What's Ahead for Hospice?

Getting Ready for 2013

Subscriber Audioconference
December 2012

Two Key Components of Readiness

1. Ability to identify & prioritize risks
2. Ability to respond to risks

The Good News: An effective compliance framework supports both

OIG Compliance Program, Guidance for Hospices
https://oig.hhs.gov/authorities/docs/hospicx.pdf

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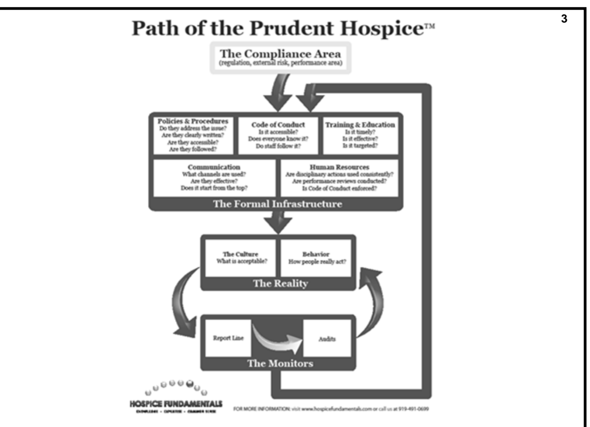

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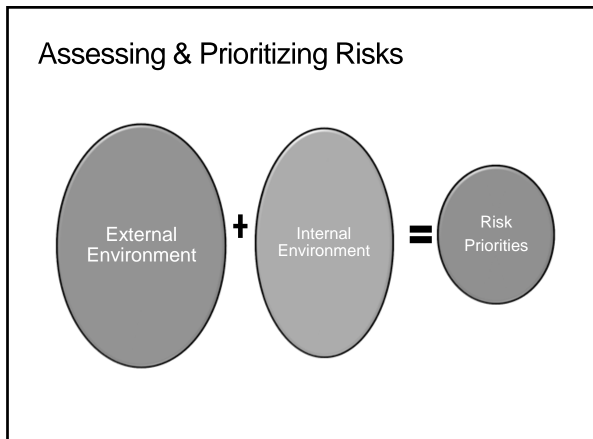
The Two Key Questions

1. What might we expect in 2013?
2. Based on the answer to #1, how can we best allocate scarce resources to meet our compliance needs?

Assessing & Prioritizing Risks



The Environment

External

- OIG
- CMS
- MACs
- ZPICs & RACs
- MedPAC
- PEPPER
- Surveys
- What else?

Internal

- Past Performance
- Outliers
- New Programs
- Resources
- Regulatory Competence
- Culture
- What else?

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What Are We Looking For?

OIG
The Office of the Inspector General

- Charged with ferreting out fraud and abuse in health care
- Releases a work plan every October organized by provider types
- Plan 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
- Releases reports at the conclusion of projects

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

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OIG Report A-06-10-00059 (June 2012)

The Catchy Title

Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice

The Project Objective

To determine whether Medicare Part D paid for prescription drugs that likely should have been covered under the per diem payments made to hospice organizations

Findings

- Using data from 2009 claims, the OIG determined that Medicare Part D paid for the following types of drugs that should have been paid for by hospices (in most cases)
  - Analgesics
  - Anti-nauseas
  - Laxatives
  - Antianxiety drugs
- Additionally, they identified some COPD and ALS medications they believed should have been covered by hospice

OIG Recommendations to CMS

1. Educate sponsors, hospice and pharmacies that it is inappropriate for Part D to pay for drugs related to terminal DX
2. Perform oversight to make sure that Part D is not paying for drugs that Medicare has already paid through via payments to hospices
3. Require sponsors to develop controls that prevent Part D from paying for drugs that are already covered under the per diem payments

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OIG Report A-02-12-0002 (August 2012)

The Catchy Title

R.I. Hospice General Inpatient Claims and Payments Did Not Always Meet State & Federal Requirements

The Project Objective

To determine whether Medicaid payments for hospice services complied with Federal reimbursement guidelines

