The ABC's of Compliance: Accountability, Best Practices and Consistency

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Date: July 28, 2022

1

Objectives

- State the top areas of focus by government contractors and auditors for home health and hospice providers in 2022.
- Identify effective communication approaches in working with government oversight personnel.
- Learn strategies to implement accountability measures, best practices, and consistency in compliance.

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Buckets of Compliance

Three buckets of compliance with "spill-over" effect.

- HIPAA:
  - Enforcement by Department of Health and Human Service's (HHS) Office of Civil Rights (OCR).
- Conditions of Participation (CoPs):
  - Enforcement by HHS Centers for Medicare and Medicaid Services (CMS) and State survey agencies under contract with CMS or Accreditation organizations.
- Billing and Payment:
  - CMS Hospice Provider Manuals; Enforcement by MACs, HHS Office of Inspector General (OIG), Department of Justice (DOJ) & State Medicaid Fraud Units.

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Bucket 1: HIPAA

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA): Legislation that provides data privacy and security provisions for safeguarding patient information. (Five Titles):
  1) NPI
  2) Transactions and Code Sets Standards (EDI)
  3) HIPAA Privacy;
  4) HIPAA Security
  5) HIPAA Enforcements
- Healthcare providers must understand and be familiar with:
  - Title II: HIPAA Administrative Simplification. It requires providers to implement secure electronic access to health data and to be in compliance with privacy regulations set forth by HHS.

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Bucket 1: HIPAA

- Recent Updates:
  - 2013 HIPAA Omnibus Rule modified HIPAA - HITECH - guidelines for Business Associates.
  - Additional Updates 2013-2021; Ongoing Updates and Reports of Breaches/Settlements:
    - **https://www.hhs.gov/hipaa/newsroom**
- Increase in Breaches and Penalties:
  - A report published in HIPAA Journal for calendar year 2021 indicates 714 breaches of 500 or more records reported to OCR, compared to 642 in 2020.
  - Increase in cybersecurity breaches
  - https://www.hipaaguide.net/hipaa-updates

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HIPPA Compliance Officer

- All providers must appoint a HIPAA Compliance Officer
  - May have a Privacy Officer and a Security Officer
- Implement Privacy & Security Policies/Procedures
- Monitor compliance
- Investigate, resolve and report breaches
- Ensure Patient Rights
- Ensure Administrative, Physical and Technical Safeguards

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Bucket 2: Conditions of Participation (CoPs)

- These regulations set-forth the requirements that providers must meet to be Medicare certified in order to receive Medicare or Medicaid payments.
- The focus is on patient care and coordination and management of that care, quality of services (QAPI), patient rights, and infection control--- to name a few. The CoPs are patient-centered and address the health and safety of the patient.
- The focus of state survey agencies or accreditation organizations is patient focused ---NOT payment centered.

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Bucket 2: Conditions of Participation (CoPs)

- Home Health CoPs:
  - Medicare SOM Appendix B: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf**
- Hospice CoPs:
  - Medicare SOM Appendix M: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf**
- Regulations versus Interpretive Guidelines
- Must be aware of updates (i.e., COVID-19 1135 Waivers and survey focus on IC, COVID, EP) NEW: QSO-21-15-ALL Memo (March 26, 2021) Appendix Z Updates: §418.113, Condition of Participation for Hospice Agencies.
- NEW Hospice Survey Changes and Enforcement Remedies

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guidelines

8

Hospice Survey Changes and Enforcement Remedies

Consolidated Appropriations Act, 2021 (Enacted 12/27/2020.)

- New hospice survey requirements
- New hospice enforcement procedures
- Regulations effective dates 2021 or 2022, depends on the item
- Published in the CMS CY 2022 Home Health Final Rule (November 2021)

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Timeline for Hospice Program Integrity Provisions

Provision	Implementation Date
Aggregate cap calculation based on rate update	Through FY 2030
Hospice Program Integrity Provisions	
• Surveys every 3 years • Accrediting organizations must report survey findings (CMS 2567 form) • Surveyor conflict of interest • Develop additional sanctions/remedies • Develop Special Focus Program • Increase penalties for not participating in Hospice Quality Reporting Program from 2-4%	• "Every 36 months" becomes permanent • Beginning **October 1, 2021** • Beginning **October 1, 2021** • No later than **October 1, 2022** • No later than **October 1, 2022** • Data collection beginning **January 1, 2022** • Payment update reduction – **FY 2024**
• GAO Report on impact of remedies on hospice	• No later than **December 27, 2023**

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What Does All this Mean for My Hospice?

