RHHI/MAC deny
 - Go through appeals process


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Stark III and Home Care


- Stark III
 - Physician self-referrals
 - Phase III implemented December 2007
 - Items and services (but not cash) may be provided to a physician up to \$300/year (calendar)
 - Cannot be contingent on volume of referrals


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False Claims



- Area of scrutiny for CMS
 - Miami area insulin billing
 - Operation Wheeler Dealer
 - Upcoding
 - Must be blatant
 - Benchmark with region






False Claims


- Qui Tam
 - ‘On behalf of the king’
 - Allows a private citizen to file suit on the behalf of the U.S. government alleging fraud by government contractors, or those that receive governmental monies
 - ‘Whistle-blower’ could receive up to 30% of recovered dollars






False Claims



- Examples
 - Billing for services never delivered
 - Routinely waiving co-payments
 - Billing more than once for a service





Pulling It Together

- Education
 - Staff
 - Avoid using 'upcoding' terminology
 - If staff see client receiving supplies from multiple suppliers, report to supervisor
 - Billing staff
 - Oversight of billing processes






Pulling It Together

- Roles
 - Have a team ready to deal with CERT/RAC requests
 - Communicate with billing
 - Checklists/audits





QUESTIONS

