4-A: Successfully Navigating Hospice Audits

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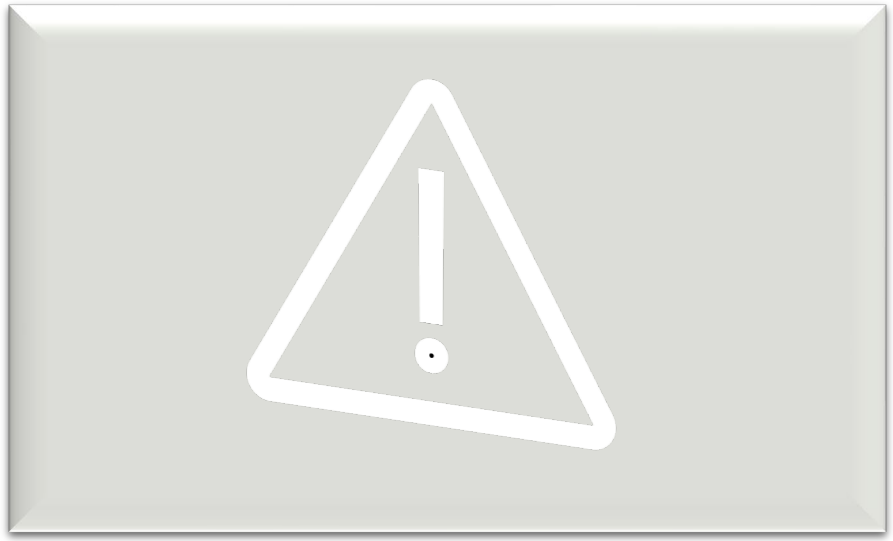
Environment

Risks

Strategies



Environment

Risks

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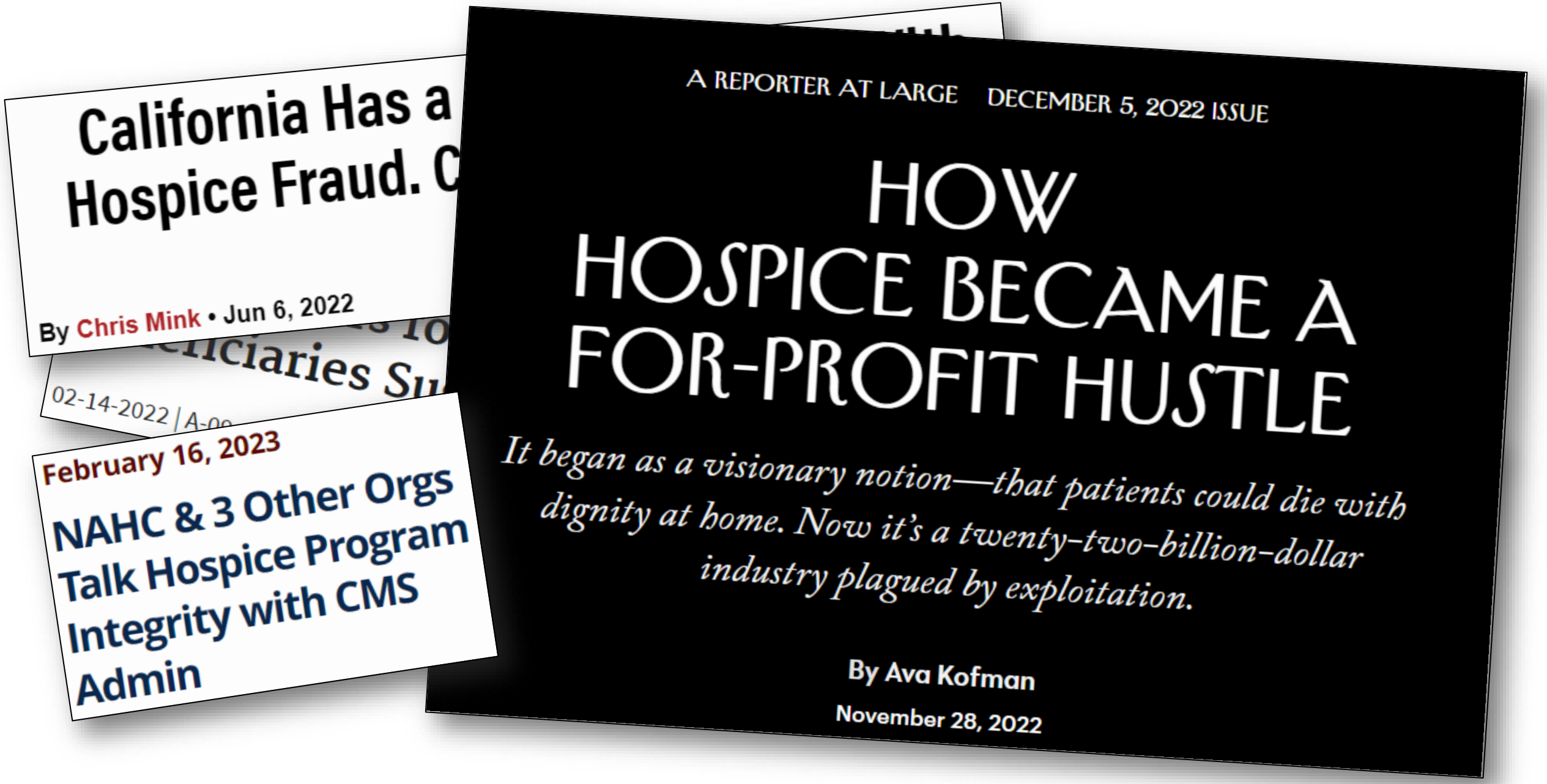

