Rehabilitation Facility CMS Compliance

2018 Report

MANAGED RESOURCES

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NOTE: The following report neither divulges nor demonstrates the specific audit findings of any single Inpatient or Outpatient Rehabilitation Facility.

1. ABOUT THIS REPORT

For over 24 years, we have been providing compliance and revenue cycle support services to healthcare organization nationwide. Our vision has been to assist our clients achieve their revenue goals by providing quality solutions, staff, and education. Today, our industry continues to evolve, particularly in the field of compliance with regulatory guidelines of specialty care facilities.

> *"...no single care facility type has experienced the sort of payback epidemic as have Inpatient Rehabilitation Facilities since the start of 2017."*

While dialysis, wound care, and surgery centers have seen their fair share of negative attention from the OIG attention, no single care facility type has experienced the sort of payback occurrence rate as have Inpatient Rehabilitation Facilities since the start of 2017. In my own 30+ years in healthcare finance, I am hard pressed to remember CMS ever before issuing paybacks with the sort of magnitude and frequency with which they are issuing to IRFs. The OIG recently reported one hospital was overpaid an estimated $10,000,000 in IRF claims. This comes on the heels of multiple similar findings at facilities across the nation.

We are proud to be the leading IRF CMS compliance firm operating today. Our team of Certified Medical Audit Specialists have led the industry as it seeks to evaluate and protect IRF units from risk of non-compliance. The goal of this report is to centralize data gained from public sources as well as our own experience and lay out a roadmap to compliance for rehabilitation facilities across the country.

Simon Zaman
President and Founder, Managed Resources

2. EXECUTIVE SUMMARY

Inpatient Rehabilitation Facility CMS payback have increased exponentially since OIG Prioritization. Paybacks exceeding $3,000,000 have been made public at 9 major systems with paybacks of less than $3,000,000 reported at dozens of facilities nationwide.

CMS made public its audit of a large University Health System (included in this report in the appendix.) The University System's audit demonstrates both the persistence and authority by which OIG is pursuing IRF and ORF repayment. While the entirety of this audit is made available in the Appendix to this report, below is an excerpt from that report outlining the point estimate arrived at by extrapolating the limited audit results via CMS authority.

ESTIMATES

Table 4: Estimates of Overpayments for the Audit Period
Limits Calculated for a 90-Percent Confidence Interval

Point Estimate	$ 4,912,305
Lower Limit	4,110,073
Upper Limit	5,714,538

This report outlines the items most commonly associated with CMS non-compliance, the mechanism and authority by which CMS initiates paybacks, as well as recommended corrective actions

As a whole, the following report has been gathered from a combination of publicly available and privately gathered data and is not meant as a reflection or demonstration of the practices of our clients, neither those which are confidential nor otherwise.

3. NATURE OF IRF CMS NONCOMPLIANCE

3.1 University Audit Results

The below is a second excerpt from the previously mentioned university audit which outlines the specific nature of CMS's findings of non-compliance:

Risk Area	Sampled Claims	Value of Sampled Claims	Claims With Under/ Over-payments	Value of Net Over-payments
Inpatient				
Claims Billed With High-Severity-Level Diagnosis-Related Group Codes	40*	$6,317,182	11	$34,552
Rehabilitation	40*	6,388,313	31	447,781
Manufacturer Credits for Replaced Medical Devices	9	294,312	4	14,033
Inpatient Totals	**89**	**$12,999,807**	**46**	**$496,366**
Outpatient				
Observation Claims with Outlier Payments	40*	$10,412,084	33	$3,198
Intensity Modulated Radiation Therapy	40**	984,658	8	2,728
Herceptin	14	52,088	0	0
Manufacturer Credits for Replaced Medical Devices	5	166,685	5	121,405
Dental	2	1,424	1	941
Outpatient Totals	**101**	**$11,616,939**	**47**	**$128,272**
Inpatient and Outpatient Totals	**190**	**$24,616,746**	**93**	**$624,638**

* OIG submitted all of these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.
** OIGsubmitted nine of these claims to a focused medical review to determine whether the services met medical necessity and coding requirements.
Notice: The table above illustrates the results of our review by risk area. In it, OIG has organized inpatient and outpatient claims by the risk areas OIG reviewed

3.2 Areas of Scrutiny

Like any payer audit, CMS audits of IRF feature multiple consistent areas of scrutiny several of which were not reflected in the above excerpt. The eleven areas of most common scrutiny for IRFs are:

