

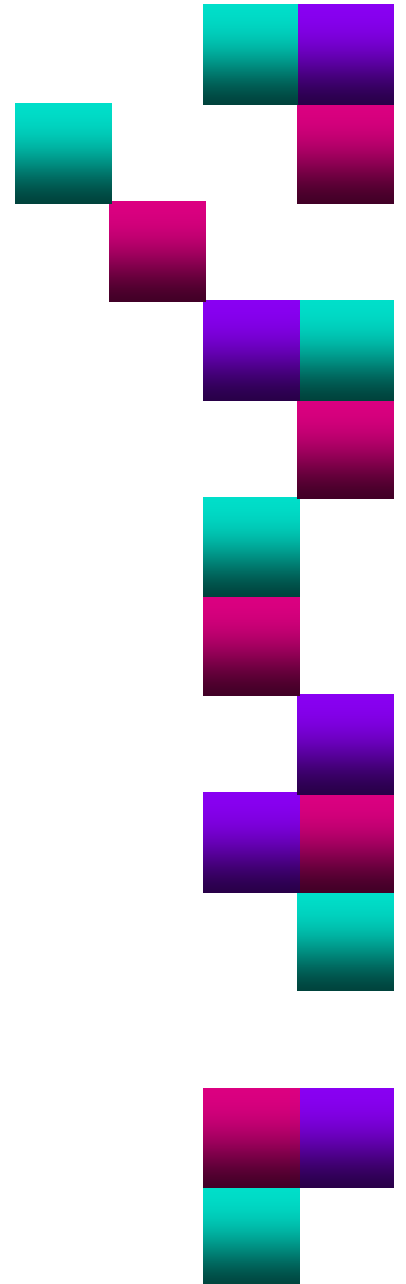
# Compliance: Clinical, Operational, Administrative & Financial Concerns

Presented by

Lynda Laff

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June , 2000



# Categories of Focus

## t Financial

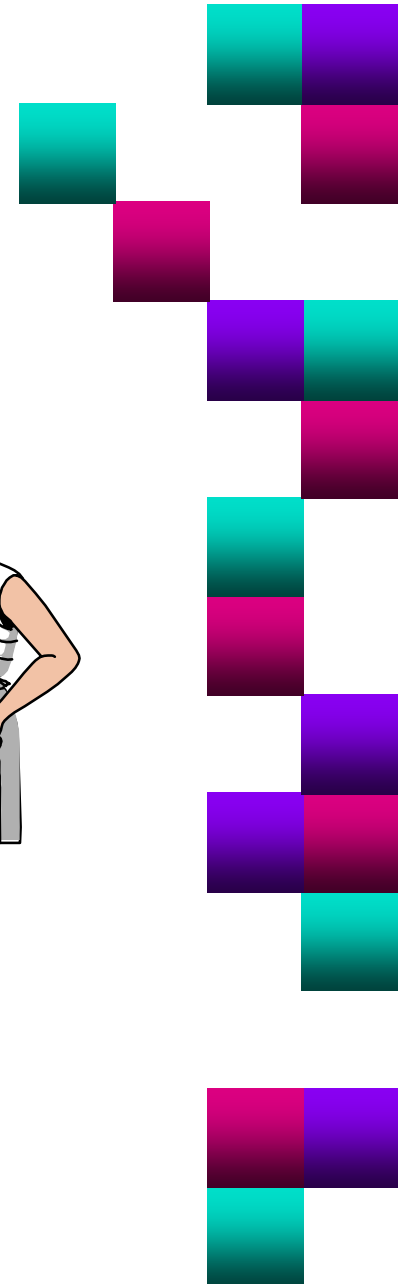
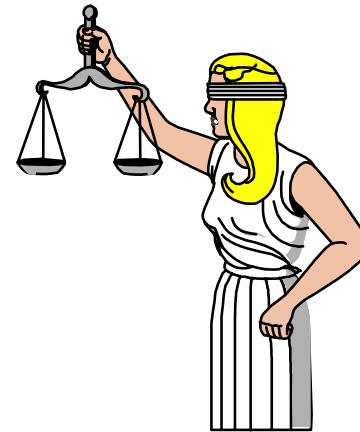
- r Billing and Processing Claims
- r Cost Reporting
- r Allocation of Costs

## t Clinical

- r Physician Orders
- r Professional Standards of Practice

## t Human Resources

- r Personnel Management
- r Wage and Labor Issues



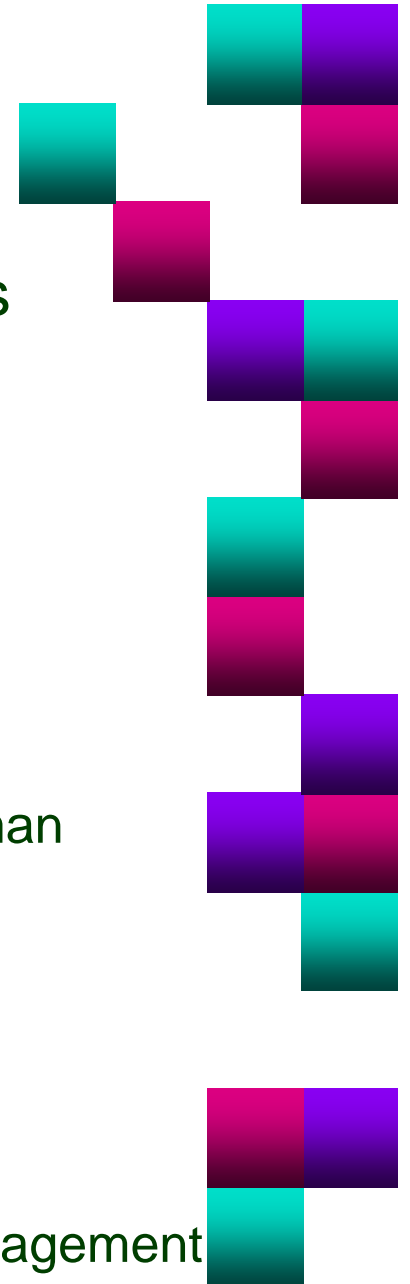
# Law and Regulation

## q State Regulations

- t DPH; licensing issues for nursing, respiratory therapy, pharmacy, aides, rehab services
- t Dept. of labor; hours, wages, workers' compensation
- t EPA; disposal of hazardous wastes
- t Dot /DMV; transportation issues, licenses