California Has a
Hospice Fraud. C
By Chris Mink • Jun 6, 2022
02-14-2022 | A-00
February 16, 2023
NAHC & 3 Other Orgs Talk Hospice Program Integrity with CMS Admin
A REPORTER AT LARGE DECEMBER 5, 2022 ISSUE
HOW HOSPICE BECAME A FOR-PROFIT HUSTLE
It began as a visionary notion—that patients could die with dignity at home. Now it's a twenty-two-billion-dollar industry plagued by exploitation.
By Ava Kofman
November 28, 2022

FIRST OPINION

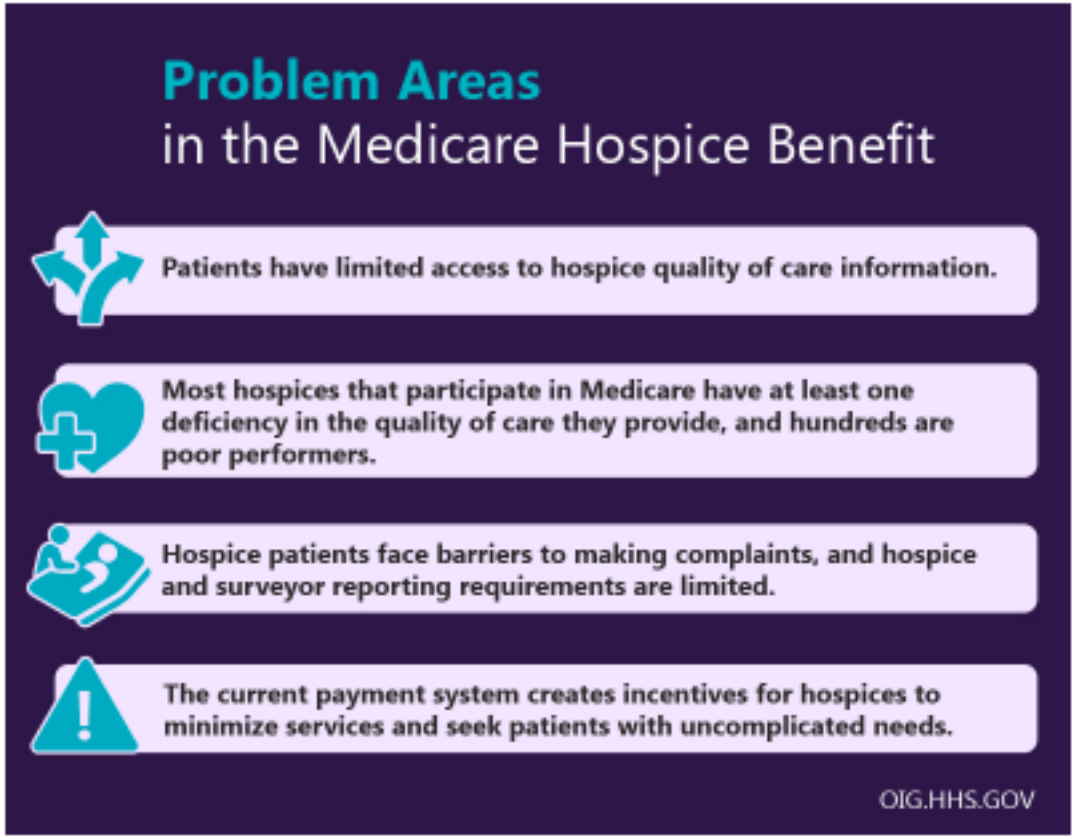
The hospice industry needs major reforms. It should start with apologies

