THE HOSPICE REGULATORY MERRY-GO-ROUND
HAVE YOU HAD YOUR ANTIVERT TODAY?
OBJECTIVES

• Name a current & proposed change in reimbursement for hospice.
• Define the impact of not using Debility & Adult Failure to Thrive as primary diagnoses.
• Describe two potential repercussions to the hospice industry from the growth of managed care in healthcare.
• Identify the steps that a hospice should take to stabilize their program in this environment.
WHY IS HOSPICE ON THE ENFORCEMENT RADAR SCREEN?
WHY THE INCREASED SCRUTINY FOR HOSPICE?

- Over 1.5 million Medicare patients per year
- ALOS continues to grow – 71.8 days
- The number of proprietary hospice programs is increasing
- Majority of hospice programs are proprietary
- Percentage of non-cancer patients continues to increase
- Use of GIP is increasing with longer lengths of stay
- Expenditures for the Medicare hospice benefit have increased approximately $1 billion per year

WHY IS HOSPICE ON THE ENFORCEMENT RADAR SCREEN?

• Data Mining
• Whistleblowers
• Budget pressure
• Audit contractors (ZPIC, MIC, RAC)
• Law enforcement (DOJ, OIG, Ags, MFCU) have experience with hospice investigations
• OIG audits & reports
INCREASED REGULATORY SCRUTINY
WHO'S LOOKING AT HOSPICE
MEDICARE CONTRACTORS – CA & NV

Medicare Administrative Contractor (MAC)
  • National Government Services

Comprehensive Error Rate Testing (CERT) Review Contractor (RC) –
  • AdvanceMed Corp.

Recovery Auditor (RA) –
  • HealthDataInsights – HDI

Zone Program Integrity Contractor (ZPIC) –
  • Safeguard Services, LLC
MEDICARE CONTRACTORS – CA & NV, CONT’D

State Medicaid Auditors- Medi-Cal

- DHHS

Payment Error Rate Measurement (PERM) Review Contractor (RC) –

- A+ Government Solutions

Medicaid Integrity Contractor (MIC) Review MIC –

- AdvanceMed
ZONE PROGRAM INTEGRITY CONTRACTORS
ZPICS – ZONE PROGRAM INTEGRITY CONTRACTORS

- Safeguard Services, LLC – California & Nevada
- Paid on a contractual basis rather than a contingency fee like RAs.
- Fraud detection and deterrence
- Statistics sampling and extrapolation of damages
ZPIC AUDITS ACTIVE IN HOSPICE

• Focus on:
  • ↑ Length of Stay (LOS)
  • ↑ Non-CA diagnosis
  • ↑ SNF care
  • ↑ Readmits after discharge
  • ↑ Higher levels of care – GIP & Continuous Care
• Technical and clinical compliance
• Medical necessity
HOW ZPIC AUDITS WORK

• Use data mining to target their investigations
• They establish a Relevant Time Frame (RTF), then request a sample of clinical records from the RTF
• All denials associated with the sample are then factored into a Charge Denial Rate (CDR)
• The CDR (% of ALL denials in sample) may be applied to all claims submitted for ALL patients during the RTF without further record review
ZPIC TORNADO EFFECT

- Potential for complete financial devastation
- Several hospices have had to close due to ZPIC audits
RANGE OF HOSPICE ZPIC CLAIMS

• In Safeguard Services, LLC region
• $0.00 to $112.8 million in hospice repayments
• Difference was in the eligibility documentation and medical necessity
• ZPIC & MAC to merge
• Focus will be on both Medicare & Medicaid integrity issues
• MAC would take on a broader role in program integrity activities
• Medicaid Integrity Contractors will be phased out
• Recovery Auditors will remain in place
• Medicare & Medicaid data will be a unified database
FOR WHAT ARE THEY LOOKING?
UNDERSTANDING ERRORS, WASTE, FRAUD & ABUSE

Mistakes

- Incorrect coding
- Medically unnecessary service

Inefficiencies

- Improper billing practices (e.g., up-coding)
- Billing for services that were not provided