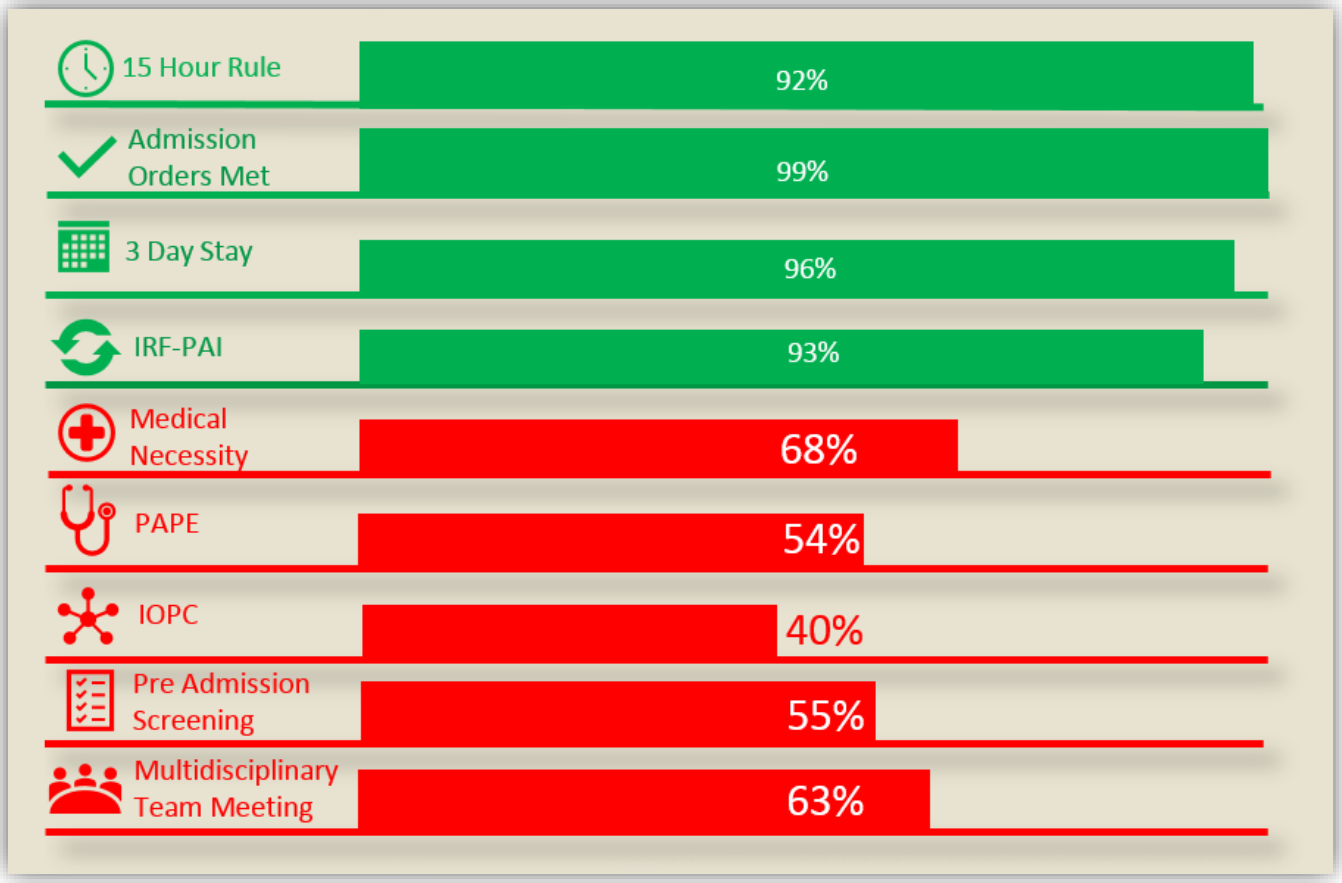
- Admission Orders
- Presumptive Compliance
- Interrupted Stay Rules
- IRF-PAI
- Medical Necessity
- Post Admission Physician Evaluation (PAPE)
- Individualized Overall Plan of Care (IOPC)
- Face to Face Physiatrist Visits
- Pre-Admission Screening (PAS)
- Multidisciplinary Team Meetings
- 15 Hour Rule

3.3 Areas of High Compliance v. High Risk

Managed Resources has found a high variance amongst the above eleven areas for OIG audit risk between different facilities. The goal of Managed Resources is to implement corrective measures to increase compliance with CMS criteria to 100%. Our advise to the IRF leadership is to aim for 100% compliance with known criteria knowing that cases can still be denied based on CMS auditors' interpretation of rules and level of Rehab care decisions. Compliance is vital as any case found to be in non-compliance can result in exponentially increased payback due to CMS's authority to apply the Six Year Look-back (see section 4.2)

3.3 Diagram of Representational Audit

The below diagram is a representative IRF compliance audit.



Again, the confidentiality of all clients has been carefully considered as well as all clients consulted on inclusions in this report. No item included is a direct reflection of any IRF or ORF with which Managed Resources has had contact. All items are typical of the Inpatient Rehabilitation Facility industry as Managed Resources has experienced them.

