

Long Term Care and the Law:

Legal Update, Medicare Retrospective Takebacks
and OIG Supplemental Guidance

Scott J. Kiepen
Michael A. Dubin

Hooper, Lundy & Bookman, Inc.
San Francisco, CA
(415) 875-8510



Hooper, Lundy & Bookman, Inc.©

California Reimbursement Issues

- AB 1183
 - License Fees
 - State Surveys
 - AB 1629 Extension
 - AB 1629 Workgroup

Budget Issues

- Effect of Special Session/Cash
- Other LTC Rate

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AB 1629 Rates

- Voluntary Supplemental Capital Schedule
- Weighted Averages
- Benchmarks
- Subacute Rates
- 2008/2009 Quality Assurance Fee
- Audit Tips

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AB 1629 Legal Challenges to Audit Decisions

- Calculation of Rate
- Insurance Costs/Deductibles and Paid Claims as Pass-through or Administration Cost
- Contract Labor

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2009 Medi-Cal Issues

- Key Leadership Changes
- Fiscal Intermediary Re-Procurement
- Medicare Part B premiums
- Provider Rate Reductions

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Federal and State Priorities in Long Term Care Sector

- Quality of Care
 - Worthless services theory of fraud
 - Neglect Issues
- Coordinated Actions by state and federal agencies
- Coordinated Actions by Department of Public Health Licensing and Bureau of Medi-Cal Fraud and Elder Abuse
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Federal and State Priorities in Long Term Care Sector

- Hospice Utilization
- DMEPOS
- Others

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Medicare Retrospective Takebacks

- Government focus on recoupment
 - Probe
 - RACs
 - PSCs
- Brief Regulatory History
- Status of the regulations and manual provisions
- What can we expect in 2009
 - LTAC
 - The need for predictability/certainty in billing (revenue stream)

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The Medicare Recoupment Case

- Types of reviews?
 - Basic Review
 - Complex Review (Reasonable charges)
- The Target of the Review
 - Consolidated billing requirements for SNFs
 - Therapy examples
- How is the process started?
 - The initiating letter/request
- Provider's Response
 - Building the record
 - The appeal trap (staying the recoupment)

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The Rebuttal Process

- The Rebuttal Process – An Overview
 - This process is separate and distinct from the appeals process
 - Focus on why the recoupment should not take place
- The Medicare Contractor provides notice of its intention to suspend. (45 C.F.R. § 405.372)
 - Special rules for harm to the Medicare Trust Fund or Fraud
- The Rebuttal
 - The carrier must give the provider the opportunity to rebut its findings prior to recoupment
 - The Provider must be given “at least 15 days” to submit its statement rebutting the recoupment (45 C.F.R. § 405.374(a))
 - Carrier must respond within 15-day
- This is not a determination and it is not appealable

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The Appeals Process -- Staying the Recoupment

- When can the recoupment be stayed? A recoupment can only be stayed from the re-determination through the reconsideration level of appeal.
- Providers have two opportunities to stay recoupment:
- First Opportunity
 - The letter must be RECEIVED by Medicare within 30 days.
 - Medicare will also stop recoupment on a letter received later, but will not refund a recoupment that has already occurred
 - Provider may appeal all or part of the claims
 - If no appeal is filed, recoupment begins on the 41st day
 - Chance of overturning recoupment at first two levels is very low as there is a lack of true impartiality
 - Compare: The CRC process

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The Appeals Process -- Staying the Recoupment (con't)

- Second Opportunity
 - If re-determination level is unfavorable or partially favorable, Medicare can begin recoupment on earlier than 61st day from the date of the Medicare Appeal Decision Letter
 - Appeal can stay recoupment at the reconsideration level (QIC)
- Interest continues to accrue regardless of whether recoupment is stopped
 - Interest accrues in both directions
 - Assessment

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The General Appeal Process

- Overlapping the recoupment deadlines are the general appeal deadlines:
 - 1st Level: 120 days (42 C.F.R. § 405.942)
 - 2nd Level 180 days (42 C.F.R. § 405.962))
 - 3rd Level: (ALJ – first impartial level) 60 days
 - Important: Date of Receipt
- Beware the Documentation Trap
 - 1st Level: Goal is to get the record as complete as possible but continue efforts to gather evidence
 - 2nd Level: New evidence still permitted, but at the end of this appeal, the record must be complete (42 C.F.R. § 405.966)

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The Standards of Proof

- The “Good Cause” Standard and its elimination
 - Transmittal 1671
 - Medicare Claims Processing Manual
- Data-mining a provider’s records by Medicare
- This will likely cause a ground war on the merits in an overpayment case.

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Where does this leave LTC providers?

- Providers need certainty and predictability in billing.
- But their billings are now subject to scrutiny for up to 3 years
- Suggestions?
 - Billing experts
 - External sources
- No regulations currently proposed

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OIG Supplemental Guidance: Quality of Care

- On September 30, 2008, the United States Department of Health and Human Services, Office of the Inspector General (OIG) published the OIG Supplemental Guidance for Nursing Facilities
- Guidance is part of series of governmental efforts to improve quality of care

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OIG Supplemental Guidance: Quality of Care

- Augments the original guidance issued in March 2000
- Because new guidance only augments original guidance, the two documents collectively should be reviewed in developing effective compliance program

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OIG Supplemental Guidance: Quality of Care

- Guidance has 5 sections
 - First two offer background and overview of compliance process for Medicare and Medicaid
 - Third section covers the fraud and abuse risk areas
 - Fourth section offers recommendations for establishing a culture
 - Fifth section addresses self-reporting to OIG

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OIG Supplemental Guidance: Quality of Care

- 5 Areas on Quality of Care
 - Sufficient Staffing
 - Comprehensive Care Plans
 - Medication Management
 - Appropriate use of psychotropic medications
 - Resident Safety

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OIG Supplemental Guidance: Quality of Care

- Accurate Claim Submission is another risk area
 - Proper reporting of resident case-mix
 - Therapy Services
 - Screening for excluded individuals
 - Restorative and personal care services

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OIG Supplemental Guidance: Quality of Care

- Federal Anti-Kickback Statute remains a significant risk area for nursing facilities
- OIG identified six sub-areas under the federal anti-kickback statute:
 - Free goods and services
 - Services contracts
 - Discounts
 - Swapping
 - Hospices
 - Reserved bed arrangements

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OIG Supplemental Guidance: Quality of Care

- **OIG grouped under a single heading three additional risk areas:**
 - Physician self-referrals
 - Anti-supplementation
 - Medicare Part D

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OIG Supplemental Guidance: Quality of Care

- **Self Reporting and benefits**
 - Recent guidance from OIG regarding Self Disclosure Protocols
 - Benefits
 - Negatives
- **Examples**

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