## q Federal Regulations/Regulators

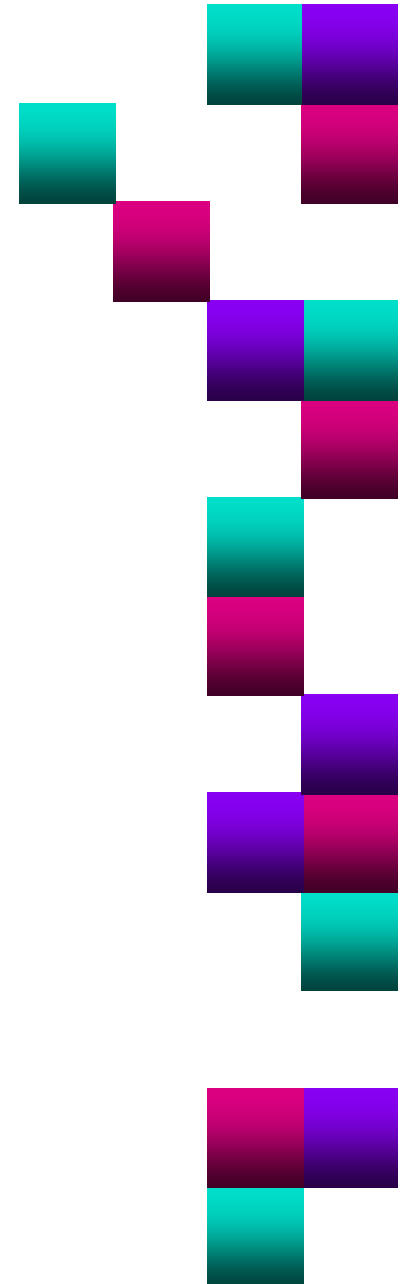
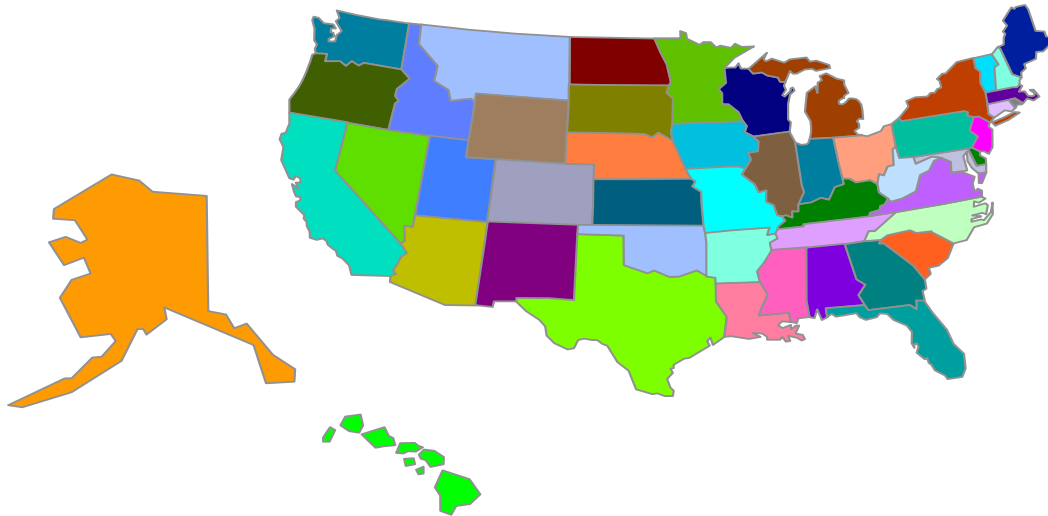
- t HCFA / CoPs
- t ADA
- t FDA
- t Dept.... of Insurance
- t OSHA
- t DEA
- t Dept.... of Health & Human Services
  - r OIG
- t Dept.... of Justice
  - r OIG
- t Dept.... of Labor
- t Office of Personnel Management



# Stagger's Lawsuit 1988

## q Expanded Coverage Criteria

- t Management and Evaluation of Care Plan
- t Skilled Observation and Monitoring

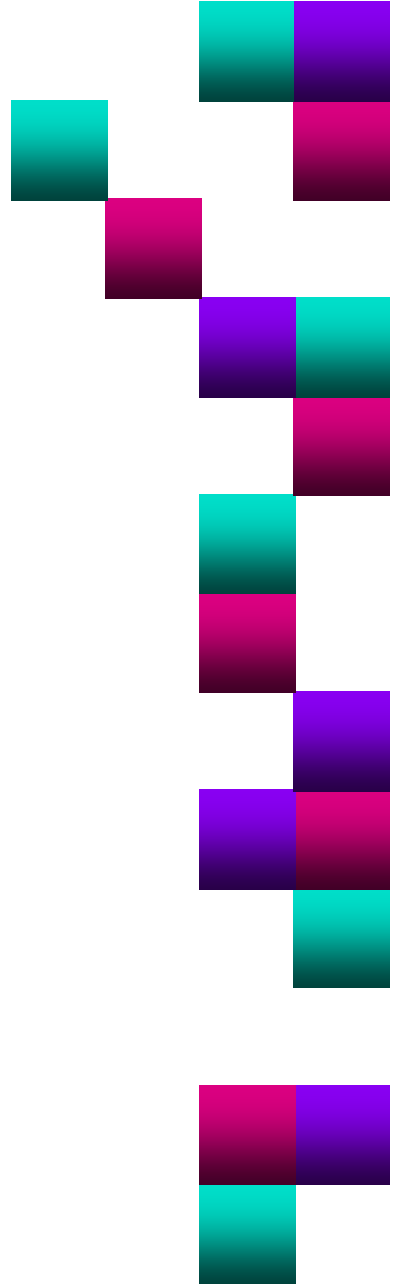


# Operation Restore Trust

- q Special Team of Surveyors
  - t frequently a combination of state and HCFA surveyors
- q Compliance with the Medicare Conditions of Participation
- q More Restrictive Interpretations of CoPs
- q Intense Scrutiny for Actual or Potential Fraudulent Practice



# Seventeen States and Counting

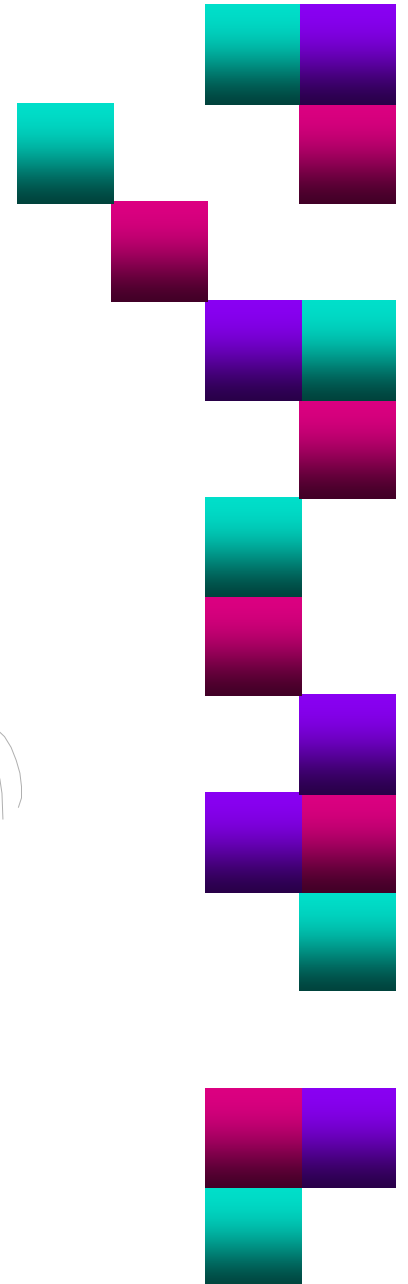


- q Florida
- q New York
- q Texas
- q California
- q Illinois
- q Arizona
- q Colorado
- q Georgia
- q Louisiana

- q Massachusetts
- q Missouri
- q New Jersey
- q Ohio
- q Pennsylvania
- q Tennessee
- q Virginia
- q Washington

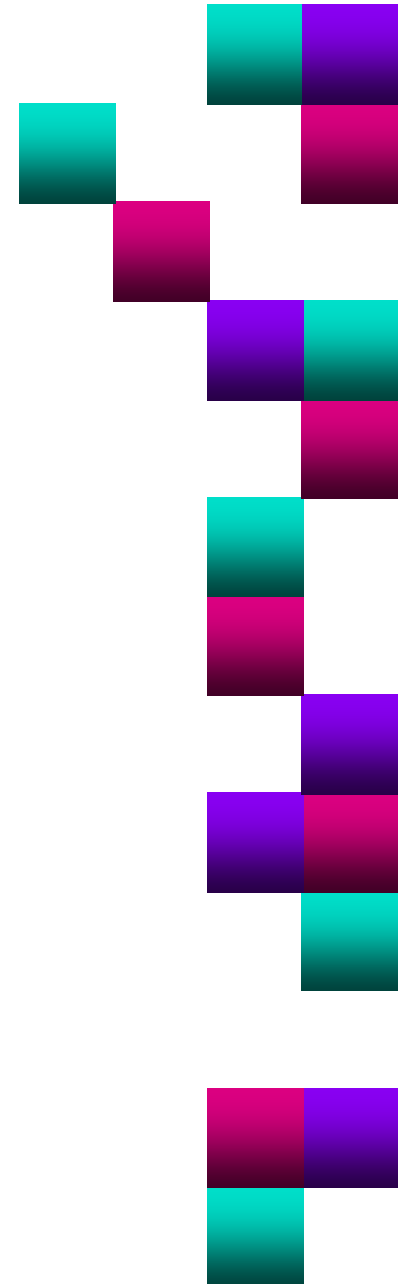
# Are You Susceptible?

