

# Therapy Utilization: Evolving Rules and Enforcement

Post-Acute Care in Transition Webinar Series

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# Goals of presentation

- Overview of federal standards for skilled therapy rehab services as well as need to meet state-specific and professional guidelines
- Understand recent clarification of Medicare coverage for rehab services
- Identify potential areas of risk for fraud and abuse
- Identify the government's perspective and enforcement activities
- Identify lessons learned from past government investigations
- Identify compliance program and audit improvement

# Background: Medicare attention to SNFs and Therapy Utilization in particular

- **2012:** Medicare paid SNFs \$32.2b (OIG Report 11.9.12)
- **2009:** OIG estimated \$1.5b paid to skilled nursing facilities (SNFs) was inappropriate
  - Upcoded claims, esp. for ultrahigh therapy
  - Failure to meet Medicare coverage requirements
  - Misreported therapy information on the Minimum Data Set (MDS)
- **2011:** nearly 5m seniors received therapy services at a cost of \$5.7b (Medicare Payment Advisory Commission, reported by *New York Times*, 2.4.13)
- 1 in 4 seniors received an exception to the therapy cap limits
- SNFs were the only Medicare provider type to receive a scheduled deadline under the ACA for compliance program mandate (that has been delayed due to as-of-yet unpromulgated regulations)

# Background: Therapy RUG Levels

- Resource Utilization Groups (RUGs): classification system to determine reimbursement levels for patients in SNFs
  - **Ultra High:** at least 720 minutes per week. Minimum 2 disciplines; one at least 5 days.
  - **Very High:** at least 500 minutes. Minimum 1 discipline 5 days.
  - **High:** at least 325 minutes. Minimum 1 discipline 5 days.
  - **Medium:** at least 150 minutes. Minimum 5 days.
  - **Low:** at least 45 minutes. Minimum 3 days.

# *Jimmo* Changes Standard for Therapy Coverage

- **January 2011:** *Jimmo v Sebelius* class action contests requirement of “improvement” for skilled rehab service coverage
- **October 2012:** Settlement reached
- **January 2013:** CMS settlement approved by court
  - Eliminates automatic claim rejection for lack of improvement
  - Broadened basis for coverage to:
    - maintenance of patient’s current condition
    - preventing or slowing further deterioration
- **December 2013:** Medicare Policy Manuals revised
  - Validated Medicare coverage of “maintenance therapy” for those who need skilled care but are not expected to recover prior function
  - Potential for improvement still relevant for services meant to restore function

# Post-Jimmo Clarification of Rehab Therapy Utilization Standard

- **42 CFR § 409.32(c) Criteria for skilled services and the need for skilled services (SNFs):** The restoration potential of a resident is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a resident may need skilled services to prevent further deterioration or preserve current capabilities.
  - Regulation unchanged, but clarified to broader interpretation
  - Medicare revised program manuals pursuant to Change Request (CR) 8458 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf>)
  - CMS educational campaign to contractors, adjudicators, providers



# Therapy Caps Remain, But . . .

- Annual per-beneficiary Part B payment limitations on Medicare coverage of physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services) in facilities
- Limit payments for services irrespective of clinical need or outcomes.
- Apply to services received in all health care settings furnishing Part B therapy services (SNF, hospital, therapist/MD office, home health agency, outpatient rehabilitation agencies (ORFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs))
- 2014 cap is \$1,920 for PT/SLP combined/OT separate \$1,920 cap
- Exceptions process permits medically necessary services beyond the cap limit and manual medical review threshold if therapist attests to the medical necessity and coding requirements are met. Extended through 3.31.15 by Protecting Access to Medicare Act (signed 4.1.14)

# 100 Day Limit Remains (as does Claims Appeal Process)

- Medicare Part B payment limitations restrict patients to up to 100 days per “benefit period.”
  - Begins when a patient is admitted as an inpatient to a hospital or a nursing home for skilled care (after a minimum 3-day inpatient stay)
  - Ends after 60 days without skilled care

