

## Part I: Preparing for Audits - ZPIC Audits

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The Centers for Medicare and Medicaid Services (CMS) are now conducting ZPIC audits. ZPIC's are conducted by Zone Program Integrity Contractors. Unlike RAC audits that target identification of overpayment and CERT audits that attempt to pinpoint improper payments, ZPIC audits focus on fraud in the Medicare Program. This means that ZPIC contractors can audit the integrity of all Medicare claims, both pre- and post-payment.

CMS has established seven ZPIC zones. Contracts have been awarded in three zones thus far, as follows:

Zone 5 – AdvanceMed: Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia

Zone 7 – SafeGuard Services: Florida, Puerto Rico, and the Virgin Islands

Zone 4 – Health Integrity: Texas, Colorado, New Mexico, and Oklahoma

ZPIC contractors are currently especially active in Zone 4.

Providers may encounter the following difficulties in connection with these audits:

Requirements to copy a large number of charts to send to the ZPIC contractor within thirty (30) days of receipt of a request for them.

If documentation sent by providers by ZPIC contractors is determined to be insufficient or is not received at all, claims are denied and monies recouped.

ZPIC contractors may place providers on 100% prepayment review.

Clearly, providers need to prepare for these types of audits now.

A key area of review for ZPIC contractors for home care clients may be whether or not patients were homebound. If patients were not homebound, claims for services provided to them are false claims. Agency managers perceive that they are extremely vulnerable regarding this issue for at least two key reasons: (1) the standards used to determine homebound status remain ill-defined; and (2) since Medicare homecare services are provided only intermittently, as opposed to continuously, agencies are unable to verify homebound status with absolute certainty.

Generally, Medicare patients are considered to be homebound if they meet the following criteria:

- (1) Patients leave home infrequently for only short durations of time for reasons other than to seek medical care that they cannot receive at home, and
- (2) When homebound patients leave home, it must take great and taxing effort and/or require maximum assistance.

Patients may remain homebound, however, if they leave home to attend religious services and adult day care programs that meet certain requirements.

The difficulty that agencies have in interpreting these standards is evident. For example, what is a "short duration of time?" What is "great and taxing effort" or "maximum assistance?"

Home health agencies must be prepared to respond to strict application of these standards by addressing two key questions:

- (1) Does the patient's clinical condition support a conclusion that the patient is homebound?
- (2) What is the patient actually doing?

Agency managers should take the following actions *NOW*:

Encourage staff members to spend less time and energy trying to understand how to interpret the standards summarized above. The standards remain difficult to understand, interpret, and apply. Even when staff members call regulators to ask for clarification or for determinations about specific cases, they may receive different answers, depending upon the person with whom they speak. In addition, staff cannot rely on verbal guidance given by regulators.

Staff should focus on “beefing up” documentation related to homebound status in the following ways:

- During the admission visit, inform each new patient about the criteria of homebound status and document that this information has been shared. Continuous quality improvement (CQI) staff members should audit retrospectively to verify that this information is provided to each new Medicare patient.
- Periodically, visiting staff should interview Medicare patients, either in person or via telephone, regarding whether they are homebound by asking pointed questions, such as:
  - Have you left home since the last time I talked with you about this issue?
  - If so, when?
  - Where did you go?
  - What did you do?
  - How long were you gone?
  - What assistance did you have each time you left home?

It may be helpful to ask nurses to obtain this information during supervisory visits. Some agencies include questions that prompt nurses to obtain this information on every visit. In addition, CQI staff should audit to make certain that this task is accomplished.

- When staff members know about a patients' conduct that might indicate that they are no longer homebound, they must immediately report this information to their supervisors. Agency staff members can no longer afford to turn a “blind eye” or a “deaf ear” to this type of information that comes their way. Staff must document that they have reported this information to their supervisors. Supervisors, in turn, must investigate information they receive related to this issue. If further investigation clearly reveals that patients are no longer homebound, supervisors must take action to terminate services to these patients. If, however, further investigation indicates that patients' homebound status is questionable, the team must hold case conferences to determine together whether the patients are still homebound. The results of these case conferences must, of course, be carefully documented.

- Agency staff should continue any documentation related to homebound status that they currently produce, including documentation of patients' functional limitations.

The documentation described above must be written in plain language and be detailed enough that regulators with little knowledge of health care, much less home care, can readily see that agencies have been continuously monitoring patients' homebound status. Of course, there are no guarantees that patients are telling the truth or that auditors will not second-guess agencies on this issue anyway. The documentation described above makes it considerably harder, however, for auditors to disallow payments for visits or to find that agencies engaged in fraudulent or abusive conduct.

(To obtain more information about fraudulent claims in a book entitled *Medicare/ Medicaid Fraud and Abuse: A Practical Guide for Providers*, send a check for \$30.00 made out to Elizabeth E. Hogue, Esq. to: Fulfillment, 107 Guilford, Summerville, SC 29483. To obtain a training video for staff on fraud and abuse issues, send a check for \$105.00 to the above address.)

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