By Ira Byock Aug. 22, 2023 Reprints

Hospice, which began in the 1970s through mid-1980s as a grassroots movement and clinical calling, has become essential to American health care. Unfortunately, along the way, hospice has fallen victim to the greed that infects American health care. Well-run hospice programs can thrive on Medicare rates, which are currently $203.40 per day. But a hospice company can make more money by avoiding high-cost, acutely ill patients while enrolling those more likely to live longer and require fewer services. The New Yorker-ProPublica investigation exposed instances of some hospice companies which recruited patients who were not terminally ill, effectively depriving them of acute medical services. More generally, corporations that put profits first also employ fewer nurses, social workers, and doctors than are necessary to effectively care for patients and families with complex needs.

Office of Inspector General – Attention on Hospice

What problems has OIG identified with the hospice program?



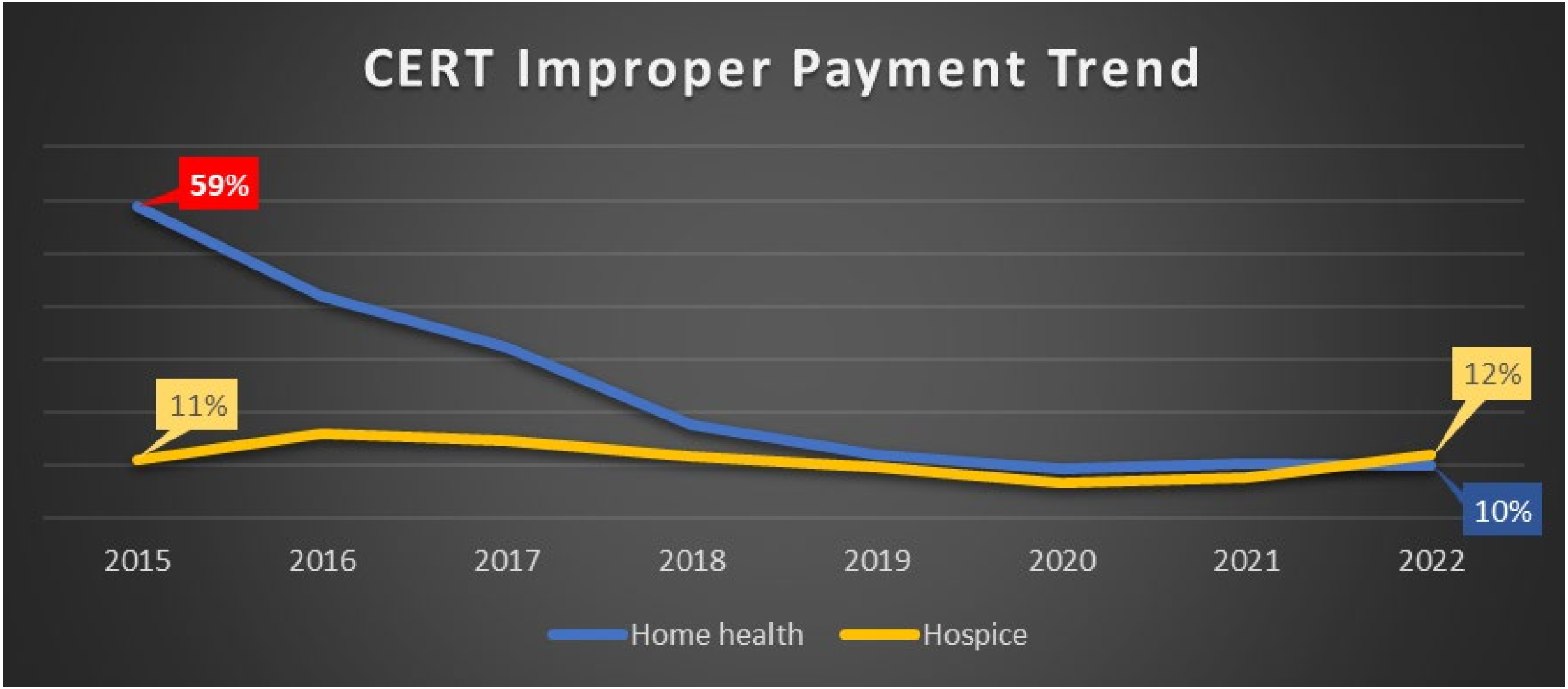
OIG's Key Priorities

- Ensuring Quality of Care and Preventing Patient Harm
- Building Transparency and Access to Information
- Promoting Accurate and Effective Billing Practices

https://oig.hhs.gov/reports-and-publications/featured-topics/hospice/

*"**CMS is looking closely at the hospice industry, as we have increasing concerns about fraud, waste and abuse in this space**. While this rule takes initial steps, this is part of a larger effort by CMS to address hospice fraud, waste and abuse that will continue this year."*

2024 CMS Proposed Hospice Payment Rule



Source: CERT improper payment reports

Table 3: Top Root Causes for Hospice

Root Cause Description	Error Category	Sample Claim Count
Physician's Certification/Recertification - Inadequate	Insufficient Documentation	34
Documentation does not support medical necessity for the service or item billed	Medical Necessity	31
Service intensity add-on (SIA) services documentation - Missing	Insufficient Documentation	18
Beneficiary election form - Inadequate	Insufficient Documentation	11
Physician narrative as part of the certification/recertification supporting terminal illness - Inadequate	Insufficient Documentation	10
Service intensity add-on (SIA) services documentation - Inadequate	Insufficient Documentation	9
Face to face documentation - Inadequate	Insufficient Documentation	7
Physician's Certification/Recertification - Missing	Insufficient Documentation	7
Face to face documentation - Missing	Insufficient Documentation	6
Physician certification was signed and dated after the claim was submitted	Other	6

