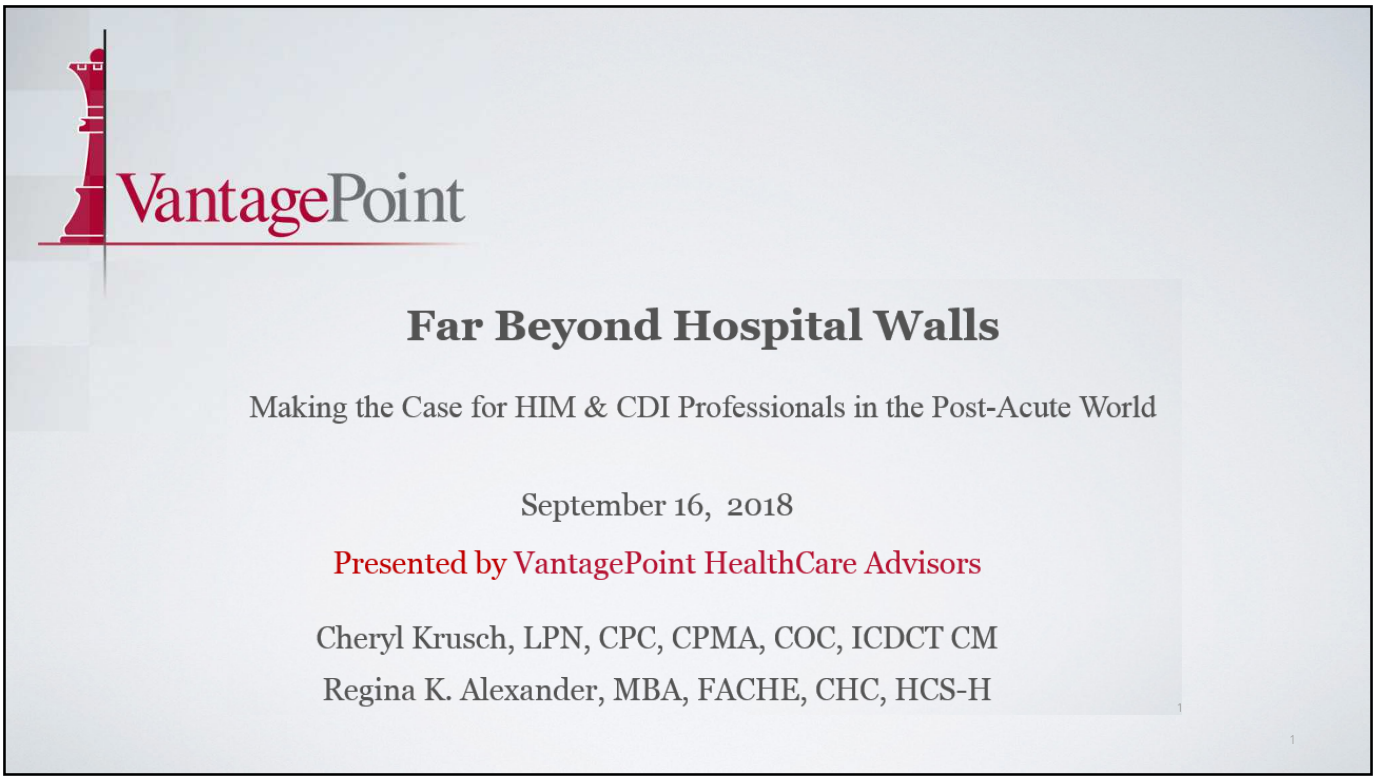
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Far Beyond Hospital Walls
Making the Case for HIM & CDI Professionals in the Post-Acute World
September 16, 2018
Presented by VantagePoint HealthCare Advisors
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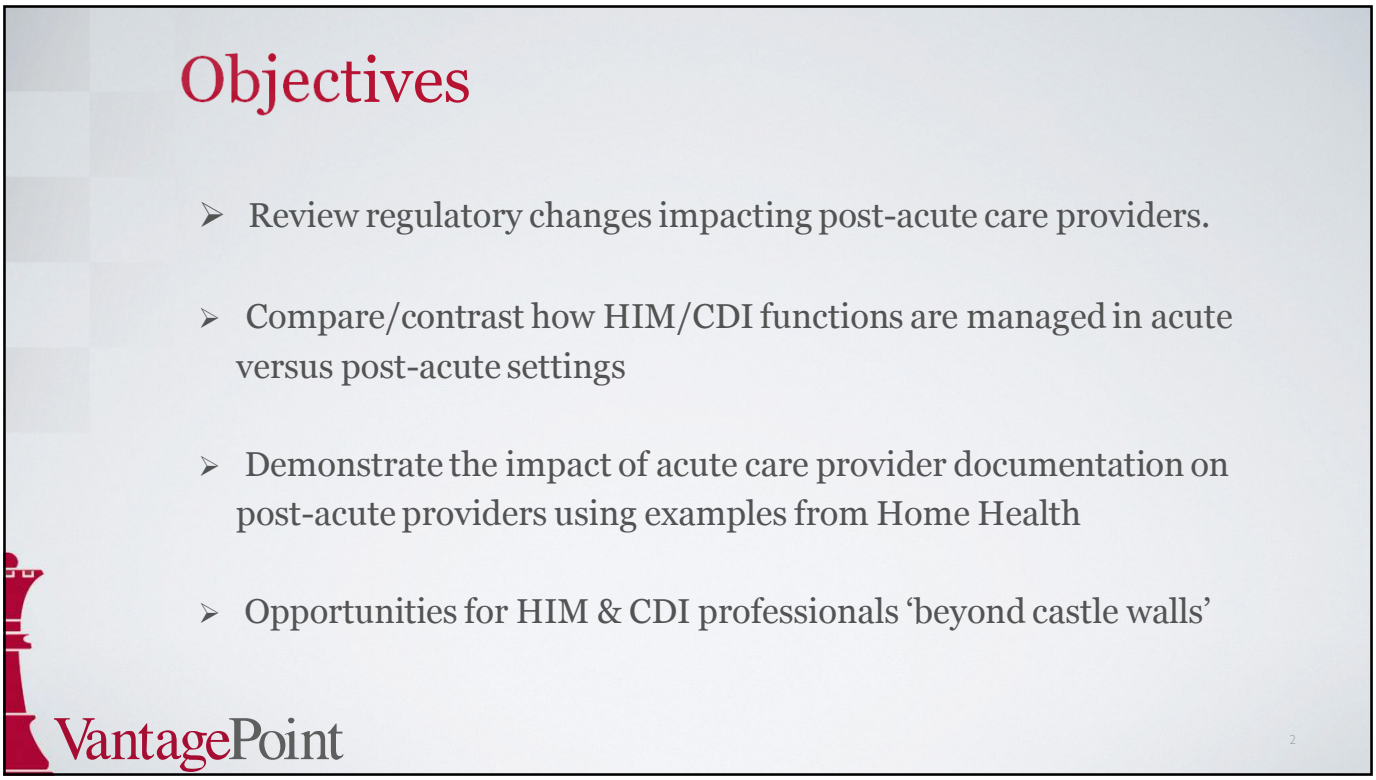
Objectives
Review regulatory changes impacting post-acute care providers.
