Quality Monitoring with "CPR" - Coding, Payback & Reporting to the OIG

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Padden, Guerrini & Associates P.C.

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Objectives

- Describe clinical documentation issues that contribute to inaccurate claim submission.
- Define the mechanics of researching and reporting a non-compliance issue through audit to disclosure and payback.
- Discuss advantages to conducting these activities under attorney-client privilege and what to expect once disclosure is made.

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Lewis Litigation Support and Clinical Consulting, LLC

Linda K. Lewis, RN, CNHA, RAC-CT is a litigation support and clinical consulting specialist with Lewis Litigation Support and Clinical Consulting, LLC in Butler, Pennsylvania who has been providing consulting services to nursing homes since 1997.

Linda works closely with attorneys, accountants, and long-term care providers to identify compliance issues and mitigate the consequences. In addition to litigation support, she provides services such as clinical documentation improvement, mock re-licensure surveys, and clinical preparation for a bundled payment environment.

Lewis Litigation Support and Clinical Consulting, LLC

Compliance – Compliance – Compliance

- Increasing scrutiny at every level of compliance
  - RAC, ZPIC, CERT
- Increasing emphasis on accountability
  - Individual vs. facility level

QAPI Monitoring

- Should be comprehensive and include MDS, supporting documentation and resultant claims
- Should include both internal and external monitoring functions
- Should identify the type of findings that trigger a referral to the Compliance Officer and a deeper dive (audit)

Compliance Plan

- Compliance Officer
- Define auditing and monitoring systems
- Must identify the reasonable steps that would be taken if a violation is detected
- Should define a process for disclosure/re-payment
- Consistent with OIG and Department of Justice guidelines

Findings That Require Additional Research

- Setting of ARD's and opening of MDSs is being backdated
- Therapy student minutes are being recorded as treatment minutes on the MDS
- Therapy treatment minutes are always in 5 or 10 minute increments
- Total therapy minutes are consistently no more than 10 minutes above the RUG floor
- There are no signed certification/re-certifications on file for traditional Medicare Part A

Findings That Require Additional Research

- Individual therapist productivity is approaching or above 100%
- A therapist documents minutes on more days of the week than s/he works
- Claims are being submitted under the presumption of coverage criteria for days beyond the ARD of the 5-day PPS assessment
- Holes in paper MARs or ADL records are filled in more than 24-hours after the event and/or by a staff member not providing the care
- The staff assessment for mood is being completed for residents capable of being interviewed

Findings That Require Additional Research

- The attending physician changes the frequency of lab orders and/or the ointment to be used for a treatment in a visit to the resident every few days
- Nursing orders are counted as physician orders

Conditions of Payment vs. Conditions of Coverage

- Conditions of Payment – CFR Title 42 §424.20
  - Physician certification - Content, timing, signature, substitution with utilization review
- Conditions of Coverage – Skilled coverage criteria – CFR Title 42 §409.31

First Things First

- Bring the non-compliant practice into compliance
  - Training and competency assessment
    - Review candidate screening and employee orientation
  - Checks and balances
    - Triple-check process
  - Improve oversight – frequency of monitoring
  - Terminate an improper arrangement (90 days)
  - Terminate an employee

Where to Begin

- Determine the scope of the non-compliance
- Proceed with audit team working under attorney-client privilege
- Sampling of records going back in time until you reach a point of compliance, OR 6 years
  - Over what period of time did the non-compliance persist
  - All records or some subset
    - Particular practitioner
  - Determine the extent of additional auditing necessary to mitigate the payback
    - Extrapolation vs. full audit

Understanding Privilege

- Audit team is in your building and in your records but can disclose NOTHING to you
- Maintain integrity of the audit room – management should not visit the auditors in the audit room while they are working or if the room is set aside for them
- All disclosure from the audit team is directly to the attorney engaged under
- Only the attorney discloses to the facility management, and likely, not until the audit is completed
- Even issues with cooperation of staff, timeliness of record retrieval, etc., is addressed through the attorney unless s/he gives approval for it to be addressed directly

Why an Attorney and Why under Privilege?

