Medicare Payment and the Plan of Care
Understanding the Connection

Subscriber Audioconference
January 2013

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

2

Objectives

- List the six Medicare coverage requirements found at 42 CFR §418.200
- Describe key differences between a state survey agency and a Medicare Administrative Contractor (MAC)
- Assess current operations for compliance with regulations

So Exactly When Did Care Planning Become a Payment Issue?

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OIG Report OEI-02-06-00221

Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements

- September 2009
- Reviewed 450 randomly selected claims of
  - Medicare beneficiaries residing in nursing homes receiving hospice services
  - Services provided in 2006
- Eligibility was not assessed
- The results
  - were horrible
  - are mentioned frequently and will guide many future activities

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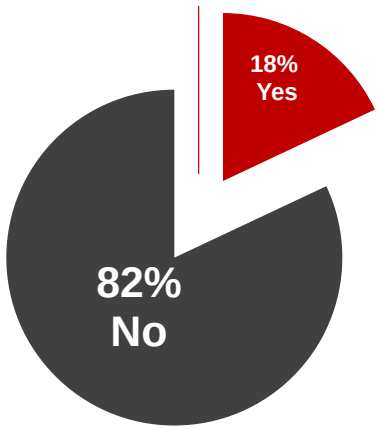
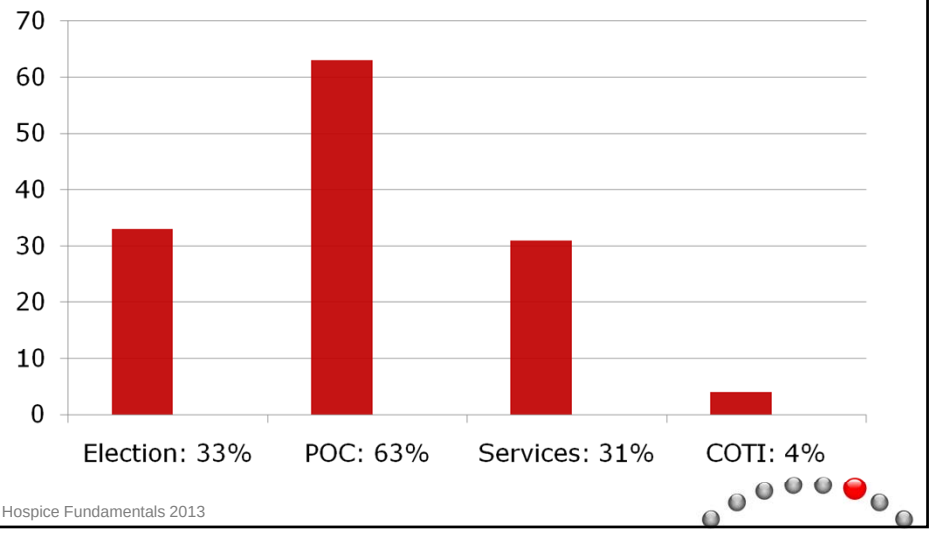
From the OIG's Perspective, % of Claims That Met Payment Requirements



(c) Hospice Fundamentals 2013

6

Problem Areas



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7

Plan of Care Problem Areas

63% did not meet POC requirements	• 1% did not establish POC • 62% did not meet at least 1 requirement (not established by IDG; did not include necessary components such as detailed description of scope and frequency of services or did not specific intervals for review -eliminated with 2008 CoPs)
31% did not provide the number of services as identified in the POC	• Provided services to the beneficiaries less frequently than identified in the POC • In the most extreme cases, there was no documentation in the medical records of any visits for a particular service

8

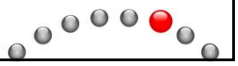
The OIG Recommendations to CMS

- Strengthen monitoring practices regarding hospice claims
- Use targeted medical reviews and other oversight mechanisms to improve compliance especially with respect to establishing plans of care and providing services that are consistent with the plans of care
- Conduct more frequent certification surveys
- Instruct MACs to consider the issues in this report when they prioritize medical review strategies
- Share this report and relevant claim information with the RACs

9

What Happened?

- First large scale look at claims that truly applied the care planning requirement
- Hospices have been a bit relaxed – knew it was a survey issue but have never considered it a payment issue
- The OIG report woke up the regulators on the payment side – hospices have been a bit slow to catch on



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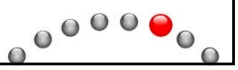
The OIG's Bridging Question

Did the plan of care exist and did it meet the specific requirements in 42 CFR §418.56?



11

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

12

Code of Federal Regulations
Title 42, Volume 2, Parts 400 to 429
PART 418 — HOSPICE CARE

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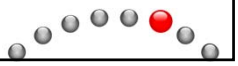
13

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.

