

MEDICARE COMPLIANCE

Face-to-Face Encounter Rule Leads to FCA Settlement; All HHAs Will Be Audited

ResCare Iowa Inc. agreed to pay \$5.63 million to settle false claims allegations that it billed Medicare for home health services even though it violated the face-to-face encounter requirement and lacked other documentation. ResCare is not alone in its documentation problems, according to the government, a reality that is sparking more activity on the home health front.

All home health agencies in the nation will be audited by the supplemental medical review contractor (SMRC), one of CMS's newer program-integrity players. The audits stem from the fact that Medicare claims often are not supported by documentation that a physician or nonphysician practitioner (NPP) has certified eligibility for home health services. Medicare pays for home health when patients are homebound, require skilled services, receive services under a plan of care and have had a face-to-face encounter with a physician or NPP.

Meanwhile, CMS has developed a draft of a clinical documentation template to guide physicians in documenting the face-to-face encounter. There are both paper and electronic formats, and CMS is holding open-door forums to solicit feedback from the industry. It's a first for CMS, which has never offered the industry templates for a progress note, Melanie Combs-Dyer, director of the CMS Provider Compliance Group, explained at the first open-door forum on Feb. 11. If adopted, their use would be voluntary. The templates come in the wake of the elimination of physician narratives. As of Jan. 1, home health certifications don't require physician narratives, according to the 2015 home health prospective payment system 2015 regulation (*RMC 7/28/14, p. 1; 11/3/14, p. 7*).

HHAs Are All Audit Targets

But some home health agencies are stumbling over certification. The Affordable Care Act (Sec. 6407) requires physicians to certify a patient's eligibility for home health as a condition of Medicare payment. Certifications are based on a face-to-face encounter with the patient no more than 90 days before home health services start or 30 days after. The face-to-face encounter must be related to the primary reason the patient requires home health services and dated and signed by the physician. But home health agencies have expressed frustration that they face claim denials for services that must be certified

by independent physicians who have no financial stake in complying with Medicare home health documentation requirements.

The kinds of documentation deficits apparently plaguing the industry were captured in the case against ResCare, which did business as ResCare Homecare Iowa. According to the settlement, between 2009 and 2014, ResCare Homecare Iowa allegedly:

- ◆ Lacked documentation to show compliance with the face-to-face encounter requirement,
- ◆ Didn't keep documentation of plans of care or orders,
- ◆ Billed for more visits than documented or ordered by the certifying physician, and/or
- ◆ Didn't have forms that patients sign agreeing to receive medical care from ResCare and allowing it to bill Medicare on their behalf.

In a statement, Nel Taylor, chief communication officer for Louisville, Ky.-based ResCare, the parent company of ResCare Iowa, said the settlement stemmed from a self-disclosure. "When the issue first arose, ResCare hired an outside firm and expert in the home health field to conduct an audit of our documentation. We brought the audit to the government agencies and disclosed the documentation errors the auditor found," she stated. "ResCare provided medically necessary, quality care to our clients. Our quality of care was never questioned." The company cooperated with the state and federal investigation, Taylor said.

The emphasis on documentation should be a wake-up call for compliance officers now that there has been a significant false claims settlement and the supplemental medical review contractor will hit every home health agency, says attorney Paula Sanders, who is with Post & Schell in Harrisburg, Pa. "I call this low-hanging fruit because it's easy for auditors to kick out claims when you're missing one of the required elements," Sanders says. "They don't even have to do a medical necessity review."

Concern about home health program integrity is intensifying in light of recent reports that documentation is falling far short of Medicare expectations. The HHS Agency Financial Report stated the improper payment

rate for home health claims jumped to 51.4% in FY 2014 from 17.3% the year before. An April 2014 audit report from the HHS Office of Inspector General found that 32% of home health claims either had no documentation of a face-to-face encounter or the documentation was missing one of the required elements. In 10% of the 644 documents audited, there was no evidence of a face-to-face encounter. *Among the other errors:* 17% lacked the signature of the certifying physician; 4% had no date of encounter within the timeframe; 3% lacked a title; and 2% had no information on when the physician signed the document. As a result, OIG said Medicare overpaid \$2 billion.

To improve compliance with Medicare regulations, CMS is acting on some suggestions in OIG's report. For one thing, the supplemental medical review contractor "will perform approximately five document-only reviews for every HHA in the country to validate that the most recent/valid face-to-face encounter is in the medical record," CMS said in its response to the report. "This will allow CMS to have better oversight of HHAs and the face-to-face requirement since one CMS contractor will be overseeing utilization." The review will take a year, and afterward, the agency will evaluate the SMRC's results and recommendations.

OIG Recommended Using a Standardized Form

OIG also recommended that CMS contemplate the use of a standardized form to ensure physicians fulfill all documentation requirements. That seems to be under way with the draft clinical documentation templates.

Among other things, they would prompt physicians to document the patient's homebound status and the need for skilled care, which were the top home-health documentation deficiencies, according to the 2014 CERT report, Combs-Dyer said. "If you don't find that, you may need to ask physicians to send more documentation," she says. But it doesn't necessarily have to come from the progress note. "As long as the home health agency can find evidence the coverage criteria is met, you are good to go," Combs-Dyer said. "It doesn't matter if it's in the progress note or in the orders," as long as somewhere in the medical record the physician has documented the patient is homebound and why; the need for skilled services; and the correct dates — a face-to-face encounter 90 days before or 30 days after home health care is ordered.

In light of industry comments, CMS is weighing whether to shorten the paper template and lengthen the electronic one, Combs-Dyer said. This and home health work flow issues around documentation will be addressed at the next open-door forum on March 11.

Some people have complained the voluntary templates are burdensome, Sanders says, but "if I have an error rate because I'm missing these elements, why not do it?"

For more information, contact Sanders at psanders@postschell.com.

The CMS electronic documentation template may be accessed at <http://tinyurl.com/kyv9o5s> and the paper template at <http://tinyurl.com/pp4jugv>. Read the OIG report at <http://tinyurl.com/n2akx6l>. ✧