National Hospice and Palliative Care Organization

MAC, ZPIC, UPIC, MIC, RAC, CERT and Other Auditors

What Does it All Mean?

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Objectives

Upon completion of this webinar, participants will be able to:

- Describe the 3 most prevalent government health care program audits hospices are facing today.
- Explain the differences among MACs, RACs, ZPICs, and UPICs and be better prepared to respond to such reviews.
- Describe 3 action steps in response to audit scrutiny

Washington Post – Dec. 26, 2013

"Hospice firms draining billions from Medicare"

By Peter Whoriskey and Dan Keating,

- "But over the past decade, the number of "hospice survivors" in the United States has risen dramatically, in part because hospice companies earn more by recruiting patients who aren't actually dying, a Washington Post investigation has found. Healthier patients are more profitable because they require fewer visits and stay enrolled longer."

The Washington Post

Hospice on the Enforcement Radar Screen

WHY?

- Optics – emergence of "for profit" hospice
- Data mining – searching for aberrant patterns
- Law enforcement (DOJ, OIG, AGs, MFCU) now have experience with hospice investigations
- Whistleblowers – False Claims Act
- Budget pressures and growth of hospice expenditures
- ZPICs and Recovery Audit contractors
- Part A MAC reviews and OIG spotlight/audits

Hospice Industry Overview*

According to MedPac March 2013 Report to Congress

- Medicare hospice payments = $13.8 billion in 2011 (over 4x the 2000 amount)
- 1.2 million Medicare patients per year
- 3,585 hospices
- Supply of hospices in U.S. grew 59% between 2000 and 2011, with for-profits accounting for almost all such growth
- ALOS grew from 54 days to 86 days between ’00 and ’11

Hospice Audit Focus Areas

- "Knowingly" admitting clinically ineligible patients/failure to discharge (LLOS)
- Poor documentation (e.g., woefully deficient CTIs or physician narratives)
- Bad forms – physician certification language subpar or in wrong place. F2F forms incorrect or incomplete
- Medically unnecessary level of service (*e.g.*, continuous care or GIP when only RHC appropriate)

Who's Looking at Hospices?

MAC

RA

ZPIC

OIG

CERT

MFCU

DOJ

MIC

PERM

UPIC

Etc.

CMS- Center for Program Integrity

Divisions within Center for Program Integrity:

- Medicare Program Integrity Group
- Medicaid Program Integrity Group
- Provider Enrollment Operations Group
- Data Analytics and Control Group
- Program Integrity Enforcement Group
- Data Sharing and Partnership Group
- Functional Statement
  - Serves as CMS' focal point for all national and State-wide Medicare and Medicaid programs and CHIP integrity fraud and abuse issues.

