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# ELIGIBILITY & CERTIFICATION THE CONTINUING SAGA

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## What You Will Learn Today

- The regulatory requirements of certification, recertification & eligibility
- The framework to ensure a solid certification / recertification process
- How to recognize appropriate documentation that supports eligibility at initial certification & recertification

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## 418.22 Certification of Terminal Illness

- Having a valid certification / recertification is a statutory requirement for coverage and payment
- Plain English
  - Follow the regulations and you will submit valid claims
  - Don't follow the regulations and you may be submitting false claims, i.e., fraud and abuse

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## Certification / Recertification Requirements

Sum of the Parts = The Whole

Certification statement  
+  
Narrative  
+  
Face to Face (3<sup>rd</sup> and beyond)  
=  
Payment requirement met

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## Increasing Scrutiny by CMS

### § 418.25 Admission to Hospice Care – effective 2006

Medical director considers

Terminal diagnosis

Other health conditions

Currently clinically relevant information supporting all diagnoses

### § 418.102 Medical Director – effective 2008

Initial certification considers

Primary terminal condition

Related diagnosis(es)

Current subjective and objective medical findings

Current medication and treatment orders

Information about the medical management of any of the conditions unrelated to the terminal illness

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## Increasing Scrutiny by CMS

- Physician narrative at certification and recertification – effective 2009
- Affordable Care Act – effective 2011
  - Face to face encounter (F2F)
  - The Secretary will medically review certain patients in hospices with high percentages of long-stay patients
- Probe edits – (can result in targeted medical review)
  - 4 of the top 10 denials related to certs (Palmetto GBA)
    - #2 - Physician narrative statement not present or not valid
    - #5 – No certification for dates billed
    - #6 – Subsequent certification not timely
    - #7 – Initial certification not timely

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## CMS Expectations From F2F

- Increased physician accountability in recertification process
- Reduced lengths of stays due to discharge of ineligible beneficiaries
- Improved quality of care
- Complementary approach with aggregate cap in preventing fraud and abuse

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## COMMON ISSUES

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And What the Regulations  
Really Say



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## Timing of Certification

### The Issue

- Not obtaining certification within the appropriate time frame

### The Rules

- If the hospice cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.
- Certifications and recertifications can be completed no more than 15 days prior to the start of the benefit period.

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## Certification Form

### The Issues

- Benefit periods (“from” and “to” dates) not on certification form
- Signatures not dated by the physician

### The Rule

The written certifications and recertifications must include the signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers.

## Role of Attending in Certification

### The Issue

- Not obtaining a certification from the attending physician

### The Rules

- For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if applicable) from—
  - The medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG); and
  - The individual's attending physician, if any.
- For subsequent periods, the only requirement is certification by the hospice medical director or physician member of the IDG.
- The attending physician is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

## Billing of a Claim

### The Issue

- Billing prior to signed certification and written narrative

### The Rules

- If the hospice cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.
- Content of certification
  - The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification....

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## Content of Narrative

### The Issue

- Narrative does not address individualized reasons for eligibility
- Narrative does not include findings from the F2F

### The Rules

- The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification & recertification forms, or as an addendum to the certification & recertification forms.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.
- The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the F2F encounter support a life expectancy of 6 months or less.

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## Attestation Statements

### The Issue

- Attestations for narrative not above physician's signature
- Attestation for F2F not above NP / physician signature

### The Rules

- Attestation for narrative to be positioned directly **above** the hospice physician's signature
- The F2F encounter attestation can be on the same page as the recertification and narrative, but must be a separate section above the signature of the physician or NP who performed the encounter
- The F2F and narrative attestation can also be a signed addendum to the certification and must be above the signature of the physician or NP who completed the encounter

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## Signatures

### The Issues

- NP signs the certification(s)
- Physician who signs the certification is not physician who composes the narrative
- Illegible signatures
- Electronic signatures –are they really?