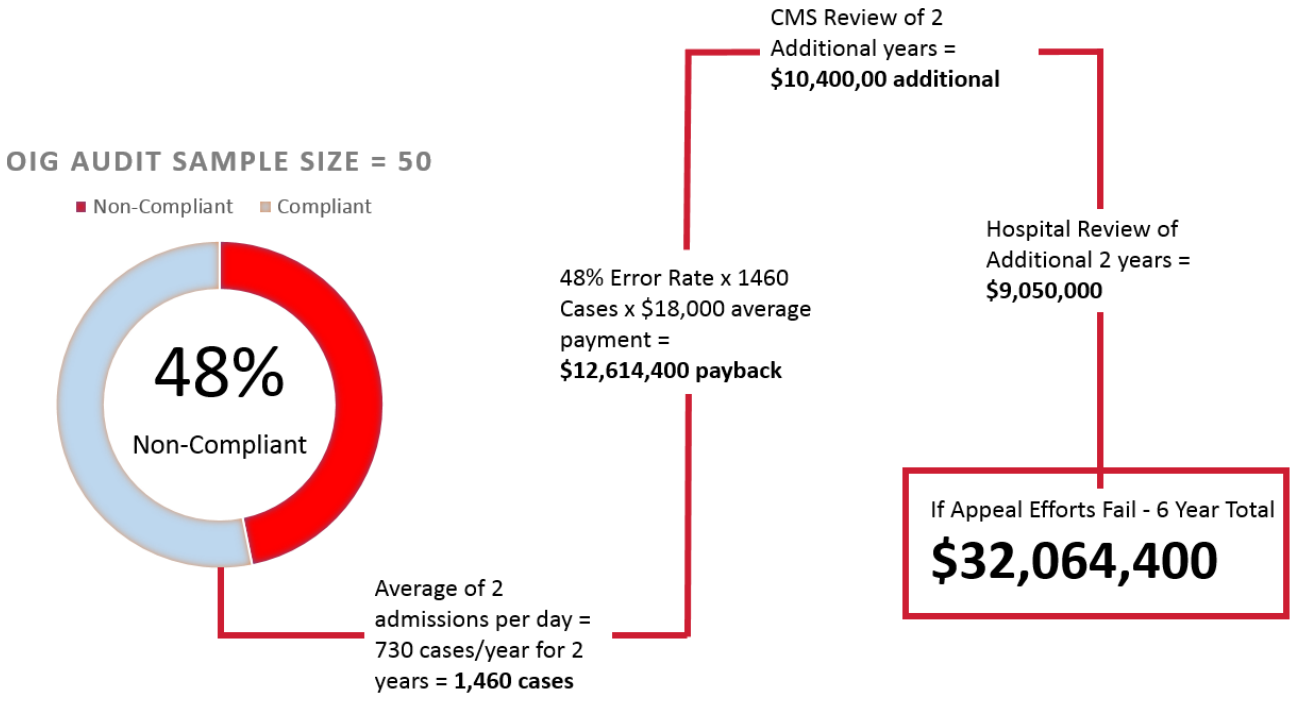
4. APPLICATION OF SIX YEAR LOOKBACK MULTIPLIER

4.1 CMS Extrapolation

The central mechanism for CMS's capacity to level substantial 6 to 8 figure payback penalties is their application of the error rate to all claims during the audit period. But the total time involved in payback is 6 years due to the Medicare 60 Day Rule. This rule allows CMS to reopen cases for 4 years and for the facility to pay back any overpayments for 6 years from the receipt of government funds.

4.2 Diagram of CMS Extrapolation and Payback Lifecycle

Consider the below representative Inpatient Rehabilitation Facility. It is a 30 bed IRF with an average of 2 admissions per day.

