Compliance Home Health & Hospice Hot Topics

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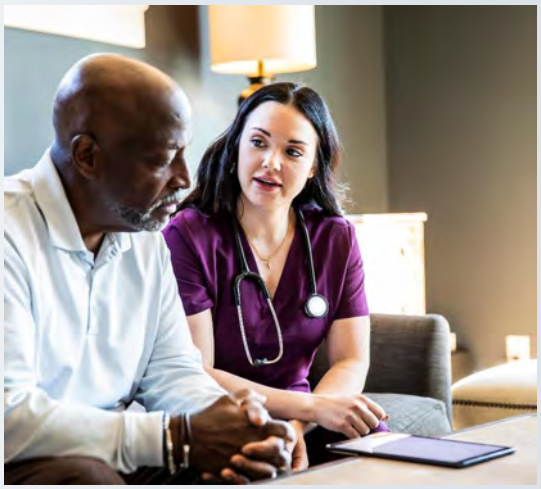
Objectives

- Review the current compliance Hot Topics and increased scrutiny haunting Home Health and Hospice.



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Why are Home Health & Hospice Providers Targeted?

- The home health and hospice benefits are costly and will continue to increase with increase in number of Medicare beneficiaries.
  - 2022 Medicare spend:
    - Hospice was $23.9 billion
    - Home Health was $132.9 billion
- **Overpayments and fraud and abusive practices are real.**

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Areas of Focus by the Government – Home Health

- Medical Necessity/Skilled Need (all disciplines, nurse, therapists)
- Homebound Status
- Therapy utilization
- Technical signatures/dates on 485/POC
- ICD-10 Coding and OASIS coding/documentation
- Face-to-Face Encounter
- Telehealth
- PEPPER Reports

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Areas of Focus by the Government – Hospice

Hospice (90- or 60-day Benefit Periods):

- Quality of Care
- Eligibility/Medical Necessity to Support 6 Month Prognosis
- Levels of Care:
  - Routine, Respite, General Inpatient (GIP), Continuous Home Care
- Long Lengths of Stay (over 180 days)

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Areas of Focus by the Government – Hospice (Cont'd)

Hospice (90- or 60-day Benefit Periods):

- Technical Requirements-Election Statement: Waiver Language, QIO and Patient Choice of Attending; CTI, Face-to-Face, NOE, etc.
  - Addendum "Patient Notification of Hospice Non-Covered Items, Services and Drugs"
    - To be provided upon request by the patient or representative
    - To include items, services and drugs that the hospice has determined to be unrelated to the terminal illness and that the hospice will not pay for
    - Must include cost-sharing information
    - Physician Narrative
- Medications paid by Medicare Part D (related to hospice diagnosis/prognosis)
- Hospice PEPPER Reports

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Current Audits

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Who's Looking….

- Medicare Administrative Contractors (MACs)
  - Medical Review: Home Health and Hospice - Targeted Probe & Educate Audits (TPE)
  - Review Choice Demonstration (RCD) for Home Health (certain states)
- Unified Program Integrity Contractors (UPICs)
  - Safeguard Services, LLC
  - Qlarant Integrity Solutions, LLC
  - Coventbridge Group
- Supplemental Medical Review Contractor (SMRC) – Noridian
- Recovery Audit Contractors (RAC) - For HH+H – Performant Recovery, Inc. – Region 5 nationwide
- Comprehensive Error Rate Testing (CERT) - Federal oversight of the MACs

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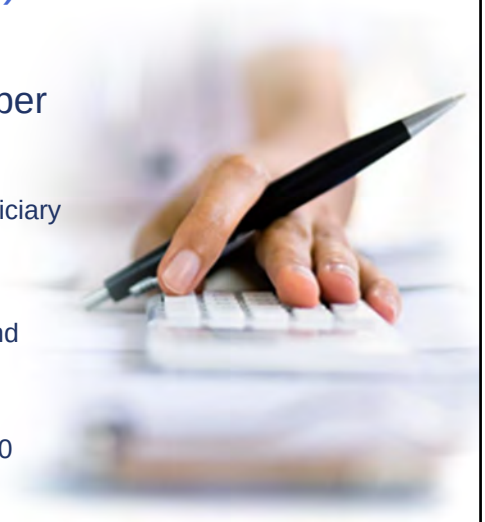
Targeted Probe and Educate (TPE)

- MACs Medical Review Program
  - MACs must develop an annual Improper Payment Reduction Strategy (IPRS) - required by CMS
    - Data is analyzed by provider, services and beneficiary
      - Historical claims data
      - Use of patterns/trends: high volume/cost and change in frequency/outliers
      - Comparative billing reports: state, regional and national
      - CMS Reports and other government reports (OIG/GAO)
      - New providers who have submitted at least 50 claims