- q High Visit Utilization
- q Rapid Growth
- q Multiple Acquisitions
- q Overpayments
- q Disallowed Costs
- q Problem Surveys



# Most Problematic Conditions

- q 484.12 Compliance with Law & Regulation
- q 484.14 Organization, Services and Administration
  - t coordination of care
- q 484.18 Acceptance of Patients, Plan of Care
- q 484.30 Skilled Nursing Services





# California Experience

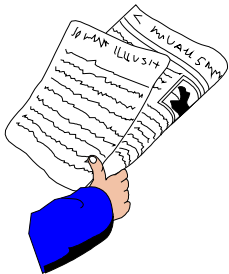
- q “The higher the per patient reimbursement, the more likely the agency did not comply with the conditions of participation”....Donna Dymon, Ph,D, surveyor with HCFA for Region IX
- q 36 of 44 of the California agencies receiving ORT surveys had at least one Condition - Level Deficiency
- q 18 of the agencies were terminated by the end of the project



# HCFA Highlights

## q Administrative

- t verification of lab certification
- t written appointment of Administrator
- t written capital budget
- t annual evaluation
- t contract issues



## q Financial

- t billing procedures/signed orders
- t overpayments
- t surety bonds

## q Clinical

- t coordination of care
- t conformance with orders/care plan
- t HHA training, competency assessment and ongoing inservicing
- t supervision



# 484.12 Compliance with Federal, State, Local Laws

- q “Surveyor requested a list of current patients from which to draw a patient sample. The agency produced a list that included their hospice patients as well as home health patients. The agency lists only ONE telephone number for both the Hospice and HHA. The agency co-mingled both Hospice and Home Health clinical records. The Home Health policy manual contained both Hospice and Home Health policies. A list of the agency’s employees was requested to select personnel records for review. All staff from both Hospice and Home Health were listed although the title indicated that the personnel were only from the HHA.”

t *The agency failed to distinguish itself from the Medicare Certified Hospice.*



# 484.14 Organization, Services, & Administration

- q “Review of contracts and interviews with the agency administrator indicated that the agency failed to monitor and control services not furnished directly by agency staff.”
- q “The agency failed to ensure that the clinical lab was certified in appropriate specialties and subspecialties of service.”
  - t “Record of patient X contained an order for a PT, PTT and CBC every other Monday. The clinical record was void of any laboratory result, reference to lab values or that the agency’s skilled nurse drew the specimen.”
  - t Also cited at the following Conditions
    - r 484.18 Acceptance of Patients, POC, Medical Supervision
    - r 484.30 Duties of the Registered Nurse



# 484.14 Coordination of Patient Services

- q “...documentation by RN and LPN regarding patient acting irrationally with paranoia, patient C/O voices in his head, patient depressed....”
- q “A skilled nurse who assessed the patient documented “does not appear to be at harm to self or other”...was not a psychiatric nurse. No evidence that the Social Worker or MD were notified of the patient’s behavior.”
- q “...documentation by the social worker indicated (with checks in boxes) that the patient was alert, oriented x 3, affect labile, mood irritable, appears appropriated. Substance abuse and alcohol abuse was checked affirmatively. Suicide risk was checked negatively. Social Worker documented “Hx of depression”. No further visits were planned by the Social Worker.”



# 484.14 Coordination of Patient Services

q “Review of the record of a patient visited by an LPN indicated that the patient’s blood pressure was documented as 94/50 and the pulse was 54. These readings were lower than the patient’s previously documented vital signs. The patient was on Lanoxin. The nurse documented that the patient was not receptive to teaching that day. There was no evidence that the LPN communicated a change of condition to his/her case manager or to the MD. The patient expired later that day.”

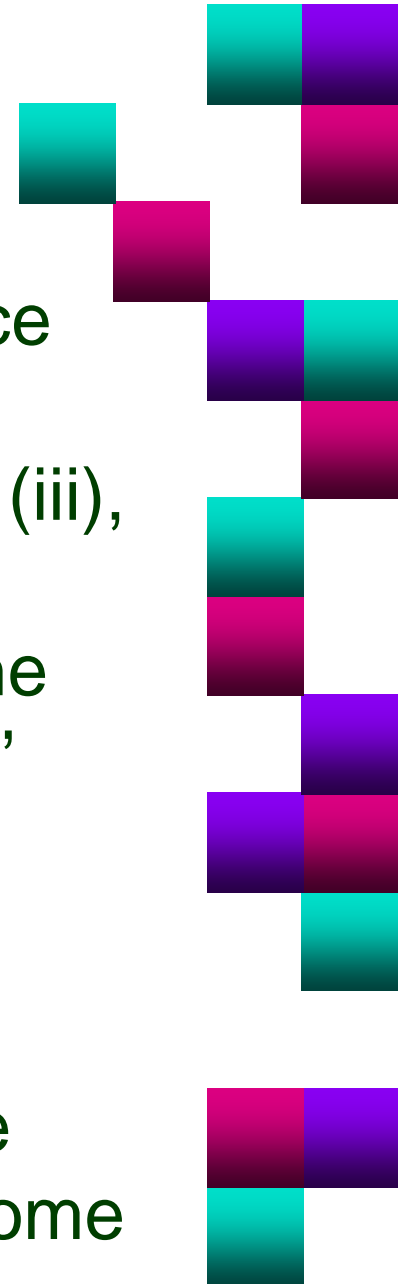
q “A review of patient complaints indicated that 25 of 25 grievance reports indicating that the agency failed to coordinate services, did not contain a resolution for any of the grievances.”

t also cited at 484.10 Exercise of Rights and Respect For Property



# 484.36 HHA Services: Standard; Competency Evaluation & In-Services

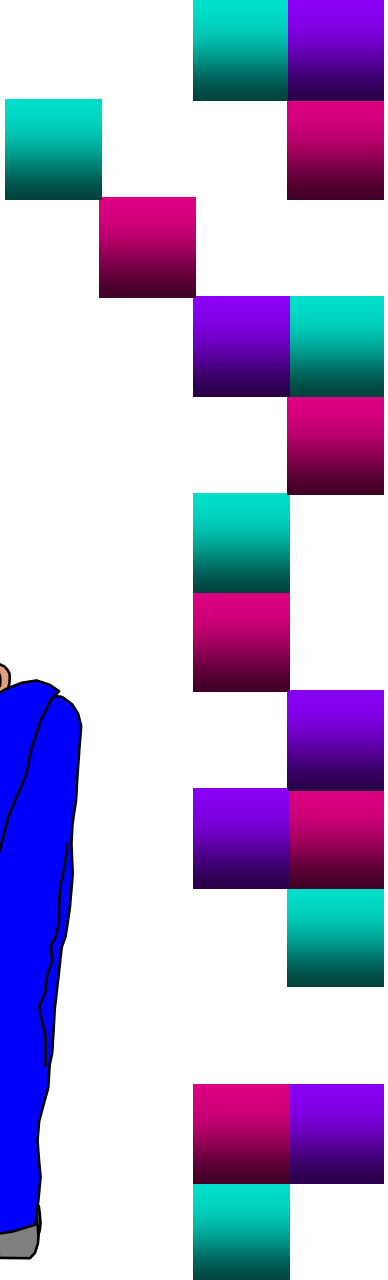
- q “...the agency failed to evaluate the performance of three of six home health aides who provided services in accordance with paragraphs (a) (1) (iii), (ix), (x) and (xi) which indicate that the home health aide be evaluated after observation of the aides performance of the tasks **with a patient.**”
- q “Three of six home health aide files had documentation that these aides had taken the homemaker test and not the home health aide test. The homemaker test did not include three subject areas that are required as part of the home health aide competency testing.”