Source: CERT improper payment reports

Environment |Audit Types

TPE

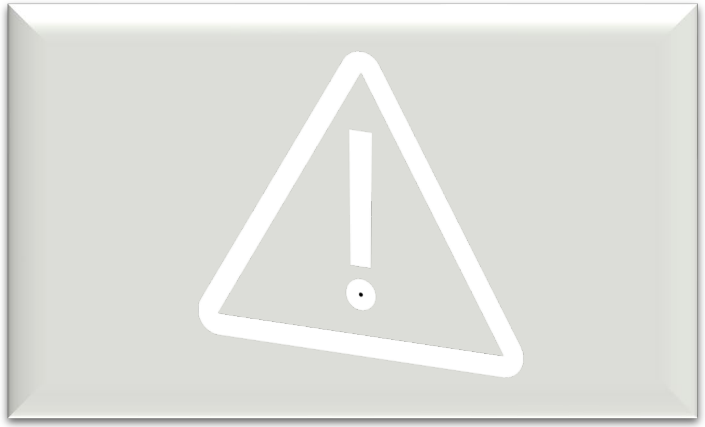
RAC

SMRC

OIG

UPIC

Environment | TPE



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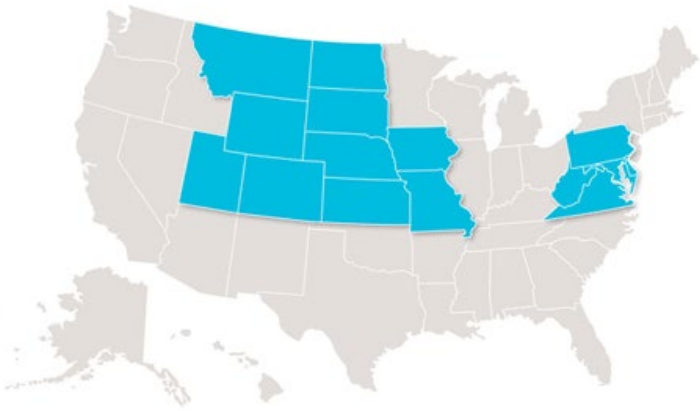
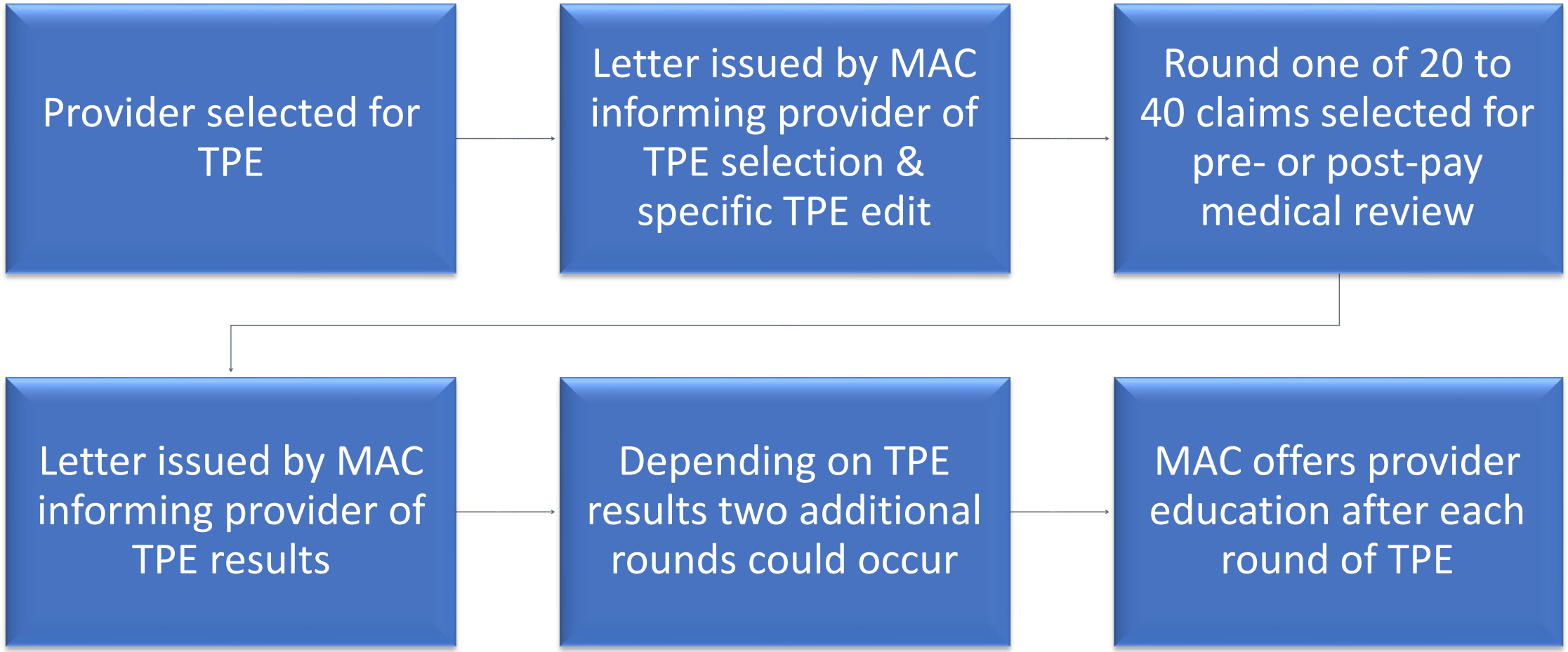
Environment | TPE

