402. Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

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OBJECTIVES
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// Overview of Medicare hospice billing changes
// Identify typical compliance risks that surface in hospice revenue cycle
// Review hospice revenue cycle benchmarks
// Assess key strategies for ongoing oversight and management of hospice revenue cycle
April 1, 2014

Centers for Medicare & Medicaid Services (CMS) implementation of Change Request (CR) 8358

Effective for claim dates of service April 1, 2014, & thereafter

KEY REGULATORY CHANGES

General inpatient care (GIP) visits

Inpatient facility identification

Post-mortem visit

New billable services

Injectable drugs

Non-injectable drugs

Infusion pumps & related drugs
GIP VISITS
// Claims must itemize billable visits & calls provided to patients receiving GIP
    // Excludes visits & calls performed in hospice inpatient facility during GIP stay
// No impact to claim payment
// Low impact to revenue cycle

INPATIENT FACILITY IDENTIFICATION
// Claims must report inpatient facility identification information, when applicable
// No impact to claim payment
// Low impact to revenue cycle
POST-MORTEM VISITS
// Claims must identify post-mortem visits occurring on day of death after time of death
// No impact to claim payment
// Moderate impact to revenue cycle
  // Required software system modifications
  // Required clinical personnel training
  // In some instances requires single visits to be coded as two visits on claims

NEW BILLABLE SERVICES
// Claims must report injectable & non-injectable drugs & infusion pumps & related drugs
// No impact to claim payment
// High impact to revenue cycle
  // Required software system modifications
  // Required clinical coordination with pharmacy supplier
  // Required billing process changes
  // In some instances, caused delayed claims submission or payments
OCTOBER 1, 2014

// CMS implementation of final payment rule for fiscal 2015

// Federal Register dated August 22, 2015
// CR 8877 dated August 22, 2015
// Effective for claim dates of service October 1, 2014, & thereafter
KEY REGULATORY CHANGES
// New payment rates
// HCPCS location codes
// Attending physician documentation
// Notices of Election (NOEs)
// Notices of Termination/Revocation (NOTRs)
// Claim diagnosis coding

NEW PAYMENT RATES
// New payment rates & wage index adjustments effective October 1, 2014
// Annual impact to claim payment
// Low impact to revenue cycle
  // May have required modifications to billing software settings
  // May have required some retraining of personnel
NEW PAYMENT RATES

// Payment rate tables available on bkd.com

// Requires following information
// Name
// Organization
// Email address
// Rate year
// State

HCPCS LOCATION CODES

// Clarification of use of Q5003 vs. Q5004

// No impact to claim payment

// Low impact to revenue cycle
// May have required modifications to billing software settings
// May have required some retraining of personnel
HCPCS LOCATION CODES

// “Q5004” to be used for patients in a skilled nursing facility (SNF) or in the SNF portion of a dually-certified nursing facility (NF)
  // Patient receiving care in solely-certified SNF
  // Patient receiving GIP in SNF
  // Patient receiving SNF care under Medicare Part A benefit for condition unrelated to terminal illness
  // Beneficiary is receiving inpatient respite care in SNF

// “Q5003” to be used when beneficiary is in NF but does not meet criteria for “Q5004”

ATTENDING PHYSICIAN DOCUMENTATION

// Election statements must now indicate patient’s chosen attending physician
// Changes to attending physician after election must now be documented in patient record
// No impact to claim payment
// Moderate impact to revenue cycle
  // May have required some modifications to patient election forms
  // May have required process implementation for documenting physician changes
ATTENDING PHYSICIAN DOCUMENTATION

// CR 9114 dated April 3, 2014
// Effective May 4, 2015
// Requires attending physician NPI number to be documented on election statement along with other attending physician designation acknowledgement

NOE

// NOEs must be received by Medicare Administrative Contractors (MACs) no later than five calendar days after election date
// Late received NOEs subject to payment penalty
// Significant impact to revenue cycle
// Requires new process controls to ensure NOEs are billed within five days
// Requires educating all personnel
NOE

// NOE must be accepted by MAC within **five calendar days** after effective date of election

// Late NOEs result in payment penalty
  // Day of admission through day prior to successful MAC received date noncovered & nonpayable