# Wedge Audits

## q Initial 14 States

- t Connecticut
- t Indiana
- t Massachusetts
- t Minnesota
- t Virginia
- t Ohio
- t Utah
- t Wyoming
- t Oklahoma
- t Tennessee
- t Louisiana
- t Texas
- t Illinois
- t Florida

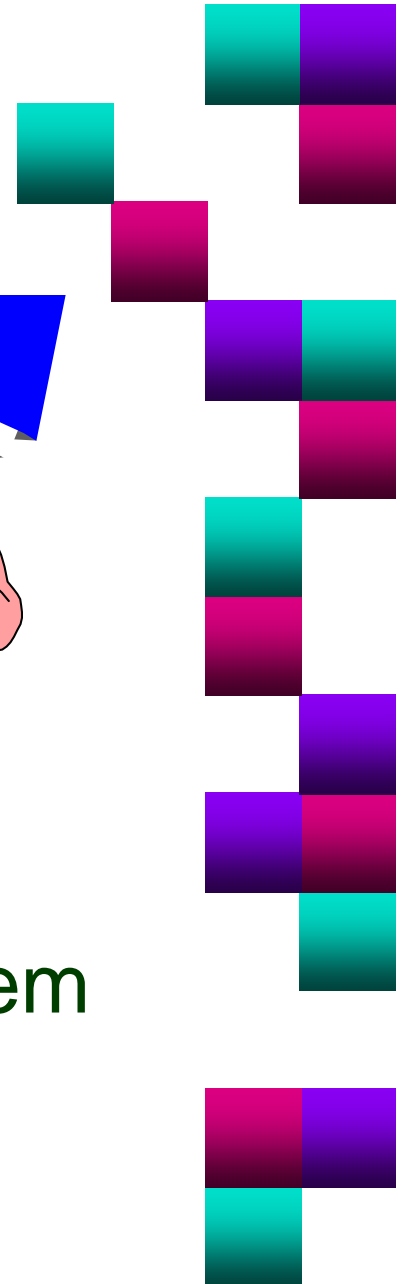
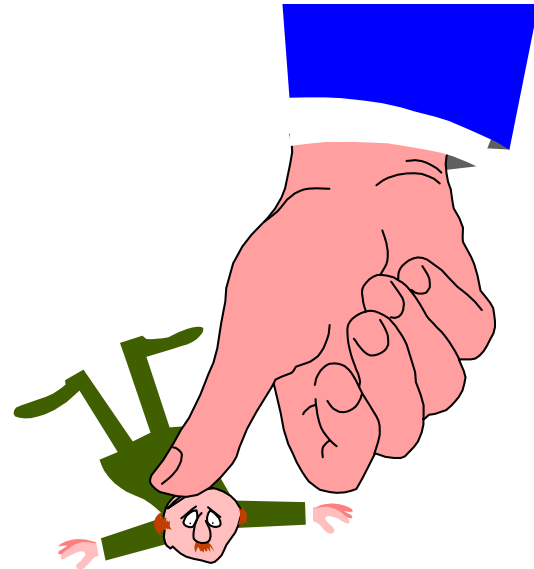




# Wedge Audits

## Target

- q High Visit Agencies
- q High Revenues
- q Multi-Office Agencies
- q Problematic Agencies, i.e.... FMR, Problem Surveys, Cost Report Issues



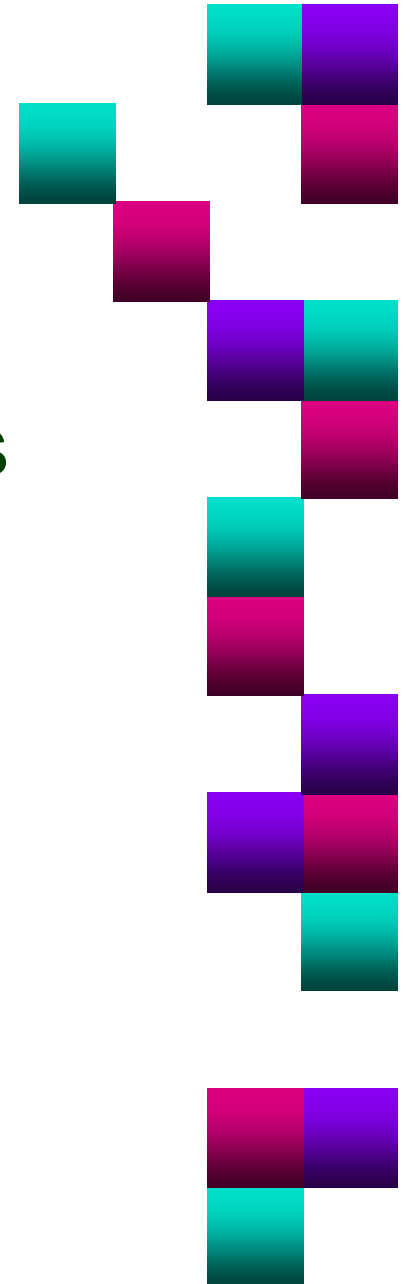
# Wedge Audits

- q Surveyors audit 15 previously selected claims and associated clinical records
- q Review for medical necessity, homebound status, conformance with physician orders
- q May perform home visits
- q May interview patients by telephone
- q Make decisions regarding percentage of “invalid” claims based on the results of clinical records & bills reviewed



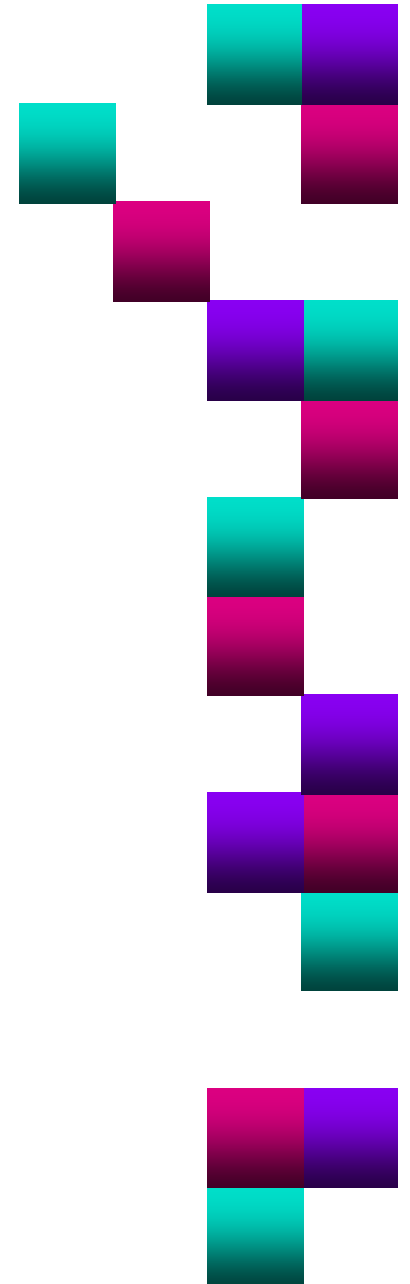
# Wedge Audits

- q Focus on recovering Medicare dollars
- q Error rate is extrapolated to a full 60 day's worth of claims
- q ***Provider's only recourse is:***
  - t accept the “verdict” of overpayment
  - t to request a 100 claim survey
  - t results applied to 1 year's worth of claims
- q Majority of providers have accepted the decision of the auditors



# Wedge Audits

- q Homebound Status
- q Signed Orders Prior To Billing
- q No Orders for a Particular Discipline or Service
- q Non-conformance With Orders
- q No Skilled Service Performed
- q Double Entries
- q Wrong Service or Discipline Billed
- q No Documentation of Visit



# Denied Visits

- q “...physician orders for patient X indicated that the physical therapist was to visit the patient 2x week x 1, 3x week x 4 and 2x week x 4. There were no visit notes for physical therapy services from 10 /22 through 11/10. Six physical therapy visits were billed within this timeframe.”
- q “(485) physician orders dated 6/10 were not signed until 10/14. Bills for 48 nursing visits, 92 home health aide visits and 27 physical therapy visits were submitted prior to 10/14.”
- q “52 year old (Medicare) patient with a peri-rectal abscess receiving BID nursing visits for a dressing change was not home when the nurse arrived. The nurse waited 30 minutes for the patient to return on his bicycle. He had “gone for a ride.” *No documentation indicating that the bicycle ride was contraindicated and/or caused problems with the patient’s wound.*”



# Denied Visits

- q “Orders indicated that a lab draw was to be performed on 8/3. The nurse had visited on 8/2 and performed a dressing change which was ordered for 3x a week. On 8/3 the nurse visited and was unsuccessful with the lab draw. No other skilled service was performed. The bill included the 8/3 visit.”
- q “The patient was receiving nursing and home health aide services. On 6/2, 6/4, 6/6, 6/8, and 6/10, the home health aide documented that the patient “did his own bath before I got there....” The home health aide checked off that she fixed the patient’s breakfast and did laundry on one visit.”