- Attorney is best qualified to research relevant prior proceedings
  - Medicare Appeals Council – Elmhurst Care Center, September 29, 2009
  - Medicare Appeals Council – Elmwood Health Center, October 30, 2009
- Disclosure is to an attorney at OIG and Justice – to level the playing field you need an attorney representing you

Building an Audit Team

- Seasoned members
  - May need to know some history
    - MDS 2.0
    - MDS 3.0
    - RUGs 44
    - RUGs 53
    - RUGs 66
    - Sequestration
    - Implementation of COT MDS and changes in EOT requirements
    - Implementation of RAI Manual changes – definitions of individual, concurrent and group therapy
- Detail oriented – working knowledge of MDS mechanics

Building an Audit Team

- Familiar with the nuances of LTC documentation
  - Nursing notes vs. flow records
- Equipment Needs
  - Portable scanner if disclosure to OIG anticipated
- Familiar with Software Applications
  - MDS software
  - Microsoft Excel

Stefanie Knaub
Padden, Guerrini & Associates, P.C.

Stefanie Knaub has run the medical billing department at Padden, Guerrini & Associates for 18 years. Her department offers all third party billing and collections to skilled nursing facilities, as well as billing and compliance audits to identify additional reimbursement opportunities, billing errors and identify staff training issues.

They offer on-site training to reimbursement staff to increase knowledge and reduce claim errors. They also specialize in accounts receivable reviews to determine to collectability of accounts, identify rebilling opportunities and maximize cash flows.

P G & A
Padden, Guerrini & Associates P.C.
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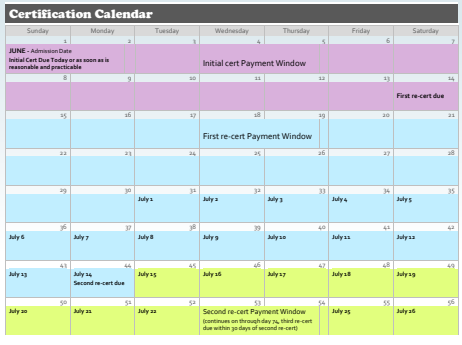
Determining Payback Amount

- Determine full or partial payback
  - Missing certs/re-certs could result in a full payback
  - Improper recording of therapy minutes could result in a lower RUG for a partial payback
- Determine if MDS is affected by findings
  - Determine coverage dates
  - Determine type of MDS
    - Scheduled MDS
    - Unscheduled MDS

Certification Payment Chart

Table 1. Certifications

Certification Type	Due Date	Medicare Payment Days
Initial certification	Upon admission or as soon as is reasonable and practicable	Days 1-14
First re-certification	By day 14	Days 15-44
Second re-certification	Within 30 days of first re-certification	Days 45-74
Third re-certification	Within 30 days of second re-certification	Days 75-100



MDS Payment Charts

Table 2. Scheduled Assessments

Assessment Type	AI (Claim Modifier)	ARD Window	Grace Days	Medicare Payment Days
5-day	10	Days 1-5	Days 6-8	Days 1-14
14-day	20	Days 13-14	Days 15-18	Days 15-30
30-day	30	Days 27-29	Days 30-33	Days 31-60
60-day	40	Days 57-59	Days 60-63	Days 61-90
90-day	50	Days 87-89	Days 90-93	Days 91-100

Table 3. Unscheduled Assessments

Assessment Type	AI (Claim Modifier)	ARD Window	Grace Days	Medicare Payment Days
Change of Therapy (COT)	00 (if stand alone COT)	Day 7 of the COT observation period	Not allowed	Day 1 of that COT observation period through next MDS start date
End of Therapy (EOT)	04 (if stand alone EOT)	1-3 days after all therapy services end	Not allowed	First day of no therapy services through next MDS start date
Start of Therapy (SOT)	02 (if stand alone SOT)	5-7 days after the start of therapy	Not allowed	First day of therapy services through next MDS start date