Bending the rules

Intentional deception

- Intentional deception

Error

Waste

Abuse
HOSPICE REGULATIONS - 42 CFR 418

- Subpart A - § 418.1 - § 418.3   General Provisions and Definitions
- Subpart B - § 418.20 - § 418.30   Eligibility, Election, Duration of Benefits
- Subpart C - § 418.52 - § 418.78   Conditions of Participation: Patient Care
- Subpart D - § 418.100 - § 418.116   Conditions of Participation - Organizational Environment
- Subpart E - Reserved
- Subpart F - § 418.200 - § 418.205   Covered Services
- Subpart G - § 418.301 - § 418.311   Payment for Hospice Care
- Subpart H - § 418.400 - § 418.405   Coinsurance
THE OFFICE OF INSPECTOR GENERAL
OIG’S FOCUS ON HOSPICE

- Coverage requirements for hospice patients residing in nursing homes
- Medicare hospices that focus on nursing facility residents ("high percentage hospices")
- Marketing practices with nursing facilities
- Compliance with Medicaid reimbursement requirements
- GIP appropriateness
- Hospital-to-GIP transfers
- Duplicate drug claims (including non-covered but hospice-related medications)
During CY09 Medicare Part D paid over $33 Million for drugs of hospice patients.

These drugs included:
- Analgesics
- Antiemetics
- Laxatives
- Anti-anxiety drugs, as well as
- Prescription drugs used to treat COPD and ALS

OIG urged the education of Part D providers, hospices & pharmacies regarding proper hospice medication coverage.

Require Part D plan sponsors to develop controls to prevent paying for drugs that hospice should be covering.
• Deduct from pharmacy’s payments for analgesics provided to beneficiaries on hospice
• Pharmacies should seek payment from hospice
• There is no instruction regarding potentially unrelated analgesics
• Directs Part D plan sponsors to recoup payments back to 2011
• Hospices are beginning to receive notices from pharmacies requesting repayment for analgesics previously paid for by Part D
WHAT HOSPICES NEED TO DO REGARDING PART D REPAYMENT

• Check the patient’s medical record to determine whether the drugs were related to the terminal illness & indicated on the POC
• If related, determine if they were provided by & paid for by the hospice
• If they were related and not paid for, the hospice should reimburse the pharmacy
• If the drug was unrelated & there is documentation to support why it is not related, share that documentation with the pharmacy & Part D plan sponsor & indicate that the hospice was not the responsible party
• If you become aware of Part D blocking all drugs due to hospice, alert CHAPCA & NHPCO
• Medicare expenditures for GIP in 2011: $1.1 Billion
• 23% of beneficiaries received GIP during their stay in hospice
• 33% of beneficiary GIP stays exceeded 5 days
• 11% lasted 10 days or more
Figure 1: Percentages of GIP Stays and Medicare Spending on GIP by Setting, Calendar Year 2011

Figure 3: Average Length of GIP Stays by Setting, Calendar Year 2011

GIP CRACKDOWN

• The Federal government recently reached a $2.7 million settlement with a hospice for allegedly billing Medicare for GIP when beneficiaries actually received routine home care, which has a lower reimbursement rate
OIG’S CONCERN OVER LACK OF GIP

- 25% of hospices provided little to no GIP, respite, or continuous care
- 429 hospices only provided routine homecare in 2011
- These hospices may become the focus of scope-of-service and quality concerns
- Companion study by OIG on medical record review of 2012 claims and clinical eligibility of GIP
OIG REQUESTS GIP RECORDS

- Spring 2013 - many hospice providers received requests for GIP records
- Random sample of records from several hundred providers throughout the country
- Includes GIP provided in hospitals, SNFs, and in hospice inpatient units
- The purpose of the review is to assess the appropriateness of GIP provided in different settings
- Evaluating GIP in hospice IPUs, SNFs & hospitals
PAYMENT RELATED RISK
MAJOR RISK AREAS

Technical Risks

Clinical Risks
MAJOR TECHNICAL RISKS

- Election Statement
- Certification & Recertification
- Plan of Care
MAJOR CLINICAL RISKS