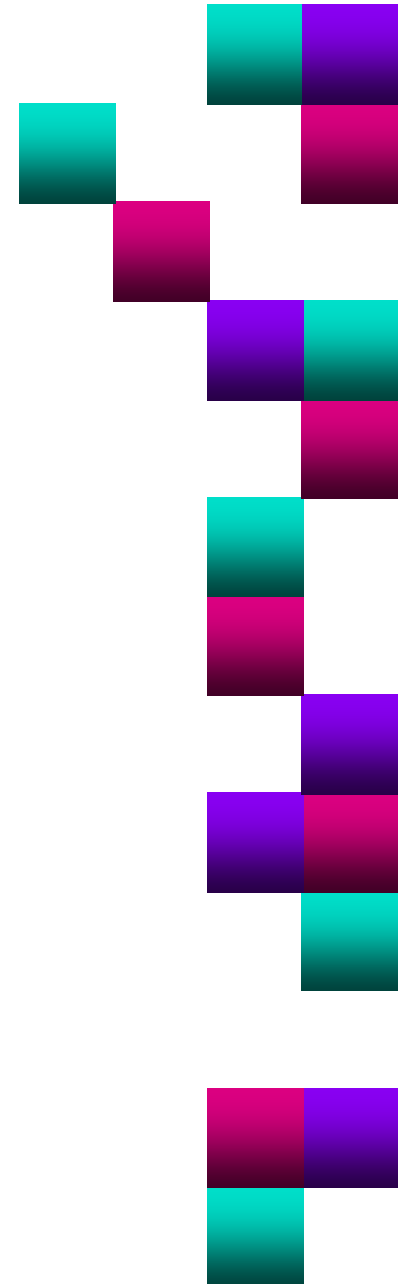
# Denied Visits

- q “Documentation on the 485 indicated that the patient was to receive nursing visits 3x a week and home health aide services 5x a week. Upon review of the clinical record it was noted that the patient received services from a physical therapist. There were no orders for physical therapy services. Bills were submitted for 23 physical therapy visits.”
- q “The clinical record indicated that a home health aide visited the patient on 9/15. A review of the patient bills revealed that a nursing visit was billed on 9/15. There was no documentation of a nursing visit on 9/15.”



# Handling An Adverse Decision

- q File for an extended payment
  - t 12 to 36 month repayment plan (requires approval from the HCFA Regional Office)
- q Request immediate reconsideration of denied claims prior to the formal wedge audit report.
  - t requires signature of the beneficiary
- q File for an ALJ hearing after reconsideration

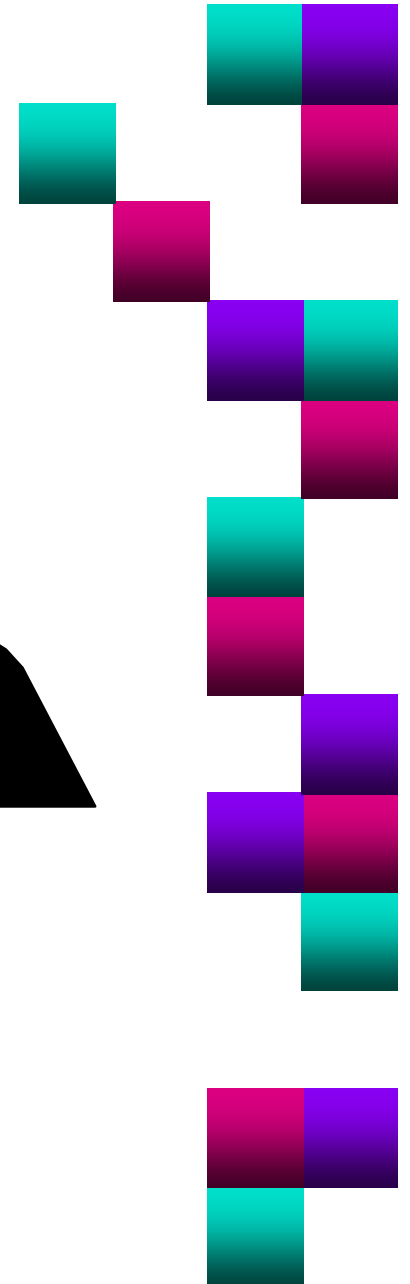
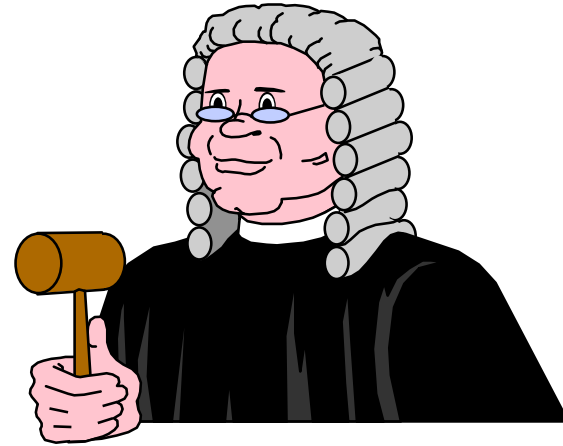




# Administrative Law Judge

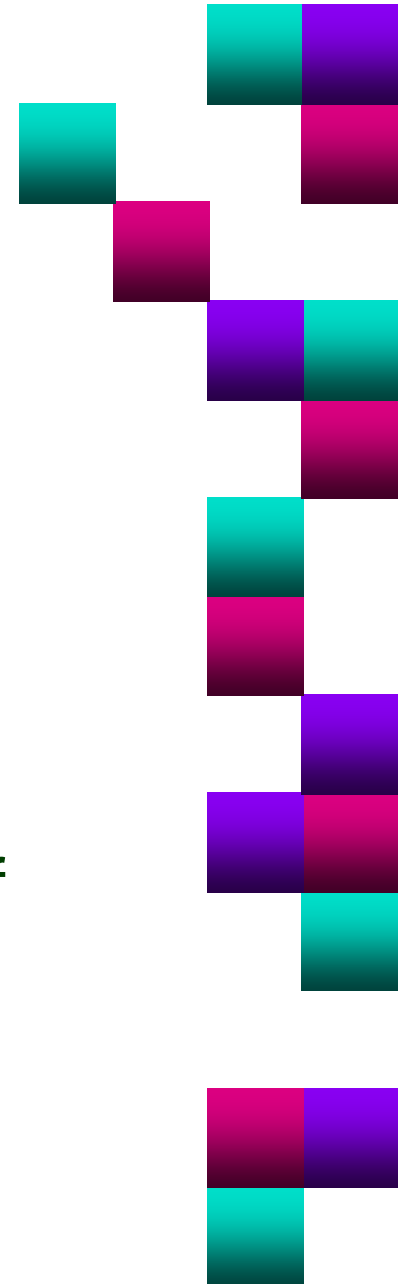
## Appeal Denials For

- q Claims billed prior to the receipt of the signed physician's order should be appealed as technical denials.
- q Any claim which may have additional information that substantiates the "medical necessity or homebound status."