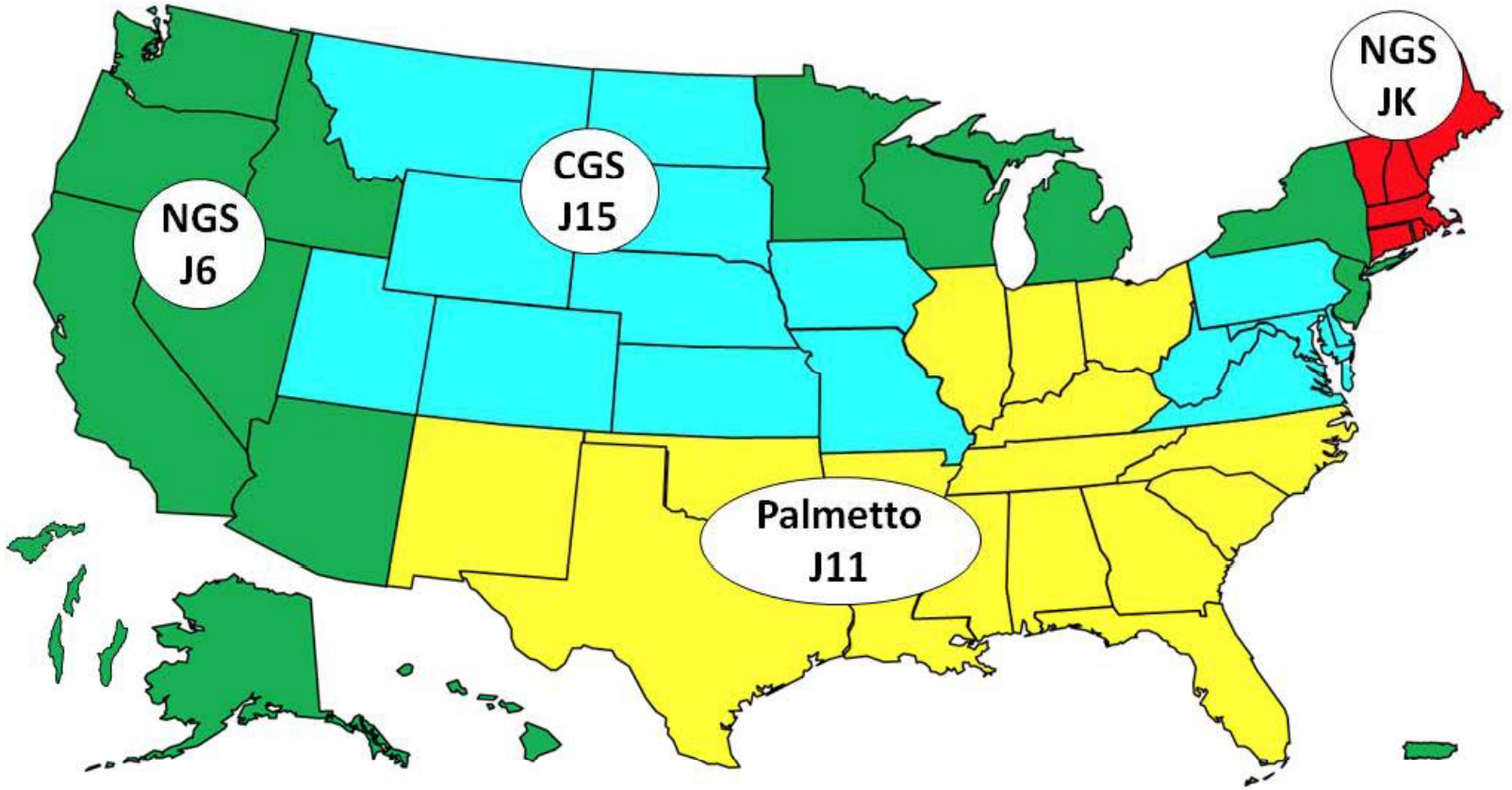
MAC

- Definition: Medicare Administrative Contractor
- Scope of Work: Enroll healthcare providers in Medicare, provide billing-related education, process Medicare claims and disburse >$365 billion annually, and audit claims for medical necessity
- Handle ADRs and first level appeals

Home Health and Hospice (HH+H) Jurisdictions

(Administered by A/B MACs)

as of October 2013



MAC Sample Edits (CGS)

Edit #	Reason
5037T	Routine home care > 730 days
5118T	LOS between 150-365; non-cancer dx
5057T	GIP for 7 or more days
5091T	Non-cancer, nursing facility-based patients, > 180 days
59BX9	Beneficiary with prior denial

Typical MAC Denials

Administrative:

- Certification/recertification is untimely or not signed
- Notice of Election is missing or incomplete
- Plan of Care is missing or incomplete
- Face-to-Face Encounter (F2FE) missing

Typical MAC Denials, cont'd.

Medical:

- Care is determined to not be reasonable and medically necessary
- Patient is not terminal / no longer terminal
- Level of care is not supported
- Physician's services not documented

MAC Challenges

- Administrative denials are difficult to overturn on appeal
- A high Charge Denial Rate (CDR) may result in Progressive Corrective Action (Targeted / Focused Medical Review), which results in serial ADRs
- MACs may refer hospice providers to law enforcement or ZPIC for additional investigation

ZPIC

- Definition: Zone Program Integrity Contractor
- Background: Established from Medicare Integrity Program (MIP), with HIPAA and MMA funds
- Scope of Work: 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

ZPIC, cont'd.

