A Day in the Life of a Hospice Medical Review Nurse

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Objectives

	At the conclusion of this session, learners will be able to:
Identify	Identify the primary contractors for CMS who may request records to be audited and top risk areas
Discuss	Discuss the audit process, including what should be included in a chart for ADR
Perform	Perform a self- audit for payment prior to billing

CMS Oversights

Medical Review Contractors

OIG Report to Congress…

- Semi-annual OIG Report to Congress reported poorly on hospices
  - 1. Lack of documented terminal prognosis to meet Medicare's requirements; this was by far the main reason for unfavorable findings
  - 2. Deficient documentation to support the level of care
  - 3. No documentation of the required F2F visit by a physician or ARNP
- Eight agencies audited
- Extrapolated dollars at risk- $4 million to $47.4 million

Who's Calling, Please?

- Multiple CMS contractors perform audits of home health and hospice claims
  - Medicare Administrative Contractors- MAC Medical Review
  - Comprehensive Error Rate Testing (CERT)
  - Supplemental Review Contractor (SMRC)
  - Recovery Audit Contractors (RAC)
  - Zone Program Integrity Contractors (ZPIC)
  - Office Inspector General (OIG)

MAC Medical Review

- They're BACK! TPE, Pre-pay reviews
  - During PHE, the MACs pressed pause, then initiated post pay reviews for 2019 and January/February 2020
  - Fall 2021 Letters sent out for Targeted Probe and Educate

What's the Difference?

- MACs use audits/medical review to ensure correct payment of claims
  - Typically, this is primarily pre-payment, since the MAC is the payer of your claims
  - At resumption of reviews, in August 2020, MACs began post-pay reviews for dates of service 1/1/19-2/29/20
  - Selects most vulnerable claims

What's the Difference

- All other contractors use post-payment audit
  - May be random (CERT)
  - May be topic driven (SMRC)
  - Highly vulnerable claims in payment safeguard contractors (UPIC, RAC)

Who Holds the Rules: Survey

- Center for Medicare and Medicaid Services (CMS)
- **Conditions of Participation (COPs) with interpretive guidelines for surveyors**
- Focus on Quality of Care- applicable to ALL patients for ALL payers

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

Who Holds the Rules: Payment

- Center for Medicare and Medicaid Services (CMS)
- **Medicare Benefit Policy Manual, Chapter 9**
- Focus is Coverage– or Payment of Services
  - Specific for the Medicare Hospice Benefit
  - What is paid for, under what conditions

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Who Holds the Rules: MACs

- CGS, NGS or Palmetto- a Medicare (CMS) Administrative Contractor (MAC)
- Who we send our Medicare bills to, and can do TPE
- Use Medicare Benefit Policy Manual Chapter 9 for decisions on payment
- **Also created the Local Coverage Determination (LCD) for further level of detail for prognostication**

Medical Review Hierarchy

6. Physician/NP visits
5. Level of Care GIP/CHC/Respite
4. Terminal Prognosis
3. POC updated q 15 days
2. Certifications/Narrative/FTF
1. Election Components

Election (418.24 and Chapter 9, 20.2.1)

Must have these components to be valid:

- Identification of the particular hospice that will provide care to the individual;
- The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;
- The individual's or representative's (as applicable) acknowledgment that the individual understands that certain Medicare services are waived by the election;
- Effective date

Election (418.24 and Chapter 9, 20.2.1)

- The individual's acknowledgment that the designated attending physician was the individual's or representative's choice.
  - The individual's designated attending physician **(if any)**. MD/DO/NP/PA
- The signature of the individual or representative.
- Information explaining the right to have a list of any "Non- related, non-covered" medications, services, or equipment
- Quality Improvement Organization (QIO) contact information for patient/representative to use if wishing to inquire re: list of "non-related and non-covered" items

Define Attending

- A physician, NP or PA who is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care and wants to maintain that primary relationship.
  - If the selected practitioner does not reciprocate, the Medical Director/ hospice physician stands alone
  - Only MD or DO can certify– so, if NP or PA was noted as attending by patient, the Medical Director (or other hospice physician) alone will certify
  - Although PA and NPs can be attending- they can not certify

