HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Fourteen
Number Four
April 2012
Published Monthly

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External risk assessment tool for inpatient rehabilitation facilities

By Bill Moran and Catie Heindel, JD

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In its Compliance Program Guidance for Hospitals,[1] the Department of Health and Human Services, Office of Inspector General (OIG) asks the question, "Has the Hospital developed a risk assessment tool, which is re-evaluated on a regular basis, to assess and identify weaknesses and risks in operations?" As each type of health care organization has its own unique risks, risk assessment tools may vary in content and design. However, depending on the type of care provided by your organization, there are certain risks that are always present and must be addressed. This is definitely the case when examining risks for Inpatient Rehabilitation Facilities (IRFs). This article will outline one method for developing a risk assessment tool for IRFs.

Importance of IRF risk assessment

Prior to undertaking the job of developing an IRF risk assessment tool, organizations should briefly remind themselves of the importance of such a task. To begin, facilities always want to ensure that they are providing the best possible care to their patients, in accordance with professional and governmental standards. Second, since health care organizations operate in a finite budgetary environment, it is vital to mitigate those risks that are most damaging to the finances and reputation of the institution, and are most probable to be found by external enforcement agents. Finally, because no organization has the resources or ability to audit every risk it has, it is important to thoughtfully choose among risk options and be judicious with any expenditures not directly related to patient care.

Elements of IRF risk assessment

Every risk assessment should focus on both internal and external risks. Internal risks are those that exist within the organization due to weaknesses in policies, procedures, systems, and personnel. Organizations learn about internal risk through audits, work groups, and observing daily interaction with policies and procedures. Because internal risks are unique to every organization, suffice it to say that these risks need to be identified and recounted when prioritizing and considering overall risk to the organization.

External risks are those that exist outside the organization and can be separated into two categories: regulatory risk and environmental risk. Regulatory risk areas can be identified by reviewing the laws, regulations, policies, and guidance promulgated by governmental entities for IRFs. Once these areas of regulatory risk are identified, organizations should examine and observe how these rules are enforced by the government and those acting on behalf of the government. The risk assessment tool proposed in this article will focus primarily on the different external risks for IRFs.

External regulatory risk areas

As mentioned earlier, to conduct a robust external IRF risk assessment, it is important to identify and record the universe of IRF regulatory risk areas, noting the written reference and a brief description for each risk area. Because there are number of regulatory risk areas, it may be easier

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to divide the risk areas into major categories, which might include:

- Conditions for Coverage/ Conditions of Participation (e.g., Medicare Hospital Provider Agreement; Discharge Disposition notice)
- Medical necessity (e.g., the three-hour rule; Medicare admission criteria)
- Billing integrity (e.g., case-level payment adjustments—early transfers; clinical research billing)
- Records management (e.g., clinical record entries; hospital admission and discharge records)

Multiple risks exist within each of these categories, and there should be a brief, one or two sentence description of each risk identified.

In addition to noting the risk category, risk area, citation or reference, and brief description of the risk, organizations may want to add other indicators to its tool, such as linkage to internal risk areas, risk in previous years, special mitigation efforts in process, and rank (e.g., high, medium, low or 1-5). Each of these indicators can be placed on a spreadsheet for easy viewing (See table 1 on page 19). Please note that this is only a sample list of a few regulatory risks, and there are many more to be considered.

External environmental risk areas

It is also important for organizations to consider the risks presented by the various government enforcement entities and those acting on their behalf. Risks associated with enforcement activities may be displayed in categories that might include the most recent OIG Work Plan, reports from the OIG Office of Audit, OIG Office of Evaluations and Inspections, OIG announced investigations, Centers for Medicare & Medicaid Services (CMS) major program updates, health care reform legislation, recent Congressional testimony, and recent government and industry conferences. Again, under each of these would be an identified risk area, citation or reference, and brief description. You may also want to prioritize the risk for each risk area (See table 2). Again, please note that this is only a sample list of a few environmental risks, and there are many more to be considered.