// NOEs containing errors not corrected by day five also considered untimely

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**October 1, 2014**

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NOE

// Four exceptional circumstances

  // Fires, flood, earthquakes, or other unusual events that inflict extensive damage to ability to operate

  // An event producing a data filing problem due to CMS or Medicare contractor system beyond control of hospice

  // Newly Medicare-certified hospice that is notified of certification after Medicare certification date or awaiting billing access from Medicare contractor

  // Other circumstances determined by Medicare contractor or CMS to be beyond control of hospice

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**October 1, 2014**
**NOTR**

// NOTRs must be received by MACs no later than five calendar days after discharge or revocation if claim cannot be billed by that time

// No impact to claim payment

// Significant impact to revenue cycle
  // Requires new process controls to ensure NOTRs are consistently billed within five days
  // Requires educating all personnel
  // Requires new communication processes to identify discharges or revocations timely
  // Requires new billing action

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**CLAIM DIAGNOSIS CODING**

// Principal diagnosis of debility, adult failure to thrive & some dementia codes no longer allowed

  // Use of codes on claim prevents claim payment

// Significant impact to revenue cycle
  // Requires new process controls to ensure codes are not used
  // Requires educating all personnel
  // May have required software updates
  // May have required new coding personnel
CLAIM DIAGNOSIS CODING
// Claims should report both principal & all coexisting or additional codes related to terminal illness & related conditions
// Principal diagnosis code should represent condition most contributory to terminal prognosis
  // Cannot report v-codes as principal diagnosis

CLAIM DIAGNOSIS CODING
// Claims cannot be coded with debility, adult failure to thrive, or dementia diagnosis codes classified as unspecified as principal diagnosis codes
  // Specific list of codes available in CR 8877
  // Claims cannot report diagnosis codes that cannot be used as principal according to coding guidelines

CLAIM DIAGNOSIS CODING
// Claims should report both principal & all coexisting or additional codes related to terminal illness & related conditions
// Principal diagnosis code should represent condition most contributory to terminal prognosis
  // Cannot report v-codes as principal diagnosis
PROPOSED FUTURE CHANGES
// **Federal Register** dated May 5, 2015, issued proposed rule for fiscal 2016
  // **Proposed** significant changes to routine home care payment
  // **Proposed** service intensity payment add-on
  // **Proposed** matching claim diagnosis coding to initial & comprehensive assessment coding
  // Other proposed requirements
"The Fraud Prevention System identifies aberrant and suspicious billing patterns which in turn trigger actions that can be implemented swiftly to prevent payment of fraudulent claims."

Annual Report of the Departments of Health and Human Services and Justice Health Care Fraud and Abuse Control Program FY 2014
402. Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

June 30, 2015

Coverage & billing compliance

Revenue cycle risks

People & process

Program integrity

TYPICAL RISKS

Available Data = Patterns & Trends

- Claims
- Levels of care
- Number & type of visits
- Drugs & pumps
- Length of visits
- Location of care
- Diagnoses
- Cost reports
- Cost per visit
- Cost per level of care
- Cost per location of care
- Cost per diagnosis
- Cost per patient
- Cost per length of stay
- Cost by period of stay

Hospice Benefit Accountability Questions

- Does care cost more in nursing facilities or other inpatient locations?
- Does care cost more at beginning, middle, or end of care?
- What is care intensity by diagnosis? Does it change based on location of patient, inpatient vs. outpatient?
- What amount of time is actually spent with patients by clinical professionals?
- What amounts & costs of drugs are involved in patient care? Does location of patient impact utilization?
What is PEPPER?

- Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes Medicare claims data statistics for one hospice in areas ("target areas") that may be at risk for improper Medicare payments.
- PEPPER compares a hospice’s Medicare claims data statistics with aggregate Medicare data for the nation, MAC jurisdiction and state.

Why are Hospices Receiving PEPPER?

