



The ABCs of Compliance:

Accountability, Best Practices
and Consistency

Accountability, Best Practices and Consistency

Never before in healthcare have we heard the word “compliance” as often as we do today. Kathleen Hessler, Director of Compliance & Risk for Simone Healthcare Consultants, says, “It is the fashionable buzz word, but the focus of compliance at provider organizations may mean different things to the board of directors or executive team than it does to the managers or staff working in home health and hospice.”

In describing the various compliance requirements, Hessler refers to the three “buckets” of compliance in which home health and hospice providers need to be vigilant, noting that some requirements overlap or spill into each other. Thinking of these three distinct buckets can break down the massive and vague concept of “compliance” and direct agencies’ compliance efforts in a more focused way.



This white paper will help home health and hospice agencies better understand the three “buckets” of compliance — and the importance of each, focusing attention on:

- Measures that help prevent violations of the state and federal Anti-Kickback laws and False Claims Acts, which the government uses to penalize providers for improper referrals and inappropriate billing practices that result in overpayments.
- An overview of steps to develop and maintain an effective compliance program that focuses on the **accountability, best practices and consistency** that are so crucial in today’s dynamic healthcare environment.

What are the three buckets of compliance?



Bucket One: HIPAA

Every health care employee should understand the basics of the Health Insurance Portability and Accountability Act's (HIPAA) privacy and security provisions, which govern how providers safeguard patients' protected health information. Healthcare entities must appoint a HIPAA Security Officer who, at a minimum, should: 1) ensure that all employees and contractors receive HIPAA education, and 2) investigate and follow through on allegations of non-compliance. Enforcement authority for HIPAA is vested by the Department of Health and Human Services (HHS) to its Office for Civil Rights (OCR).



Bucket Two: Conditions of Participation

The Medicare Conditions of Participation (CoPs) implemented by the Centers for Medicare and Medicaid Services (CMS) constitute the second bucket of compliance, which is setting forth the requirements for providers to receive Medicare and Medicaid payments. Although similar in many respects, the Medicare CoPs for hospice (2008) are a separate and distinct set of regulations than the home health CoPs. CMS completed a comprehensive update of home health CoPs that became effective in January 2018. Medicare requires that provider agencies be surveyed every three years and/or if a complaint is filed against the provider agency alleging violations of the regulations.



Agencies working on CoP implementation and survey preparation need to be aware that surveyors do not focus on billing requirements or compliance for clinical documentation as a condition of payment. In short, the CoP regulations focus on patient rights, quality, performance improvement processes, and coordination of care. They are inclusive of provisions on patient privacy and confidentiality, thus providing overlap with HIPAA laws and compliance.



Bucket Three: Medicare Billing and Payment Requirements

The third bucket of compliance includes Medicare and Medicaid billing and payment issues. Documentation and billing requirements are set forth in the Medicare Benefit Manuals and Claims Manuals – with some clear overlap on CoPs. While Medicaid programs may often mirror the Medicare regulations, they can vary in scope.

The Office of Inspector General (OIG) has set forth seven elements of a compliance program to guide providers in implementing effective compliance efforts, and in promoting an understanding among employees of the seriousness of violating state and federal laws. A solid compliance program will provide education to staff about the harm and potential criminal penalties associated with payments for referrals, and training on the requirements for proper clinical documentation and requisite billing practices.

7

Seven Fundamental Elements of a Compliance Program

1. Implementing written policies, procedures and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
6. Enforcing standards through well-publicized disciplinary guidelines.
7. Responding promptly to detected offenses and undertaking corrective action.

