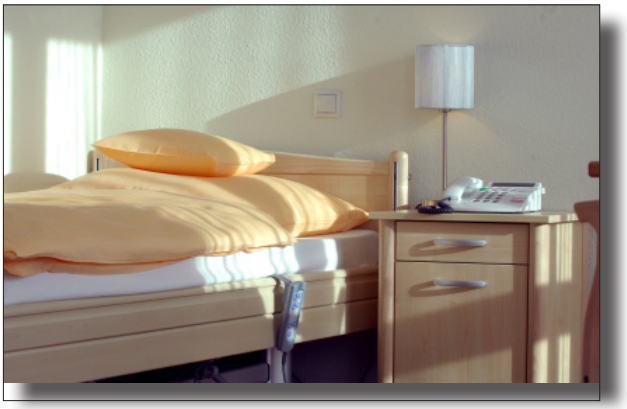
PERSPECTIVES | Whitepaper

PREPARING FOR GOVERNMENT AUDITS: HOSPICE SERVICES



INTRODUCTION

Most people would agree that the Centers for Medicare and Medicaid Services (CMS) are completely justified in seeking to ensure that the long-term and acute care services they pay for are appropriate and meet federal standards. After all, ours is a rapidly aging population that is increasingly reliant on the Medicare/Medicaid system. From a purely budgetary standpoint, it makes perfect sense to put checks and balances in place to make sure the dollars are spent where they should be.

In 2010, CMS launched its Medicare Recovery Audit Contractors program (RAC) to help do exactly that—primarily, to review care provider billings to identify and recover overpayments and, to a lesser extent, identify and reimburse for underpayments. CMS reports that, in fiscal year 2014 alone, the program had recouped $2.39 billion.

In the healthcare industry, new focus areas are being identified by the Office of the Inspector General (OIG) and CMS on a regular basis, and these same focus areas can easily become the subject of investigation by the Department of Justice. Among the areas of focus most on the radar of our long-term care clients are atypical antipsychotic medications, hospice services, and physical therapy services. In this three-part series of whitepapers, we'll take a look at each of these issues—examining how they came to be focus areas, what your organization needs to do to be in compliance with CMS standards, and what you can do now to prepare for, or respond to, audits.

HOSPICES UNDER THE MICROSCOPE

The modern hospice movement came to the United States in the early 1970s, and its utilization has grown swiftly ever since. By the late-1990s, hospice was a respected part of the healthcare landscape and a multi-billion dollar industry, with Medicare expenditures reaching $2.2 billion by 1998. The utilization of hospice care and the accompanying Medicare expenditures exploded over the following years—with Medicare payments for hospice service reaching $15.1 billion by 2013.

Throughout this period of dramatic growth, eligibility criteria for the Medicare hospice benefit have remained largely the same. Coverage is available to those who elect palliative treatment (i.e., care focused on pain relief and stress relief) rather than curative treatment, and who have a life expectancy of 6 months or less. Patients are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods. At the beginning of each benefit period, an attending physician must certify that the beneficiary is terminally ill, with a life expectancy of 6 months or less if the disease follows its normal course.

There are 4 levels of hospice care. Routine Home Care covers basic care services, including nursing and home health services, on either an inpatient or at-home basis. Respite Care is short-term inpatient care intended to relieve the patient's regular caregiver. It is meant for occasional use, and is therefore not reimbursed for more than 5 consecutive days. General Inpatient Care takes place in a hospice inpatient unit, hospital or skilled nursing facility (SNF); it is primarily for pain and symptom management that cannot feasibly be provided in other settings. Continuous Home Care is used in times of crisis when pain relief or symptom management requires constant care. Continuous Home Care is covered as necessary to maintain the patient at home or in a nursing facility.

Hospice has been a fixture in the healthcare industry for the past 40 years. So, why have hospices now found themselves in the spotlight? The answer lies in the changing nature of hospice care itself. Hospice originally began as an alternative care setting to serve cancer patients, whose life expectancies could be estimated with a high degree of reliability due to a clear understanding of the progression of their disease. Now, though, hospice service has expanded to include patients with other terminal illnesses, but whose life expectancies cannot be well estimated due to the unpredictability of their diseases. Patients now enter hospice care with conditions such as heart disease, Alzheimer's, and COPD—and this has equated to significantly longer lengths of stay. For example, in 2008, the conditions with the longest average lengths of stay were neurologic conditions (129 days), COPD (104 days), and debility (94 days). Cancer diagnoses—the original service population for hospice—had the shortest length of stay at 53 days.