- CMS is tasked with protecting the Medicare Trust Fund from fraud, waste and abuse.
- The provision of PEPPER supports CMS’ program integrity activities.
- PEPPER is an educational tool that is intended to help providers assess their risk for improper Medicare payments.
### 402 Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

#### June 30, 2015

**TYPICAL RISKS**

### Target Area: Live Discharges

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| Live Discharges | For discharges beginning July 1, 2012:  
*revised as of the Q4FY13 release*  
N: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to “40”, “41” or “42”, excluding: beneficiary transfers (patient discharge status code “50” or “51”); beneficiary revocations (occurrence code “42”); beneficiaries discharged for cause (condition code “H2”); beneficiaries who moved out of the service area (condition code “S2”)  
D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice) |

Source: PEPPER training resources  
http://pepperresources.org/Training-Resources/Hospices

### Target Area: Long Length of Stay

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
</table>
| Long Length of Stay | N: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)  
D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period |

Continuous Home Care Provided in an Assisted Living Facility *new as of the Q4FY14 release*  
N: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (revenue code = “0652”) were provided while the beneficiary resided in an Assisted Living Facility (HCPCS code = “Q5002”)  
D: count of all beneficiary episodes ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = “Q5002”) for any portion of the episode |

Source: PEPPER training resources  
http://pepperresources.org/Training-Resources/Hospices
**402 Hospice Revenue Cycle: Optimizing Compliance & Effectiveness**

**PEPPER**
Program for Evaluating Payment Patterns Electronic Report

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Target Area Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care Provided in an Assisted Living Facility *new as of the Q4FY14 release</td>
<td>( N ): count of Routine Home Care days (revenue code = &quot;0651&quot;) provided on claims ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = &quot;Q5002&quot;)</td>
</tr>
<tr>
<td>Routine Home Care Provided in a Nursing Facility *new as of the Q4FY14 release</td>
<td>( D ): count of all Routine Home Care days (revenue code = &quot;0651&quot;) provided by the hospice on claims ending in the report period</td>
</tr>
</tbody>
</table>

**TYPICAL RISKS**

Source: PEPPER training resources

http://pepperresources.org/Training-Resources/Hospices
### 402. Hospice Revenue Cycle:
#### Optimizing Compliance & Effectiveness

#### CGS Widespread Probe Edit Description

<table>
<thead>
<tr>
<th>Edit No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5037T</td>
<td>Edit selects hospice claims with revenue 0651 routine home care (RHC) &amp; length of stay greater than 730 days</td>
</tr>
<tr>
<td>5057T</td>
<td>Edit selects hospice claims with revenue code 0656 GIP with at least seven or more days billed on claim</td>
</tr>
<tr>
<td>5091T</td>
<td>Edit selects hospice claims billed with HCPCS code “Q5003” and “Q5004” and any non-oncologic diagnosis code &amp; length of stay greater than 180 days</td>
</tr>
<tr>
<td>5118T</td>
<td>Edit selects hospice claims for beneficiaries in identified states with length of stay between 150-365 days &amp; non-oncologic diagnosis codes</td>
</tr>
<tr>
<td>598X9</td>
<td>Edit selects hospice claims due to previous denials for selected beneficiaries</td>
</tr>
<tr>
<td>59974</td>
<td>Edit selects hospice claims with occurrence code 32 (ABN) &amp; revenue code 0656 GIP</td>
</tr>
</tbody>
</table>

Source: CGS  
http://www.cgsmedicare.com/hhh/medreview/med_review_edits.html

#### TYPICAL RISKS

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>CGS Denial Reason Code Description</th>
</tr>
</thead>
</table>
| 5FFTF         | Missing, incomplete, untimely face-to-face (FTF) encounter  
| 5PNOE         | Missing, incomplete, untimely election statement  
| 5PCER         | Missing, incomplete, untimely certification or recertification  
| 5PRLT         | Reduced level of care  
| 5PTER         | Six-month terminal prognosis not supported  
| 5PRLM         | Documentation does not support level of care  
| 5PPOC         | Hospice plan of care does not meet requirements  

Source: CGS  
http://www.cgsmedicare.com/hhh/medreview/hos_drc.html
## 402. Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