Findings

- 56% of the reviewed claims did not meet the payment requirements for GIP care
- State had not properly handled the beneficiary cost of care contribution
- Also identified payments that the Medicaid department had made for medications that should have been covered as part of the hospice per diem

CMS
Centers for Medicare & Medicaid

The Four Faces of Medicare

CMS CENTRAL

S+Cs

ROs

MACs

QIOs

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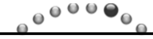
How They've Been Spending Their Time

- Working on hospice payment reform – first set of changes will take place with FY 2014 rates
- Adding additional coding for live discharges to allow more precise analysis of type of discharges
- Considering how to establish controls to limit Part D payment for medications that should be covered by the hospice
- Reminding hospices that all claims should include diagnosis codes for the terminal and related diagnoses
- Getting hospice quality reporting underway

MACs
Medicare Administrative Contractors

- Medicare contractors
  - Set their own work plans
  - Receive some direction from CMS
- Pay attention to CMS instructions to contractors
- Pay attention to what your MAC is doing (question information that does not sound correct)



Focus Areas

- Length of Stay
- Non – Cancer Diagnoses
- General Inpatient Level of Care
- Technical Areas (reviewed on every chart)
- Care Planning Process

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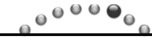
Subpart F – Covered Services §418.200

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.
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.
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 individuals terminally ill must be completed as set forth in Sec. 418.22.

ZPICs
Zone Program Integrity Contractors

- New and improved version of the Program Safeguard Contractors
- Variety of hospice activities
- Using extrapolation to calculate paybacks
- Can be long lap time between request for records and decision



RACs
Recovery Audit Contractors:

- Still no hospice specific projects
- Derivative projects have been in place for a few years
- Test claims for hospice care in nursing homes in 2012 – no announcement of project approval to date

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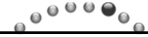
MedPAC
Medicare Payment Advisory Commission

- The Thinkers
- Independent Congressional agency established by BBA 1997
- Issue reports to Congress in March and June
- Meeting transcripts available (and searchable)
- The majority of the changes we have seen in the past few years are a direct result of MedPAC recommendations

http://medpac.gov/

PEPPER

- Program for Evaluating Payment Patterns Electronic Report
- Information only – but the same data is available to all regulatory and investigatory entities
- Initial reports issued in 2012
  - Live discharges
  - Length of stay
- This round has no specificity regarding live discharges but new coding will change that



Where did the darts cluster?

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Readiness Component #2

1. Ability to identify & prioritize risks
2. Ability to respond to risks

Once a risk area is identified

- What regulations guide the area?
- How compliant are current operations?
- What changes need to be made?
- How will effectiveness of changes be assessed?
- How will individual compliance with changes be assessed?

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Risk Area: Certs & Recerts

- Guiding Regulations
- Problem Areas
- Sample Audit / Monitoring Work Plan

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Certifications & Recertifications

- A technical payment provision
- Regulations
  - found in Subpart B
  - apply to all Medicare patients
- Medicaid has similar requirements but can vary a bit from state to state – check on them

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42 CFR 418 Subparts

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

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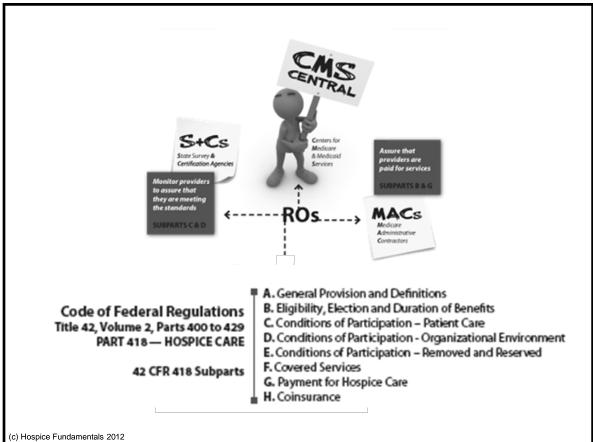

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Beware This Phrase

“We just had a survey and everything was OK.”