### The Rules

- NPs cannot certify or recertify terminal illness (not permitted under current statute)
- Only the recertifying physician can sign the certification and compose physician narrative
- Program Integrity Manual required a legible identifier in the form of a handwritten or electronic signature for every service provided or ordered

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## Timing of F2F

### The Issues

- F2F not completed before the beginning of the next benefit (60 day) period
- F2F not completed before admission into 3<sup>rd</sup> or subsequent

### The Rules

- A hospice physician or hospice nurse practitioner must have a F2F encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3<sup>rd</sup> benefit period
- The F2F encounter must occur prior to, but no more than 30 calendar days prior to, the 3<sup>rd</sup> benefit period recertification, and every benefit period recertification thereafter
  - Can be done on the first day of the benefit period



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## Timing of F2F & Narrative

### The Issue

- Narrative completed prior to F2F

### The Rules

- The brief narrative explanation is still required but now must include an explanation of why the clinical findings of the face-to-face encounter support a prognosis of 6 months or less
- So, can't do the narrative prior to completion of the F2F

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## Exceptional Circumstances

- In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a F2F encounter prior to the start of the benefit period
- In such documented cases, a F2F encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a F2F encounter, a face to face encounter can be deemed as complete.

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## Document Exceptional Circumstances

- Electronic
- On Paper
  
- Recommend
  - Print screen of CMS data system used and attached to file for evidence that CMS data system was not available

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## F2F Not Timely

- When the F2F encounter is not timely
  - > than 30 days before the benefit period or effective date of election (for those admitted in the 3<sup>rd</sup> or subsequent period)
  - After the effective date of election or beginning of benefit period
- Results in failure to meet recertification eligibility requirements and ceases to be eligible for the Medicare Hospice Benefit
- Hospice can continue to care for patient but assumes financial responsibility

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## F2F Not Timely

- Patient then readmitted when certification for eligibility criteria are met (F2F occurs not > 30 days prior to benefit period)
  - Election
  - Benefit period dates
  - Initial and comprehensive assessments
  - Plan of care

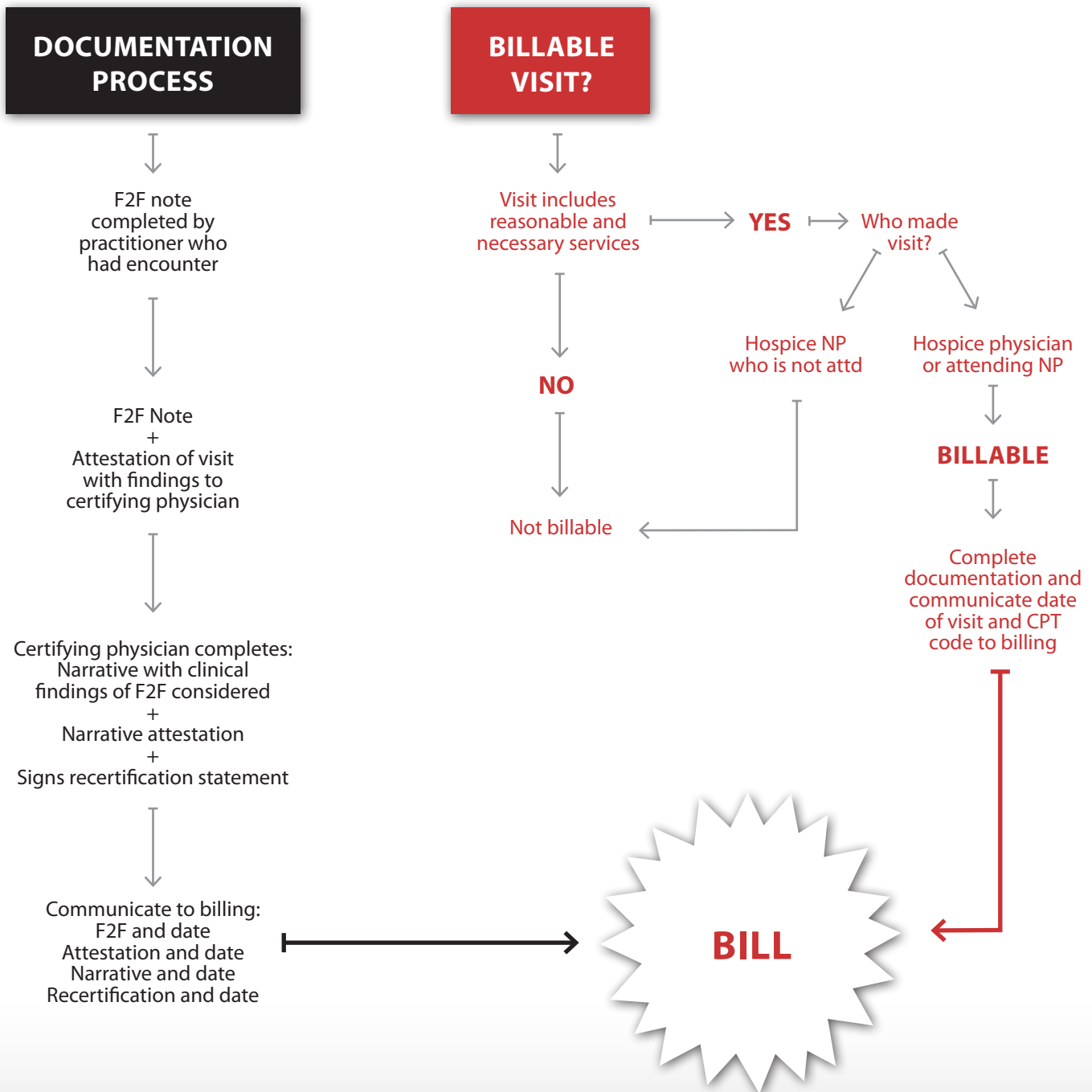
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## Again, Why Is It So Important?