- Seven geographic zones (Safeguard Services, Cahaba, Health Integrity, AdvanceMed)
- Investigate potential fraud and abuse
- Conduct investigations (on-site, etc.) with "investigators"
- Perform medical review and data analysis
- Identify the need for administrative actions (*e.g.*, payment suspensions, prepayment or auto-denial edits, etc.)
- Refer cases to law enforcement for potential civil or criminal prosecution

ZPIC Challenges

- For-profit contractors (themselves under OIG scrutiny for not referring more to law enforcement)
- Selection of clinical records from a Relevant Time Frame (RTF)
- Use of sophisticated data mining tools and data analysis techniques during the investigation
- Compare findings to other hospices
- Conducting more pre-pay reviews

ZPIC Challenges, cont'd

- All denials associated with the sample are then factored into a Charge Denial Rate (CDR)
- Denials often focus on technical and clinical eligibility (*e.g.*, certs/recerts, chronic vs. terminal)
- Extrapolation Effect – big $$

Extrapolation Effect

- The CDR (% of ALL denials in sample) may be applied to all claims submitted for ALL patients during the RTF without further clinical record review.
- Example: 75% of sampled records were denied; therefore the 75% denial rate is applied to all claims in the RTF.

Consequences of ZPIC Audit

- Pre- and post-payment reviews
- **Suspension of payment**
- Denial of payment
- Revocation of Medicare Provider Number
- 15 day "Rebuttal" Period
- Referral to MAC for recoupment of "overpayments"
  - Appeal rights then kick in

Consequences of ZPIC Audit, cont'd

- Referral to HHS-OIG or DOJ if potential fraud
  - Criminal prosecution
  - Civil prosecution
  - Civil monetary penalty
  - Administrative sanctions

ZPIC Challenges

- ✓Unannounced requests
- ✓Clinical documentation demands and timeline
- ✓Rigorous data analysis
- ✓Delayed response following production of documents (although ZPICs getting faster)
- ✓Potential for conflicting interpretation of Medicare coverage guidelines

ZPIC Preparedness Strategy

Document

- Medical necessity/eligibility
- Conditions of participation
- Technical billing compliance
- Organized files
- Compliance plan
- Self-audits of risk areas and vulnerabilities

Defend

- Appoint your “A team”
- Prepare well-crafted, timely response
- Produce documentary evidence, supplemented by attestations/affidavits
- Involve legal counsel early
- Challenge use of extrapolation
- Appeal

Appeals

Level	Submission Timeline	Decision Timeline	Comments
1. Redetermination	**120 Days**	**60 Days**	MAC determination; paper review only
2. Reconsideration	**180 Days**	**60 Days**	QIC determination; paper review only
3. Administrative Law Judge	**60 Days**	**90 Days**	ALJ determination; tele- or video-conference; $120 or more must be in dispute
4. Medicare Appeals Council	**60 Days**	**90 Days**	Appeals usually related to ALJ errors (e.g., “patient not homebound”)
5. Federal District Court	**60 Days**	**90 Days**	$1,180 or more must be in dispute

MIC

- Definition: Medicaid Integrity Contractor
- Scope of Work: To ensure that Medicaid claims paid were:
  - For services provided and properly documented
  - Billed properly with appropriate codes
  - For covered services
  - Paid according to Federal and State laws, regulations, and policies.

3 Types of MICs

Review MIC:

- Analyze Medicaid claims data to identify high risk areas and potential vulnerabilities
- Provide leads to the Audit MICs
- Use data-driven approach to ensure focus on providers with truly aberrant billing practices

3 Types of MICs, cont'd

Audit MIC:

- Conduct post-payment audits (field and desk audits)
- Fee-for-service, cost report and managed care audits
- Audits will identify overpayments and States will collect overpayments and adjudicate provider appeals

3 Types of MICs, cont'd

Education MIC:

- Use findings from Review & Audit MICs to identify areas for education
- Work closely with Medicaid partners and stakeholders to provide education and training
- Develop training materials, awareness campaigns and conduct provider training