### Hospice Revenue Cycle:
- **Optimizing Compliance & Effectiveness**

#### Reason Code
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5SH1B</td>
<td>Physician certification or recertification was not received in timely manner</td>
</tr>
<tr>
<td>5SH1F</td>
<td>Physician certification or recertification was not received</td>
</tr>
<tr>
<td>5SH1G</td>
<td>NOE did not meet statutory/regulatory requirement</td>
</tr>
<tr>
<td>5SH1L</td>
<td>Information provided does not support that your illness is terminal</td>
</tr>
<tr>
<td>5SH1S</td>
<td>FTF encounter requirements not met</td>
</tr>
<tr>
<td>56900</td>
<td>Provider failed to submit documentation within 45 days</td>
</tr>
</tbody>
</table>

### NGS Top Denial Reasons

#### Widespread Probe Edits
- Jurisdiction K (CT, MA, ME, NH, VT, RI)
- 5AH01 – Length of stay greater than 365 days
- 37% denial rate for paid dates 02/01/14 – 07/31/14

### Typical Risks

#### Reason Code
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5CF36</td>
<td>Not hospice appropriate</td>
</tr>
<tr>
<td>5CF01</td>
<td>GIP not reasonable and necessary</td>
</tr>
<tr>
<td>56900</td>
<td>Auto deny, requested records not submitted</td>
</tr>
<tr>
<td>5CFH6</td>
<td>Initial certification not timely</td>
</tr>
<tr>
<td>5CFH9</td>
<td>Physician narrative statement not present or not valid</td>
</tr>
<tr>
<td>5CFNP</td>
<td>No plan of care submitted</td>
</tr>
<tr>
<td>5CFH2</td>
<td>No certification present</td>
</tr>
<tr>
<td>5CFTF</td>
<td>FTF requirements not met</td>
</tr>
<tr>
<td>5CFH3</td>
<td>No certification for dates billed</td>
</tr>
<tr>
<td>5CFH7</td>
<td>Subsequent certification not timely</td>
</tr>
<tr>
<td>Other</td>
<td>Other reasons</td>
</tr>
</tbody>
</table>

#### Denial %

<table>
<thead>
<tr>
<th>Denial %</th>
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<tbody>
<tr>
<td>28%</td>
</tr>
<tr>
<td>18%</td>
</tr>
<tr>
<td>12%</td>
</tr>
<tr>
<td>11%</td>
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<tr>
<td>9%</td>
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<td>8%</td>
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<td>4%</td>
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<tr>
<td>2%</td>
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<tr>
<td>2%</td>
</tr>
<tr>
<td>3%</td>
</tr>
</tbody>
</table>

#### Source:
PGBA [Link](http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%2011%20Home%20Medical%20Review~General~9TGLY61142?open&navmenu=Medical~Review)
Departments of Justice and Health and Human Services announce over $27.8 billion in returns from joint efforts to combat health care fraud

Administration recovers $7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record

More than $27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HCFA) Program, Attorney General Eric Holder and HHS Secretary Sylvia M. Burwell announced today. The government’s health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars in Fiscal Year (FY) 2014 from individuals and companies that attempted to defraud federal health programs, including programs serving seniors, persons with disabilities or those with low incomes. For every dollar spent on

Another powerful tool in the effort to combat health care fraud is the federal False Claims Act. In 2014, the Civil Division of the Justice Department and the United States Attorneys’ Offices obtained $2.3 billion in settlements and judgments from civil cases involving fraud and false claims against federal health care programs such as Medicare and Medicaid. Since January 2009, the Justice Department has recovered more than $15.2 billion in cases involving health care fraud. These amounts reflect federal losses only. In many of these cases, the department was

Similar to the technology used by credit card companies, CMS is using its Fraud Prevention System to apply advanced analytics to all Medicare fee-for-service claims on a streaming, national basis. The Fraud Prevention System identifies aberrant and suspicious billing patterns which in turn trigger actions that can be implemented swiftly to prevent payment of fraudulent claims. In the second year, the system saved $210.7 million, almost double the amount identified during the first year of the program.

