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Spring Potpourri

Subscriber Audioconference
May 2013

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

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Today's Plan

1. Office of the Inspector General
   a. Report: Medicare Hospice: Use of General Inpatient Care (OEI-02-10-00490)
   b. GIP Record Requests
2. New Approved RAC Hospice Issue
3. Medicare Part D & Hospice
4. Top Ten Survey Deficiencies – Calendar Year 2012
5. Proposed Rule: *FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform*
   a. Diagnosis Reporting on Hospice Claims
   b. Proposed Update to Hospice Quality Reporting Program
   c. Update on Payment Reform & Data Collection
   d. Wage Index Changes

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Office of the Inspector General

Hospices—General Inpatient Care *(OEI; 02-10-00490; expected issue date: FY 2013; work in progress)*

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.

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Step One: Memorandum Report

- Released May 4th
- Describes the use of hospice GIP in 2011 via analysis of data from the National Claims History file
- During 2011
  - total GIP care expenditures: $1.1 billion;
  - Represents 8% of the total Medicare hospice expenditures of $13.7 billion
- A companion report "will look at the appropriateness of hospice general inpatient care provided to beneficiaries"

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Some Highlights from 2011 Data

- 23% of HMB beneficiaries received GIP care
- 71% of this group received GIP at the start of their hospice care
- 33% had stays longer than 5 days
- 11% of all stays were 12 days or more
- Stays were much less likely to start on Saturday or Sunday than on a weekday
- Ends of stays were steady throughout the week
- 27% of hospices (963 providers) did not provide any GIP at all
- Of those, 429 only provided routine home care
- Location of care GIP / % of Dollars Spent
  - 58% Hospice Inpatient Units / 67%
  - 33% Hospitals / 25%
  - 8% SNFs / 8%

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Step Two: Medical Record Review

- Hospices started receiving record requests for "medical record documentation for a random sample of Medicare hospice claims" the end of April
- If your program submitted a claim for any Medicare GIP days you had a chance to receive the letter
- See Be Aware of 5.7 OIG GIP Record Requests

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Step Two: What We Know & Don't Know

What we know

- Records must be postmarked by May 15th; photocopies only
- All requests were for dates of service in 2012, from – through dates included some days of GIP care
- Requests represented stays in all allowable GIP locations

What we assume

- That claims will be evaluated on two areas
  - Supporting higher level of care
  - Meeting Conditions of Payment
- That the process will move fairly quickly

What we don't know

- Total number of claims requested
- If $$$ will be recouped

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Recovery Audit Contractors

What is the Recovery Audit Program?

The mission of the Recovery Audit Program is to identify improper Medicare payments made on healthcare claims. These audits may result in the identification of Medicare overpayments and/or underpayments. Providers that may be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Part A and Part B.

CMS Webpage

Region A: Performant Recovery www.dcsrac.com
Region B: CGI https://racb.cgi.com/default.aspx
Region C: Connolly www.connollyhealthcare.com/RAC
Region D: HealthDataInsights, Inc.
http://racinfo.healthdatainsights.com/home.aspx?ReturnUrl=%2f

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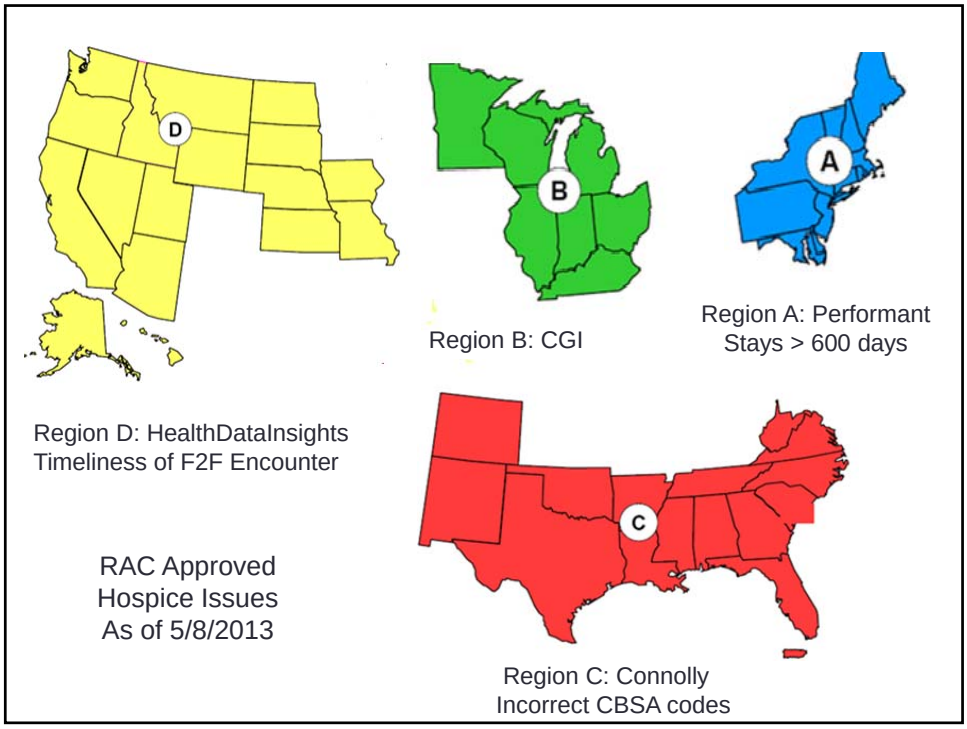

