Off to a Good Start: Quality of Care and Regulatory Considerations at Time of Admission

Part 1

Subscriber Webinar
January 2015

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Why Is This Topic Important?

- Compliance with Regulations
- Resource Consumption
- Patient / Family Experience

What's the Difference?

Conditions of Participation

Subparts C & D
Care Delivery / All Patients

Conditions of Coverage

Subparts B & F
Payment / Medicare Patients

"A hospice can't submit a timely plan of correction if there is no one there to write it."

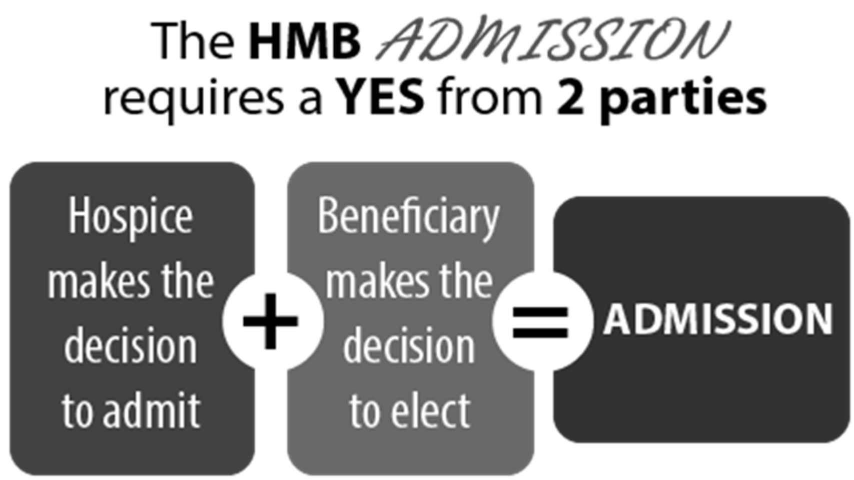
Roseanne Berry, MSN, RN
Partner, Hospice Fundamentals

Today: The Key Coverage Questions

1. Was the beneficiary's eligibility assessed?
2. Was a valid initial certification of terminal illness completed by the hospice medical director / physician?
3. Was a valid initial certification of terminal illness completed by the non-hospice attending physician (if there is one)?
4. Was a valid election completed?

For Each:

Purpose
Paper
Person
Timeframe
Comments



Certification

Election

42 CFR 418 Subparts

A. General Provision and Definitions
B. <u>Eligibility, Election and Duration of Benefits</u>
C. Conditions of Participation – Patient Care
D. Conditions of Participation - Organizational Environment
E. Conditions of Participation – Removed and Reserved
F. <u>Covered Services</u>
G. Payment for Hospice Care
H. Coinsurance

Subpart F – Covered Services §418.200

To be covered, hospice services must meet the following requirements.

1. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
2. The individual must elect hospice care in accordance with Sec. 418.24. [Subpart B]
3. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in Sec. 418.56. [Subpart C]
4. The plan of care must be established before hospice care is provided.
5. The services provided must be consistent with the plan of care.
6. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22. [Subpart B]

Subpart B – Eligibility, Election & Duration of Benefits

418.20	**Eligibility requirements**
418.21	**Duration of hospice care coverage - Election periods**
418.22	**Certification of terminal illness**
418.24	**Election of hospice care**
418.25	**Admission to hospice care**
418.26	**Discharge from hospice care**
418.28	**Revoking the election of hospice care**
418.30	**Change of the designated hospice.**

1 Assessment of Eligibility

Purpose To determine if the beneficiary is eligible to elect and to receive services under the hospice Medicare benefit

Paper A process rather than a specific form or type of form. Information comes from various sources; may be a high degree of verbal transmission initially which is then supported by written information that becomes part of the clinical record

1 Assessment of Eligibility (con't)

Person Referral Intake
Admission Team
Hospice Physician
Attending Physician

Timeframe Information gathering starts when referral comes in and continues through the time of election and decision on certification

§418.25 Admission to Hospice Care

a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).
b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
   1) Diagnosis of the terminal condition of the patient.
   2) Other health conditions, whether related or unrelated to the terminal condition.
   3) Current clinically relevant information supporting all diagnoses.

§418.22 Certification of Terminal Illness

b) Content of Certification

2) Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification as set forth in paragraph (d)(2) of this section. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

If someone from the OIG visited your hospice and asked you to explain the process for determining eligibility at the time of admission, what would you say?

2 & 3 Initial Certification of Terminal Illness (CTI)

Hospice Medical Director

Purpose To demonstrate that the hospice physician

- has evaluated the beneficiary, and
- made a determination that the person has a life expectancy of six months or less should the disease run its normal course

Community Attending

Purpose To obtain input from the attending physician

- that supports eligibility;
- assumes that this individual will have the most knowledge about the beneficiary's history and the anticipated course of the disease

2 & 3 Initial Certification of Terminal Illness (CTI)

Paper Form with five very specific required elements; no CMS mandated form

Required Elements

1. Statement that the "individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course."
2. Brief narrative explanation of clinical findings that support a life expectancy of six months *
3. Physician signature and date
4. Attestation that the physician composed the brief narrative based on his/her review of the medical record or examination of the patient
5. Benefit period dates to which the certification applies

See Regulatory Language at §418.22

Comments CTI Brief Narrative

- The brief narrative only needs to be completed by one physician – can be the attending or the hospice medical director

  "In the case of the initial certification, we require either the attending physician or the hospice medical director to compose and sign the narrative."
  FY 2010 Hospice Wage Index Final Rule

- Must have proper attestation regardless of which one does it
- If you are asking the attending physician to complete it be aware of how it may impact referrals
- How are yours looking? Claims are being denied due to missing or inadequate brief narratives

