How to Ensure Compliance, Program Integrity and More!

Katie Wehri, CHC CHPC
Hospice Operations Expert
NAHC

October 2014

Objectives

- Describe the current compliance environment for hospices
- Review the reasons for concern about hospice compliance
- List and explain regulatory areas of vulnerability and hospice-wide areas of vulnerability
- Outline key components necessary for program integrity
TOP PRIORITY

Elimination of abuse, fraud and waste
• $1 spent on healthcare related fraud and abuse activities recovers $7.90 (2012)

• Since 1997 $23 billion recovered, $14.9 billion 2009-2012

“Relentless pursuit of healthcare fraud”

HCFAC Report, 2013

Reasons for Concern – Hospice Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$3 Billion</td>
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<tr>
<td>2010</td>
<td>$13 Billion</td>
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<tr>
<td>2012</td>
<td>$15 Billion</td>
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<tr>
<td>2012 – Hospice + Outside Hospice</td>
<td>$16.1 Billion</td>
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</tbody>
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Reasons for Concern - Length of Stay

**Diagnosis**
- Cancer: 51 days
- Neurological: 139 days

**Patient Location**
- Home: 90 days
- NF: 112 days
- ALF: 154 days

**Median LOS**: 17-18 days

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**Medicare Hospice Margins**

- 5%-6%: 2008
- 8%-9%: 2011
Reasons for Concern - Hospice

MedPac
- Hospice in the nursing facility
- LOS
  - Payment structure incentivizes long lengths of stay
  - LOS by location
  - LOS by diagnosis

Reasons for Concern - Hospice

- OIG Reports
  - 2013
    - Medicare Hospice: Use of General Inpatient Care
    - Recommendation Follow-up Memorandum: Frequency of Medicare Recertification Surveys for Hospices Is Unimproved
    - Medicare Could Save Millions By Implementing A Hospital Transfer Payment Policy For Early Discharges to Hospice Care
    - Referencing earlier reports (2009, 2007)
    - Agrees with MedPAC recommendations to decrease incentives for long lengths of stay
Reasons for Concern – Hospice Data

Findings from 2014 Abt Technical Report
- Beneficiaries dying without skilled visits in the last days of life
- Over- and under-utilization of GIP, CC, and IRC
- Live discharges
- Non-hospice spending for beneficiaries during a hospice election


The Result

- Eligibility
  - RAC approved issue - Hospice documentation will be reviewed to determine the appropriateness of payments for hospice care services for Medicare beneficiaries
  - MAC audits
  - OIG studies

DOJ suit against at least three hospices ranging from $3M to $112M
The Result

• Part D
  – “recoupment” of payments for all prescription analgesics paid in 2011 and 2012 for Part D enrollees receiving hospice services
  – Prior Authorization (PA) process
• Inpatient
  – OIG Work Plan
  – OIG studies
  – MAC reviews

The Result

• Hospice Bundle
  – CR 8273 - Deny inpatient hospital claims if the principal dx on the claim matches one of the dx on the hospice claim
  – Rescinded
  – NOE/NOTR and attending physician
  – Hospice diagnoses
Current Environment

Vulnerable Areas

- Eligibility
  - For hospice benefit
  - Level of care
  - Continuing eligibility
- Length of stay
  - Location
  - Diagnosis
- Hospice bundle
Vulnerable Areas

- Site of service
- Marketing practices
  - Anti-kickback
  - Inducement
  - Payment tied to # of admissions, etc.
- HIPAA
- Personnel
  - Qualifications
  - EEOC
  - FLSA
  - OSHA, etc.

Vulnerable Areas

- Patients not eligible
  - Not terminally ill
  - Not eligible for the level of care billed
  - Documentation supports *prognosis*
  - Technical components of election statements, CTIs, and Plans of Care
Medicare Hospice Eligibility

• Entitled to Medicare Part A
• Certified as terminally ill – medical prognosis is 6 months or less if the illness follows its normal course
  – Based on the clinical judgment of the hospice medical director/hospice physician and the attending physician (if any) for the initial cert
  – Medical director/hospice physician for recertifications

Medicare Hospice Eligibility

• Clinical judgment
  – Diagnosis of the terminal condition of the patient
  – Other health conditions (related or unrelated)
  – Current clinically relevant information supporting all diagnoses
• Brief narrative
  – Justification
  – Must synthesize the patient’s comprehensive medical information
Medicare Hospice Eligibility

• LCD vs. prognosis
• Physician reviews clinical information and hospice assessments
• F2F
  – Attestation is required on the CTI/F2F form
  – A summary is not required on the form – but can do so voluntarily
  – Clinical note from encounter should be detailed

Medicare Hospice Eligibility

• Must a patient decline in order to remain eligible?

• Does decline equal eligibility?

