Hospice Insights: The Law and Beyond

Episode 4: The Next Wave from OIG – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Audits

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Speaker	Statement
Meg Pekarske	Hello! Welcome to Hospice Insights – The Law and Beyond, where we connect you to what matters in the ever-changing world of hospice and palliative care. "The Next Wave from OIG – DMEPOS Audits." In today's episode, Bryan Nowicki and I discuss the latest round of OIG audits which focus on DME supplies and their relatedness to a patient's terminal prognosis. Whether or not you are subject to these audits, we share strategies for withstanding government scrutiny of your relatedness to terminations, including the who, when, why and how of your decision-making. This is Meg Pekarske and I'm here with Bryan Nowicki. You and I are usually at my round table talking about issues and so thanks for joining me, Bryan.
Bryan Nowicki	You're welcome!
Meg Pekarske	And this is probably going to be a shorter podcast, but maybe we're going to end up talking about this for 20 minutes. But the thing that I thought would be interesting for us to talk about today, Bryan, is the recent OIG audits related to DME that came out and so these audits, which I want you to sort of dig into here – the take-away is they look very similar to the Part D kind of audits that OIG did. So we expect that there is going to be a similar negative report that may come out as a result of this. Which is, I think, from the very big picture standpoint, something we need to be aware of. And at its core, it's all about relatedness and are we actually covering what we said we wanted to cover? But let's unpack this for a second. So Bryan, what are these OIG DME audits?

Speaker	Statement
Bryan Nowicki	So what OIG is doing, as you said, consistent with the Work Plan, is they are looking at particular patients, particular hospice patients, who have obtained or were provided with DME or other – it's the DMEPOS audit. So Durable Medical Equipment, Prosthetics, Orthotics and Supplies. So they look at the patient and then they – it appears that they then find what hospice that patient was with and then they go to the hospice and ask for a number of records relating to that DMEPOS. Related to the patient for a certain month, but then also they ask some pointed questions about that relatedness issue. So we're seeing clients get these requests, much like the Part D and of course, as you said, if it turns out anything like Part D, it's going to be a big issue with OIG. It's going to lead to more questions and more enforcement efforts so, you know, better to get out on the front end of this and know what's coming.
Meg Pekarske	And so in terms of how they pulled this, similar to – I think we did an earlier podcast episode on the RN Supervisory Visit Audit they did a while ago – but they had essentially used claims data to say, 'oh, there was a gap of more than 14 days in RN visit' and so that really dictated both the hospices and the sampling. And what I'm expecting here is there were things that were separately billed to Medicare that were DME and so they're taking these claims and then asking us about those patients that are on our hospice. Because they're asking about, you know, did you cover these items and if so, why and if not, why?
Bryan Nowicki	So right. So that kind of gets to the question. So I think the methodology you described is exactly right. They're looking for a claim that was submitted where something, a DMEPOS, was paid for outside the hospice benefit. And you can tell they're questioning that because of the three questions they ask, the last one is 'should the hospice have covered this under its pay level?
Meg Pekarske	Yeah.
Bryan Nowicki:	Leading up to that, they asked a couple of very similar questions. Was that item, was it used to manage or palliate the diagnosis or symptom related to the terminal diagnosis or related conditions. And then they also ask, was the item medically appropriate and clinically necessary for the palliation of the terminal prognosis or related conditions. And then they ask the question, 'should it have been covered.' So as you answer these questions, if you get one of these audits, read them carefully. Make sure there is consistency among the answers. They also ask for documentation where you had communications with the DMEPOS provider about whether it was related, what kind of analysis was done to determine that. So it's obvious that they are really getting at that relatedness issue.