- Pre- or post-pay medical review
- Conducted by MACs
- Targeted at specific providers based on specific edits
- Up to three rounds of 20-40 claims
- Must achieve payment error rate below MAC-specific target threshold
  - CGS = 25% payment error rate



Environment | TPE



Environment | TPE

Review Topic	Edit Numbers	Description	Review Type
LOS with Non-Oncologic Diagnosis	5D000 5E000 5F000	This edit selects hospice providers who submitted claims with length of stay (LOS) >730 days and non-oncologic diagnosis code	TPE Prepayment Review
GIP LOC	5D006 5E006 5F006	This edit selects hospice providers who submitted claims with revenue code 0656 greater than or equal to 7 days	TPE Prepayment Review
New Providers	5D008 5E008 5F008	This edit selects hospice claims for relatively new providers who have submitted at least 50 claims.	TPE Prepayment Review
LOS 313-515 days	5D010 5E010 5F010	This edit selects hospice providers who submitted claims with length of stay (LOS) >730 days and non-oncologic diagnosis code	TPE Prepayment Review

Source: https://cgsmedicare.com/hhh/pubs/news/2024/05/cope156281.html

Environment | TPE

Review Process:
The TPE review process includes up to three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, CGS will refer the provider to CMS for additional action, which may include additional rounds of TPE review, 100% prepay review, extrapolation, referral to a Recovery Auditor, and/or referral for revocation. **Discontinuation of review may occur with appropriate improvement, and an error rate of <25%**, achieved during the review process.

Dear Administrator:

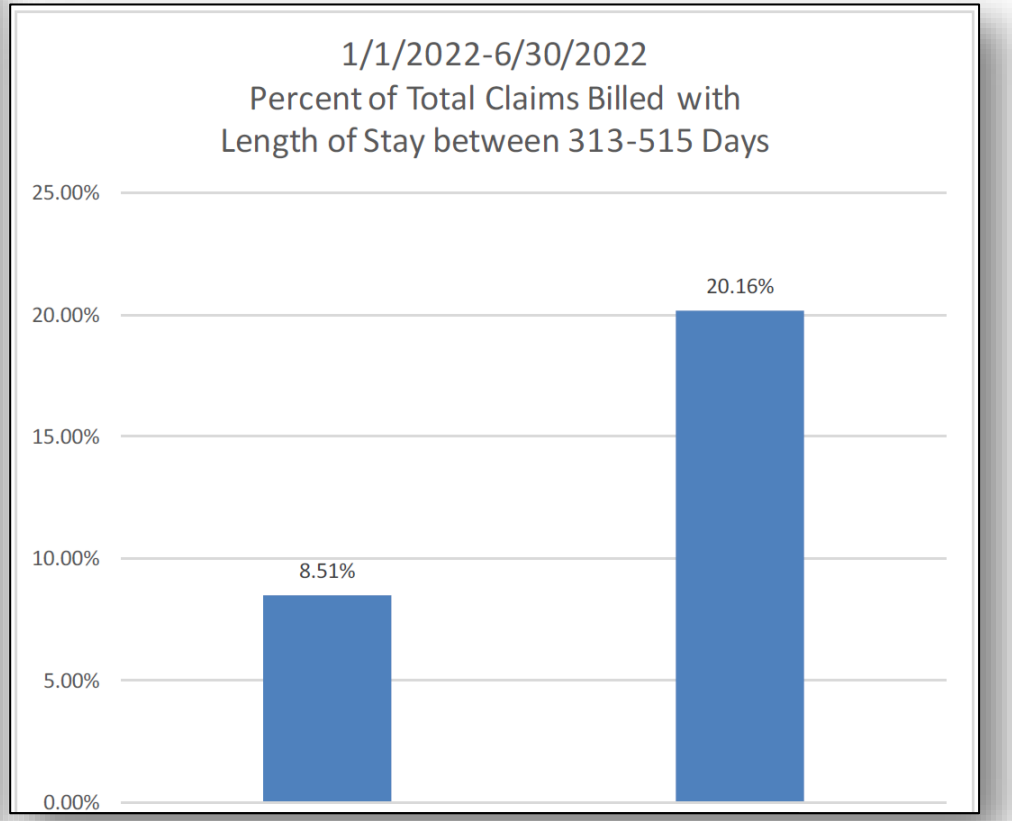
As a Medicare Administrative Contractor (MAC), CGS Administrators, LLC is required by the Centers for Medicare and Medicaid Services (CMS) to analyze claims payment data in order to identify areas with the greatest risk of inappropriate program payment. CMS has authorized Jurisdiction 15 to conduct the Targeted Probe and Educate (TPE) review process.