- Eligibility for hospice & General Inpatient/Continuous Care
- Discharges & Revocations
- Related vs. Not Related to the terminal illness
CERTIFICATION OF TERMINAL ILLNESS
CAUTIONS REGARDING THE TECHNICAL REQUIREMENTS FOR CERTIFICATION

• Certification of Terminal Illness and Recertification
  • Adhere to oral and written CTI requirements
  • Example - Hospice admits 6/1 and fails to obtain oral certs, written certs are not received from both physicians until 6/22 - Therefore, cannot bill 6/1 - 6/21
  • Physicians must date their own signatures
  • Print physician name under signature or have a signature identification log
ISSUES REGARDING THE TECHNICAL REQUIREMENTS FOR CERTIFICATION

• Physician Narrative Statement
  • The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less, “as evidenced by”
  • Only the certifying physician can complete the narrative
  • Be careful if the F2F is done between 16-30 days out, that the narrative is not written and recertification signed any earlier than 15 days prior to the start of the benefit period
  • F2F must occur prior to the physician recertification
DISCHARGE DUE TO MISSED F2F

- Patient not considered terminally ill for Medicare
- CMS requires Hospice to discharge the patient but can re-admit once the F2F encounter occurs
- CMS also expects hospice to continue to care for the patient at its own expense until the required F2F occurs
- Once the F2F and recertification is completed, the pt may then be readmitted to hospice
- The patient starts a new benefit period
- The hospice generates new orders, initial and comprehensive assessments and care plans
CLINICAL ELIGIBILITY
DOCUMENTING MEDICAL NECESSITY FOR HOSPICE CARE
ELIGIBILITY

• #1 Hospice Risk Area
• Does the patient meet clinical criteria?
GREATEST RISK, THE TRIPLE THREAT

- Long Length of Stay
- Non-CA Diagnoses
- Facility Based Care
On February 15, 2012, hospice company XYZ, Inc., agreed to pay $25 million to resolve allegations that it submitted false claims to federal programs for medically unnecessary continuous home care services billed at a higher rate than routine care services. As a result, XYZ, Inc., entered into a Corporate Integrity Agreement (CIA) with HHS/OIG.
MEDICAL NECESSITY = REASONABLE & NECESSARY

• Documentation is integral to supporting the medical necessity for the service
• The most clear cut way to support medical necessity in an audit is documenting medical decision-making
• Complete documentation of the IDG “thought process,” including issues being ruled out will support medical necessity and higher levels of services billed
• Not furnished primarily for the convenience of the patient, the attending physician, or another physician or supplier
MEDICAL NECESSITY

• For medical review purposes –

  • Each claim billed stands alone & requires sufficient support of the ongoing medical necessity of the hospice services being provided
  • Medical necessity is identified in the initial and ongoing comprehensive assessments
  • The plan of care should be developed based on the initial & updated assessments
  • All interventions must be in direct response to the established plan of care
“There was no indication in the submitted documentation that the beneficiary’s life expectancy was 6 months or less. There was no documentation of co morbidities that would have contributed to a short life expectancy. The documentation shows that the patient required full time custodial care, but not the services of Hospice.”

-Comments extracted from a de-identified ZPIC finding
DEBILITY & ADULT FAILURE TO THRIVE

FY 2014 HOSPICE WAGE INDEX AND PAYMENT RATE UPDATE; [CMS-1449-P]
CMS clarified that “debility” and “adult failure to thrive” should not be used as principal hospice diagnoses on the hospice claim form.

Claims will be returned to the provider (RTP) beginning Oct. 1, 2014 for a more definitive principal diagnosis.

“Debility” and “adult failure to thrive” could be listed on the hospice claim as secondary or related co-morbid diagnoses.