Source: oig.hhs.gov

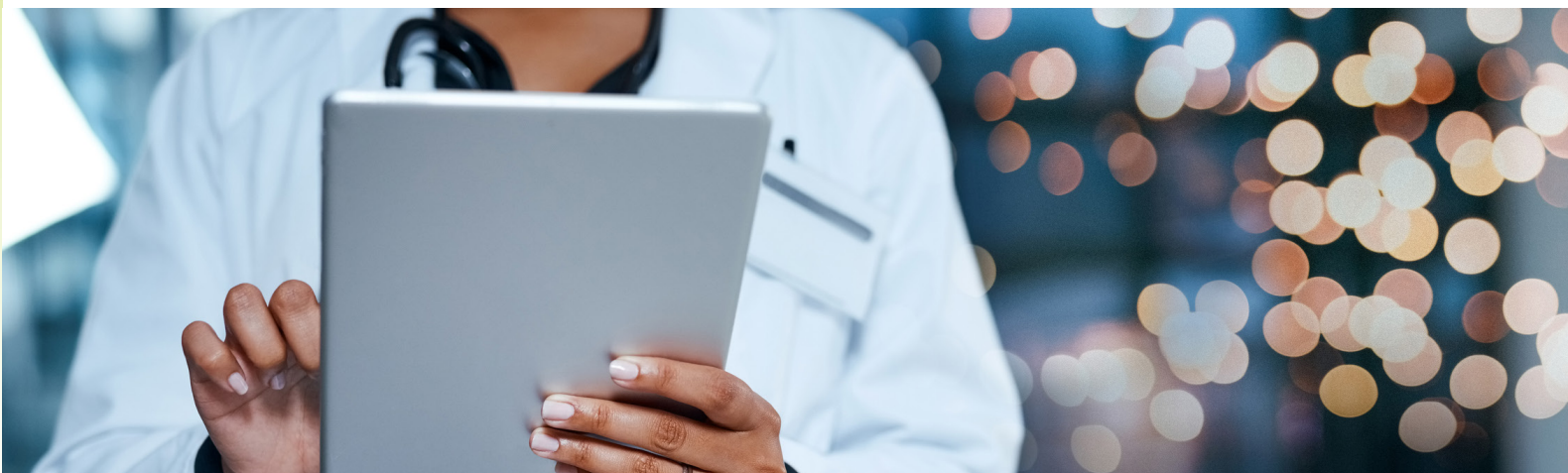
“Compliance can be complicated due to the ‘spill factor’ across the three buckets,” Hessler emphasizes. For example, some billing requirements — such as having a signed plan of care, showing that there was a face-to-face encounter with a certifying physician and conducting interdisciplinary group meetings for hospice — are addressed in the CoPs and the Medicare Manuals.

Providers are under increasing scrutiny from a variety of government watchdogs since the OIG declared that rooting out home health and hospice fraud and overpayments is a top priority. Medicare government contract payors and auditors such as the Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs) and United Program Integrity Contractors (UPICs) have stepped up activity in recent years, putting more agencies in the hotseat over billing and payment practices. With data analytics, these contractors monitor billing practices among like providers and compare them to determine what providers will be targeted for audits. When the results of audits demonstrate potential abusive or fraudulent practices, the OIG works with the Department of Justice (DOJ) to further investigate agencies in question.

“Compliance can be complicated due to the ‘spill factor’ across the three buckets.”

Kathleen Hessler, Director of Compliance & Risk for Simone Healthcare Consultants

Since Medicare revenue is the financial backbone of home health and hospice agencies across the country, ensuring that billing and payment policies and procedures are compliant is critical. The stakes are high considering the cost in dollars, resources and time that providers incur during audits, appeals and legal proceedings. Sizable financial penalties, criminal and civil charges, and exclusion from government programs can ultimately be levied.



Accountability, Best Practices and Consistency

Agencies can formalize their compliance functions by taking a proactive approach and adhering to best practices. If an agency has an effective compliance plan in place yet finds itself with an overpayment situation, the OIG and DOJ are often willing to mitigate damages. According to Hessler, an effective program in billing and payment compliance, if proactive, should reduce the likelihood of audits and investigations, thus minimizing the risks of overpayments or legal proceedings.

“In the current climate, preventive compliance efforts are absolutely essential to avoiding problems requiring legal representation, and the expense and struggle involved in defending an agency’s integrity,” Hessler says.

Hessler recommends these “best practice” steps to create and maintain a prevention-focused compliance program:

Create a dedicated compliance team and name it.

This may sound simplistic, but as home health and hospice providers face reimbursement pressures, tight labor markets and other challenges, they should identify top-notch clinicians or other leaders within the organization who can take on a compliance-focused role. For a multi-location provider, compliance demands mean having leaders at both the corporate and agency level in designated roles.