- If your hospice has not had regular surveys, the hospice will have a survey at least every 36 months.
- Surveyors will be trained, educated and tested – they may potentially pick up on more condition-level deficiencies.
- Surveys will be posted for the public to review
- Condition-level as well as frequent deficiencies will lead to enforcement actions/sanctions.

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Enforcement Remedies

- Temporary Management
- Payment Suspension
- Civil Monetary Penalties (CMP)
- Directed Plan of Correction
- Directed Inservice Training
- Termination
- Continuation of Payments

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12

Payment Suspension

- Suspend payment for new admissions
- Payment suspension period not to exceed 6 months and would end when the hospice program had achieved substantial compliance or was terminated.

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CMP – Civil Monetary Penalties

- Noncompliance with one or more conditions of participation regardless of whether the hospice program's deficiencies pose an immediate jeopardy (IJ) to patient health and safety.
- Impose per day or per instance
- Could impose CMPs for each day of IJ
- May impose for the number of days of noncompliance since the last standard survey, including the number of days of IJ.

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CMP – Civil Monetary Penalties (cont'd)

- **Not to exceed $10,000 per day**
  - Upper, middle and lower range
  - Adjusted annually
- **Considerations for penalty amount**
  - Size of the hospice program and its resources
  - Evidence of a self-regulating QAPI system that indicates ability to meet the conditions of participation and to ensure patient health and safety.
  - Administrative Hearing Process

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CMP Ranges

Range	Description of Deficiency	Civil Monetary Penalty
Upper range	For deficiency that poses IJ to patient health and safety.	$8,500 to $10,000 per day of condition level non-compliance.
Middle range	For repeat and/or a condition-level deficiency that di not pose IJ but is directly related to poor quality patient care outcomes.	$1,500 to $8,500 per day of noncompliance with the CoPs.
Lower range	For repeated and/or condition-level deficiencies that did not constitute IJ and were deficiencies in structures or processes that did not directly relate to poor quality patient care.	$500 to $4,000 per day of noncompliance.

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16

Top 10 Survey Deficiencies: Hospice CY 2021 - 2022 YTD

CoP/Standard	L-Tag	Tag Description
418.56(b)	L0543	Standard: Plan of care
418.60(a)	L0579	Standard: Infection Control - Prevention
418.54(c)(6)	L0530	Standard: Comprehensive Assessment – Drug Profile
418.56(e)	L0545	Standard: Content of Plan of Care
418.56(e)(2)	L0555	Standard: Content of Plan of Care – Coordination of Services
418.56(c)(2)	L0547	Standard: Content of Plan of Care – Scope and Frequency of Services
§418.76(g	L0625	Standard: Hospice aide assignments and duties
§ 418.56(d)	L0552	Standard: Review of the plan of care
§ 418.54(b)	L0523	Standard: Timeframe for completion of the comprehensive assessment
§ 418.56(c)(4)	L0549	Standard: Drugs and treatment necessary to meet the needs of the patient

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Top 10 Survey Deficiencies: Home Health CY 2021 - 2022 YTD

CoP/Standard	G Tag	Tag Description
§484.60(a)(2)	G574	Standard: Content of Plan of Care
§484.55(c)(5)	G536	Standard: Content of the Comprehensive Assessment: Medications
§484.60	G572	Standard: Plan of Care
§484.70(a)	G682	Standard: Infection Prevention
§484.70(a)	G684	Standard: Infection Control
§484.110(a)(6)	G1022	Standard: Discharge and Transfer Summaries
§484.75(b)(3)	G710	Standard: Resp. of Skilled Professionals: Provide Services Ordered in the Plan of Care
§484.60(b)(1)	G580	Standard: Only As Ordered By Physician
484.60(b)	G578	Standard: Conformance with Physician Orders
§484.60(c)(1)	G590	Standard: Promptly Alert Relevant Physician of Changes

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Bucket 3: Compliance with Billing and Payment

- Hospice:
  - Medicare Benefit Policy Manual - Chapter 9: Coverage of Hospice Services Under Hospital Insurance.
  - Medicare Claims Processing Manual: Chapter 11, Processing Hospice Claims
- Home Health:
  - Medicare Benefit Policy Manual –Chapter 7- Home Health Services
  - Medicare Claims Processing Manual: Chapter 10- Home Health Agency Billing
- Medicare Program Integrity Manual:
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
- For current manuals: Check website:
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

There is spill over from CoPs to payment requirements

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Why are Home Health and Hospice Providers Targeted for Focused Audits?