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Meg Pekarske	Yeah and I think that this is – when we talk about the government digging deeper, I mean, I think it's both, you know, was – did you intend to cover this? Because I think that that's something that is oftentimes overlooked when you look at the OIG reports. The premise is more like hospice is a bad actor, you should have paid for this and you intentionally didn't pay for this one might be led to believe, when instead, I feel like through our work, oftentimes the hospice made the decision that is in most instances right, that this is related. We intended to pay for it. And with this DME, we pay – oftentimes hospices are paying a patient per day amount and so we would argue we did pay for this. We expected it to be covered. We have documentation of that. And then sort of unbeknownst to us, this gets billed to some other part of Medicare. And so I think when you and I talked about this, we see similar trends here of – I'm worried that the story is going to be the narrative on the medication is hospices aren't covering these things because they're making decisions that this isn't related when more often than not it's we said it was related but we don't have a stop on the Medicare billing system, and so don't know when people bill outside, essentially look elsewhere for payment rather than coming to us.
Bryan Nowicki:	Right. In that regard, it's very similar to, I think, the unfortunate narrative that came out of Part D where they found hospices were not paying or covering the pharmaceuticals and it was the hospice's fault. Even though the hospice may not have any idea that their patients are being provided with medications through Part D and there's nothing the hospice can do. Hospices often have done a lot to communicate with their pharmacies, their PBMs, to alert them. But yeah, hospices were the villain in that story and this kind of has a possibility of going the same way, for almost the same exact reasons. That hospices can do whatever they can to try to let people know that they're covering everything, but you're still going to have DMEPOS providers who might erroneously be separately billing Medicare to get that double payment.
Meg Pekarske:	Or they – sloppiness. Because obviously – yeah. Whether or not it's actually truly a double payment to them or is it just looking to the wrong provider.
Bryan Nowicki	Well, right. Yeah. I mean, I don't know that they're going to find a lot of fraud going on here. I mean, it is just the absence of coordination.
Meg Pekarske	Yeah.
Bryan Nowicki	But for some reason it becomes the hospice's problem. Even though the system is really not set up to allow to give the hospices the tools to put the stop or identify through the Medicare system that these are all hospice patients and alert people through the government's way of contacting everybody and being able to reach out to everybody that these other providers should be aware of this. And communicate with the hospice pro-actively.

Speaker	Statement
Meg Pekarske	Yeah. The other secondary point – and I think none of the audits have gotten as much into this, but I think this remains an important point and take-away is – as there continues to be focus on relatedness, I think that really critical to have well-documented determinations. And so oftentimes we intended to cover this and it's the provider, the DME provider billed someone else and so it's not really our decision-making that's being questioned. But I think it is possible, especially when we're saying something is not related, of really having that be well documented. And Dr. Ed Martin and I – he's from Hope Health out in Rhode Island – we did a presentation at NHPCO in fall about relatedness and sort of the challenges around that and how you document that. Because I think that, you know, this is sort of the low-hanging fruit of 'oh, is there an erroneous bill that's being paid by Medicare.' I think the other issue that could be coming is, did you make the right decision and it's probably always going to be questioned when it's – you determined something is unrelated, what kind of support do you have for that. And obviously, the election changes that are forthcoming here, all of this focuses on what are you saying you're going to cover and all that stuff. So I mean, when you look really big picture, you see all these dots connecting around coverage and communicating coverage and ways to make sure that the hospice is indeed paying for all of these things. But as you point out, Bryan, healthcare is incredibly complex. Lots of moving parts. Lots of different billing systems. And it's very complicated and, you know, we are not masters of the universe.
Bryan Nowicki	Yeah, and I think from these audits, as I mentioned, they are asking for documentation that is specific to making those determinations of relatedness. Now, I think the medical record itself can comprise documentation. Sometimes the medical record could get specific and actually have that analysis kind of explicit and laid out in the medical record. There may be other times when you're just looking at the data in the medical record to try to draw inferences from, you know, what were people thinking for this particular piece of equipment. What from the medical record can you use to see whether this conclusion was drawn one way or another by the hospice. But when you're just relying on the medical record absent of a specific analysis, you're taking your chances.
Meg Pekarske	Yeah.
Bryan Nowicki	So to have that analysis in the record is going to provide more clarity for the hospice to try to recreate these decisions years after the fact. Because in these current rounds of audits, they're going back years, as they typically do.
Meg Pekarske	Yeah. Yeah.

Speaker	Statement
Bryan Nowicki	This is going back four and five years to say what about this patient's wheelchair or whatever it was. Was this related or not? And you go back to the medical record back then and maybe there's an analysis, maybe not. If you have some medical record, just notes and such, that might relate to that analysis. But how do you really demonstrate how this has been done? Because it's clear, I think, that OIG is expecting that kind of analysis to take place.
Meg Pekarske	Yeah. And I think that's always the challenge and I think the challenge people have is applying current standards to past practices. Because there's been, you know, significant evolution around how people document relatedness, both the conclusion about is it related or not related. I mean, currently, I think most folks have that on the care plan or their med sheet or whatever. You know, is this related or not? But I think your point, Bryan, and I think as we get prepared for the election changes as they come out of showing your rationale and again, especially when you're making a decision not to cover something. I mean, saying 'I'm going to cover this,' you know, that's really not going to be scrutinized.
Bryan Nowicki	Right.
Megan Pekarske	It is really when you're making that decision about it's not related. And I think, as Ed Martin and I talked about in our session, really important that the physician is involved and ideally documenting that. Obviously RNs or nursing staff have a role in that, too. But I think, you know, making sure that physicians are using their clinical judgment on this. Because I think there are, you know, we had a very lively discussion during our session and there were a lot of doctors in the audience and there are hard calls to be made. You know, we deal with some very complex patients and so anyway, I think these are hard decisions but, you know, again, I think the large focus of this are things that were erroneously billed that we probably wanted to cover, but because we are not masters of the universe, didn't, but it wasn't because our documentation said we didn't want to cover this. I mean, obviously we don't know every single example, but I think in our experience, more often than not, that is the cause and, you know, there's only so many safeguards you can put in place to prevent someone from billing outside the benefit, because we can't see that they do that and our ability to police that is very difficult.
Bryan Nowicki	And I think your suggestion about physician involvement is a really good one. Just like in audits where we're defending patients and we have physicians certifying them, we like to present material and further supporting descriptions and opinions by other physicians, because we always want to out-credential whoever's reviewing this.
Megan Pekarske	Yes.