Longer lengths of stay are acceptable if the patient is recertified at the beginning of each benefit period as still likely to die within 6 months. What raises red flags for the Office of the Inspector General (OIG) and CMS, however, is the fact that longer lengths of stay are of greater financial benefit to the hospice. Medicare pays a scaled daily rate for hospice care, from $147 for routine care to $855 per day for continuous care (in 2011). Despite the great difference in the daily payments, hospices actually make a higher profit during routine care days, when reimbursements are the lowest. When more intensive care is required, personnel and related direct costs for care are considerably higher. Thus, a much larger percentage of the Medicare reimbursement goes to offset these costs. But for a longer stay, when care is most intensive at the very beginning and at the very end of the stay, it's the days in between (when little direct care is needed and there are fewer direct costs) that hospices make a profit. So, the longer a patient is in hospice care, the better the financial

returns. While this is simply a fact of life in mathematical terms, it has caused OIG to examine how hospice is being used. In general, OIG and CMS question whether hospices are too broadly applying the concept of "end of life."

In its preliminary research into hospice growth and trends, OIG found evidence that the greatest growth in hospice use and related claims occurred among SNF residents. Between 2005 and 2009, Medicare saw a 70% increase in hospice expenditures among this population, while the number of SNF residents receiving hospice care increased by 40%. In 2009, OIG launched an investigation to examine the degree to which these claims met coverage requirements. Subsequent studies conducted in 2011 and 2013, revealed additional findings in regard to hospice use that, taken together with the 2009 study, have placed hospice squarely in the sights of OIG, CMS and the RACs.

2009: COVERAGE REQUIREMENTS FOR SNF HOSPICE CLAIMS

OIG's 2009 study revealed widespread issues with hospice claims. Not unlike the problems uncovered in their reviews of claims for atypical antipsychotic drugs (see our whitepaper *Preparing and Responding to RAC Audits: Atypical Antipsychotics*), documentation was lacking in a majority of claims reviewed. Thus, most of the claims did not meet requirements for reimbursement. The study found that:

- **82%** of SNF hospice claims did not meet at least one Medicare coverage requirement
- **33%** did not meet election requirements, meaning that either the medical record included no election statement at all, that the statements did not explain hospice care is palliative, that statements did not explain that patients waived Medicare coverage of some services related to their illness, or the statements contained misleading information about the right to revoke election of hospice care.
- **63%** did not meet plan of care requirements, meaning that no plan of care was included, that the plan of care was not established by an interdisciplinary group, that the plan didn't include required components (like detailed scope of service or frequency of service), or that the plan did not specify intervals for review
- **31%** of claims showed that fewer services were rendered than were outlined in the patient's plan of care, meaning either a fewer number of services were provided or services were not provided as frequently as outlined
- **4%** did not meet certification of terminal illness requirements, meaning that documentation did not specify that prognoses were for life expectancy of 6 months or less, that the prognosis was not supported by clinical information and documentation, or the certification was not signed by a physician

As with other regulatory focus areas, these findings carry the serious implication that a majority of claims are likely

erroneous in terms of CMS requirements, and are therefore eligible for recoupment by CMS. Worse yet, companies showing persistent errors may be suspected of fraud and abuse. As with other compliance issues, documentation failures may pose a catastrophic financial risk for providers.

2011: HOSPICE UTILIZATION IN SNFs

The 2009 study further showed that 31% of Medicare hospice beneficiaries lived in SNFs. A deeper examination into hospice use among this population raised additional concerns by revealing disparate enrollment and reimbursement trends for SNF residents, particularly among for-profit hospices.

- Industry-wide, **8%** (n = 263) of hospices had 2/3 or more of their Medicare patients living in SNFs. These hospices are now known as "high-percentage hospices."
- Among these high-percentage hospices, **72%** were for-profit. Industry-wide, only 56% percent of all hospices are for-profit.
- Industry-wide, for-profit hospices were reimbursed **29% more** on average per patient than non-profit providers, and 53% more than government-owned hospices.
- High-percentage hospices received an average Medicare reimbursement of **$3,182 more** per patient than their lower-percentage counterparts.
- High-percentage hospice patients' median length of stay was **3 weeks longer** than the median length of stay for typical hospice patients.
- **51%** of high-percentage hospice patients had ill-defined conditions, such as Alzheimer's disease, mental disorders or COPD, as their primary diagnosis, compared to 32% of all other hospice patients.

The OIG's findings raised concern that the high-percentage hospices may be purposely targeting SNF residents with diagnoses that require longer lengths of stay but less complex care—which equates to longer-term Medicare reimbursements and greater profits over time.