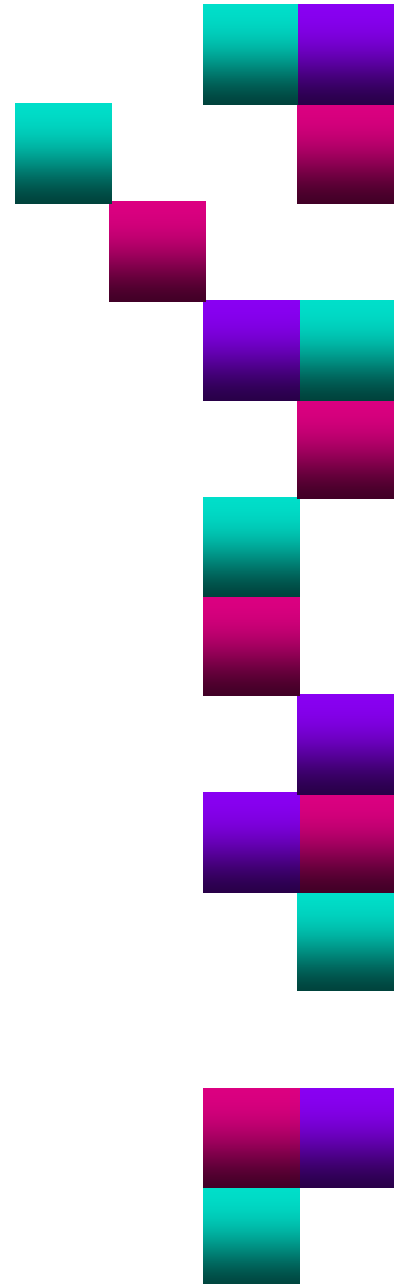
# Know Your Rights

- q Request Proof of Identity of the Surveyors
- q Clarify What Organization the Surveyor Represents
- q Photocopy the Credentials
- q Accompany the Surveyor When Paperwork Is Copied
- q Request an Exit Conference With Disclosure of Claims Taken to the Intermediary
- q Ask Why These Claims Are Questionable
- q Request to Tape the Exit Conference
- q Ask to Accompany Surveyors on Home Visits



# Don't....

- q Argue With a Surveyor
- q Change or Alter Anything in the Clinical Records
- q Obstruct the Survey Process in Any Way

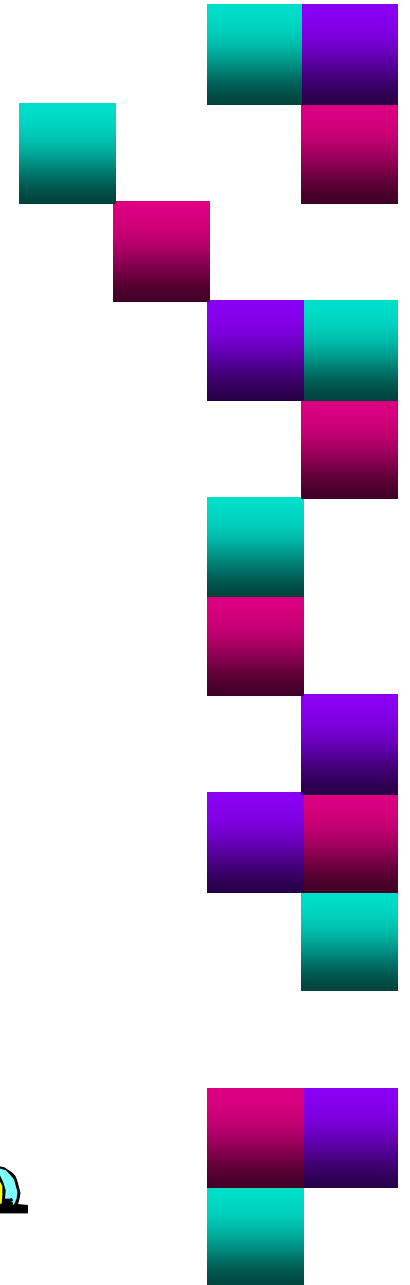
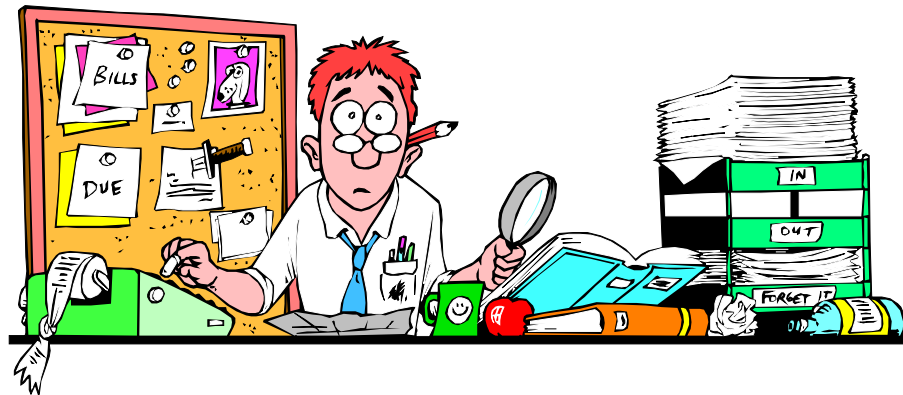


# An Ounce of Protection .....

## The Internal Audit

### Assures Compliance with

- q Financial Records
- q Cost Reports



# Purpose of the Internal Audit

Records are in Compliance with:

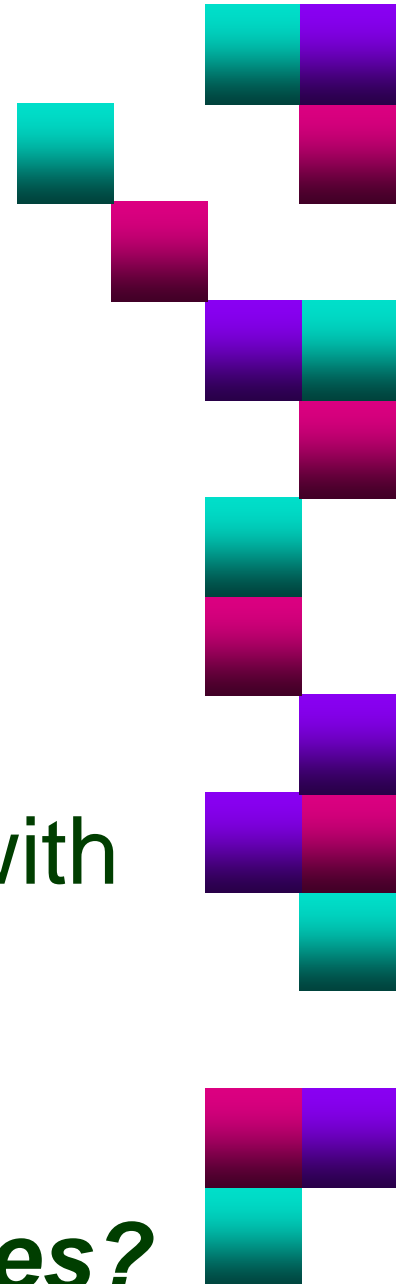
- q Existing Law
- q Regulation
- q Instructions
- q Government Pronouncements
- q GAAP where Applicable
- q Agency's Internal Written Policies