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Hospice Medicare Surveys

- **Brenda Blunt**, MSN, RN, CHPPN: new hospice lead consultant in CMS Survey & Certification area (Kim Roche's former position)
- Recently presented at NAHC and shared CY 2012's Top 10 Survey Deficiencies
- Survey Reminders
  - Unlike some other providers, no statutory requirement for frequency of hospice surveys
  - Budget allows for a targeted sample of for 5% of hospices on annual basis; all hospice providers are to be surveyed every 6 ½ half years
  - Surveyors do not look at eligibility or Subpart B requirements

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CY 2012 Top 10 Survey Deficiencies

Reminder

- Surveys are conducted using Conditions and Standards from Subparts C & D
- Requirements apply to all patients, regardless of payor source

What we don't know:

- How many surveys were done
- Breakdown of total deficiencies or any geographic patterns

What we do know

- Four out of Top 10 are from 418.56: IDG, Care Planning and Coordination of Services
- Four new ones from 2011 list
- Nine out of the ten are from Subpart C: Patient Care

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Medicare Part D & Hospice

- More information requests from Rawlings Financial Services Pharmacy Division related to pharmacy claims paid by Medicare Advantage / Medicare Part D programs
- Requests typically include a list of medications for a specific beneficiary for a specific time period
- For each, hospice is to indicate via Yes and No check boxes if it is covered by hospice
- Looks as if Part D controls at delivery point may be coming in 2014 - could eliminate one problem but will create a procedural challenge

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Wage Index Proposed Rule

A ship that sails every year…

- Hospice payment rates and wage index are updated annually; material is published in the Federal Register
- In addition to payment information, CMS often wraps both proposed rules and "clarifications" in the package
- Required for proposed rule changes and also used in areas in which CMS wants to obtain more information, CMS solicits comments on specific items within the document
- Any interested party may submit comments within the time frame indicated when the proposed rule appears in the Federal Register

This year they have outdone themselves!

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What We Will Cover Today

- Too much material to cover it all in depth today
- Will focus primarily on the portion that will require the most attending: DX reporting on hospice claims

III. Provisions of the Proposed Rule
   A. Diagnosis Reporting on Hospice Claims
      1. ICD-9-CM Coding Guidelines
      2. Use of Nonspecific, Symptom Diagnoses
      3. Use of "Mental, Behavioral and Neurodevelopmental Disorders" ICD-9-CM Codes
      4. Guidance on Coding of Principal and Other, Additional, and/or Co-existing Diagnoses
      5. Transition to ICD-10-CM

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Diagnosis Reporting on Hospice Claims

- Labeled as a "clarification of existing ICD-9CM coding guidelines"
- First "clarification" was in the FY 2013 Wage Index notice
  - Noted that hospices were required to follow coding guidelines
  - Instructed hospices to include all "coexisting or additional diagnoses related to the terminal illness or related conditions
  - Reported that 77% of hospice claims only included one DX
- Preliminary analysis of Oct – Dec 2012 claims data shows that 72% of providers only reported one DX on the claim

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Section 1. ICD-9-CM Coding Guidelines

- Reviews original hospice regulations that tied in coding requirements
- Notes that due to lack of coding information analysis of current claims does not allow CMS to appropriately determine if a case-mix adjustment would be a reasonable payment methodology – too little data
- Makes shaky argument that using only one DX code does not lend to "a comprehensive, holistic and accurate description of beneficiaries' end-of-life conditions and may not fully reflect the individualized needs in the individual's required plan of care"

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Section 2: Use of Nonspecific, SX Diagnoses

- Acknowledges changes in reported hospice DX since 1983
- States that by nature debility and adult failure to thrive are the result of multiple primary conditions that contribute to terminal decline
- Notes that under coding guidelines, codes under classification "Symptoms, Signs, and Ill-defined Conditions are not to be used as principal DX when a related definitive DX has been established or confirmed by the provider
- States opinion that if multiple primary conditions are present and being treated (included taking medication), that meets the criteria of having an "established and/or confirmed" DX

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Section 2: Use of Nonspecific, SX Diagnoses

Repeat of the shaky argument that a principle DX from the non-specific ICD-9-CM category "does not encompass the comprehensive, holistic nature of the assessment and care to be provided under the Medicare hospice benefit."

