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'Audits are back,' and COVID-19 care is in the hot seat

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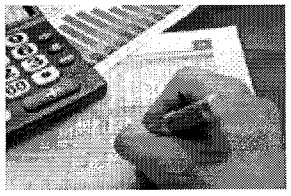

Flexibilities granted to providers during the ongoing public health em ergency are likely to result in increased medical reviews and automat ed denials, a therapy billing specialist is warning.

Those increased rejections will probably coincide with a pick-up in au dits meant to enforce the Patient Driven Payment Model's coding and billing requirements, as well as other reviews determining whether providers continued delivering therapy at app ropriate levels after PDPM's launch.

"Just as things were starting to get into full swing with PDPM, COVID changed everything," Kim Karr, assistant director of clinical Services at CHS Therapy, said last week. "But multiple

sources are citing that as we eventually transition out of the public health emergency, medic al review will be used to ensure that dollars were correctly given and that facilities used the m correctly."

Karr hosted a session on managing medical review responses during The American Associati on of Post-Acute Care Nursing's annual conference.

Among waivers Karr says are likely to draw scrutiny are any related to telehealth, and Waive r 1135, which exempts Medicare Part A SNF stays from the normal three-day hospitalizatio n requirement for coverage.

Waiver 1135 has continued to foster confusion among skilled nursing providers. Though a bl anket waiver, it still requires nursing homes to document that COVID-19 was prevalent in th eir community during a resident's stay; explain how a resident's condition might have precipi tated an acute stay in non-COVID times; and provide records supporting medical necessity f or any Part A stays that extend beyond 100 days.

"It's important to note that we can't just use it because a resident had COVID or because the re's COVID in the building," Karr said. "It really has to be a question of, would you normally s end the resident to the hospital for this condition? ... What has changed for this resident and what additional skilled care am I providing that I wasn't before the diagnosis of COVID?"

Karr noted that the Health and Human Services' Department Office of Inspector General ha s already expressed the use of 1135 waivers would likely result in audits. But she also remin ded providers that being audited or facing an automatic denial does not indicate that a facilit y has committed fraud — or that the provider won't eventually be reimbursed for care delive red.

Instead, she emphasized the importance of documentation, monthly triple checks and a robu st self-auditing system that takes into account the anticipated emphasis of the coming year.

A pause, followed by new audit pressures

In response to COVID-19, the Centers for Medicare & Medicaid Services suspended improp er payment-related activities between March and August 2020. The agency also adjusted ho w it will measure improper payments rates, which must still be reported per the Payment Int egrity Information Act of 2019.

It's unclear yet how much audit activity and improper payment findings were curtailed over t he last calendar year. Fiscal 2020 figures reported by CMS last November were based on cla

ims submitted between July 1, 2018, and June 30, 2019. Fiscal 2021 rates, which would incl ude much of the audit pause attributed to COVID-19, have not yet been reported.

Karr, however, expects activity to pick up, if not negative findings, necessarily.

"Audits are back," she said. "You can anticipate 2021 will have a higher volume as RACs star t catching up, especially for Medicare Part A PDPM reviews, as well as for Part B threshold r eviews."

Providers shouldn't be caught off guard by the fact that therapy provision will be audited; C MS was open during the PDPM's rule-making process that it expected therapy service to re main steady despite the model's move away from therapy hours as the basis of pay.

PDPM also limits the use of group and concurrent therapies, a stipulation that may not have been top-of-mind in 2020 given that almost all therapy was provided in isolation during the pandemic. Now, providers should take heed if they get an MDS pre-submission warning that a resident's level of group therapy is above the 25% cut-off. Karr said that may be justified in some cases, such as if the patient were hit by COVID-19 or otherwise hospitalized, but provi ders must be sure they are documenting any conditions that lead to overages.

She also warned providers using telehealth to remain vigilant, recognizing that several watc hdog agencies and some payers have already shown they'll carefully review claims using mo difiers.

CMS is closely monitoring use of the 95 modifier for telehealth, Karr said. And HHS has alrea dy announced a False Claims Act working group to combat telehealth fraud during the public health emergency.

All that could push up the number of providers facing audits; a January 2019 survey found s ome 60% of healthcare providers had been audited, with one-third of those resulting in nega tive findings.

TOPICS: AAPACN | AUDITS | CORONAVIRUS / COVID-19 | PATIENT DRIVEN PAYMENT MODEL | PDPM

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Kimberly Marselas is senior editor of McKnight's Long-Term Care News. She joined the staff in 2021 after working as a contributor for eight years. A proud journalism graduate of the University of Maryland, Kim started her career as a daily newspaper reporter and has always been drawn to stories involving children and seniors (and food). She is a fast and dedicated reader and a slow and somewhat less-dedicated half marathoner. She lives in central Pennsylvania with her husband and three children.

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