

A Fall Potpourri

Subscriber Ask the Experts Call
October 2012



Today's Plan

- The FY 2013 OIG Work Plan
- New NH Survey Protocols
 - Quality of Life
 - Advance Directives
- PEPPER
- Related / Unrelated
- Quick Medical Review Update

The OIG Work Plan

- Released every fall
- Sets forth projects to be addressed during the fiscal year by one of the OIG offices
 - Office of Audit Services
 - Office of Evaluation and Inspections
- Plan is organized by provider type

FY 2013 OIG Work Plan Hospice Items

Hospitals

1. Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care

Hospice Care

2. Hospice Marketing Practices and Financial Relationships with Nursing Facilities
3. Hospices - General Inpatient Care

Medical Reviews: Other Medicaid Services & Payments

4. Hospice Services: Compliance With Reimbursement Requirements

Hospice Items: FY 2013 OIG Work Plan

Hospitals

Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care

We will determine the extent to which acute care hospitals discharge beneficiaries after a short stay to hospice facilities. Analysis of Medicare claims data demonstrates significant occurrences of a discharge from an acute care hospital after a short stay that is immediately followed by hospice care. Medicare pays a full PPS rate to hospitals that discharge beneficiaries for hospice care (42 CFR § 412.4(e)). In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital or, for certain DRGs, to postacute care settings, such as a skilled nursing facility. (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged “early” and then admitted for additional care in other clinical settings. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to hospice facilities. *(OAS; W-00-12-35602; various reviews; expected issue date: FY 2013; work in progress)*

Hospices

Hospices—Marketing Practices and Financial Relationships with Nursing Facilities

We will review hospices’ marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed services to nursing facility residents. We will focus our review on hospices that have a high percentage of their beneficiaries in nursing facilities. *(OEI; 02-10-00071; 02-10-00072; expected issue date: FY 2013; work in progress)*

Hospices—General Inpatient Care

We will review the use of hospice general inpatient care in 2011. We will also assess the appropriateness of hospices’ general inpatient care claims. Federal regulations address Medicare CoPs for hospice at 42 CFR Part 418. We will review hospice medical records to address concerns that this level of hospice care is being misused. *(OEI; 02-10-00490; expected issue date: FY 2013; work in progress)*

Medicaid

Hospice Services—Compliance With Reimbursement Requirements

We will determine whether Medicaid payments by States for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients’ illness and death. An individual, having been certified as terminally ill, may elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS’s State *Medicaid Manual*, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than \$816 million. *(OAS; W-00-11-31385; W-00-12-31385; various reviews; expected issue date: FY 2013; work in progress)*

<https://oig.hhs.gov/reports-and-publications/workplan/index.asp#current>

New NH Surveyor Protocols



Two Updated Protocols

Advance Directives & Quality of Care

- Both will have significant impact on the care of individuals dying in the facility
- Effective Date: No later than November 30, 2012
- Will provide an opportunity for hospices to strengthen their partnerships with facilities
- The Links
 - [Advance Directives](#) [Quality of Care](#)

A Word about NH Surveys

- Facilities are surveyed at least every 15 months; span can be anywhere from 9 – 15 months
- Surveys are unannounced and a certain % performed “after hours” and on weekends
- Complaints can spur additional surveys
- Surveys are conducted by a team
- Deficiencies categorized under F tags; correspond to our hospice L tags

Survey Results

- Immediately posted in facility
- Deficiencies
 - Ranked by scope and severity
 - Posted on Nursing Home Compare when submitted to the State
 - Can lead to monetary damages

Deficiencies Are Ranked in Two Ways



Scope: How many residents are affected?

Isolated > Pattern > Widespread

Severity: What is the potential or actual negative outcome?

Level 1 > Level 2 > Level 3 > Level 4

From Nursing Home Compare

1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.	03/02/2012	03/27/2012	 4 = Immediate jeopardy to resident health or safety	Few
Have a program that investigates, controls and keeps infection from spreading.	09/13/2011	10/05/2011	 2 = Minimal harm or potential for actual harm	Few

Nursing Home Surveyor Protocols

Like our Surveyor Interpretive Guidelines on steroids

www.cms.gov
Internet Only Medicare Manuals
State Operations Manual
Appendix PP



http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Changes to Surveyor Protocols

Even with no change in regulatory language, compliance expectations can change quite dramatically.