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Common Problem Areas

Process
- Lack of understanding of the who, what and when
- Process broken up between so many people that no one oversees or understands the entire process
- No final check before claim is submitted

Paper/EMR
- Forms that are missing some of the elements

People
- Poorly written physician narratives
- Missing signatures or dates

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Fundamentals First
Certifications and Recertifications

- Percentage
  - 100% monitoring by trained staff ongoing
  - 100% auditing until error free
- Elements - audit your forms (one time activity)
- Process
  - Understanding
  - Monitoring
  - Follow-Up

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Work Plan Example: Certifications / Recertifications

What / How Many	When	Who	Comments
Certification date and element check 100% of claims	Pre-billing, on-going	Operations/ Team Clerk	Monitor
20% all admissions in month for certification date and element check	Pre-billing January, April, July, October	Compliance	Audit
20% of all recertifications in month recertification date and element check	February, May, August, November	Compliance	Audit
20% of all physician narratives for quality	March and September	Compliance	Audit

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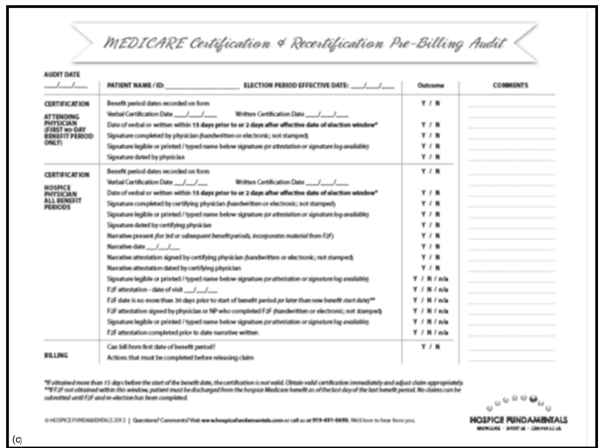

MEDICARE Certification & Recertification Pre-Billing Audit

AUDIT DATE ___/___/___

	PATIENT NAME / ID: ________ ELECTION PERIOD EFFECTIVE DATE: ___/___/___	Outcome	COMMENTS
CERTIFICATION ATTENDING PHYSICIAN (FIRST 90-DAY BENEFIT PERIOD ONLY)	Benefit period dates recorded on form	Y / N	
	Verbal Certification Date ___/___/___ Written Certification Date ___/___/___		
	Date of verbal or written within **15 days prior to or 2 days after effective date of election window***	Y / N	
	Signature completed by physician *(handwritten or electronic; not stamped)*	Y / N	
	Signature legible or printed / typed name below signature *(or attestation or signature log available)*	Y / N	
	Signature dated by physician	Y / N	
CERTIFICATION HOSPICE PHYSICIAN ALL BENEFIT PERIODS	Benefit period dates recorded on form	Y / N	
	Verbal Certification Date ___/___/___ Written Certification Date ___/___/___		
	Date of verbal or written within **15 days prior to or 2 days after effective date of election window***	Y / N	
	Signature completed by certifying physician *(handwritten or electronic; not stamped)*	Y / N	
	Signature legible or printed / typed name below signature *(or attestation or signature log available)*	Y / N	
	Signature dated by certifying physician	Y / N	
	Narrative present *(for 3rd or subsequent benefit periods, incorporates material from F2F)*	Y / N	
	Narrative date ___/___/___	Y / N	
	Narrative attestation signed by certifying physician (handwritten or electronic; not stamped)	Y / N	
	Narrative attestation dated by certifying physician	Y / N	
	Signature legible or printed / typed name below signature *(or attestation or signature log available)*	Y / N / n/a	
	F2F attestation - date of visit ___/___/___	Y / N / n/a	
	F2F date is no more than 30 days prior to start of benefit period *(or later than new benefit start date)***	Y / N / n/a	
	F2F attestation signed by physician or NP who completed F2F *(handwritten or electronic; not stamped)*	Y / N / n/a	
	Signature legible or printed / typed name below signature *(or attestation or signature log available)*	Y / N / n/a	
	F2F attestation completed prior to date narrative written	Y / N / n/a	
BILLING	Can bill from first date of benefit period?	Y / N	
	Actions that must be completed before releasing claim		