# Standards of conduct for rehab services provided to Medicare beneficiaries

- “medically necessary” and requiring “skilled intervention”
- ordered by the physician
- under the supervision of a licensed PT, OT, or speech therapist
- based on goals and treatments appropriate for patient’s condition
- supporting the beneficiary’s plan of care
- documented in the clinical record timely and accurately (e.g. actual employee treatment time for group therapy or concurrent therapy)
- patients discharged when they reach their maximum benefit from skilled therapy services
- all services adhering to federal, state and professional licensing guidelines, regulations

# What are skilled nursing or rehab services?

- Services furnished pursuant to MD orders that
  - require the skills of qualified technical or professional health personnel such as RNs, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech language pathologists or audiologists; and
  - must be provided directly by or under the **general supervision** of these skilled nursing or skilled rehabilitation personnel to ensure the safety of the patient and to achieve the medically desired result.
- General Supervision: initial direction/periodic inspection/not physically present but readily accessible

*Medicare Standard (IOM)—100-02, Medicare Benefit Policy Manual, Chapter 8): 30.2.1 - Skilled Services Defined (Rev. 37, Issued: 08.12.05 Effective: 09.12.05) ([www.cms.gov/center/snf.asp](http://www.cms.gov/center/snf.asp))*

# When is a service a skilled service?

- A prescribed service is skilled if its inherent complexity is such that it can only be performed safely and/or effectively by/under the general supervision of skilled nursing/rehab personnel
  - e.g. administration of IV feedings and IM injections
  - insertion of suprapubic catheters
  - ultrasound, shortwave, and microwave therapy treatments.
- Medicare contractors (i.e. the MAC) consider the nature of the service and the skills required for safe and effective delivery of that service
- While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

*30.2.2 - Principles for Determining Whether a Service is Skilled (Rev. 1, 10.01.03)*

## E.g. Skilled Physical Therapy Services:

- Directly and specifically related to active written tx plan based on initial evaluation performed by a qualified PT post-admission (before services are provided) and approved by MD (repeated for readmission)
- Complexity and sophistication of service level or patient condition requires the judgment, knowledge, and skills of a qualified PT
- Services must be provided with the expectation, based on MD assessment, of patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;
- Services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and
- Services must be necessary and reasonable (in amount, frequency, and duration) for tx of patient's condition

30.4.1.1 - General (Rev. 73, 06.29.07)

# When are services unskilled?

- Fail to meet Medicare manual requirements for covered therapy svc's
- Provided by professionals or personnel who do not meet the qualification standards or are not appropriately supervised
- Services by qualified people that are inappropriate to the setting or patient conditions
- Palliative procedures that are repetitive or reinforce previously learned skills, or maintain function after a maintenance program has been developed.
- Related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation
- Services not provided under a therapy plan of care
- Services describing activity without reference to goals

*Internet only manuals (IOM)—100-02, Medicare Benefit Policy Manual, Chapter 15: 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (also 220.3) (Rev. 63, Issued: 12-29-06); Pub. 100-04, chapter 5, and Pub. 100-08, ch. 13*

# When does therapy billing amount to fraud?

- **Defining fraud:** obtaining (or attempting to obtain) services or payments by dishonest means with intent/knowledge/willingness to cause an unauthorized benefit to the provider or another person.
  1. Accepting or offering kickbacks, bribes or rebates
  2. Using another person's Medicare card or number
  3. Billing for items or services that were not provided
  4. Billing twice for the same service (same or different date)
  5. Billing for non-covered services and disguising them as covered
  6. Billing Medicare and another insurer, or the patient, in a deliberate attempt to be paid twice



# When does therapy billing amount to abuse?

- **Defining abuse:** engaging in practice that results, either directly or indirectly, in unnecessary costs to the Medicare/Medicaid Program.
  1. Over-utilization of medical and health care services
  2. Improper billing practices
  3. Increasing charges to Medicare beneficiaries, but not to other patients
  4. Routine waiver of deductibles and co-insurance
  5. Not adjusting accounts when errors are found

## Government's Perspective: Fraud Enforcement is Profitable

- Profitability is now a driving force behind the continued increase in audits, investigations, and prosecutions.
- Health Care Fraud and Abuse Control program not only pays for itself, but it produces an unequaled return on investment (“ROI”) for a Government program.
  - The average ROI for HCFAC, since 1997, is \$5.1 returned to every \$1.0 expended.
  - The average ROI over the three years has increased to \$7.2.
  - In 2013 alone, \$4.3 billion was secured by the Federal government in health care fraud judgments and settlements, which does not even include additional state Medicaid settlements.