Followed by the firecracker:

> "In this proposed rule we would clarify that 'debility' and 'AFTT" would not be used as principal hospice diagnoses on the hospice claim form. When reported as a principal diagnosis these would be considered questionable encounters for hospice care and the claim would be RTP for a more definitive principle diagnosis."

Section closes with request for comments

> " We solicit comments regarding these ICD-9-CM coding guideline clarifications."

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Section 3: Mental, Behavioral, ICD-9-CM Codes

- A number of commonly used hospice dementia codes are more properly considered “manifestation” codes that need to be preceded by an etiology code
- Codes are not being sequenced properly
- This section is much more clear-cut and reminds us that we need to improve our coding skills
- Comments solicited for this section as well

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Section 4: Coding Principal & Other DX

Section opens by pulling in coding guidelines related to inpatient hospital admissions and noting that

> “The principal DX is defined in the Uniform Hospital Discharge Data Set (UHDDS) as ‘that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.’ ”

Next transitions to data related to beneficiaries with hospital stay that were admitted to hospice within 3 days of discharge

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Table 3: Principal Hospice Diagnoses and Incidence of Same Diagnoses from Hospitalizations within Three Days Prior to Hospice Election, FY 2009-2011

ICD-9 Diagnoses		Instances of Principal Hospital Diagnosis…	…That Then Also Became Hospice Principal Diagnosis	
Label	*ICD-9 Code Ranges*	#	#	*% of Total Instances of Principal Hospital Diagnosis*
Lung & Chest Cavity Cancer	162-165s	32,428	27,939	86.2%
Colo-Rectal Cancer	153-154s	10,360	8,270	79.8%
Blood & Lymphatic Cancer	200-208s	15,491	12,747	82.3%
Breast Cancer	174-175s	1,881	1,651	87.8%
Pancreatic Cancer	157s	11,334	9,887	87.2%
Prostate Cancer	185s	1,764	1,520	86.2%
Liver Cancer	155-156s	6,710	5,009	74.6%
Bladder Cancer	188s	2,844	2,218	78.0%

Source: FY 2009-2011 Hospice claims matched with hospital inpatient claims where no more than three days passed between hospital discharge and hospice admission.

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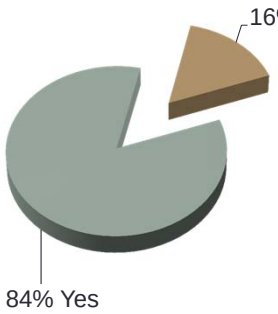
Table Data in Pie Chart Form

Percentage of beneficiaries that were admitted to hospice with primary cancer DX



- Gaming the system?
- Major disconnect between coding and clinical?

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Section 5: Transition to ICD-10-CM

Current go-live date: October 1, 2014

Basic messages of the section

- Clarification and requirements will move forward to the ICD-10
- Crosswalking / mapping tools will be available
- Don't substitute those for learning and implementing the ICD-10

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Questions for the Prudent Hospice

Where are you now in these process steps?

- Determining terminal diagnosis and related conditions
- Categorizing additional diagnoses into related and unrelated
- Including terminal diagnosis and related conditions DX coding on claim
- Making coverage determinations
- Documenting determinations
- Implementing a review process when a beneficiary's terminal diagnosis and related conditions are changed to assure that you are reviewing the plan of care for changes to related and covered

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Questions for the Prudent Hospice

Debility and Adult Failure to Thrive

- What % of total terminal diagnoses are they?
- What % of total terminal diagnoses is each?
- What process can you put in place now for new admission to potentially find a more appropriate terminal diagnosis and related condition(s)?
- What process can you put in place now to begin to review each current beneficiary with these terminal diagnoses and potentially find a more appropriate terminal diagnosis and related condition(s)?
- Remember: Implement a review process when a beneficiary's terminal diagnosis and related conditions are changed, that you are reviewing the plan of care for changes to related and covered