You have been selected for Targeted Probe and Educate Review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations. Targeted Probe and Educate Review consists of up to three rounds of review. A Prepayment sample of 20-40 claims will be selected for review with each round.

You are receiving this letter because analysis of your billing data has indicated aberrancies that may suggest questionable billing practices.

A prepayment review has been initiated to probe a sample of your claims billed with the following:

- A length of stay between 313-515 days and a from date of service on or after July 1, 2022.



Audit Environment | TPE

May 20, 2024

Targeted Probe & Educate Update: January – March 2024

The information below describes the CGS J15 Home Health & Hospice Targeted Probe & Educate (TPE) program's progress from January through March 2024.

Findings

Based on data analysis, Medical Review initiated complex review edits for specific providers that demonstrated a high risk for improper payment. CGS offered education throughout and upon completion of each round of TPE review. TPE results for home health and hospice services are listed below.

Results	5D008 Round 1	5E008 Round 2	5D010 Round 1	5E010 Round 2	5D006 Round 1	5E000 Round 2
Probes Completed	6	10	13	1	1	3
Providers Compliant after Round Completion	1	6	0	0	1	1
Providers Non-compliant after Round Completion *(advancing)*	5	4	13	1	0	2
Providers with Non-Responses to ADRs for Round	0	0	2	0	0	1
Education Contacts	13	10	21	1	2	5

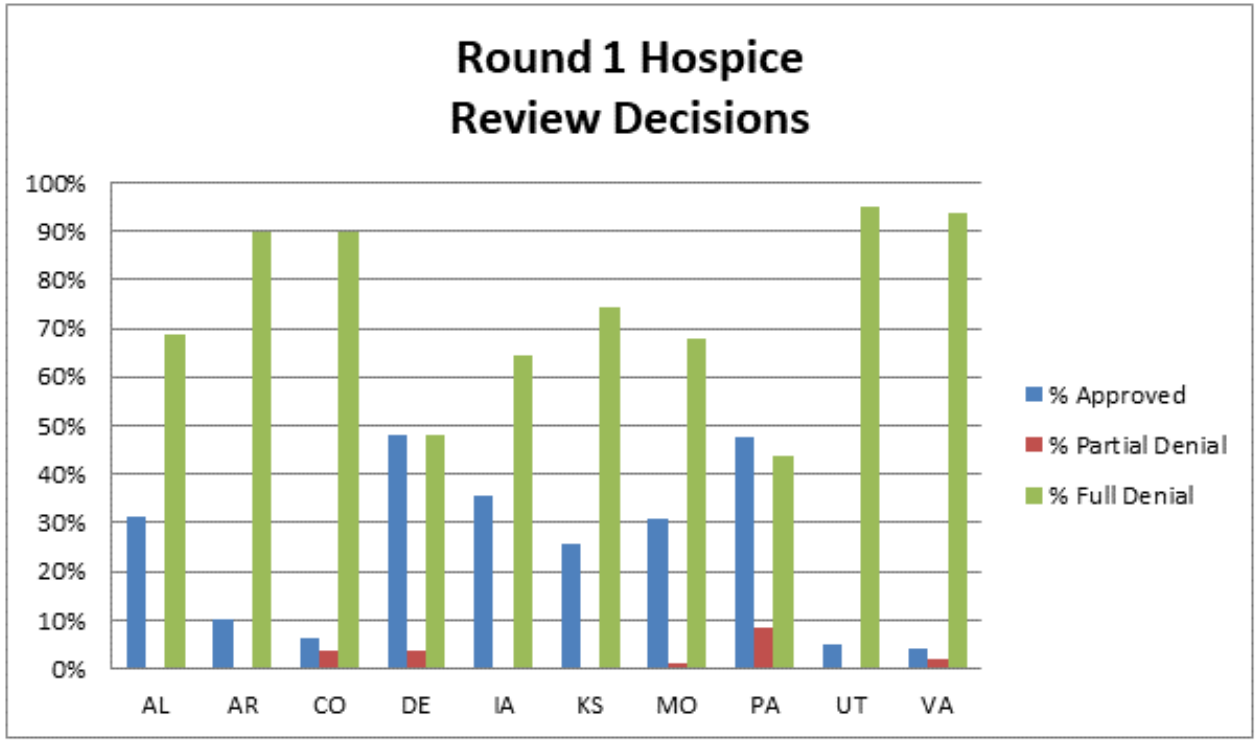
Source:
https://cgsmedicare.com/hhh/pubs/news/2024/05/cope156281.html