The use of a strong risk assessment tool is essential for prioritizing an organization's risks, which in turn, helps to design a plan to mitigate the most important risks through revised policies and procedures, education for staff, and then monitoring and auditing those risk areas. Once performed, the risk assessment is a valuable tool for informing the executives in the organization and the board of directors about where the most vulnerable parts of its operation reside. This type of information is essential for executive and board members to understand in order for them to perform their oversight and accountability duties. A robust risk assessment is an invaluable tool for governance. It makes sense to do it right.

1. Fed Reg vol 63, no 35, February 1998. Available at http://oig.hhs.gov/authorities/docs/cpghosp.pdf

Table 1: IRF External Regulatory Risk Identification Tool

EXTERNAL REGULATORY RISKS			
Risk Area	**Citation/Reference**	**Description of Risk**	**Ranking**
Conditions for Coverage/Conditions of Participation			
Classification of IRFs - 60% Rule (changed in 2010 Rule, from 75%)	42 CFR §412.29(b)(1)-(2); Medicare Benefit Policy Manual (100-02), Chapter 1, Section 140.1.1.	IRF does not meet required threshold for CMS-13 qualifying discharges as a percentage of all discharges	3
		Inaccurate assignment of impairment or qualifying diagnosis code	1
Medical Necessity			
3-hour rule (therapy services)	42 CFR § 412.622(a)(3)(ii)	Failure to furnish intensive therapy services 3 hours a day, at least 5 days a week, during patient's IRF stay	2
Billing Integrity			
Billing for non-employed providers	42 CFR § 412.604(e)	Inappropriately billing for inpatient services performed by non-employed providers (e.g., nurse practitioners, radiologists, etc.)	1
Incorrect discharge status code	42 CFR §412.624(f); Claims Processing Manual (100-4), Chapter 3, Section 140.2.3; CMS MLN. "Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors." Apr. 2011.	Failure to use proper status code for patients transferred from an IRF to another rehabilitation facility, a long-term care hospital, an inpatient hospital or a nursing home.	2
Records Management			
Clinical record entries	42 CFR §412.23(b); 42 CFR §412.29(i).	Failure to have periodic clinical entries in the patient's medical record that indicate the use of a coordinated interdisciplinary team approach in the rehabilitation of each inpatient.	3

Table 2: IRF External Environmental Risk Identification Tool

Table 2: External Environment Risk Areas			
Risk Area	**Citation or Reference**	**Brief Description**	**Rank**
HHS OIG Work Plan			
IRF admissions	HHS OIG Work Plan 2012. "In-Patient Rehabilitation Facilities."	Failure to ensure appropriateness of admissions to inpatient rehabilitation facilities (IRFs).	1
Level of therapy provided	HHS OIG Work Plan 2012. "In-Patient Rehabilitation Facilities."	Failure to monitor the level of therapy provided for beneficiaries in IRFs, specifically focusing on how much concurrent and group therapy is being provided.	2
OIG Audit and Evaluation Reports			
IRF claims with transfer code 05.	HHS OIG. "Review of Jurisdiction 5 Payments for IRF Claims Billed with Patient Status Code 05 for Calendar Year 2007." (A-01-10-00518). Feb. 2011.	IRFs incorrectly coded 24 of the 53 claims that we reviewed with patient status code 05. These beneficiaries were actually transferred to facilities that were subject to the Medicare transfer regulations, e.g., inpatient hospitals, skilled nursing facilities, and Medicaid-only nursing homes.	3
Recent Congressional Testimony			
Medical necessity/ Appropriateness of service site for post-acute care	MedPAC's Annual March Report to the Congress on Medicare Payment Policy. Committee on Way and Means. Subcommittee on Health. United States House of Representatives. 17 March 2009.	This report discusses ways to lower the costs of post-acute care. The testimony of Glenn Hackbarth, the Chairman of MedPAC, focuses on medical necessity/appropriateness of care setting for the provision of post-acute care, asserting that the level of care provided in inpatient rehabilitation hospitals and long-term care hospitals are not medically necessary after a hospital admission.	2