“The CMS made changes to surveyor guidance for Advance Directives in Appendix PP of the SOM to provide clarification to nursing home surveyors when determining compliance with the regulatory requirements for Advance Directives. *The regulatory language remains unchanged.*”

9/27/2012 Memo

Subject: F tag 155 – Advance Directives – Advance Copy
CMS Survey & Certification Group

New Survey Protocols #1

F 155 Advance Directives

§ 483.10(b)(4) – The resident has the right to refuse treatment... and

§483.10(b)(8) – The facility must comply with the requirements...relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

F 155 Criteria for Compliance

The facility is in compliance with 42 §CFR 483.10 (b)(4) and (8), if the facility has:

- Established and implemented policies and procedures regarding the right to formulate advance directives, and to accept or decline treatment and other related interventions;
- Informed and educated the resident about these rights, including the facility's policies regarding exercising these rights;
- Determined whether the resident has an advance directive in place or has offered the resident the opportunity to develop an advance directive;
- Documented when the resident is determined not to have decision-making capacity and therefore decision-making is transferred to the health care agent or legal representative;

F 155 Criteria for Compliance (continued)

- Helped the resident to exercise these rights based on explaining risk and benefits of accepting or declining treatment;
- Incorporated the resident's choices into the medical record and orders related to treatment, care and services;
- Consistently maintained advance directives and resident goals and in the same section of the clinical record or other document filing system for all appropriate residents, where those documents are easily retrievable by staff during both routine and urgent or emergent situations; and
- Monitored the care and services given to the resident to ensure that they are consistent with the resident's documented choices and goals.

Deficiency Categorization Example

Level 3 Actual Harm that Is Not Immediate Jeopardy

The facility failed to identify the medical orders that detailed the resident's wishes to forego lab work, IV antibiotic treatment and IV hydration for the resident's 7th episode of aspiration pneumonia. Furthermore, the nurses refused to allow the resident to attend his son's wedding, insisting that the resident remain in the nursing home so that a chest x-ray and blood work be done, which went against the resident's expressed wishes. The resident suffered emotional harm.

Deficiency Categorization Example

Level 4 Immediate Jeopardy

As a result of the facility's failure to obtain and implement medical orders related to life-sustaining treatments, after the resident had documented choices, the resident was transferred to the hospital for an acute change of condition against his wishes, where he was resuscitated against his documented wishes, despite the facility's knowledge that the intervention was against the resident's wishes.

New Survey Protocol #2

F 309 Quality of Care

42 CFR 483.25 Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

New Section

Review of a Resident at or Approaching End of Life

F 309 Criteria for Compliance

For the resident approaching the end of life, the facility is in compliance with F309 Assessment and Management of Care at End of Life, if staff:

- Assessed the resident's clinical condition, risk factors, and preferences and identified the resident's prognosis and its basis;
- Initiated discussions regarding advance care planning and resident choices to clarify resident's goals and preferences regarding treatment at the end of life;
- Recognized and advised the resident and/or the resident's legal representative that the resident was approaching the end of life and, if the resident was not already receiving palliative care, advised that care could potentially be shifted to a palliative focus;

F 309 Criteria for Compliance (continued)

- Defined and implemented resident-directed care, treatment interventions, services, and support; consistent with the resident's choices, rights, goals, comprehensive assessment, care plan and the recognized standards of practice.
Compliance with this criteria is done in the attempt to manage pain and other physical and psychosocial symptoms and meet the resident's physical, mental, psychosocial, and spiritual needs;
- Communicated the resident's goals and preferences to the facility interdisciplinary team, as well as the hospice, emergency department, hospital or home health team in the event of a transfer; and
- Monitored and evaluated the impact of the interventions provided to address the resident's end of life condition and revised the approaches as appropriate.