- The home health and hospice benefits will continue to increase with increase of Medicare Beneficiaries.
- Monitoring spending outside of the Medicare Hospice Benefit
- Overpayments and Fraud and abusive practices are real
- Mandates under the Patient Protection and Affordable Care Act (ACA)
- Government Initiatives
- Government reports demonstrate patterns of potential or actual abusive practices
- Government data analytics help determine who will be the target of an audit
  - Data comparisons: state, regional, MAC jurisdiction, national
  - PEPPER Data; claims, quality, and beneficiary data

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Examples of Government Auditors/Audits - 2022

- OIG/DOJ: Work Plans, Audits and Reports (Published Results)
- SMRC: Supplemental Medical Review Contractors
- RAC: Recovery Audit Contractor
- CERT: Comprehensive Error Rate Testing (Federal oversight of the MACs).
- UPIC: Unified Integrity Program Contractors
- ADR: Additional Data Request
- TPE: Targeted Probe and Educate

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OIG/CMS Program Integrity Audits

- Random sample of 100 claims
- "Computer matching, data mining and data analysis techniques that identified [hospice] [home health] claims that were at risk for noncompliance with Medicare billing requirements."
- Extrapolation
- Draft report issued with opportunity to respond (30 days)
- Final reports are public – available at https://oig.hhs.gov/reports-and-publications/oas/cms.asp

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Recovery Audit Contractor - RAC

- For HH+H – Performant Recovery, Inc. – Region 5 nationwide
- Post-pay reviews to detect and correct past improper payments
- Key Areas of Focus:
  - HH (approved 1/10/18): Medical Necessity for all states except RCD states.
  - Hospice (approved 2/1/21): Continuous Home Care Level of Care-Medical Necessity.

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Unified Program Integrity Contractors (UPIC)

- Replaced the ZPICs and consolidated other integrity program activities.
  - To *"ensure compliance with Medicare regulations, refer suspected fraud and abuse to [our] law enforcement partners, and/or revocation of providers that are non-compliant with Medicare regulations and policies" and "is responsible for preventing, detecting and deterring fraud, waste and abuse in both the Medicare and Medicaid program."*

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Who are the UPICs?

5 Jurisdictions:

- Safeguard Services LLC
  - Northeastern
  - Southeastern
- Coventbridge Group
  - Midwestern
- Qlarent Integrity Solutions, LLC
  - Southwestern
  - Western

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Targeted Probe and Educate (TPE)

Medicare Administrative Contractors (MACs)

- Conducting Targeted Probe and Educate (TPE) audits again that were on hold during the pandemic - CMS announced resumption on August 12, 2021.
- MACs are looking to ensure that payments are made appropriately, and that no payments were made that should not have been.
- High claim error rate or unusual billing practices
- Items and services that have high national error rates and are a financial risk to Medicare.
- Acceptable error rate varies based on item or service under review – known as Payment Error Rate or "PER".
- PER: total Medicare dollars would have been paid versus dollars denied

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Targeted Probe and Educate (TPE)

- Once the MAC identifies the risk, claims review is initiated (i.e., high denial rates or unusual billing patterns)
  - Validate issue
  - Target and Probe of 20-40 claims
    - Initial request for records may be a smaller number of patients if agency has small census (but a total of 20-40 for round one is still applicable)
    - Benchmarks established
    - One-on-one provider education
    - Providers with high error rates will continue to second and possibly third rounds
    - Failure to improve after 3 rounds of education sessions will be referred to CMS .
      - May include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action.

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Areas of Focus by the Government: Home Health

Home Health:

- Face-to-Face Encounter
- Skilled Need/Medical Necessity (all disciplines, nurse, therapists).
- Long LOS
- Short LOS (LUPA and just over LUPA)
- Homebound Status
- Therapy Utilization: PT, OT, Speech, Duplication of Services
- Technical: signatures/dates on 485
- ICD-10 Coding and OASIS coding/documentation
- Care Plan Implementation and Updates
- PDGM Comorbidities and Admission Source
- COVID-19 Telehealth
- Referral Relationships/Incentive Programs
- PEPPER reports

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Home Health Denial Reasons

- Medical Necessity/Skilled Need (all disciplines, nurse, therapists).
- Homebound Status
- Therapy Services
- Technical Signatures/Dates on 485/POC
- Face-to-Face Encounter

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Areas of Focus by the Government: Hospice

Hospice:

- Eligibility/Medical Necessity to Support 6 Mo. Prognosis
- Levels of Care:
  - Routine, Respite, General Inpatient (GIP), Continuous Home Care (CHC)
- Long Lengths of Stay (over 180 days)
- Patients in SNF & ALF
- Technical Requirements: (Election Statement: Waiver Language and Patient Choice of Attending; CTI, Face-to-Face, NEW NOE Addendum).
- Medications paid by Medicare Part D (related to hospice diagnoses/prognosis)
- Inappropriate Referrals
- Paying Hospice Medical Director more than Fair Market Value
- Incentive Programs
- Relationships with Nursing Facilities
- PEPPER Reports

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Hospice Denial Reasons

- Certification not signed timely by the physician
- The physician narrative was not present or was not valid
- Missing face-to-face encounter
- Eligibility: The information provided does not support a terminal prognosis of six months or less in accordance with the Medicare hospice requirements.
- Level of care not supported by documentation
- The notice of election is invalid/not present
- Initial certification not signed by the physician
- No certification present in the documentation submitted for the dates billed.
- Missing documentation to support the level of service billed

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2022 OIG Work Plan: Home Health

- Home Health Agencies' Emergency Communication Plans: Strengths and Challenges.
- COVID-19 Telehealth
- Partial Completion:
  - Infection Control at HHAs during the COVID-19 Pandemic
  - Health and Safety Standards in Social Services for Adults
  - Medicaid Home Health Services for Beneficiaries with Chronic Conditions.
  - Several Nursing Home Work Plan items have relevance to HHAs.

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2022 OIG Work Plan: Hospice

- Nationwide Review of Hospice Beneficiary Eligibility
- HH and Hospice: Medicare Hospital Payments for Claims Involving Acute and PAC Transfer Policies.
- Joint Work with State Agencies
- Review of Hospice Inpatient and Aggregate Cap Calculations
- Medicare Payments Made Outside of the Hospice Benefit
- Hospice Home Care: Frequency of Nurse On-Site Visits to Assess Quality of care and Services.
- OIG COVID-19 Fraud Alert March 2021
- Completed:
  - Review of Hospices: Compliance with Medicare Requirements

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I Received an Audit Request… What Do I Do?

- Identify the contractor and type of audit (MAC, UPIC, SMRC, OIG…).
- Do not panic…
- Do not ignore the letter or let the letter sit on your desk -----or any desk! These are time sensitive…
- Take immediate action:
  - Notify your compliance officer
  - Consider engaging legal counsel and outside consulting firm to assist …with record organization….other.
  - Organize records for ease of auditor review; submit timely
- Plan for Appeal

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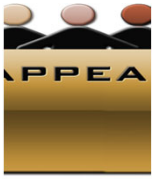
34

Provider Appeal Rights



1. Redeterminations Conducted by the MAC.
2. Reconsiderations (Qualified Independent Contractors—QICs) Second level of appeal filed to QIC.
3. Administrative Law Judge (ALJ)
4. Medicare Appeals Council (DHHS).
5. Judicial Review ---U.S. District Court.

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Where to start with Payment/Corporate Compliance

- Establish a formal compliance program with the seven elements as set forth by the OIG guidelines:
  - Home Health 1998
  - Hospice 1999
- Include Update Guidance: U.S. Department of Justice Criminal Division Evaluation of Corporate Compliance Programs (Updated June 2020)
- Frequent the HHS OIG website to review any new Home Health and Hospice Corporate Integrity Agreements (CIA)—review and study these as a source of information for best practices.
- https://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp

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OIG Seven Elements of a Compliance Program

1. Policy/Procedure/Written Code
2. Compliance Officer/Committee
3. Training/Education
4. Communications/Anonymous
5. Auditing Monitoring ---Internal & External monitoring by experts (Attorney Client Privileges issues/ethics).
6. Disciplinary Measures
7. Disclosure /Timely Investigations and Reporting.

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Accountability

- Governing Board involvement and knowledge
- Executive Team involvement and knowledge: CEO, COO, CFO, CCO, CNO, CIO, Medical Director, other.
- Marketing Team
- Human Resources
- Clinical Management and staff clinicians/care providers
- Revenue Cycle and Billing personnel
- Other (Refer to OIG CIA Requirements)

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Accountability: Executives & Employee

- Create a dedicated Compliance Team
  - Appoint Compliance Officer/Manager who has requisite education
  - For multi-location providers, compliance demands mean having leaders at the corporate offices and agency level.
  - Ensure proper policies and procedures are in place
- Educate clinical staff on how their documentation forms the basis for billing and payment
  - Provide ongoing education and training in documentation on eligibility and technical billing requirements-- Consider peer review of clinical records.
  - Conduct a forms review
  - Clinical staff must understand the regulations and clinical documentation payment requirements.