Compare/contrast how HIM/CDI functions are managed in acute versus post-acute settings
Demonstrate the impact of acute care provider documentation on post-acute providers using examples from Home Health
Opportunities for HIM & CDI professionals 'beyond castle walls'
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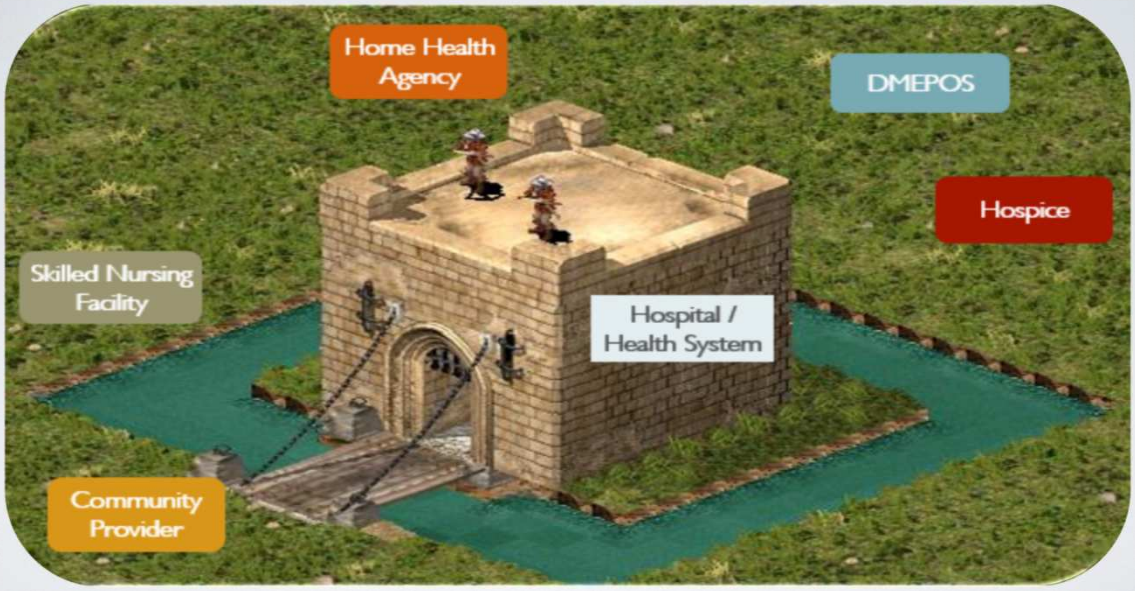
The Land Beyond Castle Walls……