Deficiency Categorization Example

Level 4 Immediate Jeopardy

The facility failed to recognize that the resident was approaching the end of life and continued to implement aggressive medical interventions against the resident's wishes. As a result, the resident experienced severe physical discomfort and/or psychosocial distress; or

The resident approaching the end of life experienced prolonged nausea; recurrent vomiting, or daily, prolonged, or repeated moderate to severe pain as a result of the facility's repeated failure to implement interventions in accordance with the doctor's orders and care plan.

Deficiency Categorization Example

Level 3 Actual Harm that is Not Immediate Jeopardy

Despite the documented choice to accept partial pain control in order to be more alert, the resident was repeatedly so lethargic or somnolent because of medication used to treat symptoms related to the end of life that he/she was unable to relate to visitors.

The URLs

Advance Directives

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-12-47.html>

Quality of Care

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-12-48.html>

PEPPER



PEPPER-Now What...

- Review your PEPPER
- LOS-beneficiaries were included if had >180 days in the reported cap year regardless of if they continued over more than 1 cap year
- Live discharges in < 25 days will look different for 2012
- Use as benchmark
 - Trends over 3 years
 - If above national for most current year
 - Determine root cause
 - Implement action plan
 - Use to guide audit plan
 - Know that the 2012 data is a done deal

Related / Unrelated



Diagnoses Related to the Terminal Illness

- In addition to the terminal diagnosis, hospice claims are also to include ICD-9 coding for “coexisting or additional diagnoses” related to the terminal illness
- Effective October 1, 2012
 - Reminder from CMS-should have been doing all along
- CMS wants a more accurate description of the patient’s conditions

DX Related to the Terminal Illness

Make sure that you have a well-defined process that includes the following

1. Identification of terminal diagnosis
2. Identification of all other diagnoses and categorization into related and unrelated
3. Proper coding of all diagnoses
4. Communication of above to the IDG and the billing department

Which Condition Is the Terminal Illness?

Guidelines

- Determine the most life-limiting symptom and then work backward to find the disease process most responsible for it
- Determine what condition most limits our ability to treat all other conditions effectively

Adapted from Alliance of Community Hospices

Determination of Terminal Illness

- Patients more often than not have multiple severe medical problems that limit life expectancy.
- What is “determined” as the terminal illness affects:
 - Which LCDs are in effect
 - What parameters to follow to document disease progression
 - What goes on the plan of care (deemed related and covered by hospice or not)
 - What goes on death certificate
- How many degrees of separation is most often the challenge

Adapted from Alliance of Community Hospices

A Condition Is Related to The Terminal Illness If

It did not pre-exist the onset of the terminal illness

AND	It is a direct complication of the treatment for the terminal illness
OR	The condition involves the same part of the body or organ system as the terminal illness. (For example, pneumonia when terminal diagnosis is end stage COPD.)
OR	The condition is a direct result of the one of the most life-limiting aspects of the terminal illness. (For example, in dementia become immobile, pressure ulcers are related)
OR	The condition is more likely to be due to the terminal illness or a complication of its treatment than to the sum of all other co-morbid conditions.

Adapted from Alliance of Community Hospices

Quick Example | 83 year old male with terminal diagnosis of end stage COPD and additional related diagnoses of cor pulmonale, pneumonia and stasis ulcers and co-morbid diagnoses of diabetes mellitus and dementia referred for hospice care.

Hospice Terminal Diagnosis: End-Stage COPD		<i>Code and Include on Claim</i>	<i>Use to Support Terminal Prognosis</i>	<i>Assume Financial Responsibility</i>
Related Diagnoses	Cor Pulmonale Pneumonia Stasis Ulcers	YES	YES	\$
Unrelated Diagnoses	Diabetes Mellitus Dementia	NO	YES	⊗

Now What?

Once you have identified the terminal diagnosis and related conditions you have declared your commitment to coverage and management

- The patient's plan of care should include information about related and unrelated conditions
- The plan of care needs to identify medications, supplies and equipment as covered or non-covered
- You may need to relook at your process for determining if a hospitalizations is related and how you communicate this to the hospital

Quick Medical Review Update



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