MDS Calendar for Scheduled PPS Assessments

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 JUNE Admission Date	2	3	4 5 Day MDS Payment Window		6	7
8 5 Day MDS ARD	9	10	11	12	13	14
15 14 Day MDS ARD	16	17	18 14 Day MDS Payment Window	19	20	21
22	23	24	25	26	27	28
29 30 Day MDS ARD	30	July 1	July 2	July 3	July 4	July 5
36 July 6	July 7	July 8	July 9	July 10	July 11	July 12
43 July 13	July 14	July 15	July 16	July 17	July 18	July 19
50 July 20	July 21	July 22	53 30 Day MDS Payment Window (continues on through day 60 if no other unscheduled assessments completed)	54	July 25	July 26

MDS Calendar for Unscheduled COT PPS Assessment

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 JUNE Admission Date	2	3	4 5 Day MDS Payment Window		6	7
8 5 Day MDS ARD	9	10	11	12	13	14
15 14 Day MDS ARD	16 Payment Changes	17	18	19	20	21
22 COT MDS ARD	23	24	25 COT MDS Payment Window	26	27	28
29 30 Day MDS ARD	30	July 1	July 2	July 3	July 4	July 5
36 July 6	July 7	July 8	July 9	July 10	July 11	July 12
43 July 13	July 14	July 15	July 16	July 17	July 18	July 19
50 July 20	July 21	July 22	53 30 Day MDS Payment Window (continues on through day 60 if no other unscheduled assessments completed)	54	July 25	July 26

MDS Calendar for Unscheduled COT Combined with Scheduled PPS Assessment

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 JUNE Admission Date	2	3	4 5 Day MDS Payment Window	5	6	7
8 5 Day MDS ARD	9 Payment Changes	10	11	12	13	14
15 COT/14 Day MDS ARD	16	17	18 COT/14 Day MDS Payment Window	19	20	21
22	23	24	25	26	27	28
29 30 Day MDS ARD	30	31 July 1	32 July 2	33 July 3	34 July 4	35 July 5
36 July 6	37 July 7	38 July 8	39 July 9	40 July 10	41 July 11	42 July 12
43 July 13	44 July 14	45 July 15	46 July 16	47 July 17	48 July 18	49 July 19
50 July 20	51 July 21	52 July 22	53 30 Day MDS Payment Window (continues on through day 60 if no other unscheduled assessments completed)	54	55 July 25	56 July 26

MDS Calendar for Unscheduled EOT PPS Assessment

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 JUNE Admission Date	2	3	4 5 Day MDS Payment Window	5	6	7
8 5 Day MDS ARD	9	10	11	12	13	14
15 14 Day MDS ARD	16 14 Day MDS Payment Window	17	18 Last day of Therapy	19 Payment Changes	20	21 EOT MDS ARD
22	23 EOT MDS Payment Window	24	25	26	27	28
29 30 Day MDS ARD	30	31 July 1	32 July 2	33 July 3	34 July 4	35 July 5
36 July 6	37 July 7	38 July 8	39 July 9	40 July 10	41 July 11	42 July 12
43 July 13	44 July 14	45 July 15	46 July 16	47 July 17	48 July 18	49 July 19
50 July 20	51 July 21	52 July 22	53 30 Day MDS Payment Window (continues on through day 60 if no other unscheduled assessments completed)	54	55 July 25	56 July 26

MDS Calendar for Unscheduled SOT Combined w/ Scheduled PPS Assessment

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 JUNE Admission Date	2	3	4 5 Day MDS Payment Window	5	6	7
8 5 Day MDS ARD	9	10	11	12	13	14
15 14 Day MDS ARD	16 14 Day MDS Payment Window	17	18 Last day of Therapy	19 Payment Changes	20	21 EOT MDS ARD
22 EOT MDS Payment Window	23	24	25	26	27 Therapy Resumes Payment Changes	28
29	30	31 July 1	32 July 2 SOT/30 Day MDS ARD	33 July 3	34 July 4	35 July 5
36 July 6	37 July 7	38 July 8	39 July 9	40 July 10	41 July 11	42 July 12
43 July 13	44 July 14	45 July 15	46 July 16	47 July 17	48 July 18	49 July 19
50 July 20	51 July 21	52 July 22	53 SOT/30 Day MDS Payment Window (continues on through day 60 if no other unscheduled assessments completed)	54	55 July 25	56 July 26