Source: HHS.gov, March 19, 2015
Hospices in assisted living facilities
We will review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities (ALFs). We will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs. Pursuant to the ACA, § 3132, CMS must reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. Our work is intended to provide HHS with information relevant to these requirements. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) Hospice care may be provided to individuals and their families in various settings, including the beneficiary’s place of residence, such as an ALF. ALF residents have the longest lengths of stay in hospice care. MedPAC has said that these long stays bear further monitoring and examination. (OEI; 02-14-00070; expected issue date: FY 2015; ACA)

Hospice general inpatient care
We will review the use of hospice general inpatient care. We will assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. We will also review hospice medical records to address concerns that this level of hospice care is being misused. Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary’s terminal illness and related conditions. Federal regulations address Medicare conditions of participation (CoP) for hospices. (42 CFR Part 418.) Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. (42 CFR § 418.28.) (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2015)

OIG RISK AREAS
// Uninformed consent to elect Medicare hospice benefit
// Admitting patients to hospice care who are not terminally ill
// Arrangement with another health care provider who a hospice knows is submitting claims for services already covered by Medicare hospice benefit

Source: OIG
http://oig.hhs.gov/authorities/docs/hospicx.pdf
OIG RISK AREAS
// Under-utilization
  // Knowingly denying needed care in order to keep costs low
// Falsified medical records or plans of care
// Untimely &/or forged physician certifications
// Inadequate or incomplete services rendered by interdisciplinary group
  // Failure to meet standards of care
  // Receiving Medicare payment for care to ineligible patients

47 Source: OIG
https://oig.hhs.gov/authorities/docs/hospix.pdf

OIG RISK AREAS
// Insufficient oversight of patients, especially those receiving more than six consecutive months of hospice care
// Hospice incentives to actual or potential referral sources
// Overlap in services a nursing home provides resulting in insufficient care by hospice to nursing home patient

48 Source: OIG
https://oig.hhs.gov/authorities/docs/hospix.pdf
OIG RISK AREAS

// Improper relinquishment of core services & professional management responsibilities to nursing homes, volunteers & privately paid professionals

// Providing hospice services in a nursing home before a written agreement has been finalized

// **Billing for a higher level of care than necessary**

// Knowingly billing for inadequate or sub-standard care

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Source: OIG
https://oig.hhs.gov/authorities/docs/hospice.pdf

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OIG RISK AREAS

// Pressuring patient to revoke Medicare hospice benefit when patient is still eligible & desires care

// Billing for hospice care provided by unqualified or unlicensed clinical personnel

// **False dating** of amendments to medical records

// High-pressure marketing of hospice care to ineligible beneficiaries

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Source: OIG
https://oig.hhs.gov/authorities/docs/hospice.pdf
## OIG RISK AREAS

// Improper patient solicitation activities

// Inadequate management and oversight of subcontracted services resulting in improper billing

// Sales commissions based upon length of stay

// Deficient coordination of volunteers

// **Improper indication of location where hospice services were delivered**

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### Typical Risks

51  Source: OIG  
https://oig.hhs.gov/authorities/docs/hospicx.pdf

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## OIG RISK AREAS

// Failure to comply with applicable requirements for **verbal certifications**

// Non-response to late hospice referrals by physicians

// Knowing misuse of provider numbers resulting in improper billing

// Failure to adhere to Medicare Conditions of Participation

// Knowing failure to return overpayments

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### Typical Risks

52  Source: OIG  
https://oig.hhs.gov/authorities/docs/hospicx.pdf
TYPICAL RISK AREAS
// Incorrectly identified benefit periods
// Untimely physician FTF encounters
// Invalid physician verbal certifications
// Noncompliant physician certification forms
// Non-substantive physician certification narrative
// Missing or noncompliant physician signatures

TYPICAL RISK AREAS
// Poorly, or lack of, documented physician roles
// Poorly documented physician coded services to support medical complexity
// Lack of Medicaid documentation for dually eligible patients, when applicable
// Systemic incorrectly billed claims
  // Lack of visits
  // Lack of medications
PERIODIC CLAIM AUDITS

- Paid claim
- Election statement
- Terminal prognosis
- Verbal & written certification
- FTF encounter
- Level of care
- Location of services
- Supporting documentation
Select paid claims sample