**If obtained more than 15 days before the start of the benefit date, the certification is not valid. Obtain valid certification immediately and adjust claim appropriately.*
***If F2F not obtained within this window, patient must be discharged from the hospice Medicare benefit as of the last day of the last benefit period. No claims can be submitted until F2F and re-election has been completed.*

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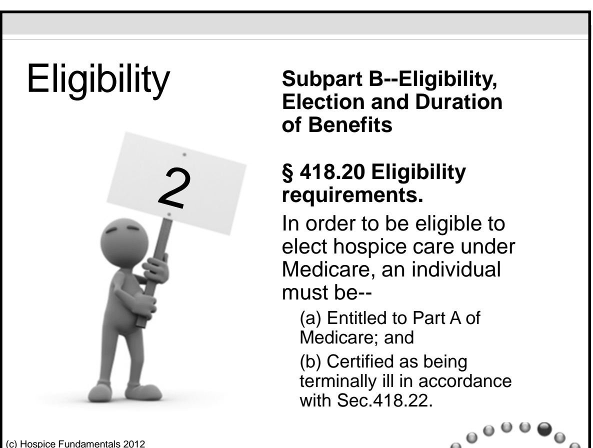
Eligibility



Subpart B--Eligibility, Election and Duration of Benefits

§ 418.20 Eligibility requirements.

In order to be eligible to elect hospice care under Medicare, an individual must be--

(a) Entitled to Part A of Medicare; and

(b) Certified as being terminally ill in accordance with Sec.418.22.

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Problem Areas

Process
- Lack of awareness of the quality of the documentation
- Weak orientation and ongoing education of patient care staff especially nurses and physicians
- Recertification process not taken seriously enough
- Failure to monitor LOS

Paper/EMR
- Bad forms / assessments
- Incomplete

People
- Poor quality documentation
- Inconsistent use of scales / assessments (PPS, FAST, etc)
- Critical thinking weak

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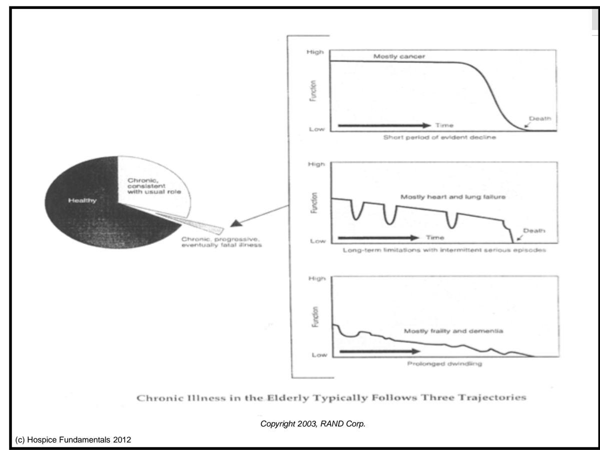