2013: HOSPICE INPATIENT UNITS

A May 2013 report also shared information on additional disparities identified by OIG. This time, those disparities involved hospice inpatient units and claims for General Inpatient Care (GIP). GIP is the second most expensive level of care, and is intended to be short-term to manage pain and symptoms when palliation cannot be achieved in other settings.

However, the report shares that length of GIP stays was notably longer in hospice inpatient units than in other settings, including SNFs:

- GIP stays were **50%** longer in hospice inpatient units than in hospitals, and 20% longer than in SNFs. Hospice inpatient GIP stays averaged 6.1 days, while hospitals had an average GIP stay of 4.1 days, and SNFs had a 4.8 day average.
- **58%** of all GIP provided to Medicare beneficiaries occurred in hospice inpatient units; hospitals provided 33% and SNFs provided 8%.
- **35%** of Medicare beneficiaries at hospices with inpatient units received GIP, compared to 12% for hospices without inpatient units.

Taken together, the findings of the 2009, 2011 and 2013 studies raise plenty of concerns for OIG and CMS about how hospice care is being delivered, by whom, and to whom.

CLAMPING DOWN: OIG RECOMMENDATIONS & IMPLICATIONS

It's not hard to understand why hospices have become a focal point for CMS. In response to its 2009 study, OIG recommended that CMS conduct targeted medical reviews to urge provider compliance with Medicare requirements. The 2011 study provided further guidance on claims that should be targeted by CMS: those from high-percentage hospices and patients with diagnoses related to long stays and less complex care. And the 2013 study shed additional light on concerns from CMS itself that GIP was being misused.

In November 2011, select RACs began reviewing test claims to assess compliance with requirements. OIG work plans from subsequent years continue to include review of hospice issues including inpatient claims, as well as claims for those receiving hospice care in SNFs.

BECOME PROACTIVE WITH YOUR DOCUMENTATION

To be in compliance, your clinical documentation must meet strict criteria, every time. It's true that auditors are looking at cases from at least 3 years past, and there is no realistic way to go back in time to ensure that proper documentation happened. So, the best option is to take a proactive approach: get a handle on what you're doing (or not doing) now, and make sure it's right going forward. The earlier you can get your own practices into alignment with compliance criteria, the better off you'll be in the long run.

Start with an objective assessment of a sample of your records that provides a look at how well you're doing overall with CMS requirements. Is the decision for hospice care fully supported in your documentation? Is patient eligibility clearly documented? Are care plans and evaluations consistently recorded?

If it sounds like a monumental task to assess a sample of your records, it doesn't have to be. Excelas has solutions available to help you take an honest and objective assessment of what you're doing. We dedicate time and human resources to complete an analysis of your documentation practices, so your staff can remain focused on more immediate tasks. In the event that you are audited, we can also help you prepare records for release or help you respond to audit findings.

EXCELAS SOLUTIONS: PROACTIVE DOCUMENTATION REVIEWS

Like any compliance issue, auditors are looking for specific information in the medical record to assess eligibility of hospice claims. Your clinical documentation is the critical foundation upon which the auditor's decisions will be made. When assessing the appropriateness of hospice services, the RACs and CMS are generally assessing whether:

- Hospice services are reasonable and necessary for the management of the pain and symptoms of the terminal illness
- The individual elected hospice care
- A plan of care is established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary groups of the hospice program
- The plan of care is established before hospice care is provided
- A certification of the individual's terminal prognosis is completed

Review of CMS-required Documentation

Excelas will review a sample of your records and provide a summary report describing whether the records contain all the specific documentation types and information required by CMS. Reviews can be customized to examine almost any criteria you specify, but a good starting point includes some or all of the following (adapted from the National Hospice and Palliative Care Organization's OIG Compliance Audit Tool):

- If election requirements have been met, including whether:
    - A signed election statement is on file
    - The election statement explains that hospice care is palliative, not curative
    - A complete explanation that the beneficiary has waived Medicare coverage of certain services related to their terminal illness

    - The election statement includes clear language about the beneficiary's right to revoke election of hospice care

- If plan of care requirements have been met, including whether:
    - A plan of care is present
    - The plan of care was established by an interdisciplinary group (IDG) whose work with the patient is documented in the medical record
    - The plan of care contains all necessary components, including a detailed description of the services to be provided (including management of discomfort and symptom relief), and scope and frequency of services needed to meet the patient's and family's needs
    - The plan of care specifies frequency of review by the IDG

- If services requirements have been met, including whether:
    - The hospice provided the number of services described in the plan of care
    - The hospice provided services as frequently as described in the plan of care
    - The medical record contains documentation of all visits for providers of each discipline and for each particular service

- If certification requirements have been met, including:
    - Certification that the individual's prognosis is for life expectancy of 6 months or less, if the illness follows its normal course
    - Clinical information and documentation in the medical record that supports the prognosis
    - Signature of the attending physician and/or hospice director

We'll provide insight into where your documentation is sufficient and where it is not meeting CMS requirements. Summary reports can be provided for individual facilities, across all facilities, or both. Like all of our work products, an internal audit for hospice services can be customized to suit your needs—get the information you need in the way that works best for you. With actionable information at your fingertips, you'll be on the path to compliance in no time.