2 & 3 Initial Certification of Terminal Illness (CTI)

Person Hospice Medical Director or Physician (always)
Attending Physician (if there is one)

Timeframe Very specific requirements

- Must be obtained no later than two days after the start of the benefit period, may be written or oral
- If initially received verbally, written certification must be obtained before a claim is submitted for payment
- Written or oral certification may be obtained no more than 15 calendar days prior to the effective date of the election

Comments Person

- For patients with a community attending, two CTIs are required for initial benefit period
  - Community attending
  - Hospice medical director or hospice physician
- For patients for whom the hospice physician is serving as the attending, only one CTI is required
- For subsequent benefit periods, CTI required from only the hospice medical director or hospice physician
- Under no circumstances may NPs complete CTIs
- When a NP (either hospice or non-hospice employed) is serving as the attending, only the hospice medical director / physician needs to complete the CTI

Who Has to Complete an Initial CTI?

When the Hospice Attending Physician Is the ⬇	Hospice Medical Director	Community Attending Physician
Community Physician	X	X
Hospice Physician	X	
Hospice-Employed Nurse Practitioner	X	
Community Nurse Practitioner	X	

Comments Signature Problems

- Illegible (if there name not typed or printed under the signature) or undated physician signatures
- Stamped signatures

Comments Timeframes

There is no recovery from a missed certification – if it happens get a new one signed asap and see billing instructions (benefit period remains intact)

Verbal certifications

- Should include full certification verbiage
- Can be taken by anyone allowed under agency policy
- Do not need to be signed by the physician

4 Election of Benefits (EOB)

Purpose To indicate that beneficiary or representative chooses to forego traditional Medicare coverage for treatment and management of the terminal condition and elect the hospice benefit instead.

Paper Election of Benefit Form

- Specialized form of informed consent having to do with payment
- No specific form mandated by CMS; each provider may design their own

Informed Consent: Generic vs Hospice EOB

Generic Healthcare

- A legal condition common to all health care providers
- Indicates that a person has
  - been given relevant facts
  - the capacity to understand the facts and the implications of giving consent
- If lacking capacity, each state has rules specifying who can act on the individual's behalf
- Protective for healthcare providers
- Unrelated to payment
- Possible to establish policies and procedures for obtaining verbal informed consent

Hospice EOB

- A second and very specific informed consent required for access to the HMB
- Must be completed by the beneficiary or his/her representative (as defined in Subpart A Definitions)
- Must contain very specific elements
- Verbal elections not allowed
- No valid election = no Medicare payment

Paper Required Elements

1. Identification of hospice and of attending physician
2. Acknowledgment
   a. That attending was choice of beneficiary (or rep)
   b. Of understanding of palliative rather than curative nature of hospice care
   c. That certain Medicare services are waived by the election
3. Effective date of the election
4. Signature of the individual or the representative
5. Date of signature

(See §418.24 for exact language)

Paper Form Problems

The Form
- Does not contain required elements (payment issue)
- Contains extraneous verbiage
- If combined with generic informed consent to receive hospice care significance can be obscured

- The Explanation
  - Too little or too much information
  - Use of hospice code words
  - Lack of realization that people are anxious, stressed and scared (to be addressed in Part 2)

4 Election of Benefits

Person Must be signed by beneficiary or representative (as defined in §418.3 Subpart A Definitions)

Timeframe No later than the day care is to start under the Hospice Medicare Benefit – known as the effective date of the election.

- May indicate a start date in the future
- May not indicate an effective date in the past

Comments Person

Problems

- Signed by someone without the authority to sign
- Signed by representative when the beneficiary has capacity

Proposed Definition Change

§ 418.3 Definitions.

Representative means an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian. The same-sex spouse of a patient must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. If a state court has appointed a representative, that person is the representative for these purposes.

Comments Timeframe

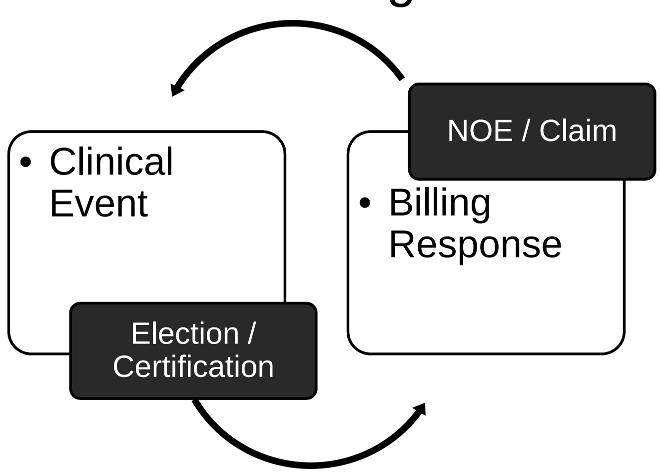
Problems

- Does not include date that hospice care is to start
- Identifies a start date that is delayed due to some circumstance; commonly planned hospital discharge that is delayed

Comments Watch For These Problems

- Billing systems that will release a claim even if a CTI element is missing
- No internal process in place to continually monitor completion of the process
- Readmissions after a lapse in care: not realizing that a face to face is required because they look like initial elections

The Clinical / Billing Connection



A Weak Connection = A Strong Pain

In Closing

- Processes at time of admission are critical – getting off track can be financially disastrous
- Evaluate your processes periodically - and have a copy of Subpart B in one hand while you are doing it
- If you've got extra pieces and parts in forms or in your steps, evaluate
- Ensure a strong connection and communication between clinical and billing office
- At least two people need to be aware of all the processes from start to finish – and be very careful with changes in positions that touch the processes

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Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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