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Hospice Quality Reporting

- Required measures will remain unchanged for FY2014 and FY2015
  - NSF #209 Comfortable Dying
  - Structural Measure
- Due to limitations of both, moving to the Hospice Item Set in July 2014

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Hospice Item Set (HIS)

- Will be required to complete and submit an admission HIS & a discharge HIS for all patients regardless of payor
- Failure to submit quality data via the HIS in 2014 would have market basket update reduced by 2% in FY2016
- Hospices would be evaluated on whether submitted data or not versus performance level for purposes of quality reporting
- For FY2015 payment (CY2014) and beyond data submission would have to be electronic with no other data submission method available

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Draft Cost Report

- Substantial expansion of the manner in which hospices will need to recognize costs in their accounting records
- Costs reported based on the level of care
- Will require most hospices to substantially expand their chart of accounts and accumulate statistical information not presently being accumulated
- Will need to segregate all direct patient care costs by multiple cost categories into the respective level of care
- Expansion relating to reporting non-reimbursable activities to include marketing, residential care, nursing facility room and board, and more

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Draft Cost Report

Actions Needed

- Accounting staff need to review immediately
- Focus on accumulating the required cost information now
- Modify manner in which general service costs are accumulated

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FY 2014 Wage Index

- Hospice payment rates for FY 2014 to increase by 1.8%
- Incorporates
  - Use of updated hospital wage index data
  - 5th year of the 7-year Budget Neutrality Adjustment Factor (BNAF) phase out
- Update to the hospice payment rates by the hospice payment update percentage
- Does not include sequestration

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Payment Reform Update

- U-shaped model of resource use
  - Tiered approach with payment based on LOS
- Short stay add-on payment
  - Similar to home health LUPA add-on
  - Would improve payment accuracy if retain current per diem system
- Case-mix
  - Need more accurate diagnosis data first
- Rebasing RHC rate
  - Involves using existing components that make up the rate and recalculating based on more current data

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Hospice Top 10 Medicare Survey Deficiencies (Calendar Year 2012)
Material Presented by Brenda Blunt, MSN, RN, CHPPN; CMS Nurse Consultant
April 2013

L Tag	Regulation	Examples Provided by CMS
L 543	**418.56(b) – Plan of Care** All hospice care and services furnished to patients and their families must follow an individualized, written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.	While continuous oxygen was part of plan of care, discussed in interviews, and during a home visit, there was no indication of respiratory or airway assessment, no interdisciplinary team notes regarding the need for oxygen use or changes. Patient was seen during visit sitting up in chair with no oxygen on - or in – the vicinity. **Widespread issue** -- Plan of Care indicates hospice aide services but there were no indications in the form of visit orders or documentation that hospice aide services were being provided. ***Hospice Fundamentals Note: From the Office of the Inspector General's perspective, also a coverage issue. See Subpart F Covered Services § 418.200 Requirements for coverage. (See p4 of this document)***
L545	**418.56(c) - Content of the Plan of Care** The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plans of care must include all services necessary for the palliation and management of the terminal illness and related conditions.	Patient had an ileal conduit but care plan did not include related orders or stomal care for the patient. Care plan had incontinence listed under functional assessment, but no mention of conduit. RN removed a patient's Foley catheter based on his wife's request, as she would rather change him and husband would find more comfortable, but care plan a month later reflected catheter care and goals related to patient having a catheter. With some frequency plans of care indicated care - wound care, oxygen, or Foley care - per standing orders but no standing orders were present in chart. Failure to have proper information in plan of care relative to wound care, either information was missing or not accurate, was also a frequent survey issue. ***Hospice Fundamentals Note: From the Office of the Inspector General's perspective, also a coverage issue. See Subpart F Covered Services § 418.200 Requirements for coverage. (See p4 of this document)***
L591	**418.64(b) – Nursing Services** The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.	Patient caregiver contacted agency that nurse had not come after two hours, and first documented RN visit was two days later after another late night call by caregiver. Patient was found with a fever, tachycardia, and abdominal pain and was sent to hospital and admitted. Caregiver called at midnight concerned that patient was having difficulty breathing; caregiver was instructed to administer morphine and Ativan. Caregiver called again 40 minutes later, was told that the nurse was coming and was instructed to give more medication. The nurse called at 1:25 am, and told caregiver to give more medications and that she was on her way. The nurse called again at 1:30 am to report that she was on the way and had spoken to the doctor. Caregiver reported to the nurse that the patient had stopped breathing. The nurse did not arrive until 2:15 am.