CMS expects providers to code the most definitive, contributory terminal diagnosis in the principal diagnosis field with all other related conditions in the additional diagnoses fields.
ICD-9 CODES TO AVOID USING AS THE TERMINAL DIAGNOSIS: 780-799

- 783.21 Abnormal weight loss
- 783.41 Failure to thrive
- 783.7 Adult failure to thrive
- 787.79 Malaise and fatigue
- 799.3 Debility, unspecified
- 799.4 Cachexia
- 799.89 Other ill-defined conditions
- 799.9 Other unknown & unspecified cause of morbidity or mortality

Along with any other code in the 780 through 799 range—but they may be listed as RELATED conditions
IDENTIFY THE PRINCIPLE HOSPICE DIAGNOSIS

• Discuss patient’s condition with the physician or medical director to determine the correct primary diagnosis

• And document:
  • **Secondary conditions**: Caused by, the primary hospice diagnosis (e.g., intractable HTN in a patient with renal CA)
  • **Related Co-morbid conditions**: Separate conditions that directly contribute to the burden of illness and resulting 6-month life expectancy

• Debility and AFTT can be utilized as secondary or related co-morbid conditions as they are likely to contribute to a life expectancy of 6 months or less and should be considered in determining eligibility
IDENTIFY THE PRINCIPLE HOSPICE DIAGNOSIS

• **Unrelated Comorbid conditions**: unrelated to, or separate and distinct from, the primary hospice diagnosis

• These may add to the burden of illness and should be identified and documented in the hospice record

• They should not be included on the hospice claims form
All Diagnoses

Primary Diagnosis or Co-Morbid Conditions that Influence Prognosis

Listed on Claim
Pay

Co-Morbid Conditions that Do Not Influence Prognosis

Not Listed on Claim
Don’t Pay
Primary and Secondary Diagnosis

- Primary Code: 332.0, Parkinson’s disease
- Other (secondary) codes: 787.20, dysphagia
- Other codes: 783.21, weight loss
- Other codes: 458.0, orthostatic hypotension
- Other codes: V12.61, history of pneumonia
- Other codes: V85.0, adult BMI below 19
DIAGNOSIS REPORTING REQUIREMENTS ON CLAIM FORM

- List the primary hospice diagnosis
- List all related “other” diagnoses
- Do not list unrelated co-morbidities
  - But be sure to list them in the clinical record
- The hospice claim includes a field for the patient’s principal hospice diagnosis, and allows for up to 17 additional diagnoses on the paper UB-04 claim, and up to 24 additional diagnoses on the 837I 5010 electronic claim
WHAT DOES HOSPICE NEED TO DO?

New Admissions

• Cease the use of debility, AFTT & other ill-defined conditions as a primary hospice diagnosis for newly admitted patients

• Select a primary diagnosis that is most contributory to the patient’s terminal disease trajectory and requires end-of-life palliative interventions

• Use other health conditions (including debility, AFTT, etc) to support the prognosis as needed
WHAT DOES HOSPICE NEED TO DO?

New Admissions (Cont’d)

• Include all prognosis-impacting conditions on the claims form
• Cover all medications & treatments for diagnoses supporting the 6 month prognosis
• If a medication is unrelated, have the medical director or hospice physician document why in the record
WHAT DOES HOSPICE NEED TO DO?

Current Patients with a Primary Diagnosis of Debility or AFTT

• Perform a census analysis to identify all patients that fall into the ICD-9 category of “Symptoms, Signs and Ill-defined conditions” (ICD9-780-799)

• Have your medical director or hospice team physician review each patient’s clinical record to identify an alternative primary diagnosis
TIPS IN SELECTING THE PRIMARY DIAGNOSIS

• Use the plan of care (POC) to see what body system requires the greatest amount of palliative interventions
• Use the drug profile to identify the issues being treated
• Ask yourself, if the patient died tomorrow, what cause of death would be listed on the death certificate
CHANGING THE PRIMARY DIAGNOSIS

- Obtain a physician order for the new diagnosis
- Obtain a new physician note that supports eligibility for the new diagnosis
- Ensure that the new diagnosis is supported by documentation in the clinical record
- Develop a new POC based on an updated comprehensive assessment
- Update the drug profile with appropriate designations of related/covered or unrelated/non-covered
- Have hospice physician document the reason for non-related medications
- Change billing codes
CHANGING THE PRIMARY DIAGNOSIS