Compare paid claims to supporting documentation

Document & quantify findings

Assess findings

Act on findings

Educate on findings

Repeat, periodically

Track & trend findings

PERIODIC CLAIM AUDITS

PERIODIC CLAIM AUDITS
**PERIODIC CLAIM AUDITS**

<table>
<thead>
<tr>
<th>Periodic Claim Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice benefit period documented on hospice election, physician certifications, and other documentation agrees to Medicare Common Working File records.</td>
</tr>
<tr>
<td>Medicare hospice election statement has been signed and dated by beneficiary or designee and effective election date agrees to initial certification date: ( ) per Medicare data system; ( ) in patient account; ( ) on initial physician certification, and ( ) on initial claim.</td>
</tr>
<tr>
<td>Medicare hospice election statement indicates patient's chosen attending physician and notifies patient that hospice services are non-curative.</td>
</tr>
<tr>
<td>If applicable, Medicaid hospice election statement has been signed and dated by beneficiary or designee and effective election date agrees to initial certification date: ( ) per Medicaid data system; ( ) in patient account; ( ) on initial physician certification, and ( ) on initial claim, if applicable.</td>
</tr>
<tr>
<td>Plan of Care (POC)</td>
</tr>
<tr>
<td>Written POC has been reviewed by FDO no less than every 15 days and all services provided conform to POC.</td>
</tr>
<tr>
<td>Hospice services and levels of care billed follow POC.</td>
</tr>
</tbody>
</table>

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**PERIODIC CLAIM AUDITS**

<table>
<thead>
<tr>
<th>Periodic Claim Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Medicare certification has been received by both attending and certifying hospice physician for initial certification period and has been signed and dated by receiving physician: ( ) no earlier than 15 days prior to election date, or ( ) no later than two days after election date.</td>
</tr>
<tr>
<td>Written Medicare certification has been received signed and dated by both attending and certifying hospice physician for initial certification period: ( ) no earlier than 15 days prior to election date; ( ) no later than two days after hospice election period with timely verbal certification but prior to claim being billed.</td>
</tr>
<tr>
<td>Written Medicare certification includes brief narrative composed by certifying physician reflecting the patient's individual clinical circumstances explaining why clinical findings from patient's medical record or examination of patient supports life expectancy of six months or less.</td>
</tr>
<tr>
<td>If applicable, written initial Medicaid certification has been obtained by required physician(s) in accordance with state Medicaid requirements.</td>
</tr>
</tbody>
</table>
PERIODIC CLAIM AUDITS

**Continuous Home Care**
- Documentation supports that continuous home care (CHC) was provided only during a period of crisis in which the patient required continuous care to achieve palliation or management of acute medical symptoms.
- During the period of crisis the patient did not reside in a hospital or inpatient hospice facility and was not receiving skilled care by inpatient facility personnel in a skilled nursing facility (SNF) bed.
- During the period of crisis a minimum of eight hours of CHC were provided within one 24-hour day beginning and ending at midnight.
- More than half of the CHC hours were performed by a registered or licensed nurse.
- All CHC hours are coded on claim by day in 15-minute increments totaling eight hours or more.

Value code "11" has been coded on claim with CBO5A code representing location of patient's residence.

**Inpatient Hospice Care**
- Inpatient hospice care (IHC) was provided by a hospice-contracted inpatient facility.
- Care was provided in a Medicare or Medicaid certified hospital, SNF, inpatient hospice facility, or nursing facility.
- Patient was discharged from inpatient facility (IHC) on day six and five days of consecutive IHC are coded on claim, (IHC) prior to day six and day of discharge is coded on claim as a reverse home care day, or (IHC) upon death in facility and day of death is coded on claim as RC day unless death occurred after day five.

Value code "08" has been coded on claim with corresponding CBO5A code representing location of inpatient facility.
PERIODIC CLAIM AUDITS

PERIODIC CLAIM AUDITS

<table>
<thead>
<tr>
<th>Period</th>
<th>B&amp;K</th>
<th>Policy Rule</th>
<th>Diagnosis Code</th>
<th>Claim Date</th>
<th>Claim Status</th>
<th>Length of Stay</th>
<th>Admission Date</th>
<th>Claim Date</th>
<th>Claim Status</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicare</td>
<td>02/01/12 to 07/01/12</td>
<td>Living</td>
<td>100</td>
<td>06/01/12</td>
<td>07/01/12</td>
<td>1,200.7</td>
<td>265.40</td>
<td>$4,519</td>
<td>$4,616</td>
</tr>
</tbody>
</table>