Review & Audit MICs

CMS Regions	Review MIC	Audit MIC
I & II	Thomson Reuters	IPRO
III & IV	Thomson Reuters	Health Integrity
V & VII	AdvanceMed	Health Integrity
VI & VIII	AdvanceMed	Health Management Systems (HMS)
IX & X	AdvanceMed	HMS

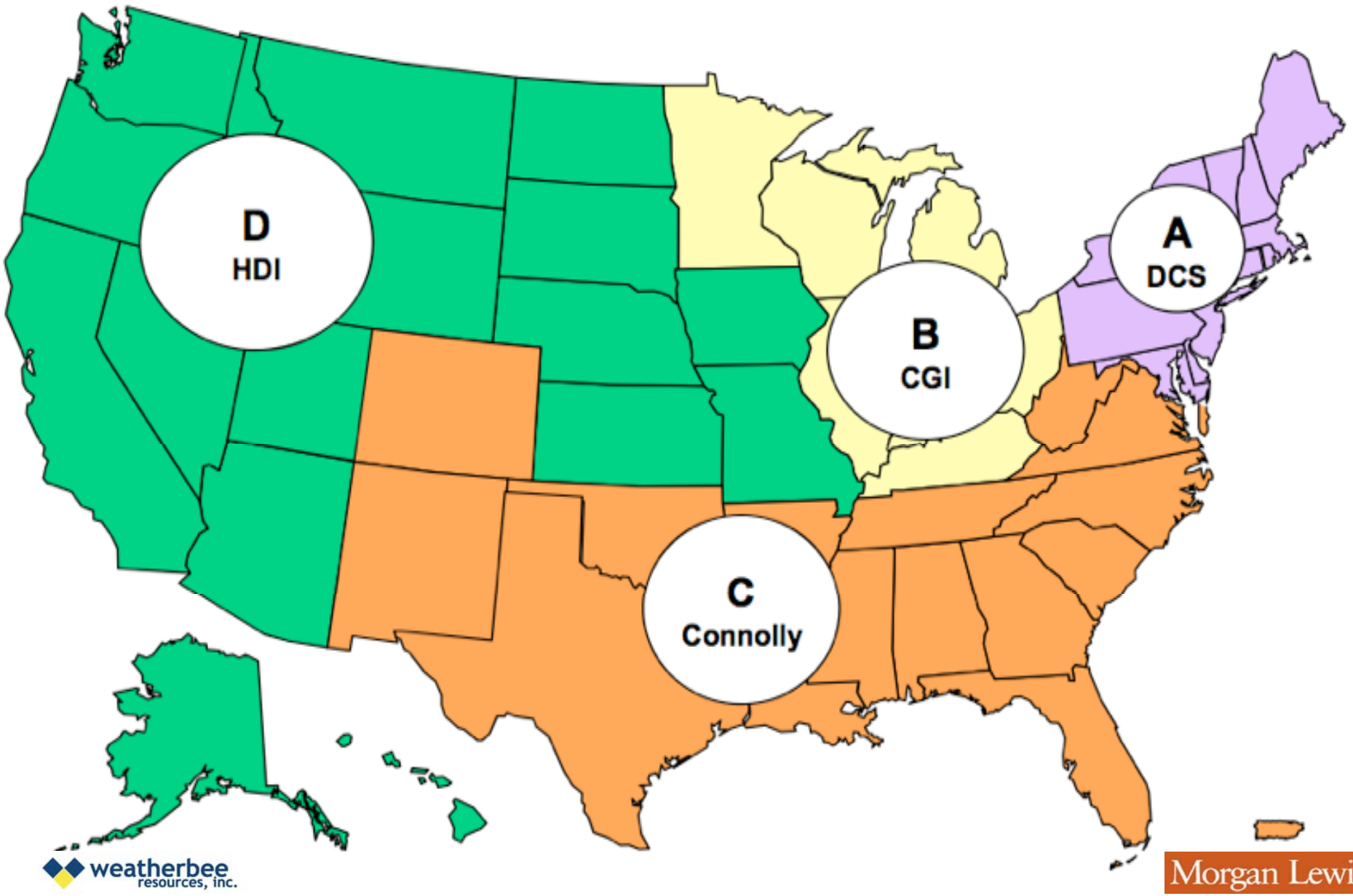
MIC Challenges

- Audit is influenced by state law (*e.g*. record retention, look back period, authority to extrapolate, appeal procedures)
- Provider outreach is not mandatory
- Review period is not set
- Time to produce records is shorter
- No limit to the number of records for review