• Compare patient over time
Medicare Hospice Eligibility

• Defined process from referral to admission
  – Lays out responsibility for obtaining the clinical information
  – Communication flow
• Technical requirements of the CTI and F2F
  – Medicare Benefit Policy Manual, Chapter 9, Section 20

Medicare Hospice Eligibility

• Technical components of the election statement
  – Medicare Benefit Policy Manual, Chapter 9, Sections 10 & 20
  – CR 8877 – chosen attending
• Technical components of the plan of care
  – Medicare Benefit Policy Manual, Chapter 9, Section 40
• Technical requirements of the NOE/NOTR and change in chosen attending physician
Medicare Hospice Eligibility

• Ongoing eligibility
  – Every update to the comprehensive assessment
    • Includes changes in level of care
• IDG summaries
• Visit notes

Medicare Hospice Eligibility – Levels of Care

• Levels of care, GIP, in particular
  – Each day of GIP
  – Documentation of the symptom or need that precipitated move to this level of care
  – Documentation of the resolution of the symptom or need
  – Must be provided
• Continuous Care
  – Not contracting unless exceptional circumstance
  – Documentation of the crisis
  – Documentation to support each unit billed
  – Location of care
Medicare Hospice Eligibility – Levels of Care

• Inpatient Respite
  – Billing five consecutive days at a time
  – Location of care
  – Caregiver breakdown – did the caregiver try?
  – One respite “episode” at a time

Hospice Bundle/Hospice Coverage

• The hospice is responsible for providing any and all services *indicated in the plan of care as necessary* for the palliation and management of the terminal illness and related conditions.

• Services must be *consistent with the plan of care and reasonable and necessary* for the palliation or management of the terminal illness and related conditions.
Hospice Coverage

Related to the Medicare Hospice Benefit

—$1 Billion total in 2012 (Medicare)

• Part D $340 Million
• Inpatient $224 Million
• Physician/supplier $202 Million

Hospice Coverage

Hospice Coverage

• Diagnosis reporting
  – new to hospices but not to CMS
  – % reporting only one dx
  – This is much more than medications – it is all treatment, supplies, dme

Note: coverage decisions should be reassessed as the patient’s condition changes (and if the dx change)

Note: Vital that the reasons something is not covered are clearly documented – specific clinical reasons pertaining to this patient

Hospice Coverage

– FY2015 Final Rule – RTP October 1, 2014
  • Debility (799.3 and 780.79)
  • Adult failure to thrive (783.7)
  • Various dementia codes in the range of 290.0 through 290.9, 293 and 310
  • CMS will implement edits related to etiology/manifestation code pairs from the Medicare code editor (MCE)

– CMS comments in 2013 and 2014 regarding
  • Adherence to ICD-9-CM coding guidelines
  • Multiple dx on claims (principal and related)
Related Conditions Defined

• Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness.


Related Conditions - Considering

• “Those conditions that result directly from terminal illness; and/or
  – result from the treatment or medication management of terminal illness; and/or
  – which interact or potentially interact with terminal illness; and/or
  – which are contributory to the symptom burden of the terminally ill individual; and/or
  – are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less”.
Hospice Coverage & Claims
Principal Diagnosis

- The full ICD-9-CM diagnosis code is required.
- Condition established after study to be chiefly responsible for the patient’s admission
- Follow ICD-9-CM coding guidelines
- **CMS continues to track provider behavior**

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Hospice Coverage & Claims
Diagnosis Coding

**Manifestation codes**
- Describe symptoms rather than etiology
- Should never be used as principal Dx; some clues in ICD-9-CM denote manifestation, e.g.:
  - “In diseases classified elsewhere”
  - “code first”
  - “not first listed Dx”
- Of particular concern relative to hospice:
  - Debility and Adult failure to thrive (20% of hospice patients)
  - SOME dementia codes (both Alzheimer’s or dementia w/Lewey Bodies can be principal Dx)
Hospice Coverage & Claims Diagnosis Coding

• Guidance
  – Are you providing multiple diagnoses on claims?
  – Ensure ongoing adherence to coding guidelines/rules; if complexities are not understood, staff should have training
  – Abandon “cheat sheets”/reliance on “hospice diagnoses”
  – Identify instances of use of manifestation codes as principal diagnosis/find alternatives
  – CMS says physician provides diagnoses, but OK for coders/billers to establish appropriate codes
  – Rely on assessing combined impact of existing diagnoses to establish prognosis – physician education

“Relatedness”

• Deliberate, defined process that is physician driven
• Case by case basis
• Documentation supporting why it is related/why it is not related
  – “clear evidence”
• Communicating to patient/family
• Communication/collaboration with other providers
“Relatedness”

A condition must be completely unrelated to the terminal illness/related conditions in order for Medicare to cover it outside of the Hospice Benefit

Relatedness

- Is the [insert medication/item/service] related to the principal diagnosis or related conditions?
  - YES
    - Is it reasonable and necessary
  - YES
    - Covered by hospice
Relatedness

• Is the [insert medication/item/service] related to the principal diagnosis or related conditions?
  • YES
    – Is it reasonable and necessary
  • NO
    – Should it be continued
    – Covered by beneficiary (or their non-Medicare insurance)

Relatedness

• Is the [insert medication/item/service] related to the principal diagnosis or related conditions?
  • NO
    – Should it be continued?
Hospice Compliance

Required or Not Required?

• ACA requires some providers to have compliance plans – hospice not specified
• Some Medicaid programs require it
• Some other insurers or state licensure rules require it
Required or Not Required?

• Benefit of having a compliance plan
  – Compliant practices
  – Become aware of potentially non-compliant practices
  – Staff have a foundation – promotes culture of compliance
  – Reduces risk
    • Effective plan may reduce penalties
  – Integrity

OIG Compliance Guidance for Hospices

Published in 1999

http://oig.hhs.gov/authorities/docs/hospicex.pdf
OIG Compliance Guidance for Hospices

1. Written policies and procedures, standards of conduct
2. Compliance officer and compliance committee
3. Conduct effective training and education
4. Develop effective lines of communication
5. Auditing and monitoring
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding to detected offenses and developing action plans to prevent recurrence

Compliance Plans

- Voluntary at this time
- Guidance first published 1999
- Effectiveness
- Seven elements