The Election Addendum

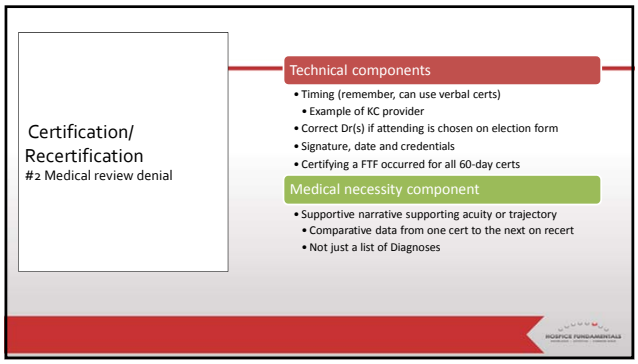
- The requirement is for the hospice to furnish an addendum listing conditions, services and items that are **unrelated** to hospice and the rationale for exclusion to the patient and family, non-hospice providers and/or MAC upon request.
- This must be **provided** within **5 days** from the start of care **if requested within five days of** start of care, or within **72 hours if requested** after the fifth day of care.
  - Ensure "Date furnished" is on your agency's addendum
- This addendum will be a condition for payment, so in the event of an ADR, the hospice should submit the signed addendum as part of any ADR if an addendum was requested. If none was requested, then the hospice can submit any documentation that reflects that there was no such request made.

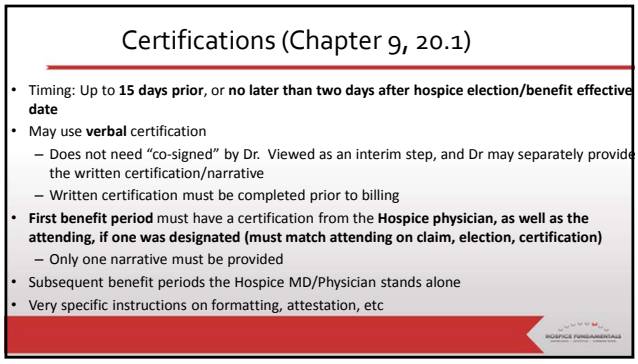
The "What If's…"

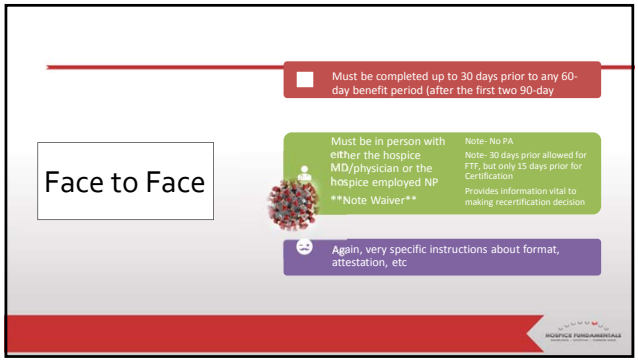
- What if it is found that no services are "unrelated" and therefore all paid for by hospice
  - CMS says to provide the Notification form anyway with that clearly documented
- What if the medications/services change and this is a patient who had asked for this document in the past?
  - CMS says the hospice is to update the information as necessary (more info is being requested in this area)

The "What If's…"

- What if my patient doesn't want to sign?
  - CMS says to inform the patient/rep that this is not an agreement, but simply a signature is to show the document was provided
  - If still not agreeable to signing, the hospice should document the conversation and provision of the form ON THE FORM ITSELF (new in FY2022!)







Let's Discuss IDG...and POC Updates

- Purpose- two fold
  - Review current plan of care- working? Not working? Update plan as appropriate.
  - Review ongoing eligibility- "Prove the case" per LCD with patient data
- "Report" ? Should already have happened

Who Holds the Keys- YOU- the IDG

- The IDG must include the 'core services'
  - RN
  - Physician
  - Social Worker
  - Counselor (spiritual care)

The TEAM must show their assessments and documentation to support technical and prognosis

POC Updates as a Condition for Payment

- All payment auditors are looking for the POC Updates to cover the dates of service being reviewed.
  - December bill selected for audit
  - IDG occurred on 12/5 and 12/19
  - Must send the 12/5, 12/19 and the last IDG in November to cover 12/1-12/4 dates
  - Looking for all of core team
    - Can be signatures, or just documentation of attendance

CERT AUDIT denials

- Submitted were copies of IDT meeting notes and attendance to support MD involvement were received for date 02/16/2017 which covered through 03/01/2017 and for date 03/16/2017 which covered through date 03/29/2017. The IDT note for 03/30/2017 **indicated MD not present nor was the MD on the attendance sheet** due to vacation. IDT sign in for 02/23/2017 had no MD and there was no note. IDT sign in for date 03/09/2017 had MD signature but there was no note. **There is insufficient documentation to support that the requirement for the WHOLE IDG/IDT updates at a minimum of every 15 days was met.** Claim denied.