L Tag	Regulation	Examples Provided by CMS
L629	**418.76(h) -- Supervision of Hospice Aides** A registered nurse must make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the hospice aide - and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.	Reviews indicated widespread problems of supervisory visits not being completed or documented. Reported time frames between supervisory visits ranged from 16 days to over 15 weeks. Given the frequency of this problem, tracking of aide supervision was suggested as a good QAPI project.
L552	**418.56(d) - Review of the Plan of Care** The hospice IDG - with the patient's attending physician, if any - must review, revise, and document the individualized plan of care as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.	No documentation that the personal physician was involved with the plan of care reviews. Patient admitted on 3lpm of oxygen, over a period of two weeks oxygen increased to 4.5lpm with no indication of a change in orders, no IDG info on the increase and SOB. Chaplain-provided support was documented but no mention or discussion regarding this care was included in IDG meeting notes. Progressing wounds with no indication of IDG addressing changing wound care, RN changing wound care and documenting. No IDG notes mention of changes to plan of care was a frequent concern. Hospice MD failed to attend some IDG meetings but no record of someone catching the physician up on what transpired as part of IDG discussions. ***Hospice Fundamentals Note: From the Office of the Inspector General's perspective, also a coverage issue. See Subpart F Covered Services § 418.200 Requirements for coverage. (See p4 of this document)***
L557	**418.56(e)(4) - Coordination of Services (Not in top 10 previous year)** Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.	Based on clinical record review, staff interviews, and patient/family interviews, a patient was admitted on a Monday with lung cancer, CHF, and COPD. Caregiver called first night regarding respiratory distress of patient and was told that he was not a patient according to the computer system, and therefore hospice staff could not assist. Eventually the caregiver was advised to give Ativan and morphine, although the family was asking about administration of Lasix, which had been ordered by hospice. No assistance or visits were provided. The family took the patient to the hospital for the last two days of life. It was discovered that the admitting nurse had been unable to sync her computer and did not notify the on-call staff of the patient's admission. Plan of care indicated that patient requested a volunteer, but there was no communication documented between nurse, case manager, and volunteer coordinator about what family was requesting. ***Hospice Fundamentals Note: From the Office of the Inspector General's perspective, also a coverage issue. See Subpart F Covered Services § 418.200 Requirements for coverage (See p4 of this document)***

L Tag	Regulation	Examples Provided by CMS
L671	**418.104 – Clinical Records (Not in top 10 previous year)** A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.	Clinical records lacking signed revocation forms, discharge summary, or events leading to discharge. Volunteer conducted bereavement counseling and kept records at her home. Volunteer was out of town so agency could not provide records.
L530	**418.54(c)(6)-Drug Profile** A review of all of the patient's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy including, but is not limited to, identification of the following: • Effectiveness of drug therapy • Drug side effects • Actual or potential drug interactions • Duplicate drug therapy • Drug therapy /lab monitoring	In signed physician orders, doctor wrote for ferrous gluconate. The order was not in the medication profile, nor was there any documentation about this addition or change. Duplicate listings for acetaminophen (acetaminophen and Tylenol) and Roxinol (Roxinol and morphine). Reason given for duplicate listings was computer synchronization issues. Medication orders failed to list oxygen orders (dose, frequency, route) – this was a frequent issue in surveys
L531	**418.54(c)(7) – Bereavement (Not in top 10 previous year)** An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.	No documented initial bereavement assessments – this was a **<u>widespread issue</u>** in surveys. This could be a good QAPI project – tracking bereavement assessments

L Tag	Regulation	Examples Provided by CMS
L651	**418.100(b) – Governing body and administrator (Not in top 10 previous year)** A governing body, or designated persons so functioning, assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by - and reporting to - the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.	No documentation of overall operation of hospice, approval of policies and procedures. Failure to meet as a hospice quality improvement committee (QAPI), no documentation of quality improvement projects or any quality assessment monitoring – meaning no data to support QAPI program. Failure to clearly appoint an administrator.

Subpart F Covered Services
42 CFR 418.200 Requirements for Coverage

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

(Numbering added by Hospice Fundamentals)

Related / Unrelated Process Steps
February 2012

Action	Who	When	How / Where
Determine terminal diagnosis and related conditions			
Categorize additional diagnoses into related and unrelated			
Make coverage determinations			
Document determinations			
Communicate DX and coverage decisions to			
IDG			
business office			
patient/family; document			
also non-coverage decisions to patient/family; document			
other providers; document			
Re-evaluate during course of care; if determination changes repeat communication steps above			
Code terminal illness and related diagnoses			
Update coding as necessary			
Monitor invoices; if hospice has not received any for covered items determine why and document			