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Health Care Bulletin

HOME HEALTH SERVICES ACTIVITIES IN THE OIG'S 2013 WORK PLAN

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On October 2, 2012, The U.S. Department of Health and Human Services Office of the Inspector General ("OIG") released its Work Plan for 2013. The OIG releases its work plan for each year in advance of the coming year. The work plan provides stakeholders in the health care industry with a broad overview of the OIG's activities in the coming year as they relate to its enforcement priorities and issues it will review and evaluate during that fiscal year. This client alert is one in a series of alerts that will outline the OIG's activities, as discussed in the 2013 Work Plan, for a specific industry sector – Home Health Services.

The OIG's activities relating to Home Health Services for 2013 are focused on a variety of program integrity issues that are discussed more specifically below.

HHAs—Home Health Face-to-Face Requirement

The OIG's Office of Evaluation and Inspections ("OEI") is going to review the extent to which home health agencies ("HHAs") are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries. Although Federal regulations require that these encounters occur within 120 days, a recent OIG report concluded that only 30 percent of beneficiaries had at least one face-to-face visit with the physicians who ordered their home health care.

This is a new item in the 2013 Work Plan, although its inclusion should not be a surprise for home health providers given the OIG's recent report documenting significant shortcomings. Providers should continue to monitor their compliance with face-to-face requirements and expect increased scrutiny from auditors. This item may also lead to further clarification of face-to-face requirements as providers seek additional guidance on the parameters of compliance.

HHAs—Employment of Home Health Aides With Criminal Convictions

The OEI is also going to examine the extent to which HHAs are complying with State background check requirements with respect to HHA applicants and employees. In a recent report, the OIG found that 92 percent of nursing homes employed at least one individual with at least one criminal conviction. While the report did not disclose the nature of the criminal conviction, the high conviction rate has once again brought this issue to the forefront.

Although this is a new item to the 2013 Work Plan, the federal focus on background checks is nothing new. Home health providers may recall that CMS' previously undertook a criminal background check pilot program. While no formal requirements came out of it, the OIG is now going to undertake a review as well. Providers should review applicable state law and their personnel files to make sure they are performing all required background checks. In addition, providers should be certain to perform a check of the OIG exclusion list, even though this is not required by state law. This should be done upon hiring and rechecked at least annually, if not more frequently.

Providers should also review relevant personnel policies to make certain they clearly identify the types of convictions that will result in a candidate not being hired. At a minimum, such a list ought to include all of the convictions that state law lists as disqualifiers. Providers may go beyond this, but in light of recent EEOC guidance on the disparate impact of convictions on certain minority groups, providers should state the additional convictions and be able to justify excluding individuals based upon these convictions. For example, given the amount of time home health workers spend driving, disqualifying applicants for convictions involving driving such as driving while intoxicated, reckless driving, etc. are legitimate reasons to disqualify an applicant.

HHAs—States' Survey and Certification: Timeliness, Outcomes, Follow-up, and Medicare Oversight

The OEI also plans to review the timeliness of HHA recertification and complaint surveys, and the follow-up of complaints against HHAs. Federal regulations require that HHAs be surveyed at least every 36 months. Although this item is directed at state survey agencies, providers are likely to see changes in their state's survey process as state survey agencies who are found to be "out of compliance" take corrective action.

HHAs—Missing or Incorrect Patient Outcome and Assessment Data

For the second straight year, the OIG is raising concerns about OASIS submission. HHAs are required to submit OASIS data as a condition of payment. The OIG will be reviewing OASIS data to determine the appropriateness of the billing codes, and will also be looking for missing or incomplete data.

Providers need to audit their OASIS data to be sure it is being submitted. Providers should also review submissions to ensure completeness. Finally, providers should review billing codes that were used in light of the OASIS submission, in order to ensure that OASIS data and billing codes are in agreement. Now that OASIS is a condition of payment, submitting OASIS data and being certain it tracks with billing codes is very important. Getting this wrong will result in lost payments.

HHAs—Medicare Administrative Contractors' Oversight of Claims

This is the second year in a row in which the OIG expressed its intention to evaluate the role of MACs in detecting and preventing improper payments. In recent years, the OIG has expressed its desire to move away from a "pay and chase" model and towards a more proactive model in preventing improper payments. As the OIG continues to pressure MACs to prevent improper payments, providers should anticipate an increase in pre-payment reviews and similar pro-active practices.

In order to prepare for this, home health providers should engage in active auditing and monitoring efforts to identify errors before claims are submitted. Providers should also be aware of and audit for patterns that the OIG and/or the MACs believe are red flags for fraudulent conduct, as these can lead to increased scrutiny whether or not actual fraud is occurring.

HHAs—Home Health Prospective Payment System Requirements

This is another repeat item from the 2012 Work Plan. The OIG will continue to monitor compliance with prospective payment system requirements, and Providers should be auditing claims and clinical records to ensure beneficiaries meet payment requirements. These include homebound status, need of intermittent skilled nursing, that services provided are medically necessary, etc. In particular, Providers should take note of CMS' revised guidance on homebound status as they perform these audits.

HHAs—Trends in Revenues and Expenses

As part of its continued focus on payments and reducing costs, the OIG will continue to examine cost report data to analyze revenue and expense trends under the home health PPS to determine whether the payment methodology should be adjusted. This review is likely to determine that home health profit margins are "too large" and in need of a reduction. Providers can prepare for this type of review by ensuring that all cost report data is accurate. It is hard to imagine the OIG will identify an increase in profit margins since the last review, because home health reimbursement is trending downward.

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Additional Information

For more information on the OIG's Work Plan for 2013, its priorities, Medicare and Medicaid program integrity initiatives in general or assistance with responding to an OIG or OEI inquiry relating to any issue, please contact **Robert Markette, Ari Markenson or Dan O'Brien** or any member of Benesch's Health Care Department:

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