• It is not necessary to cancel any claims already processed with the original diagnosis

• The diagnosis can be changed on the next claim, or an adjustment may be made to a prior claim if needed

• If the patient has no clear alternate diagnosis that can be supported by clinical documentation, and the POC has not changed over time to reflect end-of-life symptom management, consideration should be given to discharge the patient
EDUCATIONAL NEEDS FOR CHANGING THE PRIMARY DIAGNOSIS

• Educate all attending physicians, explaining the reason for the changes & involve them in the determination of the primary diagnosis
• Discuss these changes with staff and referral sources, including contracted nursing facilities and assisted living facilities
• Be cautious of physicians finding the next easiest diagnosis to assign their hospice patient referrals (e.g. Alzheimer’s) as the diagnosis must meet the LCD guidelines
ICD-10

- ICD–10 will replace the ICD–9 on October 1, 2014
- A critical issue associated with the transition to ICD–10 involves the matter of cross-walking between ICD–9 and ICD–10 code sets
- Obtain a 2014 coding book with the conversion tables
- Send someone from your agency to training. Many of the rules will be different
ICD-10

- Even veteran coders will need to start from scratch
- Coders need to brush up on anatomy & physiology as diagnosis coding will require more specificity of site of disease processes, including site and side of body for wound and fracture codes
- ICD-10 is owned by the World Health Organization, they will be providing guidance on use of ICD-10 codes
- It may be time to consider an external contracted coding company to assist in coding and billing
ICD-10 RESOURCES

• General ICD-10 information
  ◦ http://www.cdc.gov/hchs/about/major/dvs/icd10des.htm

• ICD-10-CM files, information, and General Equivalence Mappings (GEM) between ICD-10-CM and ICD-9-CM
  ◦ http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm

• CMS Educational Tools
  ◦ www.cms.gov/ICD10
DISCHARGE NOTIFICATION

ABN / NOMNC / DENC
FORM ACRONYMS

• **ABN** – Advance Beneficiary Notice of Non-coverage - CMS-R-131 Form (03/11)

• **NOMNC** – Notice of Medicare Non Coverage - CMS Form 10123 (revised and effective on May 1, 2012)

• **DENC** – Detailed Explanation of Non Coverage - CMS Form 10124 (revised and effective on May 1, 2012)
What Notices and Why?

Generic NOMNC – When Hospice services are being terminated.

- Services will not continue – no further action
- Services will continue – ABN is provided

DENC if appealing
WHEN TO ISSUE AN ABN

1. Ineligibility because the patient is no longer terminally ill

2. Specific items or services that are billed separately from the hospice per diem rate, such as physician services are not reasonable and necessary

3. The hospice level of care (GIP & Continuous Care) is no longer medically necessary – should only issue if patient/representative refuse to decrease level of care and wish to appeal
CR 8371 - DEMAND BILLING OF GIP LEVEL OF CARE

- CMS Publication 100-4 Claims Processing Manual, Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32)
- Occurrence Code 32 is reported on the claim with the date the ABN was provided to the beneficiary
- The services in question are submitted as covered services and when billing for both ABN related and non-ABN related services, the hospice appends the GA modifier to the line item(s) related to the ABN
- Medicare may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN
- If the GIP coverage is denied the MAC is directed to pay at the Routine Home Care rate
WHEN ABNS ARE NOT REQUIRED FOR HOSPICE

1. Revocations
2. Transfers
3. Respite care beyond 5 consecutive days
4. Emergent care not approved/coordinated by hospice
5. Medications, DME, or supplies – that may be related to the terminal illness; are deemed not part of the hospice palliative plan of care
ABN/NOMNC/DENC RESOURCES


HOSPICE QUALITY REPORTING PROGRAM

• Hospices should currently be collecting data for the QAPI Structural Measure and NQF 0209/Pain measure for all of 2013.
• Data submission deadline for 2013 data is April 1, 2014.
• 2% market basket financial penalty FY 2015 if not submitted.
• In calendar year 2014: the QAPI structural measure and NQF #0209/Pain measure will be discontinued.
• Reminder: CoP QAPI requirements remain the same.
HOSPICE ITEM SET (HIS)