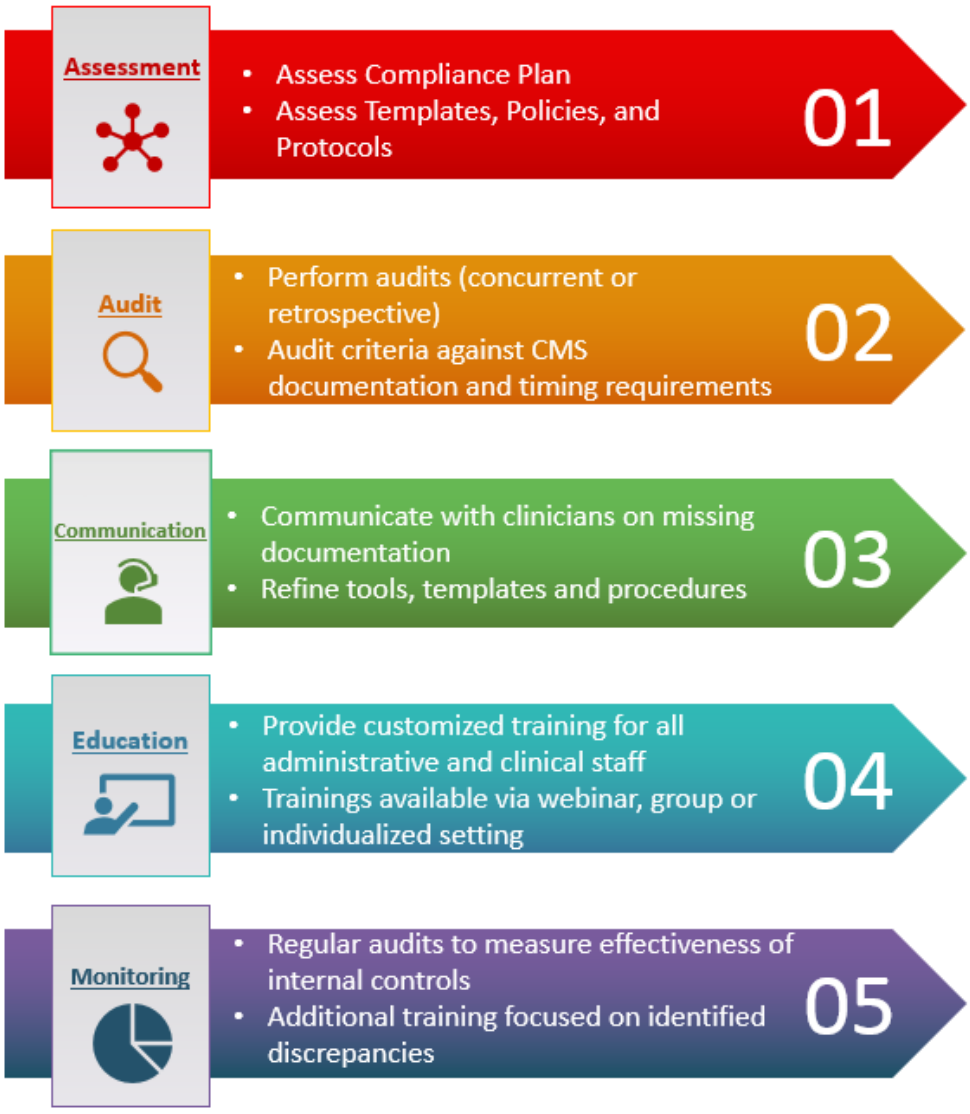


As the above diagram demonstrates, limited samplings have quickly become more significant figures in IRFs since the official OIG prioritization.

5. CORRECTIVE ACTION PROCEDURE

5.1 Corrective Action Workflow

The below diagram outlines the recommended practices for corrective action to reduce risk of CMS non-compliance. The below diagram is discussed at greater length in the subsequent sections of this report.



5.2 Assessment

Prior to the implementation of an audit, it is recommended that each facility and system receive a third party evaluation of their current compliance plan and activities. Rather than leading with the audit results, by beginning with a holistic view of current practices, Managed Resources both fewer

has observed both fewer disruptions in the implementation of the ultimate corrective measures but also greater effectiveness and efficiency in so doing.

5.3 Audit

While it is not the interest of this report to infer strategic decision in the absence of the necessary financial information for each facility, it is strongly encouraged that both IRFs and ORFs engage an objective third party to conduct a CMS compliance audit. These audits should be designed to illuminate the facility's specific risks of non-compliance. An audit can pinpoint areas of non-compliance so education and corrective measures can be targeted, minimizing the disruption to the facility staff.

5.4 Communication

Managed Resources has found that a significant portion of non-compliance stems from ineffective cross-departmental communication leading to non-compliant documentation, particularly those between clinical and non-clinical staff. Utilizing audit results as indicators for workflow and process improvements has yielded many of the most long lasting and effective compliance measures yet observed. These results may yield updated meeting agendas and schedules, new documentation templates, and general procedures.

5.5 Education

Conventional education has focused on in-facility services including: seminars, one-on-one sessions, and expert coaching or "shadowing" of staff. These training protocols have shifted over the previous decade as technology has improved such that web-based and video trainings have become more prevalent. While each modality presents advantages and disadvantages over the other, it must be noted that a comprehensive training effort hinges not only training existing staff but ensuring that future staff, both clinical and non-clinical, perform their duties in CMS compliant practice.

5.5 Monitoring

Targeted and ongoing audits should be considered a critical piece of compliance so long as IRFs and ORFs remain under OIG prioritization. The purpose of these audits is to provide insight into potential

vulnerabilities eventually leading to systematic adjustment or specific trainings. Depending on the case volume of each facility, the frequency of that external audit could be as frequent as quarterly or annually.

6. APPENDIX