Speaker	Statement
Bryan Nowicki	And so if we can say these are kind of physician analyses that are taking place, and the OIG is instead using non-physician reviewers, whatever clinician they may be, but they're non-physicians, it gives us that little edge to keep pushing that these are complex and you really do need a physician to look at these. Because I think up and down with auditors, including OIG, they tend to rely on the lower-cost clinicians. They don't bring physicians in to all of these so it gives us a bit of edge if we are ever put in a position of having to challenge results.
Meg Pekarske	Well and I think another important point that you're raising is the role of contemporaneous documentation. So after the fact conclusions I think are always – I mean, obviously, we argue when we're defending hospices that this is just a Monday morning quarterbacking kind of evaluation. So the more a hospice has of 'I connected the dots at the time' and you have this documented and I know we talk about this and I won't go off on a tangent here, but when we're defending audits, that physician narrative is probably one of the most important things in the medical record. Because it is that dot-connecting document. It explains the why behind the conclusion which I think, you know, as auditing continues to evolve, it's going to be about the 'why did you believe this to be true?' because, you know, we've talked about AseraCare on this podcast, but I think that standard and being able to take advantage of the principles that the 11th Circuit held in that case, it really goes into the 'why I believe this to be true' and that someone can disagree with me, but it doesn't necessarily make me, the hospice physician, wrong.
Bryan Nowicki	That contemporaneous note is really such an advantage hospices can have. They're seeing the patients day in and day out. They can make the contemporaneous, real-time note by a physician and just as a standard of evidence, that is always going to be viewed more reliably than somebody's recollection after the fact or somebody trying to interpret a medical record years after the fact.
Meg Pekarske	Yeah.
Bryan Nowicki	And AseraCare does raise a lot of suspicion about a subsequent review of a medical record years after the fact, by a non-physician. So it gives us a lot of good language that we can use in a lot of ways, in a lot of audits. Prognostication and now the relatedness issues. A lot of those principles in AseraCare are helpful here and they're there for hospices to take advantage of and we would encourage that.
Meg Pekarske	Well, and I think the take-away, really, from our discussion is, you know, not that there is something you're going to be able to do to say 'I'm never going to get audited again.' I mean, I think these things are going to continue to happen for all the reasons we've already talked about in this and other podcasts. It's really 'how do I best prepare to defend myself when this does happen?' And I think a linchpin here is really your hospice physicians and having engaged hospice physicians who are doing that dot connecting on a

Speaker	Statement
	contemporaneous basis, because that is going to put you in the strongest stead when you have to defend a non-relatedness determination or, you know, medical necessity on terminal illness. And so I just think so much of what we talk about in hospice law and beyond is really the critical role of those physicians and someone who is really learned in this area is, in terms of a compliance program, probably one of the most important things hospices can do.
Bryan Nowicki	Yeah. And there are so many ways you can get audited. It's because you've done something wrong or you have an aberrant billing pattern or with these DME audits, they're actually going from the patient and reverse engineering it back to the hospice.
Meg Pekarske	Yes. Yeah.
Bryan Nowicki	So it's not anything the hospice did specifically, but they're starting at the patient level. So you're right. Don't think that you can avoid the audit. But what we're talking about are ways to come out of these audits better. To be better prepared to address them and hopefully get out of the audit once it's begun.
Meg Pekarske	Yeah. Well, great conversation, Bryan. Thanks for sharing your time and thoughts. I think this was helpful. And so until next time, Bryan.
Bryan Nowicki	Always happy to do this. This was pretty timely. So until next time.
Meg Pekarske	Thank you!
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