- Medicare requirement in order to receive reimbursement
  - Must have a written certification and narrative statement before you submit a claim for payment
  - Must have completed a face to face encounter prior to 3<sup>rd</sup> and subsequent benefit periods
  - All must be compliant with required time frames
- Permits billing for all days of service

# Certification Process for 3rd and Subsequent Benefit Periods

F2F Visit by Hospice physician (employed, contracted, or vol) or NP (employed or vol) not more than 30 days prior to start 3rd period and subsequent periods



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## Operational Checks

- What is your process for obtaining and communicating certifications and recertifications
- How do you identify patients up for recertification
- How do you know the certifications / narratives are completed prior to billing
- What is your process for verifying the signature of the attending

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## Operational Checks

- What happens when the physician forgets to date the certification
- What about the signatures you can't read
- Do you have the benefit period dates on the certification / recertification form
- Are your policies in alignment with regulations and your practices
- How well does narrative support eligibility
- How well does F2F documentation support eligibility
- Does the 3<sup>rd</sup> and subsequent narratives include findings from the F2F encounter

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## FRAMEWORK FOR AUDITING & MONITORING

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## Ongoing Monitoring

- Admission checklists
- Certification / recertification checklist
- EMR stops and holds
- EMR billing reports
  
- Does the staff doing the monitoring / checklists know the rules?
- Documentation supports eligibility – How do you know?

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## Auditing as Part of Compliance Plan

- Prebilling basis
- Completed by someone outside of the process
- % to audit
- Certifications, narratives, F2F
  - Paper
  - EMR
  - Do they match
  - Elements
- What are the results
  - What do you do with them

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## DOCUMENTATION SUPPORTING ELIGIBILITY - PAINTING THE PICTURE

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## Local Coverage Determinations (LCDs)

- Developed by MAC
- Provide medical criteria for determining prognosis
- Use as guidelines for documenting terminal illness
- If a patient meets certain criteria, they are deemed eligible
- If a patient doesn't meet the LCD,
  - Patient may still be eligible for the MHB
  - But documentation must say why
- Not the legal standard for hospice eligibility
  - However, are followed by reviewers when reviewing an ADR
- Need to understand and document to the LCDs

## Eligibility Assessment Tools

- Functional performance measurement tools
  - Karnofsky Performance Scale (KPS)
  - Palliative Performance Scale (PPS)
  - Functional Assessment Staging (FAST)
  - ADLs
  - New York Heart Association Classification (NYHA)
- Nutritional status measurement tools
  - Weight scales
  - Body Mass Index (BMI)
  - Mid Arm Circumference (MAC)
- Cognition measurement tools
  - Mini-Mental Exam
  - FAST



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## Painting the Picture

- Comparison charting
- Subjective writing
- Use of comment boxes
- Clear and detailed descriptions
- Avoid non descriptive phrases such as “stable, appears weak, slow decline” and replace with descriptions “only up in chair for 1 hour before falls asleep”
- Specific discipline’s documentation
- Illustrate why beneficiary is considered terminally ill

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## Documentation-Admission

- Why hospice?
- Why now?
  - Hospitalization
  - Change in condition
  - Decline
  - Symptom exacerbation
  - Additional care needs
- Compare to Local Coverage Determinations (LCDs) that best fits the patient
- Clarify all secondary and co-morbid conditions for consistent documentation
  - Document impact on prognosis
- Use of standard assessment tools for the right diagnosis

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## Documentation-Recertification

- Why Hospice?
  - Have benefit of 60-90 days of documentation
- Why Still?
  - Is there decline
  - Is there disease progression
- Still compare to LCDs
- Use of standard assessment tools for the right diagnosis
- Comparison documentation
- Impact of terminal illness, co-morbid and secondary conditions
- Hospice care is managing what symptoms

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## WHAT DOES A GOOD NARRATIVE LOOK LIKE?

