Nursing Homes Brace for Onslaught of Federal and State Audits

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Medicare- and Medicaid-certified long term care facilities (skilled nursing facilities (SNFs) and nursing facilities (NFs), respectively) across the country are preparing for an onslaught of federal and state audits, if they are not already the subject of such reviews. The U.S. Department of Health & Human Services, Office of Inspector General (OIG) has made no secret of its belief that SNFs have been overbilling Medicare. With the singular exception of its Work Plan for Fiscal Year 2002, OIG has identified therapy billing, including the accuracy of Minimum Data Set (MDS) and resource utilization groups (RUGs) coding, as a target of enforcement every year since 1997.[1] In its November 2012 report on the topic, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More than a Billion Dollars in 2009*, OIG reiterated its longstanding belief that SNFs have been misbilling Medicare by submitting inaccurate, medically unnecessary, and fraudulent claims and that the government needs to improve its monitoring and enforcement activities in this area.[2]

OIG's November report grabbed national attention. An article in the *Wall Street Journal* described the report as "part of a years-long initiative by [OIG] to rein in costs at the 15,000 nursing homes that provide skilled nursing, for which the government paid $32.2 billion in fiscal 2012."[3] While this is not surprising given the tenor of the report and others upon which it builds, providers may be troubled by the *Wall Street Journal's* account that "[t]he OIG termed its overall look into this issue Operation Vacuum Cleaner."[4] The moniker speaks for itself, and providers are well advised to heed its warning.

In the November report, OIG examined only a small number of claims, 449 claims from a stratified random sample of 245 stays with a service date in 2009. OIG projected their findings to the total population of 6,444,273 claims.[5] Through this extrapolation methodology, OIG concluded that SNFs billed an estimated 25% of claims in error in 2009, accounting for inappropriate payments of $1.5 billion.[6]

OIG Recommendations to CMS Will Increase Scrutiny

OIG made five recommendations to the Centers for Medicare & Medicaid Services (CMS) that will have an immediate impact on nursing facilities across the country. Nursing facilities should anticipate increased scrutiny as a result of the OIG recommendations, all of which CMS agreed to implement.

1. CMS is increasing and expanding its review of SNF claims and is instructing its contractors to conduct more medical reviews.

CMS is expanding the scope of these medical reviews to more closely scrutinize the MDS items that SNFs commonly misreport. CMS is also instructing its contractors to identify SNFs or SNF chains with recurring problems, target those SNFs in their review, and possibly refer them for further investigation, depending upon the nature of the issues.[7]

The Medicare Recovery Auditor for Region B, CGI Technologies and Solutions Inc. (CGI), which covers Indiana, Michigan, Minnesota, Illinois, Kentucky, Ohio, and Wisconsin, is currently requesting test claims from selected SNFs and seeking approval from CMS in regards to ultra-high RUG[8] claims with the probable outcome that this will become an "approved" recovery audit contractor (RAC) issue for SNFs in this region. CGI is sending providers additional development requests for medical records to enable CGI to perform complex reviews that pertain to the ultra-high RUG.

2. CMS is enhancing its Fraud Prevention System to identify SNFs that are billing for higher-paying RUGs. Special focus will be directed at the incorrect reporting of certain MDS items, such as therapy and activities of daily living, which place Medicare beneficiaries in higher-paying RUGs. SNFs with a high percentage of claims for ultra-high therapy and for high levels

of assistance with activities of daily living will be targeted for further review through the Fraud Prevention System.[9]

3. CMS will be monitoring compliance with the new therapy assessments. CMS, the Medicare administrative contractors (MACs), and the RACs will closely monitor SNFs' utilization of "change of therapy" assessments and "end of therapy" assessments. The analysis will focus specifically on identifying SNFs that are using the assessments infrequently or not at all. MACs, and then RACs, will then target SNFs for review to establish whether therapy assessments are being completed, as required.[10] CMS is also further expanding its monitoring activities to analyze therapy services by provider type (for-profit, nonprofit, and government).
4. CMS is exploring changes to the current method for paying for therapy.
5. Through the survey process, CMS will be examining the accuracy of MDS items. CMS has already taken steps to implement this recommendation by providing training and guidance to nursing home surveyors to more closely monitor the accuracy of the MDS. OIG has recommended that surveyors particularly focus on the categories of MDS that were identified as problematic and to cite facilities for deficiencies when necessary.