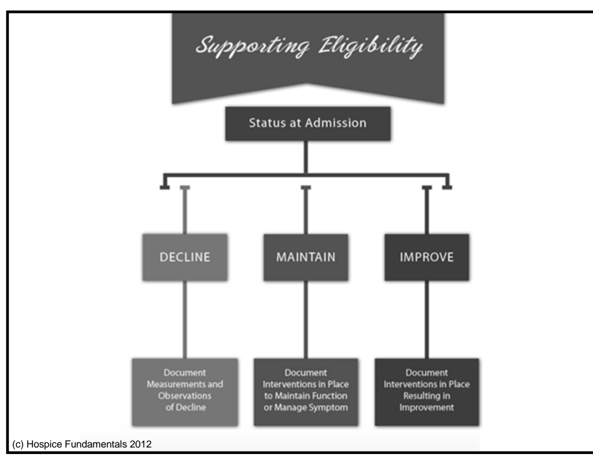

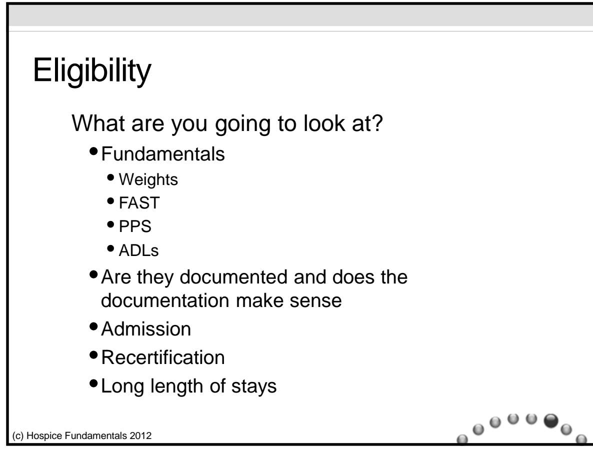

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Sample Work Plan: Eligibility

What / How Many	When	Who	Comments
Eligibility audits for all patients with a LOS > 180 days focusing on current benefit period	Until completed	Compliance	Audit One time only review
Eligibility audits for all patients with LOS > 1 year	Monthly for patients to be recerted in month	Compliance/ Clinical Ops	Audit Established once above review is completed
Hospice Eligibility Audit –total of 15% of all recerts for the month to include those with LOS > 1 year	Monthly	Compliance	Audit
Hospice Eligibility Audit – 20% of admissions			

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Care Planning

Subpart F – Covered Services §418.200

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The Condition and the 5 Standards

§418.56 IDG, Care Planning & Coordination of Services

- §418.56 (a) Approach to Service Delivery
- §418.56 (b) Plan of Care
- §418.56 (c) Content of the Plan of Care
- §418.56 (d) Review of the Plan of Care
- §418.56 (e) Coordination of Services

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Care Plan Items – Top 10 Survey Deficiencies

L Tag	Section	Regulation
L543	§418.56(b)	Standard: Plan of care
L545	§418.56(c)	Standard: Content of the plan of care
L555	§418.56(e)(2)	Ensure that the care and services are provided in accordance with the plan of care
L552	§418.56(d)	Standard: Review of the plan of care

CMS 2012

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Problem Areas

Process

- No monitoring to see if what was to be delivered was delivered
- No measureable goals
- No care plan at all

Paper/EMR

- Unwieldy computer generated care plans

People

- Not tying delivery of care to care plan

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Sample Work Plan: Care Planning

What / How Many	When	Who	Comments
20% of all admissions. Plan of care identified the patient/ family 's immediate needs during the initial assessment	January & July	Compliance	Review sample from each admission nurse.
20% of all admissions. The initial plan of care was developed before services were provided			
20% of all current patients. Plan of care is reviewed/revised as frequently as the patient's condition requires but no less frequently than every 15 calendar days	February & August	Compliance/ Clinical Ops	Review sample from each team.
20% of all current patients. Care is provided according to the plan of care			
20% of all current patients. Visit frequencies for each discipline correspond to frequencies on the plan of care			

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Reporting Results

- Analyze results
- Limit distribution
- Report in context
- Label *Confidential Information-For Quality Improvement Purposes Only*
- Compliance Committee
- Board

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Summary

- Understand the external environment
- Know your past performance
- Determine your priority risk areas
- Develop an annual work plan
- Follow the plan
- Revise if and when necessary
- Commit to a compliance framework

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Contact Information

info@hospicefundamentals.com

Susan Balfour
919-491-0699
susan@hospicefundamentals.com

Roseanne Berry
480-650-5604
roseanne@hospicefundamentals.com

Charlene Ross
602-740-0783
charlene@hospicefundamentals.com

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Sample Work Plan: Certifications / Recertifications

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Hospice Risk Area Considerations - 2013

		Related / Unrelated	Hospice Care in the NH	GIP	Eligibility / LOS	Certification Recertification Elements	Care Planning	Live Discharges
OIG	Work Plan		x	x				
	Part D & Hospice	x						
	RI GIP in SNF Report		x	x				
MedPAC								
CMS		x						x
MACs	Palmetto				x	x	x	
	CGS*		x	x	x	x	x	
	NHIC				x	x	x	
	NGS				x	x	x	
PEPPER					x			x
ZPICs		Assume All Categories						
RAC		X (other providers)	X (test claims)					

*Current CGS widespread edit list

December 2012
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