Physician Documentation:
- Admission date of 02/01/12 was patient's hospice benefit period. Claim included in review spanned patient's eight benefit periods, which began 02/01/12.
- Admission date of 06/01/12 was patient's hospice benefit period. Claim included in review spanned patient's four benefit periods, which began 06/01/12.
- Vertical certification was signed and dated by nurse indicating certification was obtained from Medical Director on 09/14/12 but medical director was not certified in vertical certification.
- Vertical certification was signed by Dr. Banger as medical director, however, Dr. Banger did not sign certification.
- Vertical certification was signed by Dr. Faber as attending physician on 09/14/12. This signature was not applicable since benefit period was not vertical certification.
- Vertical certification was signed by nurse and entered certification obtained by Dr. Faber was signed 15 days prior to benefit period, which is beyond the 15 days allowed by Medicare.
PHYSICIAN'S CERTIFICATION OF TERMINAL ILLNESS FOR MEDICARE HOSPICE BENEFIT

Certification/Recertification Statement: For the benefit period of 6/1/12 to 12/31/12, I certify that the patient is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. I believe this to be true because of the following clinical findings:
- Progressive Swelling
- Cachexia
- Anorexia
- Increasing Fatigue

(Hospice Medical Director Signature) (Date by physician)

Received verbal certification from Medical Director: Date: 6/1/12

Received verbal certification from independent attending physician: Date: 6/1/12

Attention Statement: By signing this certification, the physician, named above, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.

FACE TO FACE ENCOUNTER VISIT ATTESTATION:

Patient Name: [Redacted]
Patient ID Number: 19510
Date of Visit: 1/30/12
Recertification Date:
Visit date must be within 30 days prior to, or the same day of, the recertification date.

FOR USE BY MD ONLY
I attest that I have had a face-to-face encounter assessing the clinical status of the above named patient on the date so indicated.

Medical Director: [Redacted]
Date signed: 1/30/12

FOR USE BY NP ONLY
I attest that I have had a face-to-face encounter assessing the clinical status of the above named patient on the date so indicated and that I have shared my findings with the certifying physician for use in determining continued eligibility for hospice care.

Nurse Practitioner: [Redacted]
Date signed: 1/30/12
PHYSICIAN'S CERTIFICATION OF TERMINAL ILLNESS
FOR MEDICARE HOSPICE BENEFIT

I certify that [patient name] is terminally ill with a life expectancy of six months or less if the terminal illness is an acute one.

[Signature]
(Day by physician)

Independent attending physician signature: [Signature]
(Day by physician)

Received verbal certification from Medical Director: [Date]
Received by: [Signature]

Received verbal certification from independent attending physician: [Date]
Received by: [Signature]

Additional Statement: By signing this certification, the physician, named above, confirms that he/she composed the narrative based on his/her review of the patient’s medical record or further examination of the patient.
ELECTION OF BENEFITS FOR HOSPICE CARE

provides care to meet patient/family needs when life expectancy is six months or less. The focus of hospice care is to treat the symptoms of the disease, rather than the disease itself and to enhance quality of life. The hospice care team includes the patient and family, the patient’s physician, the hospice medical director, licensed nurses, social workers, clergy, counselors, home health aides, volunteers and others. Medical, nursing and other students under the supervision of hospice staff may be involved in providing hospice care. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Attestation: I confirm that this narrative is based on my review of the patient’s medical record and/or examination of the patient.
Hospice Revenue Cycle:
Optimizing Compliance & Effectiveness

402. Hospice Revenue Cycle:
Optimizing Compliance & Effectiveness

June 30, 2015

REVENUE CYCLE PROCESSES

Intake → Eligibility & authorization → Service delivery

Documentation → Pre-billing audit → Claims submission

Claims tracking & collecting → Payment posting & reconciling → Reporting

REVENUE CYCLE PROCESSES
People-based | Task-based
---|---
Person driven | Technology driven
People & process based | Workflow & work queue based
Dependent on process flow | Dependent on system & process build
Dependent on people knowledge | Dependent on technology support
Prone to functional silos | Prone to functional silos
Prone to under utilization of automation | Prone to over utilization of automation
Internal controls & oversight critical | Internal controls & oversight critical