State Audits Are Also on the Rise

Several states have initiated nursing home-specific audits, many driven by Section 6411 of the Affordable Care Act, which require states to contract with RACs to identify overpayments and underpayments by the state Medicaid agency and to recoup overpayments.

In Pennsylvania, the state Medicaid agency announced that beginning in January 2013, a contingency fee-paid contractor, HMS, would begin a comprehensive financial billing review for nursing homes. Initially, the review will be conducted in three counties. All Medicaid nursing homes will be subject to a 100% record review covering a four-year period. The impact of these audits on providers and the costs of producing 100% of records covering a four-year period within 30 days are a cause of great concern.

In New York, the state will be launching an MDS audit through the Office of the Medicaid Inspector General (OMIG). OMIG will be auditing all "high risk MDS records." Nursing homes are identified as high risk if their case mix index increased by more than 5% from January 2011-January 2012. It is anticipated that approximately 304 nursing homes will be audited.[11]

HMS will also conduct Medicaid financial audits in Indiana. These audits cover 100% of all Medicaid-eligible residents and will look at all financial-related activity. Similar audits are also being conducted in New Jersey.

What Does This Mean for Providers?

Nursing homes should become familiar with their therapy and MDS data. Facilities should assess how much therapy is being provided and look closely at the provision of ultra-high therapy levels. Facilities should also carefully review those MDS categories that OIG found to have a high level of misreported information, including:

- Therapy minutes and days for physical, occupational, and speech therapy;
- Special care (e.g., intravenous medication, tracheostomy care);
- Activities of daily living (e.g., bed mobility, eating);
- Oral/nutritional status (e.g., parenteral feeding);
- Skin conditions and treatments (e.g., ulcers, wound dressings);
- Nursing rehab/restorative care (e.g., grooming, communication, transfer);
- Continence;
- Problem conditions (e.g., fever, delusions, vomiting);
- Disease diagnosis;
- Medications, physician orders, respiratory therapy; and
- Physician visits.[12]

Facilities are well advised to review records for residents who have high scores for assistance of activities of daily living, as this is another area targeted by OIG in its report. On August 31, 2012, CMS developed and issued comprehensive billing reports (CBRs) that were sent to 5,000 SNFs across the country that consistently billed for a high number of services at the ultra-high therapy RUG level. Facilities that received CBRs should review them carefully and consider performing an internal review of their billing practices.

To the extent that providers have not done so, they should identify and mobilize an audit response team, which should include assigning responsibility for record gathering, record review, data submission deadlines, and appeal deadlines. In addition, providers should identify names of auditors responsible for their region, including the Medicaid and Medicare RACs, the Zone Program Integrity Contractors (ZPICs), and the Medicare Integrity Contractor (MIC). Several of these contractors have pictures of their envelopes on their websites. Large organizations may find it useful to print and distribute these pictures to their mail clerks.

Prepare for the Impact of the *Jimmo-Sebelius* Settlement

On January 24, 2013, the U.S. District Court for the District of Vermont approved the settlement of *Jimmo v. Sebelius*.[13] *Jimmo* was a class action lawsuit challenging Medicare's so-called improvement standard for coverage of skilled maintenance services in home health, nursing home, and outpatient therapy settings. The settlement provides that Medicare beneficiaries can continue to have coverage for these services even if the beneficiary's condition does not improve. To date, many audits of therapy services have resulted in denials for services provided to beneficiaries on the basis that they had plateaued or otherwise failed to show improvement.

The settlement, retroactive to January 18, 2011, and applicable to both Medicare Part A and Part B services as well as Medicare Advantage, covers all beneficiaries and is not limited to particular conditions or diseases. It allows beneficiaries to receive skilled services to maintain or slow deterioration regardless of the underlying illness, disability, or injury.[14]

The settlement further establishes a process called "re-review" for Medicare beneficiaries who were denied SNF care, home health-care, or outpatient therapy services (physical therapy, occupational therapy, or speech therapy) because of the improvement standard. The settlement does not extend coverage benefits but changes the standards for determining medical necessity. CMS has not yet issued guidance to providers regarding application of the settlement. Because the settlement is effective now, providers should review their therapy policies. While Medicare will now cover skilled maintenance therapy, it is important that all elements of such services be well documented. Providers who have had therapy claims denied because CMS applied the improvement standard should be alert for further guidance that may allow them to re-open those claims retroactive to January 18, 2011.