# Who Are The Government Contractors?

Type of Contractor	Responsibility
Medicare Administrative Contractors (MACs)	Process claims submitted by health care providers / suppliers, and submit payment to providers in accordance with Medicare rules and regulations (includes identifying and correcting underpayments and overpayments)
Recovery Audit Contractors (RACs)	Identify and correct underpayments and overpayments not identified by MACs. <b>Paid on a contingency fee basis (9 – 12.5%)</b>
Medicaid Integrity Contractors (MICs)	Prevent and detect Medicaid fraud, waste and abuse through review of actions of individuals or entities furnishing items or services under Medicaid
Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs)	Identify cases of suspected fraud and take appropriate corrective actions
Comprehensive Error Rate Testing (CERT)	Collect documentation and perform reviews on statistically valid random samples of Medicare FFS claims to produce an annual error rate

# How Do Contractors Select Claims for Review?

Type of Contractor	Claims Selection Criteria
Medicare Administrative Contractors (MACs)	Claims from providers with a past history of improper billing or data analyses of paid claims
Recovery Audit Contractors (RACs)	Data analyses of the services most likely to have been paid improperly CMS approves the RAC's selection of services and the criteria to be applied in reviews
Medicaid Integrity Contractors (MICs)	Data analyses and referrals from CMS
Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs)	Reviews of providers flagged as "high risk" Referrals from other contractors Data analyses to identify patterns by a provider or industry that suggest potential fraud
Comprehensive Error Rate Testing (CERT)	Random samples of processed claims

# Comparing RAC and MIC Processes

- MICs not paid on contingency basis
- MICs identify but do not collect overpayments
- MICs more likely to use extrapolation to maximize takebacks
- No limitation on number of MIC requests
- Sampling laws vary by state
- Different appeals process for MICs, which varies by state, with generally shorter appeal timeframes

# Zone Program Integrity Contractors

- ZPICs respond to requests for information from federal law enforcement agencies (e.g., OIG, USAO) and provide requested claims information and data analyses
- Top ZPIC issues include:
  - Billing for services not furnished
  - Patterns of overutilization
  - Vacant supplier / provider locations
  - Medically unnecessary services
  - Stolen provider / beneficiary information
  - Schemes of collusion (e.g., kickbacks)
- Office of Inspector General, Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight (Nov. 2011), available at <http://oig.hhs.gov/oei/reports/oei-03-09-00520.pdf>.

# Zone Program Integrity Contractors

- ZPIC audits typically are unannounced or initiated with very little notice
  - May be pre- or post-payment
  - May interview staff and beneficiaries
  - Utilize statistical sampling and extrapolation to determine overpayment amounts
  - Assume it is not random
- Home health and DME have been a priority of ZPIC reviews
- In some cases, ZPICs work with CMS to issue payment suspension; CMS has new authority under ACA to suspend payments based on “credible allegations of fraud” (defined to include contractor data mining)

# What Can We Learn From Past Investigations?



# OIG 2013 and 2014 Work Plans

- **SNF**

- Questionable billing patterns for Part B services during nursing home stays
- Hospitalizations of nursing home residents for manageable and preventable conditions

- **Home Health**

- Face to Face Requirement
- Employment of Home Health Aides with Criminal Convictions
- States' Survey and Certification: timeliness, Outcomes, Follow-up and Medicare Oversight
- Missing or Incorrect OASIS Data
- MAC's Oversight of Claims
- PPS Requirements
- Trends in Revenues and Expenses

- **Hospice**

- Hospice in ALFs
- Marketing Practices and Financial Relationships with Nursing Homes
- General Inpatient Care

# Amedisys

- April 2014 settlement of FCA allegations spanning 2008-2010 for \$150 million
- The government alleged that Amedisys submitted Medicare claims for medically unnecessary care and for patients who were not homebound and misrepresented patient care needs to boost reimbursements.
- The underlying FCA complaints also included allegations that Amedisys charged below-market rates for patient coordination services to oncologists who referred to Amedisys, in violation of Stark and Anti-Kickback laws.