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Our Journey into the Forrest

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But first, what does VantagePoint do as an IRO?

U.S. Department of Health & Human Services

Office of Inspector General
U.S. Department of Health & Human Services

About OIG | Reports & Publications | Fraud | Compliance | Exclusions

Home > Compliance > Corporate Integrity Agreements

Corporate Integrity Agreements

OIG negotiates corporate integrity agreements (CIA) with health care providers and other entities as part of the settlement of Federal health care program investigations arising under a variety of civil false claims statutes. Providers or entities agree to the obligations, and in exchange, OIG agrees not to seek their exclusion from participation in Medicare, Medicaid, or other Federal health care programs.

CIAs have many common elements, but each one addresses the specific facts at issue and often attempts to accommodate and recognize many of the elements of preexisting voluntary compliance programs. A comprehensive CIA typically lasts 5 years and includes requirements to:

- hire a compliance officer/appoint a compliance committee;
- develop written standards and policies;
- implement a comprehensive employee training program;
- retain an independent review organization to conduct annual reviews;
- establish a confidential disclosure program;
- restrict employment of ineligible persons;
- report overpayments, reportable events, and ongoing investigations/legal proceedings; and
- provide an implementation report and annual reports to OIG on the status of the entity's compliance activities.

Related Information

- Corporate Integrity Agreement Documents
- Corporate Integrity Agreement FAQs
- Quality of Care CIAs
- CIA Compliance Resources
- CIA Enforcements

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Claim Reviews are a Common Component of a CIA

2. *Claims Review.* The IRO shall conduct a review of claims submitted to and reimbursed by the Medicare and Medicaid programs by or on behalf of [redacted] and the [redacted], to determine whether the items and services furnished were medically necessary and appropriately documented, and whether the claims were correctly coded, submitted, and reimbursed for each three-month period during the term of this IA (Quarterly Claims Review) and shall prepare a Quarterly Claims Review Report, as outlined in Appendix B to this IA, which is incorporated by reference. The first three-month period for purposes of the Quarterly Claims Review requirement shall begin 30 days after the Effective Date. Each Quarterly Claims Review Report shall be submitted to OIG within 60 days following the end of the three-month period covered by the Quarterly Claims Review.

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Post-Acute Providers in the News

[not in a good way]

Texas Home Health Care Owners Make OIG's Most Wanted List

How Two Nursing Home Staffers Uncovered A $230M Medicare Fraud In Columbia, Tennessee

By BLAKE FARMER • JUN 11, 2018

Fraud Watch: Miami Home Health Owners Indicted in Scheme

July 24, 2016

SNF owner led record $1 billion Medicare fraud ring, authorities say

Illinois' home health care industry rife with fraud, tainted by unscrupulous physicians

Fraud Verdict May Cost Skilled Nursing Facility Operators $345 Million

OIG Puts the Pressure On as Hospice Fraud Cases Pile Up

By Robert Holly | June 24, 2018

In March 2018, Health and Palliative Services of the Treasure Coast and two of its businesses paid $2.5 million to settle a False Claims Act (FCA) case related to hospice billing.

A month later, Horizons Hospice agreed to pay more than $1.2 million to resolve allegations that the company fraudulently billed Medicare and Medicaid for services to patients who did not have a life expectancy prognosis of six months of less.

Both settlements came more than a year after Chemed Corporation (NYSE: CHE) and various wholly-owned subsidiaries—including Vitas Hospice Services and Vitas Healthcare, the biggest for-profit hospice chain in the country—agreed to pay a whopping $75 million to resolve a government lawsuit with similar allegations.