#1 Denial: Terminal Prognosis Not Supported

- 84% of the denials related to "not terminal"
- Based on documentation
- Acuity or Trajectory
- Physician's narrative for recertification
- All IDT's documentation support for terminal decline

How Can Our Hospice Use LCDs?

- Provides guidelines
  - Admissions
  - Recertifications/ ongoing care
- Provides consistency
- Educational for identifying hospice-eligible patients= Referral sources
- IDT Format

Creating a "Culture of Eligibility" in Your IDT Meeting

- Be sure every clinician in your organization has a current copy of the LCD guidelines.
- Keep a copy in IDT, and review one at the beginning of every meeting; "LCD of the Week."
- Use LCD-specific worksheets for admissions and recertifications.
- Review the LCD guidelines for every admission and recertification before it is presented.

A17
A18

Four Paths of Eligibility

1	2	3	4
Meets **ALL** the Local Coverage Determination (LCD) criteria	Meets most of the LCD criteria AND has documented **rapid clinical decline**	Meets most of the LCD criteria AND has **significant comorbidities**	**Physician's clinical judgment** is that the patient has a limited prognosis
Patient presents with known diagnoses, & S/S match with LCD to support prognosis	Nutritional decline • Functional decline • Progressive deterioration while receiving appropriate care • Hospital utilization • Serial lab assessments	Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and	Clinical assessment + experience + evidence based knowledge

Levels of Care Beyond Routine

- Anytime a higher level of care beyond "Routine" is billed for, we must show the reason for each day
- Initially for GIP- the hospice shows the symptoms putting the patient in crisis
- Ongoing in GIP, must show continued need why the symptoms can not be managed on Routine care

Slide 29

A17 For #4, will you discuss the challenging of defending these claims during a government review? This is the category with the most risk associated.
Author, 5/13/2020

A18 Verbally discussing.
Author, 5/18/2020

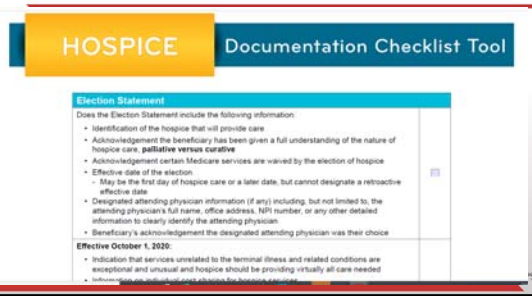
All in the Wording...

Avoid	Alternate Examples
No complaints	Interventions effective in managing (insert symptom)
Patient stable	Care needs being managed by (insert intervention)
Patient sleeping	Patient resting quietly after earlier (insert intervention)
GIP for pain management	GIP to manage uncontrolled pain in (insert location); continues to require titration of (insert med)
Requires monitoring	Condition monitored ongoing for (insert symptom)
Patient nonverbal	Requires skilled nursing assessment for nonverbal signs of pain/discomfort
Interventions effective	Effectiveness of symptom management is continuously reevaluated to achieve optimum comfort
Support given	Listened to patient express fear of dying; provided education on disease process, or similar
Complains of shortness of breath	Voiced complaint of SOB with evidence of use of accessory muscles, pursed lip breathing, unable to carry on conversation
Patient anxious	Patient asks not to be left alone, fidgeting with buttons on shirt, talking rapidly
Education provided	Explained medication changes to wife – purpose, expected outcome, side effects

Change in Condition= Change in Treatment

- Does the documentation show what was tried before?
- Does the plan of care reflect the interventions to be used to manage the patient's needs?
- Are there new treatment orders?
- Are there new medication orders?
- Are the changes effective?

Self Check!



Actions of the Prudent Hospice™

- Know the "Hot-Topics"- Who is looking at what and why?
  - MACs
  - Supplemental Medical Review Contractor
  - MedPAC and OIG influence
- Know your own risks by performing routine reviews using tools provided
  - Establish a compliance program
- Know the payment rules, on which you would be audited against
  - Chapter 9 of the Medicare Benefit Policy Manual
  - MAC LCDs

To Contact Us

Hospice Fundamentals
561-454-8121
heretohelp@hospicefundamentals.com

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