RA (formerly RAC)

- Definition: Recovery Auditors (f/k/a Recovery Audit Contractors)
- Scope of Work: To detect and correct past improper payments so that CMS can implement actions that will prevent future improper payments.
- Paid based upon a % of recoveries

RAC REGIONS



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Recovery Auditor Review Process:

3 Types of Review:

Automated – no medical record needed

Semi-Automated – claims review using data with potential human review of documentation

Complex – clinical review required

RA Challenges

- Conduct post-payment reviews
- Most hospice approved audits are automated (*e.g.*, related to DME or pharmacy) and hospice providers have no idea they are occurring
- If a trend is identified, the RA can ask for approval of a complex review of clinical records.

UPIC

- Definition: Unified Program Integrity Contractor
- Scope of Work: Proposed unified contractor that will focus on both Medicare **and** Medicaid integrity issues. Designed to share information and best practices to improve detection and prevent payment of fraudulent claims across a number of public and private payers.
- CMS consolidation and contracting likely not to occur until at least 2015

UPIC, cont'd

Effects of UPIC implementation:

- ZPIC and the MAC program integrity units would be folded into the UPICs
- MICs will be phased out
- RAs and Medicaid RACs still in place
- Proposed consolidation of all Medicare/Medicaid data into one unified database

CERT

- Definition: Comprehensive Error Rate Testing
- Scope of Work: To evaluate the MACs effectiveness by measuring errors made by carriers
- Usually 1-2 claims per hospice tested

BISC

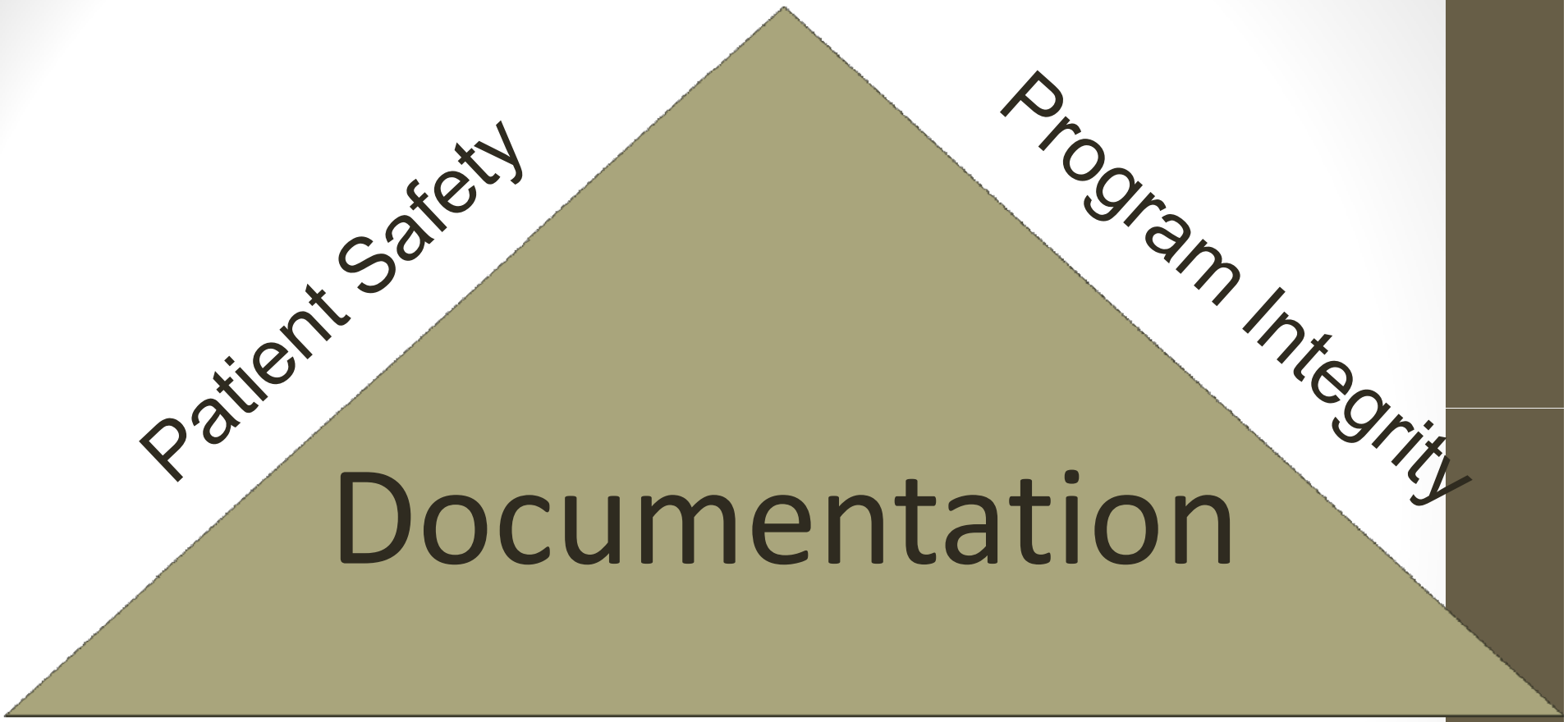
- Definition: Benefit Integrity Support Center
- Scope of Work: Develop quality fraud cases for referral to the OIG and other law enforcement
- Some regional activity inquiries related to
  - Financial relationships with other entities
  - Contracts with internal staff members