Fraud Watch: Michigan Agency Owner Guilty in $8 Million Fraud Case

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How Many Post-Acute Providers Feel

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Active OIG Work Plan Components with Post-Acute Care Focus & HIM-y type stuff

- *Review of Home Health Claims for Services with 5 to 10 Skilled Visits*
- Adult Day Health Care Services furnished per plan of care & eligibility requirements [Medicaid]
- *Home Health Compliance with Medicare Requirements*
- Trends in Hospice Deficiencies and Complaints
- Potentially Avoidable Hospitalizations of Medicare & Medicaid Eligible Nursing Facility Residents
- *Review of Hospices' Compliance with Medicare Requirements*

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Long-Term Care SNF/LTCH/Nursing Home

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SNF/LTCH/Nursing Home Fun Facts

- 65% of adults will require some sort of LTC, 35% will require at least 1 year in a nursing facility. (LongTermCare.gov 2017)
- 15,656 Nursing Homes / 1,694,777 beds (CDC, 2015)
- 56,525 fewer beds than in 1995, 5% reduction in # of facilities
- Proportion of for-profit ownership: 70%
- Medicare pays SNFs an average of $450-per-day, LTCHs $1,400 and in contrast, $73-a-day for home health care. (Forbes, Aug. 29, 2018)

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Regulatory Challenges

- FY19 – CMS SNF value-based purchasing program readmission measure: potential for + or – payments based on ***all-cause*** 30-day hospital readmission
- Patient-Driven Payment Model (PDPM) Proposal: changes formula used to determine SNF PPS per diem rate for individual patients, introduces length of stay incentives into the model.
- Targeted MAC *Probe & Educate* audits for high dollar/high error rate claims.
- Bipartisan Budget Act of 2013 phase in of site neutral payments reducing aggregate payments to LTCHs by $28 million each year with full effect in FY21 (HFMA, April 2018)

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How the HIM Skill Set Adds Value in SNF/NF/LTCH

- Robust clinical documentation and data analysis will be required to manage PDGM and appeals associated with all-cause readmission & MAC audits.
  - ✓ HIM & CDI professionals have experience responding to audits
- LTC facility adoption of certified EHRs significantly lags other sectors of the healthcare industry.
  - ✓ Hospital-based HIM professionals experienced in implementing, using, and maintaining EHRs.
- IMPACT Act of 2014 requires SNFs to report standardized data through MDS.
  - ✓ HIM coding and abstracting skills are a great fit to manage this process

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Hospice

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Hospice Basics

- 4,382 Medicare certified hospices (as of 2016)
- 2 physicians certify patient's qualifying terminal diagnosis
  - *Must be supported by acute medical record.*
- Terminal diagnosis coded first, followed in sequence by all diagnosis supporting terminal & relevant tertiary coded to highest level of specificity (new requirement as of 2016).
- Daily reimbursement based on level of care:
  - Routine (RHC), GIP, Continuous (CHC), Respite (IRC)
  - *Hospice record must support level of care provided as well as continued eligibility.*

Principal Diagnosis	Percentage
Cancer	27.2 %
Cardiac and Circulatory	18.7 %
Dementia	18.0 %
Respiratory	11.0 %
Stroke	9.5 %
Other	15.6 %

Level of Care	Percentage of Days of Care
Routine Home Care (RHC)	98.0 %
Continuous Home Care (CHC)	0.2 %
Inpatient Respite Care (IRC)	0.3 %
General Inpatient Care (GIP)	1.5 %

Total Days of Care*	Percentage of 2016 Medicare Payments for 2016
1-60	19.2 %
61-180	25.1 %
181-365	26.5 %
>365	29.2 %

Source: NHPCO (2017)

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Regulatory Challenges for Hospice

- Reduction of 'administrative burden' simultaneous with increasing scrutiny by HHS OIG re: FWA.
- Bipartisan Budget Act of 2018 & Physician Assistants
- Hospice Quality Reporting Program (HQRP): non-compliance = 2% reduction in Medicare payments
- IMPACT Act – Medicare certified Hospices mandatory surveys every 36 months for 10 years.
- Hospice CoP since 2008 require reporting *all diagnosis related to terminal condition*. FY2016 Final Rule requires **all diagnosis**, including behavioral health.

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How HIM Skills Add Value in Hospice

- Hospices need trained coders capable of effective querying and identifying all diagnosis to the highest level of specificity, not just the terminal or related conditions.
  - ✓ Inpatient coding professionals (CCS/CIC credentialed) well positioned to assist agencies in meeting CoP.
- Clinical documentation integrity and completeness is critical for the honest Hospice to defend level of service rendered and certification of terminal illness.
  - ✓ HIM professionals are experienced in ensuring medical records are complete & compliantly maintained.