RUG Rate Sheet Lancaster County 2016

EFFECTIVE FOR SVCS BEG. 10/01/2015

RUG-IV Category	Labor Component	x Wage Index	Indexed Labor Portion	+ Non Labor Portion	= Total Federal Payment at 100 %	Increase Per BIPA of 2000 for FY 2016'	BIPA Adjusted Federal Payment
RUX	542.78	0.9440	512.38	242.72	755.10	0.00	755.10
RUL	530.96	0.9440	501.22	237.43	738.65	0.00	738.65
RVX	483.11	0.9440	456.06	216.04	672.10	0.00	672.10
RVL	433.44	0.9440	409.16	193.82	602.98	0.00	602.98
RHX	437.71	0.9440	413.20	195.73	608.93	0.00	608.93
RHL	390.40	0.9440	368.54	174.58	543.12	0.00	543.12
RMX	401.52	0.9440	379.03	179.55	558.58	0.00	558.58
RML	368.40	0.9440	347.77	164.74	512.51	0.00	512.51
RLX	352.62	0.9440	332.87	157.68	490.55	0.00	490.55
RUC	411.56	0.9440	388.45	184.01	572.46	0.00	572.46
RUB	411.56	0.9440	388.45	184.01	572.46	0.00	572.46
RUA	344.08	0.9440	324.81	153.86	478.67	0.00	478.67
RVC	353.01	0.9440	333.24	157.86	491.10	0.00	491.10
RVB	305.70	0.9440	288.58	136.70	425.28	0.00	425.28
RVA	304.52	0.9440	287.46	136.17	423.63	0.00	423.63
RHC	307.61	0.9440	290.38	137.55	427.93	0.00	427.93
RHB	276.86	0.9440	261.35	123.80	385.15	0.00	385.15
RHA	243.73	0.9440	230.08	108.99	339.07	0.00	339.07
RMC	270.23	0.9440	255.16	120.84	375.94	0.00	375.94
RMB	253.67	0.9440	239.47	113.44	352.91	0.00	352.91
RMA	208.72	0.9440	197.03	93.34	290.37	0.00	290.37

Issuing The Payback

- Cutting a check
- Performing Claim Adjustment
  - Within billing software package
  - FISS (Fiscal Intermediary Shared System)
    Medicare's online system

Adjusting a RUG for Lower Payment

- In order to adjust a claim to a Lower RUG for payment takeback:
  - Has no time limit on when adjustment can be done
  - Bill type will change to a 217
  - Add DCN (document control number) to box 64 of the claim
  - Use condition code D2 and adjustment reason code OT
  - Add notes in Remarks box stating change in RUG score
  - Make RUG change

Adjusting a RUG for Higher Payment

- In order to adjust a claim to a Higher RUG for payment:
  - Must be within 120 days of the date of service of the claim
  - All claim adjustment instructions are identical to previous example

Provider Liable Days

- Determine that no payment should have been made
  - Entire Medicare A stay
  - One MDS or cert payment window
- Provider liable days will not be paid by Medicare, will not be the resident's responsibility, but the days will still count as used from the resident's 100 Medicare Part A Skilled Nursing benefit period

Adjusting a Claim to Reflect Provider Liable Days

- In order to adjust a claim for provider liable days for payment takeback:
  - Has no time limit on when adjustment can be done
  - Bill type will change to a 217
  - Add DCN (document control number) to box 64 of the claim
  - Use occurrence span code 77 with date span of non-payable days
  - Use condition code D9 and adjustment reason code OT
  - Provider liable days listed as covered days
  - Add notes in Remarks box pertaining to the reason for provider liable days

Managed Care Payers

Mary Kate McGrath, Esquire
Marshall Dennehey Warner Coleman & Goggin

Mary Kate McGrath, Esq., is an associate in the Health Care Department in the Philadelphia, Pennsylvania, office of Marshall Dennehey Warner Coleman & Goggin.