• Proposed to begin the use and submission of HIS on **July 1, 2014**

• Electronic data submission on admission and discharge of every patient on or after 7/1/2014

• 7 new quality measures

• Hospices who fail to report quality data via the HIS system in 2014 will have a 2% market basket reduction for FY2016 (10/1/2015)
HOSPICE ITEM SET MEASURES

- NQF #1617 Patients Treated with an Opioid who are given a bowel regimen
- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #1638 Dyspnea Treatment
- NQF #1639 Dyspnea Screening
- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by the patient) (modified)
MEASURES

Specifications of proposed measures are found at:

National Quality Forum (NQF)
Final Report on Palliative and End of Life Measures

http://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx#t=1&s=&p=
EXPERIENCE OF CARE SURVEY

- Post-death family caregiver survey
- Proposed start date: CY2015
- January – March 2015 – “dry run” for at least 1 month to “test” conditions before public reporting of the data
- Mandatory compliance with continuous monthly data beginning April 1, 2015 through December 2015 for FY 2017 payment update
- Fewer than 50 deaths in 2014: exempt
HOSPICE EXPERIENCE OF CARE SURVEY

• 3 versions determined by location of death:
  • Home
  • Nursing Home
  • Inpatient care

• Focuses on the patient/caregiver experience of care, rather than patient satisfaction

• Includes questions about provider communication and care plus patient and family characteristics

• Hospices must contract with a vendor for survey administration and quarterly data submission
CR 8358 – ADDITIONAL DATA REPORTING REQUIREMENTS FOR HOSPICE CLAIMS

- Hospice staff visit data for GIP level of care
  - Skilled nursing facilities (site of service HCPCS code Q5004)
  - Hospitals (site of service HCPCS codes Q5005, Q5007, Q5008)
- NPI Number of Facility where Hospice Patient is Receiving Services
- Visits on Date of Death
- Injectable and Non-injectable Prescription Drugs
- Infusion Pumps
HOSPICE PAYMENT REFORM

Current models being studied by Abt Associates:

- MedPAC recommended U-shaped model
- Tiered model
- Short stay add-on, similar to home Health Low Utilization Payment Amount (LUPA)
- Case-mix model
- Rebasing the Routine HC rate
- Site of service adjustment for hospice patients in nursing facilities
CMS is soliciting proposals Under Category 1 - Models that are designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings.

CMS specifically stated during a recent Webinar that proposals designed to reduce hospice spending were being sought.

What is CMS’ goal?
- To further limit access to hospice care?
- Are they seeking ways to change the payment structure?
- Could it actually lead to greater access to hospice?

The stated goal of this round of funding is to “propose new payment and service delivery models that will provide better health, better health care, and lower costs through improved quality.”
FINAL LTC RULES FOR HOSPICE CARE

MEDICARE & MEDICAID: REQUIREMENTS FOR LTC FACILITIES; HOSPICE SERVICES; FINAL RULE – 78
FEDERAL REGISTER 124 (6/27/13) PP. 38594-38606
LTC FACILITY FINAL RULE ON HOSPICE CARE IN NURSING HOMES

- Effective 8/26/13
- Provided complimentary regulations for the LTC industry regarding how hospice patient’s care should be provided in a LTC facility
- Includes the following requirements:
  - Contract language
  - Collaboration
  - Plan of Care
  - Training
- Update your contracts & training materials with the new requirements
HIPAA OMNIBUS RULE

- Published 1/25/13

- Compliance deadline was 9/23/13

- Items needing hospice action include:
  - Conduct a risk analysis of security of PHI
  - Assure encryption specifications
  - Update policies & procedures
  - Update staff training