REVENUE CYCLE PROCESSES

Notice of election (NOE) billing requirements
- Patient election
- Physician certification, verbal
- FTF encounter, if applicable
- Initial plan of care

Claim billing requirements
- Patient status
- Month ended
- Signed & dated physician certification
- Pharmacy & infusion pump invoices
- Levels of care confirmed
- Services documented
- Nursing facility room & board

REVENUE CYCLE PROCESSES
Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

Revenue cycle processes

Senior financial leader
Revenue cycle manager

Medicare billing specialist(s)
Medicaid billing specialist(s)
Insurance billing specialist(s)
Payment posting specialist(s)
Insurance authorization specialist(s)

REVENUE CYCLE PROCESSES

Revenue cycle meetings

Marketing
Finance
Intake
Clinical
Compliance
Billing

75
76
402: Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

June 30, 2015
### Revenue Cycle Processes

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Inpatient Hospice Care</th>
<th>Revenue Analysis</th>
<th>Cash Analysis</th>
<th>Current Through 30 Days</th>
<th>Aged Accounts Receivable Analysis</th>
<th>Net Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospice Care</td>
<td>$59,265</td>
<td>$59,265</td>
<td>$59,265</td>
<td>$59,265</td>
<td>$59,265</td>
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<tr>
<td>Total</td>
<td>$118,530</td>
<td>$118,530</td>
<td>$118,530</td>
<td>$118,530</td>
<td>$118,530</td>
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<tr>
<td>Aged accounts receivable</td>
<td>$141,480</td>
<td>$141,480</td>
<td>$141,480</td>
<td>$141,480</td>
<td>$141,480</td>
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<tr>
<td>Aged accounts receivable</td>
<td>$4,100</td>
<td>$4,100</td>
<td>$4,100</td>
<td>$4,100</td>
<td>$4,100</td>
<td>$4,100</td>
</tr>
</tbody>
</table>

### Medicare Payment Analysis

- 26 Number of patients with services in July
- 15 July claims paid in August
- 11 Missed claim payments

$96,625 Estimated net revenues from July claims
- $62,908 Total payments from July claims paid in August

$33,717 Estimated missed payment opportunity

10 Net days of revenue
65% Percent of prior month revenues collected in current month

- 43 days in Medicare receivables
- Could have been further reduced by up to 10 days
- Potential improvement represents approximately $34,000 in one month's cash
### Suggested Hospice Performance Guidelines

<table>
<thead>
<tr>
<th>Metric</th>
<th>Poor</th>
<th>Average</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare days in AR</td>
<td>45 days or more</td>
<td>35 days</td>
<td>25 days or less</td>
</tr>
<tr>
<td>Total days in AR</td>
<td>55 days or more</td>
<td>45 days</td>
<td>40 days or less</td>
</tr>
<tr>
<td>Medicare AR older than 120 days</td>
<td>10% or more</td>
<td>7%</td>
<td>3% or less</td>
</tr>
<tr>
<td>Total AR older than 120 days</td>
<td>10% or more</td>
<td>8%</td>
<td>5% or less</td>
</tr>
<tr>
<td>Collections</td>
<td>Less than 100%</td>
<td>100%</td>
<td>More than 100%</td>
</tr>
<tr>
<td>Medicare write-offs</td>
<td>1% or more</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total write-offs</td>
<td>3% or more</td>
<td>2%</td>
<td>1% or less</td>
</tr>
<tr>
<td>Days to bill claims</td>
<td>More than 5 days</td>
<td>5 days</td>
<td>Less than 5 days</td>
</tr>
</tbody>
</table>

#### HOSPICE METRICS

- Where the magic happens
- Your comfort zone

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**Summary**

- June 30, 2015
CHALLENGE YOURSELF

// Assess compliance with latest regulatory requirements
// Identify potential threats to cash flow
// Conduct periodic objective claim audit
  // Randomly select 10 – 20 paid claims from past three to six months
  // Review documentation supporting claim
  // Document & quantify findings
  // Assess impact of findings
  // Implement plan of correction, if needed

QUESTIONS
402. Hospice Revenue Cycle: Optimizing Compliance & Effectiveness

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