Mary Kate has focused her legal career on the defense of health care providers, hospitals, health systems, rehabilitation centers and skilled nursing facilities. She also handles matters involving fraud and abuse, including defending and advising health care clients regarding government payment programs, electronic discovery and privacy matters.

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When to Retain Counsel?

- As soon as the facility becomes aware of a potentially inaccurate claim submission.
- The Attorney Client Privilege will apply to the communications which are necessary to investigate the genesis of the potentially inaccurate claim submission.

Bringing Counsel into Mission Control

- Counsel will take an objective assessment of the moving parts, and will provide a perspective that may be difficult to maintain for those directly involved.
- Counsel will serve as a liaison between the facility and all members of the audit team, preserving the important need to keep distance between the audit team and the facility.
- Counsel will communicate with the government on behalf of the facility.

Time is of the Essence

- No matter how inadvertent or unintentional, inaccurate billing practices are a serious matter, and carry significant potential for penalty.
- Penalties include monetary amounts, the right to intervene in facility management through exercising exclusion authority such as a corporate integrity agreement (CIA) and even criminal penalties.
- Comporting with timing requirements and promptly disclosing a potential inaccuracy serves to mitigate the severity of the government response.

What is Exclusion Authority?

- Section 1128(b)(7) of the Social Security Act (42 USC 1320a – 7(b)7) provides the OIG with the ability to exercise permissive exclusion authority in response to any conduct which may be pursued under the False Claims Act.
- The OIG now follows a "risk assessment continuum", in which a facility is placed on a scale of high to low risk.
- The OIG response could include corporate integrity agreements, and specific monitoring by the OIG of the facility.

Four Factors of OIG Risk Assessment

- Nature and circumstances of conduct
- Conduct of facility during investigation
- Significant ameliorative effects (whether appropriate disciplinary actions were taken against those responsible for the billing practice)
- History of Compliance.

Self-Disclosure and 1128(b)(7) authority

- Under the new guidelines, the OIG has established that it may "release" its exclusion authority, when a facility has self-disclosed the issue.
- Taking government involvement off the table is a strong argument for self-disclosure.

Disclosure to the OIG

- Detailed letter – preferably from your attorney to the OIG – disclosing the issue
  - Mission of the organization
  - Organization commitment to compliance
  - Dates of discovery
  - Time and expense in determining scope of problem
  - Qualifications of those conducting the audit
- OIG will assign an attorney and perhaps also report to Dept. of Justice who will also assign an attorney
- One or the other of those attorneys will take the lead in researching the disclosure and calculating a penalty amount

Let the Attorney Work the Process

- Once the approach to the government is made, the attorney representing the facility facilitates movement through resolution of the claim.
- This takes enormous pressure off of administration, and allows those at the facility to avoid racing heart beats and high blood pressure in efforts to avoid a misstep.
- The attorney fields all communication, interprets messages and provides counsel so the facility is well-equipped to make confident decisions throughout the negotiation process.

Meetings, Meetings and More Meetings

- Expect several meetings throughout this process, not only with the attorney and audit team, but also with the government once the disclosure is made.
- Investigators and attorneys will request access to the records, and will request face time meetings during their investigation of billing practices.
- Once their investigation is completed, investigators and attorneys will meet to discuss their findings and recommendations.
- Having an attorney present during these meetings will assist with disclosing appropriate, non-privileged information.

The Negotiation Phase

- Once the government has reached a conclusion about the value of the prior inaccuracies, the attorney can field these communications, and prepare the facility for the next steps.
- The attorney advocates on behalf of the facility, providing evidence of the remedial measures, in efforts to avoid punitive action by the government, and negotiate a reasonable outcome for the facility.
- Having remedial measures in place is invaluable tool during negotiations, because it indicates a good faith effort to remedy the issue.

Resolution

- The audit team and the attorney will provide the facility with all of the information necessary, so the facility is in control of a difficult and potentially stressful process.
- Forewarned is forearmed, and the self-disclosing facility is in a stronger position than the ambushed facility, maintaining stronger negotiation ability and the ability to avoid government involvement in the facility.
- With the support of the audit team and the attorney, the facility will make it through the experience with the knowledge necessary to avoid these issues in the future.