# Health Care of Virginia (HHA)

- HHA was ordered in December 2011 to pay \$323K in restitution for allegedly submitting claims to the Virginia Medicaid program for services rendered by untrained personal care aides.
- Investigation indicated that HHA falsified training certificates and patient assessments.
- Two defendants pled guilty for their roles in the fraud scheme

# Miami HHAs

- August 2012 owner and operator of 2 Miami HHAs pled guilty for participation in a \$42 million home health fraud scheme.
- According to plea documents, the defendants conspired with patient recruiters for the purpose of billing for unnecessary home health care and therapy services.
- Allegations also included that kickbacks and bribes were paid to:
  - patient recruiters in return for these recruiters providing patients and
  - physicians in exchange for home health and therapy prescriptions, plans of care, and medical certifications

# Dallas HHAs

- February 2012, a Federal grand jury indicted a Dallas-area doctor and owner of an association of health care providers in a \$374 million home health care fraud scheme, the largest fraud case indicted in terms of the amount of loss charged against a single doctor. The indictment charged the defendant with fraudulently certifying or directing the certification of more than 11,000 individual patients from more than 500 home health agencies for home health services over five years.
- December 2011 owners of a Dallas HHA and 1 patient recruiter pled guilty to charges related to participation in a scheme to submit fraudulent claims by falsifying documentation related to homebound status as well as time sheets and patient visit logs

# Odyssey Healthcare (Hospice)

- February 2012 – Paid \$25 million to resolve FCA allegations that between 1/06 – 1/09 the Hospice submitted claims for services that were medically unnecessary.
- Specifically, allegations surrounding billing Medicare for continuous or crisis care services when the patients were not experiencing a crisis.

# Voyager HospiceCare

- June 2012 paid \$6.1 million to resolve allegations that it violated the FCA
- Specifically, allegations surrounding the submission of claims between 1/04 – 1/08 for ineligible beneficiaries who did not have a terminal prognosis of six months or less

# Diakon Hospice Saint John

- December 2011 paid \$10.6 million to resolve FCA claims
- Specifically, allegations surrounded the submission of claims for Medicare beneficiaries who were not eligible for hospice from 10/1/04 – 9/30/10



# Diversified Health Management (HHA)

- August 2012 numerous parties paid \$9.4 million to settle FCA allegations that the defendants submitted false cost reports for cost report years 1999, 2000, and 2001.
- Allegedly, the costs reports concealed the “related party” relationship between the agencies and their management company.

# How Can We Make Compliance Programs More Effective?

# What Should be Accomplished During Compliance Committee Meetings?

- Receive reports from the CCO related to the operation of the compliance program
  - Training and education
  - Hotline reports or disclosures of wrongdoing
  - Potential or existing government investigations or litigation
  - Internal or external audits
  - Compliance risk assessment
- Assist in the analysis of the organization's risk areas
- Review any emerging compliance issues and monitor the progress of addressing identified compliance issues
- Oversee monitoring of internal and external audits and investigations

# What Should be Included in a Compliance Audit Plan?

- Develop an audit schedule that methodically evaluates:
  - The organization's areas of vulnerability
    - Operational issues - e.g., proper billing, contracts
    - Compliance issues - e.g. training documentation, documentation of background checks and exclusion screening
  - Whether the compliance program is accomplishing its goals
- Benchmark audit results
  - Static performance or a decline suggests that the compliance program is not fully effective

# Lessons Learned

- The importance of effective chains of communication of compliance issues
- The importance of individual accountability for compliance throughout the organization
- The compliance program is only one aspect of the organization's efforts to ensure compliance – quality processes are equally important

# Questions?

# Contact Us



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**Thank you.**