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## Diagnosis Dementia - Recertification

- Dementia, FAST 7B, 5% weight loss in past 3 months despite supplements, dysphagia
- Co-morbidities include COPD, oxygen dependent

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## Diagnosis Adult Failure to Thrive - Admission

- Has lost 14 lbs (12%) last 4 months (was 114lbs and currently 100 lbs), BMI 19
- PPS 40% - needs 1 – 2 person assist in all ADLS
- Co-morbidities – dementia with a FAST 6E, CHF and is oxygen dependent

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## WHAT DOES GOOD F2F DOCUMENTATION LOOK LIKE

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## Dementia

### Summary of Clinical Findings and Visit

Mr. S is completely dependent on staff for care. He is fearful of staff and notably uneasy and scared when I introduced myself and began the physical assessment. He spoke no intelligible words to me. Staff states he refuses care at times and requires Ativan frequently for agitation and unsettled behaviors. He can no longer feed himself or propel his own WC which he could do 4 months ago. Now leans to right when in WC and unable to hold himself upright. His dysphagia has worsened over the past 6 months and now consumes only 25% of meals. Current weight is 105 lbs, BMI of 21 with 10 lb weight loss over 6 month period.

## Adult Failure to Thrive

### Summary of Clinical Findings and Visit

Ms K is completely dependent on staff for care. On admission (3 months ago) she was able to propel self with WC, but is not able to anymore. Her daughter was in the room at the time of the physical assessment and has noted a significant decline in cognitive and physical abilities in the past month. Now she requires 1 – 2 person assistance in all ADLS. Her appetite is fair and feeds self only with verbal cues. She is beginning to pocket food during meals. She appears cachexic. Her current weight is 104.8 (BMI 17.9) which is a 15 lb weight loss since admission 6 months ago.

## Eligibility Documentation

- Document every patient's weight on admission and every recert period
  - Weights cannot be estimated
  - Watch for the wild fluctuations or inconsistencies in NF patients
- Calculate the BMI on every patient on admission and every recert period
- Obtain a midarm circumference (MAC) on every patient on admission and every recert period
- Calculate the FAST on every Alzheimer's patient on admission and every recert period
  - Even if Alzheimer's is not the primary diagnosis
- O2 sats for patients dependent on oxygen on admission and recert
- PPS on admission and every recert

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## The Documentation Should

- Be specific to that individual patient
- Have narrative notes to explain information noted on a checklist or EMR
  - Use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Illustrate progression of terminal condition

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## Remember, When a Patient Appears to Have “Stabilized”

- Get back to the diagnosis—why was this person admitted to hospice?
- Have you been managing the symptoms or the disease?
- What do you expect the disease process to look like?
- What are you monitoring for?
- What secondary conditions are present?
- What co-morbidities are present?
- How does this person look compared to a well person of the same age?
- What interventions are in place that is contributing to this plateau?

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### Common Eligibility Documentation Errors

- Using words like ... stable, unchanged
  - Document abnormal findings consistently
- Failure to regularly weigh or measure
  - Obtain baseline measurements
- Hospice Aide does not document patient response
  - Document how patient tolerates ADLs
- Generic documentation about ADLs
  - Document how much assistance is needed with each ADL that requires assistance (min, mod, total)
- No consideration of intensity of care
  - Patient has had no skin breakdown due to the 24 hour RTC attention provided by daughters turning ever 2 hours
- Failure to report injuries or falls, episodes of confusion or abnormal behaviors

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### Summary – Documenting Eligibility

- What distinguishes the patient as terminal and not chronic
  - Compare current to previous
  - Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments
- Document decline
  - On admission
  - At every recertification (at minimum)

## Resources

- Medicare Hospice Regulations
  - § 418.22 Certification of Terminal Illness
  - § 418.25 Admission to Hospice Care
  - § 418.102 Medical Director
- CMS Manual Medicare Benefit Policy Manual Chapter 9 - Section 10, 20 and 40
- NHPCO Regulatory Compliance Website
- Hospice face-to-face guidance PowerPoint, Hospice Center webpage
- Change Request 6698 – Signature Guidelines for Medical Review Purposes

## To Contact Us

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