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What Agencies Need to Know-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
    - Can be a Focus TPE for specific diagnosis, specific number of visits (2-6), or in Hospice for a focus level of care, such as GIP, long length of stay
    - Selected sample 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
      - **Error rate tolerance differs by MAC. CGS: 25%, Palmetto 20% and NGS 15%**
    - 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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Top Denial Reasons in Home Health

- Records not submitted
- Face-to-Face requirements not met
- Initial certification was missing, incomplete or invalid
- Documentation does not support medical necessity or skill
- Documentation does not support homebound status
- No physician orders for services provided

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Top Denial Reasons in Hospice

- The Notice of Election is Invalid as it doesn't meet regulatory requirements
- Records not submitted
- Patient is not hospice appropriate, or information provided does not support a terminal prognosis of six months or less
- Physician narrative statement is either not present or invalid
- Initial certification is not timely
- No valid election statement submitted
- Subsequent certifications not timely
- Face-to-Face requirements are not met

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New Hospice Fraud Prevention Measures and Survey Updates

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Hospice Fraud Prevention Measures

- As of August 2023, site visits had been conducted of over 7,000 hospices and nearly 400 were being considered for administrative action
- As of January 1, 2024, new Medicare provider enrollment activities:
  - New 36-month rule for transfer of a Medicare provider number
  - “Managing Employees” include the hospice administrator and medical director have to be disclosed
  - Criminal background checks (fingerprinting) requirements for owners upon initial Medicare enrollment
- As of 5/1/24, all hospice patient attending physicians and hospice physicians must be enrolled in Medicare or file as opt-out

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Hospice Survey Changes

Consolidated Appropriations Act, 2021

- New hospice survey requirements
- New hospice enforcement procedures
- Special Focus Program

What does this mean for a Hospice Agency?

- Surveys at least every 36 months
- Surveyors will be well trained, educated, and tested—they may potentially pick up on more condition-level deficiencies
- Surveyor teams will be multidisciplinary
- Surveys will be posted for the public to review
- Condition-level and frequency deficiencies will lead to enforcement actions/sanctions.

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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% • GAO Report on impact of remedies on hospice	• "Every 36 months" becomes permanent • Beginning **October 1, 2021** • Beginning **October 1, 2021** • No later than **October 1, 2022-IN PROCESS** • No later than **October 1, 2022-EXPECTED in FY 2024 HH Proposed Rule** • Data collection beginning **January 1, 2022** • Payment update reduction – **FY 2024** • No later than **December 27, 2023**

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Hospice 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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Civil Monetary Penalties

- 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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Civil Monetary Penalty 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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Top Survey Deficiencies

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Top 10 Survey Deficiencies: Home Health CY 2021-2023 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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Top 10 Survey Deficiencies: Hospice CY 2021-Sept 2022

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(c)	L0545	Standard: Content of Plan of Care-Individualized
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)	L0531	Standard: Content of the Comprehensive Assessment-Bereavement Assessment

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Preventative Measures-Let SimiTree Help…

- ✓ Pre-Bill Audits
- ✓ ADR Packet Review
- ✓ Annual Post Pay Audits
- ✓ Annual Compliance Risk Assessment
- ✓ Mock Survey and Survey Readiness
- ✓ Plan of Correction Assistance
- ✓ Appeal Assistance

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Learn more about SimiTree **at SimiTreeHC.com.**

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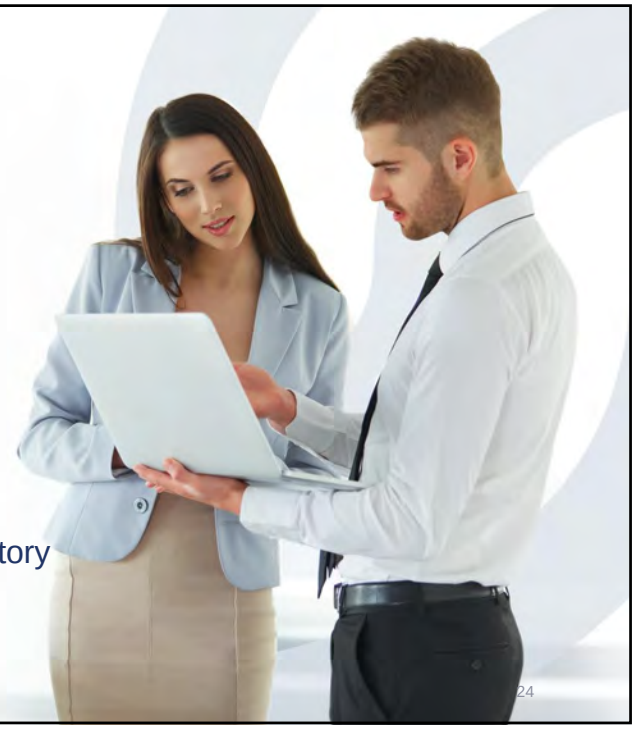

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