CALIFORNIA UPDATES
Effective Jan 1, 2013
Hospice inpatient units/homes were previously licensed as CLHF, Special Hospital: Hospice or SNF
Allows a licensed and Medicare certified hospice provider to operate a hospice inpatient facility
Providers will have the option to operate a hospice facility within the physical plant of another licensed facility; hospital or SNF
If the facility represents itself to be a hospice and uses the word “hospice facility,” or “hospice home,” it must be licensed as a hospice facility
HOSPICE FACILITY LICENSE

• Max of 24 beds
• Must have an RN 24 hr./day
• Only a licensed hospice can apply for a hospice facility license
• A HHA licensed hospice must first apply for a hospice program license
• Licensing fee will be the same as CLHF for the 1st year, $312/bed
• Hospices are required to follow Medicare COP 418.110 – Hospices that provides inpatient care directly
HOSPICES OPERATING CLHF

- Hospices that operate a CLHF may continue to do so if they remove hospice from the name and do not represent themselves as a hospice.
- If GIP is going to be provided, the hospice must be licensed as a hospice facility.
- Hospices may convert to new license by submitting an application and fee to Central Applications Unit (CAU) of CDPH. Once the completed application has been approved and surveys are performed (if required), the CDPH will issue the license accordingly.
NEW HOSPICE FACILITIES

• All new facilities that are in process of building a Hospice facility must apply for an initial license
• This is causing some confusion with the District Offices and CHAPCA is working with CDPH to clarify the process
• Hospices will need to submit their applications directly to the District Office of CDHP for review and approval of the application
• CAU will not process these applications
CDHS - UPDATED MEDI-CAL ALL PLAN LETTER

- Due to be published 10/28/13
- Clarifies the following:
  - There is no pre-authorization for hospice services, except for the GIP level of care
  - Room & board (R & B) is to be billed through the hospice and is not considered LTC, therefore the Plan is responsible for payment for R & B the entire length of hospice election
  - Plans must pay hospice at the Medicaid published rates, at a minimum
  - Identifies the Concurrent Hospice & Curative Care for Children program as well as the California Children Services for Life Limiting Condition program
THE HEALTHCARE ENVIRONMENT

- Healthcare Reform
- Budget crisis
- Sequestration & decreasing reimbursements
- Expanding managed care products
- Dual eligible demonstration projects
- Increasing mergers and acquisitions
- Increasing regulations and reporting requirements
- An aging society
- Decreasing availability of healthcare personnel
WHERE ARE THE GOOD ‘OLE DAYS
NO WORRIES, I HAVE EVERYTHING UNDER CONTROL
ALL SYSTEMS NEED MAINTENANCE
STEPS TO PROTECT YOUR PROGRAM
FALSE CLAIMS ACT

• Providers must report and return overpayments (accidentally or otherwise) to Medicare/Medi-Cal within 60 days of identifying the overpayment

• Under PPACA, failure to return an overpayment within 60 days exposes a provider to liability under the FCA
AUDIT CURRENT RECORDS

• Do not do retro-active review, you will be held to the self-reporting rules
• Hold current claims while reviewing current documentation
• Adjust claims based on the audit results
• Evaluate:
  • Technical compliance
  • Clinical eligibility
  • Medical necessity
  • Higher levels of care
  • Proper discharge notification
COMPLIANCE

• Follow the Medicare Statutes, Regulations (Conditions of Coverage & Conditions of Participation)
• Admit patients who are eligible and qualify under the LCD guidelines
• Cease the use of Debility & AFTT
• Document progressive decline
• Follow certification and recertification regulations carefully, including required physician narratives and face-to-face encounters for the 3rd and subsequent benefit periods
• Assure your physician narratives are legible & clinically support the 6-month terminal prognosis
COMPLIANCE – CONT’D

• Update contracts for HIPAA and LTC rule compliance
• Assure that your NOMNC, ABN & DENC are provided to patients in a timely manner
• Train staff well on all of the changing rules and regulations
• Monitor all mail
• Respond to ADRs and Audits timely & thoroughly
• If you become aware of an overpayment, repay it within 60 days
• Always alert your attorney of audits & overpayments
• Have strong QAPI & Corporate compliance programs
QUESTIONS
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