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39

Best Practices & Managing Risk

- Conduct pre-bill audits and use data analytics to track billing patterns.
  - Review PEPPER reports and other current EMR reports that provide dashboard measures and patterns, percentages.
  - Self-monitoring reduces the likelihood of abusive or reckless habits and potential overpayments.
  - Consider external auditors for quarterly or annual audit & education
- Identify the billing and payment issues under scrutiny and develop an audit plan.
  - Develop quarterly and annual audit plans for oversight and to focus on identified problem areas.
  - Distinguish compliance audits and QAPI activities
- Frequent CMS/OIG/DOJ websites and use resources such as state and national provider associations and industry experts, including Counsel.

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Best Practices & Managing Risk

- Educate Governing Board & Executive Team
  - Private or Public: The government is looking to provider governing Boards for effective oversight of healthcare providers ---and to monitor company quality and compliance.
  - See "Practical Guidance for Health Care Governing Boards on Compliance Oversight" on OIG website.
  - See also: "A Toolkit for Health Care Board."
  - Go to: www.oig/hhs/gov for additional resources and guidance for compliance related issues.

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41

Best Practices & Managing Risk

- **Clinical/Documentation and QAPI & Compliance Committees**
  - Practical hands-on documentation (training and practice) consistent with regulations.
  - Education on payment requirements
  - Physicians, nurses/practitioners, therapists/chaplains, MSW
  - QAPI/Compliance: Pre-Bill auditing and monitoring for eligibility/technical documentation requirements.
  - **FORMS** Review for technical billing issues
- **Revenue Cycle and Billing**
  - Provider should have expert employee clinician who understands the regulations and payment requirements; this person should communicate to Electronic Medical Record vendor (EMR) vendor to ensures forms are correct.
  - EMR education/Billing education and implementation of pre-bill edits
  - Routine pre-bill reviews/audits of final claim ready to bill

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Best Practices & Managing Risk

- **Human Resources:**
  - On hire & monthly: OIG Exclusion checks
  - Code of Conduct/Standards of Ethics: introduce on hire and signed by employees, independent contractors; vendor education.
  - Annual employee attestation (and exit interview attestation) that employee is not aware of non-compliance with policy or violations of the law.
  - Set up expectation of exit interview on hire
  - Disciplinary Practices
  - Access to EMR and settings—determine who and implement oversight
- **Marketing & Referral Sources**
  - Training and education
    - Role playing; case studies; use agendas & sign-in sheets
  - Review any bonus plans for Employees
  - Ensure no bonus plans based on referrals for Independent Contractors

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43

Consistency and Oversight

- **Develop Annual Audit Plan and Compliance/HIPAA Program Effectiveness and Risk Assessment.**
  - Present to Governing Board
  - Ongoing auditing and monitoring of key billing and documentation risk areas
  - Identify overpayments and timely report/repay
  - Ensure implementation of reporting and follow up processes in accordance with organization policies and Compliance/HIPAA Program.
  - Providers should consider having annual check-up:
    - Pre-bill audits (a percentage of average daily census per Provider number)
    - Compliance and HIPAA program risk and effectiveness assessment (recommend performed by outside firm).
      - Utilize OIG and OCR Risk Assessment Resources
    - May consider post-claims billed and paid audits but conduct these under attorney client work product.

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44

Final Reminders

- Corporate Compliance and Survey Readiness Should be an Ongoing, Agency-Wide Effort:
  - Educating all levels of your staff about the federal and state home health and hospice regulations, including the federal Conditions of Participation (CoPs) and Conditions of Payment should be a part of your survey readiness and compliance plan, orientation for new staff, and continuing education for all staff.
  - Conduct mock surveys at least annually using CMS survey protocols:
    - Ensure ongoing review/observation to ensure staff knowledge and implementation of policies and procedures.
  - Train staff and managers regarding survey processes and their roles in survey readiness and regulatory compliance.
  - Ensure all staff and managers understand the agency's Corporate Compliance Plan and each individual's responsibilities.
  - **Staff/Management accountability**

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45

Compliance is everyone's job!

Compliance is a collaborative effort across your organization, departments, and provider locations.

Compliance requires consistency and continuous oversight of practices.

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46

"Readiness for opportunity makes for success. Opportunity often comes by accident; readiness never does."

- Sam Rayburn

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47

47

Questions?

48

48

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49

49