# The Process to Assure Compliance Includes

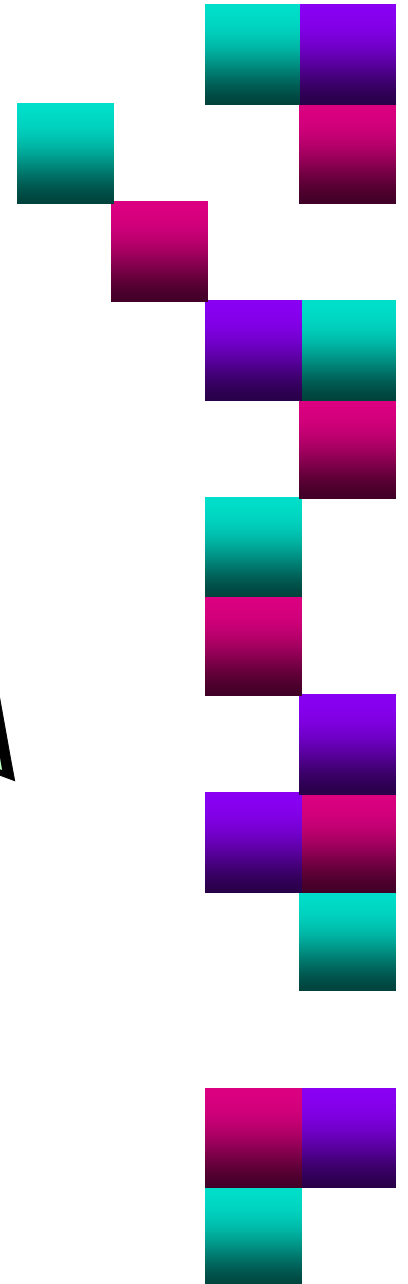
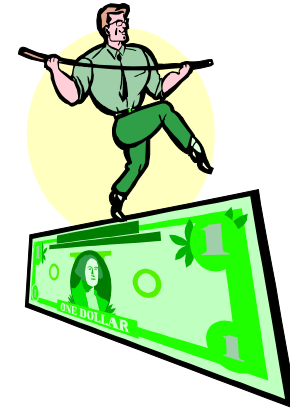
- q Periodic Review of Books & Records
- q Review of Internal Systems
- q Sampling Usage  
(Everything Over \$ Xxx)
- q Appointment of Compliance Officer with Responsibility that the Plan Works at Every Level

***Is the Agency following its policies?***



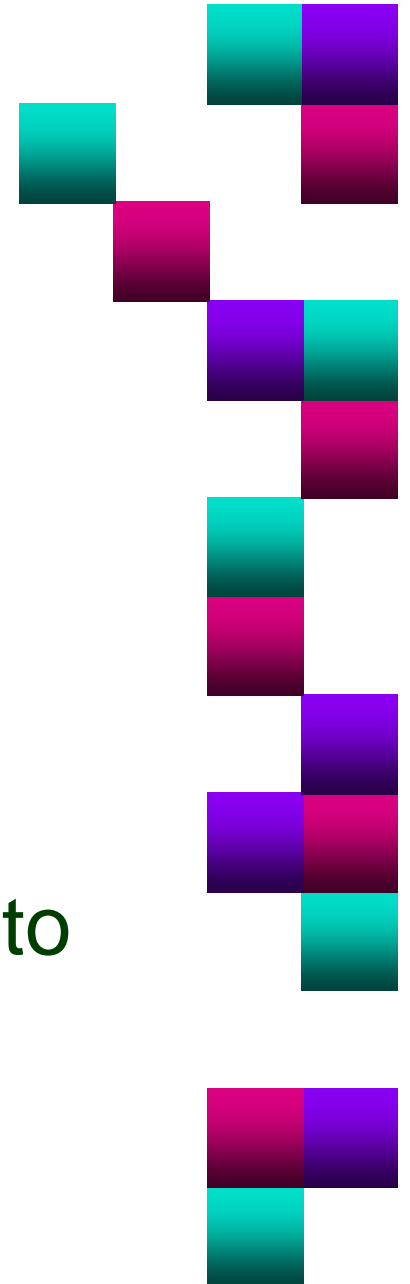
# Agency Policy Must Relate To

- q Capitalization of Assets
- q Hiring & Firing of Personnel
- q Compensation & Benefits
- q Expense Reimbursement
- q Merit & Step Increases & Bonuses
- q Non-Paid Overtime



# If Outside Consultants are Utilized

- q They Should be Engaged Directly by the Provider's Legal Counsel to Maintain Attorney-Client Privilege and
- q Protection From Workpaper Discovery
- q Otherwise, Consultant may be Obligated to Notify HCFA, etc.





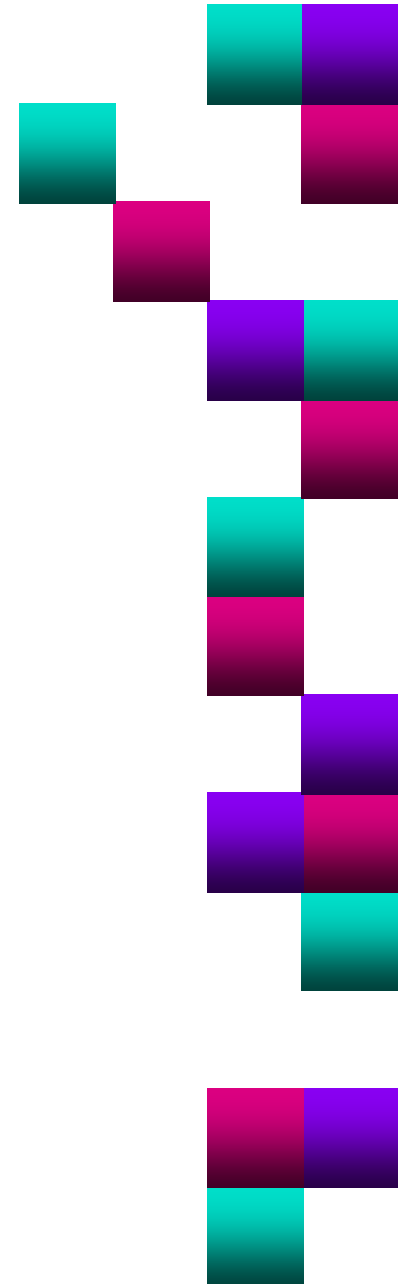
# Use of Internal Staff

## Pros

- q Less Expensive
- q Intimate Working Knowledge

## Cons

- q Potential Conflict of Interest
- q Desire to Please Management
- q Potential Lack of Compliance Skills



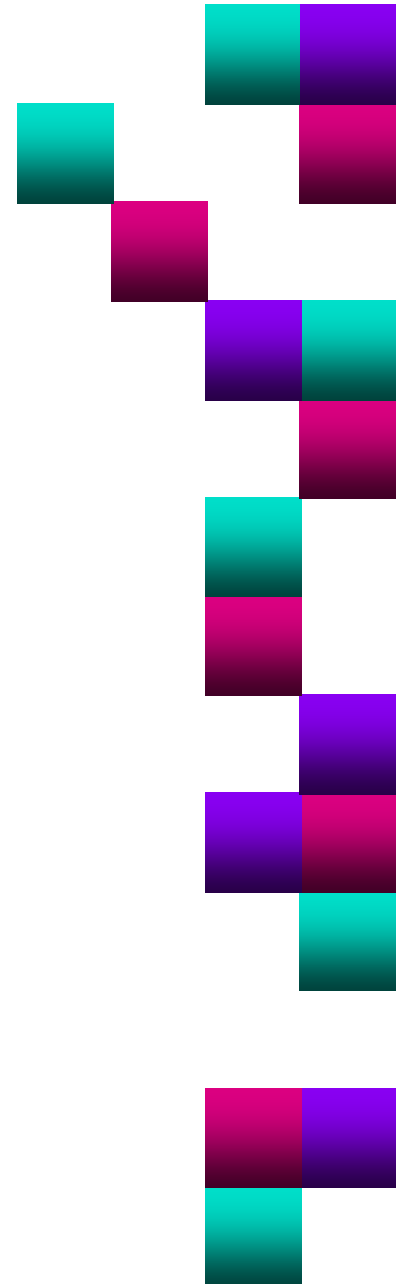
# Use of Outside Consultants

## Pros

- q Experience with Expertise
- q Avoids Conflicts of Interest
- q No Responsibility to Please Management
- q Dedicated to Properly Perform Review in a Timely Manner