This comprehensive approach is working well for Compassionate Care Hospice (CHC), a Parsippany, New Jersey-based company currently serving patients in multiple locations across 20 states. Stella Hardy, Director of Compliance and Quality at CHC says, “We support our locations around the country through education resources, as well as by optimizing processes and procedures so that agencies know practices have been vetted and approved and should pass muster even under rigorous review by auditors and other parties.”

Educate clinical staff on how their documentation forms the basis for billing and payment.

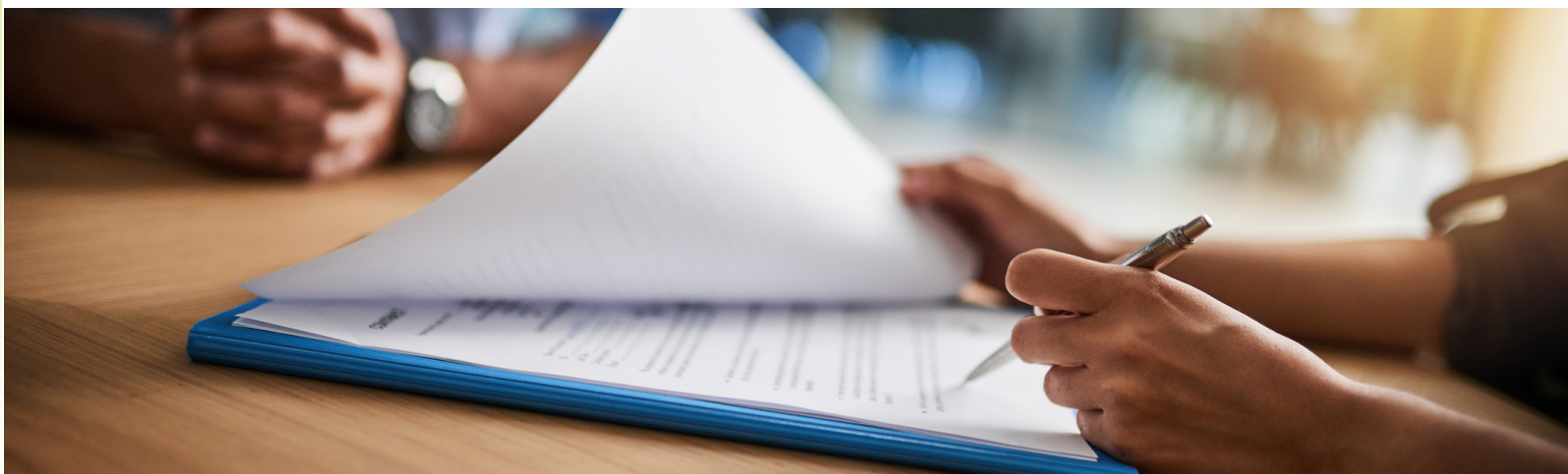
Even home health and hospice providers that are operating in an above-board manner sometimes find themselves in jeopardy because their documentation is not strong enough to prove that they are compliant with billing and payment rules, Hardy says. Documentation on hospice eligibility or medical necessity and homebound status for home health patients lends itself to subjectivity making timely and measurable documentation critical.

Hessler and Hardy concur that a compliance program is only effective if documentation practices are consistent and training and education is ongoing. Continuous internal monitoring and auditing with intermittent or annual external clinical record reviews and follow-up education is crucial.

“Medicare requires technical documentation compliance such as the correct timing of signatures and dates, the use of attestations, and specific language requirements for consents, to name a few. We see payment denials for lack of compliance with technical correctness. We offer a service to review forms to ensure this level of accuracy,” adds Hessler. Agencies should work with their EHR vendor to make sure they have the correct forms and edits electronically set.

“We see payment denials for lack of compliance with technical correctness. We offer a service to review forms to ensure this level of accuracy.”

Kathleen Hessler, Director of Compliance & Risk for Simone Healthcare Consultants



Conduct pre-billing audits and use data analytics to track billing patterns.

Compassionate Care Hospice has benefited by doing pre-billing audits, Hardy says. This involves reviewing claims before they go out the door to catch any correctable errors and address them. These audits are a way to self-monitor and reduce the likelihood of questionable patterns and potential overpayment issues. Simone's compliance team provides ongoing remote support for agencies by conducting pre-bill audits and providing education where gaps or weaknesses are detected.