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Home Health Agencies

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Home Health Agencies: By the Numbers

- Approximately 12,400 agencies in the U.S.
- 46% located in southern states (most) 8% in Northeast (least)
- 80% for-profit ownership model
- Third largest provider of long-term care services
- Most common chronic disease – diabetes
- $71 billion annual revenue, 72% paid by public programs

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Per CDC Fast Stats (2014)
& U.S. Census (2016)

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Another Home Health

CERT improper payment rate – 42%
[as of 2016]

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Regulatory Challenges for Home Health

- New Home Health CMS Conditions of Participation: January 13, 2018
- CT Medicaid- July 1, 2017 : New Face-to-Face Documentation Requirements for Initial Orders of Home Health Services
- Patient-Driven Groupings Model (PDGM) proposed for 2020.
- Pre-Claim Review Demonstration (PCRD) [aka Let's Make a Deal with a goat behind every door]
  - Choice between pre-payment review, post-payment review, or no review in exchange for a 25% payment reduction & liability for RAC

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How HIM Skills Add Value in Home Health

- PDGM will require HHAs to correctly sequence diagnosis codes and select codes to the highest level of specificity.
  - ✓ HIM coding and CDI expertise is needed for HHAs if/when reimbursement is directly impacted by accurate coding
- § 484.110 Condition of participation: Clinical records. 2018 changes now look a lot like standards hospitals follow in respect to authentication and required contents.
  - ✓ HIM ROI & record analysis skills a great fit to keep HHAs CoP compliant.

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Clinical Documentation Audit Rule of Thumb

- Not documented = not done
- Poorly documented = poorly done
- Incorrectly documented = fraudulent

Keeping this in mind.....

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Certifying Provider Record Must Support Medical Necessity of Home Care Services Ordered

History of Present Illness

Obesity (Follow-Up): The patient is being seen for follow-up of obesity. The patient reports doing well, a weight gain of pounds and a weight loss of 5 pounds.
Interval symptoms: stable poor eating habits, stable depressed mood, stable anxiety, denies dyspnea, denies fatigue, denies back pain and denies joint pain. The patient is not currently on medication for this problem.
Diet: She consumes a diverse and healthy diet.Weight Issues: She has weight concerns.Exercise: She does not exercise regularly.Smoking: She does not use tobacco.Alcohol: She denies alcohol use.Drug Use: She denies drug use.
Disease management: the patient is not doing well with her goals. Diet plan: low carbohydrate diet. Due for: diabetes screening and lipid profile.
Atrial Fibrillation (Follow-Up): The patient presents with paroxysmal atrial fibrillation. The treatment strategy for this patient is rate control. She has no comorbid illnesses. She has no significant interval events.
Symptoms: denies palpitations, denies chest pain, denies exercise intolerance, denies dyspnea on exertion and denies dizziness. Associated symptoms include no syncope, no focal neurologic deficit, no tendency for easy bleeding and no tendency for easy bruising.
Lifestyle: Diet: She does not have a healthy diet.Weight Issues: She has weight concerns.Exercise: She does not exercise regularly.Smoking: She does not use tobacco.Alcohol: She denies alcohol use.Drug Use: She denies drug use.

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Certifying Provider Record Must Support Medical Necessity of Home Care Services Ordered

History of Present Illness:
1. follow up
   75 y.o female here for routine follow up
   feels fine, no cp or sob

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Essential (primary) hypertension (I10), chronic.
2.	Assessment	Type 2 diabetes mellitus with other oral complications (E11.638), chronic.
	Plan Orders	The patient had the following test(s) completed today: GLUCOSE.

Ummm. So why were home care services ordered by the same provider on the same day as this visit ??????????

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What story do these code selections tell?

11. ICD-9/10-CM M51.37	Principal Diagnosis Other intervertebral disc degeneration, lumb	Date 12/13/2011
12. ICD-9/10-CM	Surgical Procedure	Date
13. ICD-9/10-CM M06.9 F32.9 F18.10	Other Pertinent Diagnosis Rheumatoid arthritis, unspecified Major depressive disorder, single episode, Inhalant abuse, uncomplicated	Date 12/13/2011 06/08/2018 12/13/2011

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HH&H Credentials

DecisionHealth

AHCC Home of BMSC & Caring Professionals

Home Care Coding Specialist – Diagnosis (HCS-D)
Home Care Coding Specialist – Hospice (HCS-H)
Home Care Clinical Specialist – OASIS (HCS-O)
Home Care Specialist – Compliance (HCS-C)

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