## Cons

- q More Expensive
- q Lack of Specific Knowledge of the Provider

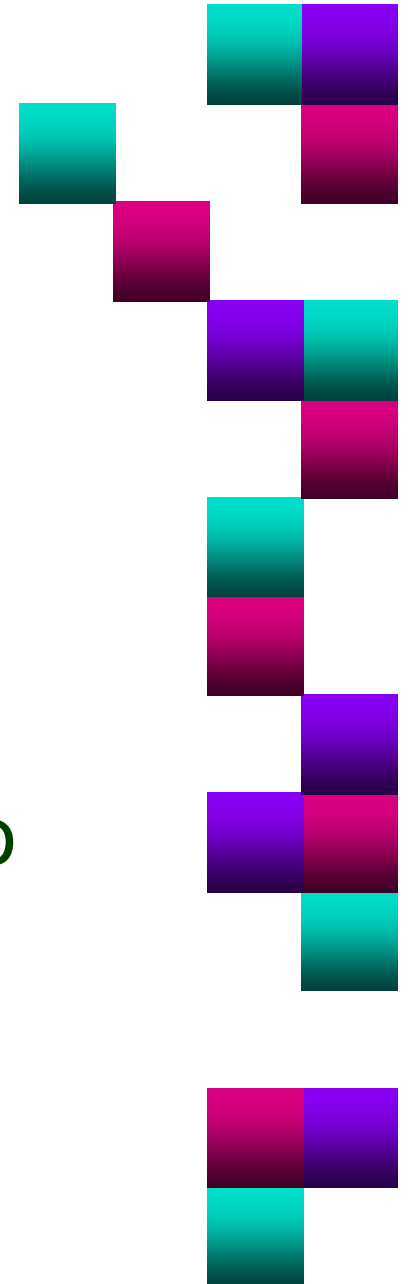


# When Should Internal Staff Be Utilized

q Large Provider with Dedicated Internal  
Audit Staff

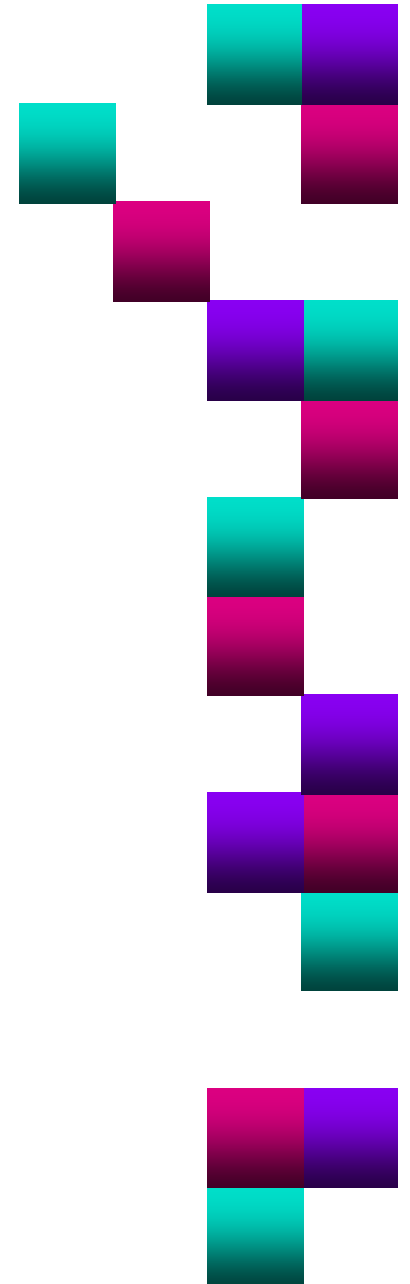
*or*

q As Staff Under Direction and Reporting to  
Outside Consultant



# Key Record Keeping Compliance Issues

- q Home Care Coordinators
- q Like-Kind Services
- q Key Employee Compensation
- q Cost Report Statistics, Census & Visits
- q Employee Time Records
- q Advertising, Community Relations and Education
- q Related Party Expenses



# Develop and Implement An Organizationwide Compliance Plan

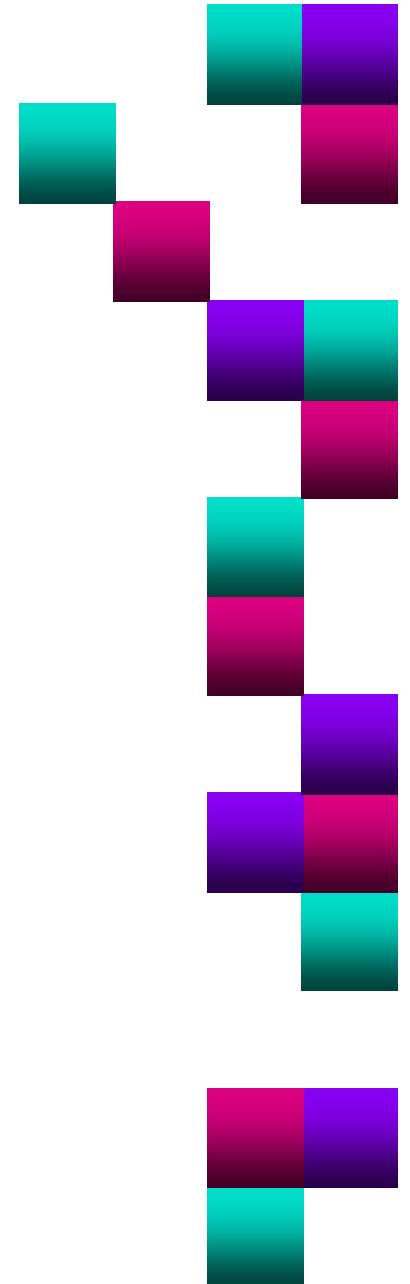
- q Appoint a Compliance Officer
  - t responsible for assuring that the Plan works at every level
- q Develop Policies and Procedures for Compliance
  - t conflict of interest
  - t confidentiality
  - t internal “hotline” for reporting complaints and/or suspected fraud
  - t admission, discharge and referral ethics
- q Educate All Employees About Ethics and Compliance
  - t access to all employees
- q Develop Internal Quality Control Procedures for High Risk Processes
- q Respond Promptly to Complaints and Identified Problems



# Process to Assure Compliance Includes

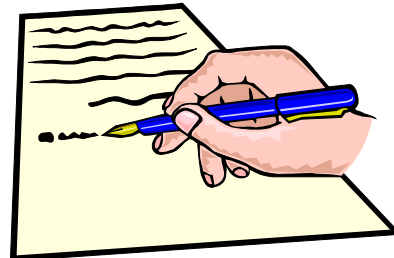
## If Provider Based

- q Compliance Plan must be Integrated with All Components of the Provider
- q Materiality of Homecare Agency Size to Other Components of the Provider is Not an Issue
- q Agency Director has Responsibility for Compliance



# Process to Assure Compliance Includes

- q Involvement of Compliance Attorney with Access to a Criminal Attorney As Needed!
- q A Written Compliance Plan that Delineates Responsibility with Access by All Employees



# Key Record

## Keeping Compliance Issues

- q Home Care Coordinators
- q Like-Kind Services
- q Key Employee Compensation
- q Cost Report Statistics, Census & Visits
- q Employee Time Records
- q Advertising, Community Relations and Education
- q Related Party Expenses





# Establish a Detailed Survey or Audit “Control Plan”

- q Identify who should be contacted immediately upon arrival of a surveyor or auditor
- q Develop specific procedures for how information is submitted to a surveyor or auditor
- q Be able to pull a current active census list as well as a discharge list
- q Implement “emergency” procedures for an unannounced clinical record pull to assure that all available documentation is filed prior to submitting the record
- q Designate specific roles for clinical managers, medical records staff and business office staff to follow during a survey or audit, i.e.... remain in designated area accessible by phone, notify field staff for immediate response in the event the surveyors make home visits, etc....



# COMPLIANCE .....

# ITS YOUR RESPONSIBILITY!