Other Auditors

- PERM (Payment Error Rate Measurement) – Measures improper payments in **Medicaid** and produces error rates for each program.
- Medicaid RACs (MRACs)
- Supplemental Medical Review Contractor ("SMRC") awarded to StrategicHealthSolutions, LLC.
- NSVC – National Site Visit Contractor (MSM Security Services and subcontractors).

Audit Impact on Providers

- Toll on human resources to deal with the audit complexities.
- Survival rather than growth mode
- Damage to staff morale
- Loss of referral sources if word spreads of "investigation"
- Live discharges/refunds/loss of staff



The Importance of IDG Documentation

Act Now

- Educate/audit on adequate documentation/care plans
- Appoint your government audit “SWAT” Team
  - Quick assessment of request
  - Marshall best resources to respond
  - Consider independent review of clinical records
- Conduct “hospice appropriateness” reviews with appropriate live discharges

Act Now, cont'd

- Ensure technical compliance on certifications of terminal illness (CTIs)
- Document eligibility determinations
- Disable EMR "cloning" and "drop down" features
- Ensure coverage for continuous care and GIP
- Cover drugs/supplies/care "related to terminal prognosis"
- Ensure robust compliance and medical review department

Act Now, cont'd

- Ensure nursing home, ALF and group home (and other referral source) financial arrangements and marketing plans are reviewed by qualified legal counsel
- Ensure CTI process comports to requirements
  - signed/dated CTIs
  - Brief narrative
  - F2FE compliance

Audit Response Checklist

- ✓Lead Audit Response Team notified/ spring into action
- ✓Identify type of contractor and purpose of audit
- ✓Ask contractor what led to review
- ✓Depending on type of contractor, consider engaging legal counsel and outside consultant to assist with response and concurrent review
  - Assessment and use of Attorney-Client Privilege
- ✓Determine if extra response time needed and if so, ask for extension

Audit Response Checklist, cont'd

- ✓Organize files and consider "hospice care summary" for each cert period
- ✓Look outside certification period documents for eligibility determinations if necessary
- ✓Keep exact duplicate copy of what is produced to audit contractor
- ✓Train/educate/CAP
- ✓Consider report/refund for identified overpayments (60 days)

Questions?

Thank You!

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