DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Responding to Governmental Requests for Home Health or Hospice Agencies Claims Reviews or Surveys
PAGE: 1 of 3	**REPLACES POLICY:** 7/1/21
EFFECTIVE DATE: February 1, 2024	**REFERENCE NUMBER:** REGS.HHA.002
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated Home Health and Hospice Agencies (HOSPs). The scope of this policy does not apply to Recovery Audit Contractor (RAC) reviews, Medicare Advantage, Managed Medicaid, other 'Commercial' Managed Care plans or reviews for non-HCA Home Health or Hospice facilities.

PURPOSE: To establish a consistent process for handling external claim reviews, comparative billing reports (CBRs), and/or surveys conducted by a governmental entity or its agent. The notification of a claim review can originate from, but is not limited to, the Office of Inspector General (OIG), Unified Program Integrity Contractor (UPIC), the Centers for Medicare & Medicaid Services (CMS) and its contractors, a State Medicaid Agency, or a company contracted by the governmental entity to perform the review. The agency's legal operations counsel should immediately be notified and sent a copy of any request or subpoena from the Department of Justice (DOJ).

POLICY: Each agency or other entity (e.g., the Parallon Specialty Services Appeals department) is required to submit specific governmental requests for claim reviews, CBRs or surveys to the Regs Helpline as outlined in the Governmental Entity Review Matrix. The matrix outlines the most common types of requests and the various actions the agency or entity must take in response to the request. The requests are categorized into three priorities:

Priority 1: Those review requests that must be submitted to the Regs Helpline and await Regulatory Compliance (Regs) guidance before proceeding. Regs will provide guidance upon receipt of the request and approve the response before submission. These agencies are typically the UPIC and OIG Federal reviews.

Priority 2: Those review requests that must be submitted to the Regs Helpline for notification but do not require action from Regs before proceeding with the request. For these reviews, Regs will acknowledge receipt of the notification and instruct the agency or Appeals department to proceed with the request. A call may be requested if additional guidance is needed.

Priority 3: Those reviews that are not required to be submitted to the Regs Helpline. For these requests, submission of the requested information may proceed without contacting Regs for guidance or review.

Common Review Types:

Comparative Billing Reports (CBRs): disseminated to the Medicare provider community to provide insight into Medicare policy and regional billing trends.

Comprehensive Error Rate Testing Contractor (CERT): collects documentation and performs reviews on statistically valid random samples of Medicare Fee for Service (FFS) claims to produce and annual improper payment rate.

Medicaid Integrity Program (MIP): reviews to prevent and reduce provider fraud, waste, and abuse in the Medicaid program.

Office of Inspector General (OIG): provides oversight of the Medicare and Medicaid program and conducts reviews to improve these programs and prevent or detect fraud, waste, or abuse.

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Payment Error Rate Measurement (PERM): measures improper payments in Medicaid and CHIP and produces error rates for each program.

Probe: a MAC review of a small sample of claims conducted to determine if a provider-specific billing error exists. Probes can be conducted prepayment or post-payment, e.g., Targeted Probe and Educate (TPE).

Review Choice Demonstration (RCD) for Home Health: helps ensure that the right payments are made at the right time for home health service through either pre-claim or post payment review, protects Medicare funding from improper payments, reduces the number of Medicare appeals, and improves provider compliance with Medicare program requirements. *Only the RCD Affirmation Rate letters are required to be submitted to the Regs Helpline*.

Supplemental Medical Review Contractor (SMRC): The SMRC conducts medical review of Medicare Part A and B claims to determine whether claims were billed in compliance with coverage, coding, payment, and billing requirements.

Unified Program Integrity Contractor (UPIC): performs Medicare and Medicaid program integrity reviews, including the identification of suspected fraud, waste and abuse. There are three UPICs assigned to specific areas of the country.

PROCEDURE:

For all Priority 1 and Priority 2:

- The Agency and Regional Ethics and Compliance Officers (ECOs) must be notified of receipt of a letter for a claim review.
- ECOs or designee must notify other senior leaders, such as the Agency and Regional Operations Leadership, and/or Service Line Leadership, as appropriate.
- ECO or designee must immediately submit the request to the *Regs Helpline*.
- Agency or responding entity should follow the Governmental Entity Review Matrix and other direction provided by *Regs* which may include:
- Proceed with gathering requested documents.
- Only provide documentation related to the specific line item(s) or issue requested by the governmental entity.
- Ensure all requested information included in the notification received from the governmental entity is included in the records.
- If an agency is unable to meet the records submission deadline, notify Regs and contact the governmental entity to request an extension.
- Follow the specific instructions provided by a governmental entity such as completing a medical record and/or claims review. The instructions may include submitting a corrected claim, providing a response letter, or documenting root cause and corrective action.

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Additional Guidance for **Priority 1 Reviews:**

Regs will:

- Provide guidance on responding to Priority 1 reviews;
- Determine, in conjunction with the agency or responsible entity if an extension is necessary;
- Determine if assistance from legal counsel is necessary;
- Review the results received from Priority 1 reviews and advise the agency or responsible entity as to next steps;
- Follow the progress of the review through to final resolution; and
- Develop education or system enhancements based on review results.

The agency or responsible entity will:

- Notify Regs immediately upon receipt of a request;
- Respond to the request according to directions provided by Regs;
- Notify Regs when the results are received;
- Submit a quarterly report to senior management and Regs for reviews where extrapolation may be involved; and
- Complete any action steps, including any rebills or appeals, as directed by Regs.

REFERENCES:

1. Governmental Entity Review Matrix- HH and HOSP
2. Reporting Compliance Issues and Occurrences to the Corporate Office Policy, EC.025
3. Claim Reprocessing Tool Requirements for Tracking Compliance Rebills/Refunds Policy, PARA.PP.COMP.013