Technology is a key tool that can capture and report billing patterns and provide benchmarks for comparison. Only in this way can agencies flag and address potential trouble spots and prepare a plan to monitor and audit. PEPPER reports are a valuable resource but providers need to review timely sources of data from the agency's EMR.



Technology is a key tool that can capture and report billing patterns and provide benchmarks for comparison.

Identify the billing and payment issues under scrutiny and develop an audit plan.

In addition to using data analytics and PEPPER reports to target providers whose data is out of line with the norm, government entities issue reports on billing practices under special scrutiny. For instance, in July 2018, [the OIG issued a comprehensive report](#) on hospice fraud and care quality concerns. In 2016, the OIG identified common nationwide characteristics of home health agencies that would trigger suspicion of fraudulent behavior. Agencies should keep abreast of the OIG Work Plans and develop an annual audit plan that is inclusive of all areas under scrutiny.

Scrutiny for hospice continues to focus on patients' eligibility for services, which means that the documentation has to demonstrate that a beneficiary has a life expectancy of six months or less given their diagnosis and prognosis. Another area of government focus is the frequency with which hospices are billing for general inpatient care and continuous home care.

Home health agencies are currently under particular scrutiny for homebound status and medical necessity of services such as therapy, according to attorney Carol Saul, a partner with Arnall Golden Gregory LLP, Atlanta, who frequently represents home health and hospice agencies. Simone's compliance team works with Saul and other health care attorneys across the country to provide expert clinical review of patient records in home health and hospice in matters where the government alleges overpayments. Hessler explains, "We are often able to refute payment denials and will provide expert witness testimony as needed in Administrative Law Judge (ALJ) hearings or for cases in litigation. We also serve as the Independent Review Organization (IRO) for companies that are under a Corporate Integrity Agreement (CIA)."

Use resources such as state and national provider associations and consultant groups.

The billing rules are complex, and agencies such as CMS and their contractors, the MACs, continuously provide additional clarifications and updates, while implementing new regulations. The steps outlined in this white paper are a starting point to an effective compliance program, but each provider will have unique challenges depending on their business structure, markets, and goals for expansion. Even the most robust internal compliance team benefits from the expertise of outside authorities that specialize in regulatory and legal affairs.



While many home health and hospice organizations devote resources to compliance, some agencies may not give enough thought to the complexities of what compliance actually means in terms of billing and payment. They might have a false sense of security by only having one or two “buckets” of compliance measures in place. “Executives and managers have expressed surprise over identified Medicare overpayments and say they don’t understand how the agency could be liable for overpayments when they just had a stellar survey,” Hessler says. “Surveyors are not there to audit for the requisite payment requirements. That’s why a comprehensive compliance program as outlined by the OIG is essential in every home health and hospice organization.”

“Compliance is everyone’s job. It is a collaborative effort across organizational divisions, departments, and provider locations, and requires consistency and oversight of practices,” she adds.

Get Expert Help for Compliance & Risk

Simione Healthcare Consultants offers comprehensive expertise to support clinical, operational, billing and financial compliance with a long track record of collaboration with health care attorneys, industry executives, governing boards, and compliance and audit departments to:

Assess clinical, documentation, billing and operational compliance

- Compliance program risk & effectiveness assessments
- Compliance program development
- Random sample probe audits and validation audits
- Pre-bill audits
- Additional documentation requests (ADRs) and focused medical review
- Reviews of billing and documentation processes
- Compliance education and seminars
- Mock surveys and survey corrective action plans

Improve clinical & technical documentation

- Customized education programs
- Customized audit tools
- Forms reviews

Determine reporting and disclosure responsibilities in partnership with legal counsel and compliance officers

- Probe/discovery audits
- Attorney privileged valid disclosure audits
- Rebuttals for redetermination and reconsiderations
- Expert witness testimony in ALJ hearings and litigation
- Acting as an Independent Review Organization (IRO) for Corporate Integrity Agreements (CIAs)

Contact

Contact Simone Healthcare Consultants to learn more about our solutions for home health, hospice and palliative care.

Fill out a request form: www.simione.com/contact/request-service

Or call for more information: **844-293-1530**