Conclusion

With federal and state audits looming, providers must prepare for the onslaught. This means they must become acquainted with the major state and federal players (RACs, MACs, MICs, and ZPICs). Additionally, providers must prepare their employees and ensure that all staff are documenting accurately. Providers should become familiar with therapy and MDS data and be prepared to address the concerns raised by OIG in its recommendations to CMS. By preparing in advance for the potential audits and investigations to come, providers will save time and money and will be better able to respond to the arrival of the "Vacuum Cleaner."

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1 *See* Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 1997, at 11, *available at* https://oig.hhs.gov/publications/docs/workplan/1997/97wkplan.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 1998, at 11, *available at* http://oig.hhs.gov/publications/docs/workplan/1998/98wpl1.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 1999, at 11, *available at* https://oig.hhs.gov/publications/docs/workplan/1999/99wkpln.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2000, at 11, *available at* https://oig.hhs.gov/publications/docs/workplan/2000/workpl.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2001, at 10, *available at* https://oig.hhs.gov/publications/docs/workplan/2001/wp2001.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2003, at 10 (RUGs assignment and MDS accuracy), *available at* https://oig.hhs.gov/publications/docs/workplan/2003/Work%20Plan%202003.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2004, at 8 (RUGs assignment and MDS accuracy), *available at* https://oig.hhs.gov/publications/docs/workplan/2004/Work%20Plan%202004.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2005, at 9 (rehabilitation and infusion therapy services), *available at* https://oig.hhs.gov/publications/docs/workplan/2005/2005%20Work%20Plan.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2006, at 5 (rehabilitation and infusion therapy services), *available at* https://oig.hhs.gov/publications/docs/workplan/2006/WorkPlanFY2006.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2007, at 7 (rehabilitation and infusion therapy services), *available at* https://oig.hhs.gov/publications/docs/workplan/2007/Work%20Plan%202007.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2008, at 8 (accuracy of RUGs coding), *available at* https://oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2009, at 10-11 (accuracy of RUGs coding, oversight of MDS accuracy), *available at* https://oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2010, at 12 (accuracy of RUGs coding), *available at* https://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2011, at I-10 (accuracy of Medicare Part A payments/RUGs), *available at* https://oig.hhs.gov/publications/workplan/2011/FY11_WorkPlan-All.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2012, at I-11 (accuracy of Medicare Part A payments/RUGs), *available at* https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf; Office of Inspector Gen., Dept. of Health and Hum. Servs., Work Plan for Fiscal Year 2013, at 10, *available at* https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP01-Mcare_A+B.pdf.

2 Office of Inspector Gen., Dept. of Health and Hum. Servs., Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009 (2012), *available at* https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf [hereinafter Inappropriate Payments].

3 Thomas Burton, Nursing Homes Said to Overbill U.S., Wall St. J., Nov. 13, 2012, at A2, *available at* http://online.wsj.com/article/SB10001424127887324073504578115390581083074.html.

4 *Id.*

5 Inappropriate Payments, *supra* note 2, at 6 and 8.

6 *Id.* at 10.

7 Inappropriate Payments, *supra* note 2, at 14.

8 The ultra-high and high-therapy RUG categories are classified in the major RUG-IV categories Rehabilitation Plus Extensive Services (RUX, RUL, RVX, RVL) and Rehabilitation (RUA, RUB, RUC, RVA, RVB, RVC). Residents who fall in the ultra-high (U) categories typically receive a minimum of 720 minutes of therapy a week, while residents who fall in the very-high (V) categories typically receive between 500-719 minutes of therapy per week.

9 *Id.*

10 *Id.* at 15.

11 Harold Brubaker, *Nursing Homes Dread Paperwork from State Audit*, Philadelphia Inquirer, Jan. 14, 2013, *available at* http://articles.philly.com/2013-01-14/business/36314367_1_audit-medicaid-money-medicare-and-medicaid-services.

12 Inappropriate Payments, *supra* note 2, at 24.

13 *Jimmo v. Sebelius*, No. 5:11-CV-17-CR (D. Vt. Oct. 16, 2012).

14 The settlement is *available at* www.medicareadvocacy.org/wp-content/uploads/20