EXCELAS SOLUTIONS: RECORD RELEASE SERVICES

In the event that you are audited and faced with preparing dozens of records for release, your first instinct may be to gather and send them as quickly as possible. While it's true that deadlines are tight, releasing disorganized, incomplete or inaccurate medical records can shed a negative light on the facility and disrupt the efficient evaluation of records by auditors.

Save your team the stress of preparing records by using Excelas' record release services. We can organize the medical record, assess its completeness, notify you of any missing record types or gaps in documentation, and ensure all pages of

the record belong to the correct person—we can even extract records from your EMR system. Within a matter of days, you can be sure that the records you release are orderly, complete and free of any "wrong patient" records.

Electronic Record Retrieval

Our medical record professionals will work remotely to extract all available portions of the record directly from your EMR system, as well as any supplemental systems you may use. We will efficiently locate and compile all the documentation needed to produce a complete medical record, saving you valuable time and resources. If your organization uses paper records in addition to your EMR, we can identify the portions of the record absent from the EMR system that are needed to compile the full record, and we can coordinate and track their retrieval.

Record Organization

Nothing can be more damaging to an audit than releasing incomplete records. Excelas' Record Organization service provides a responsive, incredibly fast overview of the medical record to ensure all key documentation types have been included. You will be alerted to any critical missing records before the chart leaves your facility. We will also organize your records so that they are chronological, indexed and easy to review—for the auditor, and for you.

Ensuring a Clean Record

Besides ensuring that you're releasing a complete record, our team can also ensure that the record is clean, free of any "wrong patient" records (e.g., records belonging to another patient/resident). You know the implications of releasing an incomplete record. But think about the additional implications of releasing records with another patient's information. Not only might that information contradict what is in your claims, but more importantly, it may raise HIPAA compliance and quality concerns.

Wrong-patient information is a common problem in records we see. Among our claims and litigation projects, 34% of records we receive for review include at least one page of "stranger" records. But when it comes to regulatory projects—the kind of projects that put a "rush to respond" burden on providers—the percentage of records released with wrong-patient information increases to nearly 43%, on average. The more records that need to be released, the higher the incidence of error becomes.

EXCELAS SOLUTIONS: RESPONDING TO ADVERSE DECISIONS

Sometimes, no matter how complete your records are, you might still receive an adverse decision or face regulatory allegations. If the best defense strategy requires an expert review, Excelas can help you keep costs under control and minimize the time expert reviews can take. Our medical analysts perform high-level data abstraction on the documents in question, providing your experts with an organized electronic record and data points already extracted for their

review. Each data point is hyperlinked to the page of the record where the pertinent information was found. Your experts can spend their time efficiently assessing the medical situation and developing their opinion, instead of sorting through extraneous information and shuffling through hundreds or thousands of pages of records.
If your team needs to understand the particulars of each patient's situation to form a response to a regulatory action, Excelas can review the records in question, pull out critical information for each patient/resident and provide unbiased summary reports outlining the medical care that was provided.

CONCLUSION

A few things seem certain. First, compliance audits are here to stay. They will come, and so will the incumbent stress of answering them. Second, appropriate medical decision-making and the proper documentation thereof is what will decide the outcome of your audit.

Assess your procedures now, whether or not you've been audited on this issue. Engage appropriate, dedicated and knowledgeable consultants and partners who can help you identify what you're doing right and where you need improvement. If you're appealing adverse decisions or answering allegations, the same holds true: work with an independent partner who can help you draw out the information that will succesfully support your claims.

Take the information your consultants provide and use it to your overall advantage, facility-wide. Educate nurses, physicians, case managers, medical record personnel and billers on what they're doing well and where they need to improve. Then, inspire your teams to follow through on it—every resident, every time.

When you need objective assistance to conduct an internal audit, prepare records for release, or respond to adverse decisions, we're just a phone call away. We've helped a growing list of clients manage their regulatory challenges. We can help you, too. *A quick, no-obligation conversation will show you the valuable difference we can make for your organization. Contact us today!*

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