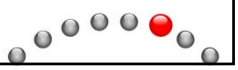


14

Subpart C
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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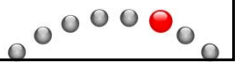
§ 418.56 IDG Key Concepts

- IDG works together to meet the needs of the patient and family
- Establishes/revises plan of care (POC)
- Coordinates care and services

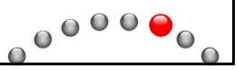


16

§418.56 IDG Regulatory Requirements

Interdisciplinary group composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families

- Hospice physician
- Registered nurse
- Social worker
- Pastoral or other counselor

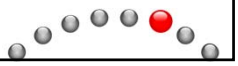


17

§418.56 IDG Regulatory Requirements (cont)

- Counselor is generally chaplain but can be
  - Bereavement
  - Dietary
- Four is not the magic number-it's the qualifications and abilities of the members

  Ex: RN who is also a chaplain

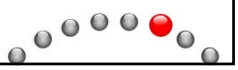


18

§418.56 IDG Regulatory Requirements (cont)

Establishes/revises plan of care

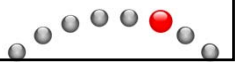
- Hospice care and services must follow an individualized written plan of care established by the IDG in collaboration with the attending physician (if any), the patient or representative and primary caregiver
- Must reflect patient and family goals and interventions based on problems identified in the assessments
  - Interventions to manage pain and symptoms
  - Scope and frequency of services to meet the needs
  - Measureable outcomes anticipated from POC



19

§ 418.56 IDG Regulatory Requirements (cont)

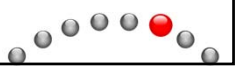
- Need to establish plan of care on day of admission
- A plan of care is a roadmap or GPS, identifies problems and what care and services will be implemented to address those problems
- Goals and outcomes are a critical piece so that you know if the plan of care (i.e., your care and services) are making a difference
- Frequencies:
  - Visit ranges with small intervals are acceptable
  - Update plan of care when there are frequent use of PRN visits



20

IDG Meetings

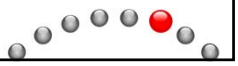
- Where do the regulations require the IDG "meeting"?
  - They don't!
- They do require the IDG
  - Works together to meet the needs of the patient and family
  - Establishes/revises plan of care (POC)
  - Coordinates care and services
  - Communicates
  - Documents their involvement



21

IDG Involvement

- Plan of care initiation and review and revisions
  - The attending physician and IDG members do not have to sign the plan of care *BUT* there must be documentation of their involvement

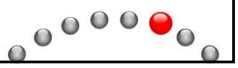


22

§418.56 IDG Regulatory Requirements

Establishes/revises plan of care

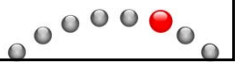
- Reviews and revises as frequently as patient's condition requires but no less frequently then every 15 days
- Revised POC must include information from updated comprehensive assessment and must note *progress* toward outcomes and goals



23

Remember That

- Just because you have reviewed every 15 days does not mean you are in compliance
- Significant changes in patients condition requires revision. Consider:
  - Change in level of care
  - Change in living environment
  - Unanticipated symptoms
- Progress towards goals means you have to have goals to compare progress towards



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

25

Problem Areas

Process

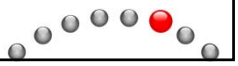
- No monitoring to see if what was to be delivered was delivered
- No measureable goals
- No care plan at all

Paper/EMR

- Unwieldy computer generated care plans

People

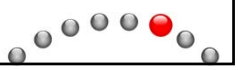
- Not tying delivery of care to care plan



26

MAC Denials

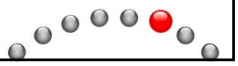
- Palmetto GBA
  - #3 No Plan of Care Submitted
- CGS
  - #5 Plan of Care Requirements Not Met



27

What the MACs Are Saying about Plans of Care & Medical Review

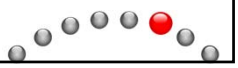
- Must be established before services are provided to be a Medicare covered day
- POC must be included in ADR for the entire dates under review
  - January 1 to 31 under review (presumes every 14 day review versus 15)
    - December 27
    - January 10
    - January 24



28

What the MACs Are Saying about Plans of Care & Medical Review

- The POC must contain certain information to be considered valid
  - Scope and frequency of services to meet the beneficiary's/family's needs
  - Beneficiary specific information, such as assessment of the beneficiary's needs, management of discomfort and symptom relief
  - Services that are reasonable and necessary for the palliation and management of the beneficiary's terminal illness and related conditions
- IDG member involvement must be evident
- CGS is not looking at content, "that's a quality issue for your surveyors"



Sample Work Plan: Care Planning

What / How Many	When	Who	Comments
20% of all admissions. Plan of care addressed the patient/ family 's immediate needs identified 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.
There is evidence all members of the IDG were involved in the revision of the plan of care.			
20% of all current patients. Visit frequencies for each discipline correspond to frequencies on the plan of care.			

Internal Processes

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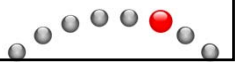
31

Internal Decisions

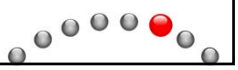
- How does the admission process result in the development of a plan of care with the IDG involvement?
- What comprises your care plan? And does your policy back you up?
  - plan of care
  - physician orders
  - medication profile
  - hospice aide assignment
  - volunteer assignment



32

Internal Decisions

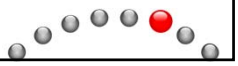
- What is considered a significant change in patient's condition triggering a revision?
  - How does this get communicated to the IDG?
  - How is the IDG involvement get documented?
- How does communication with attending physician occur?
- How will compliance be monitored – how will you know if the right things are happening
  - Services delivered as ordered
  - Updating



33

When the Payment Side is Looking

- People use same terminology for different things
- Don't make reviewers hunt for things or allow them to define what they see or don't see
  - Consider cover letter on ADRs explaining what constitutes the plan of care, where you find documentation of IDG involvement, where progress or lack of progress is documented
- Make sure to include plans of care for all days under review



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