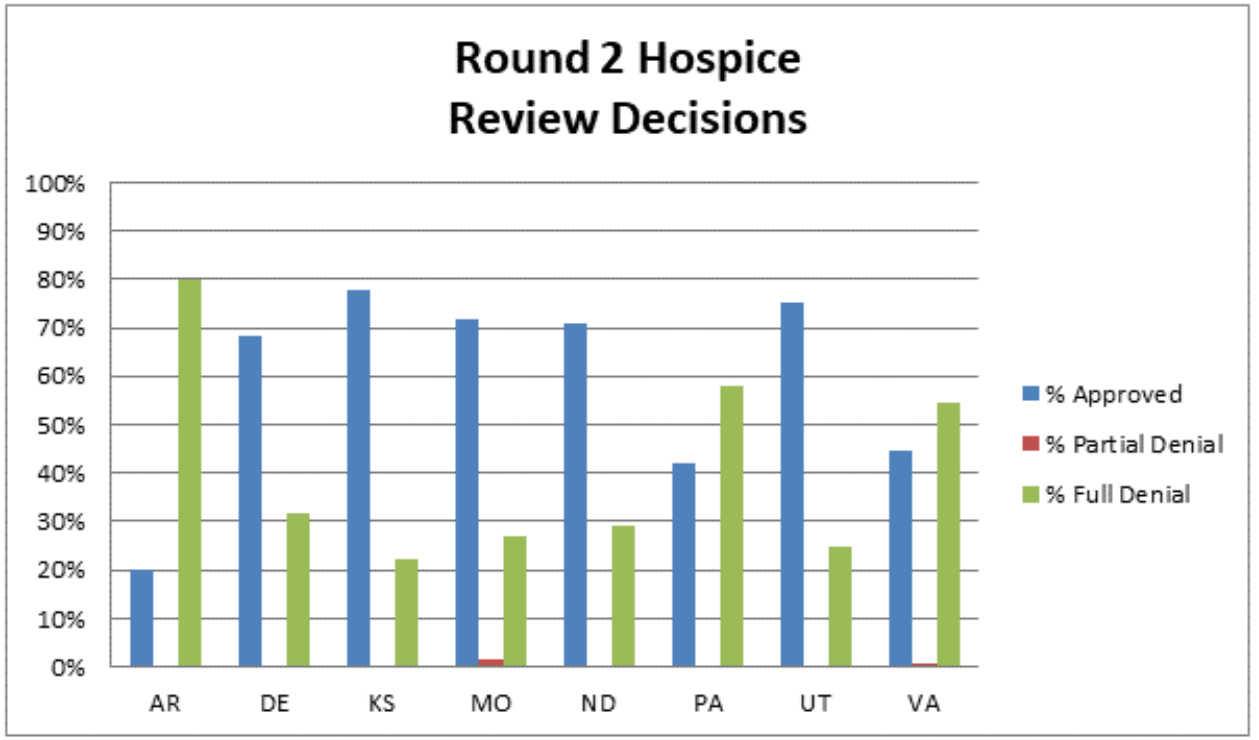
Environment | TPE

Top Denial Reason Codes (Jan – March 2024)			
Rank	**Denial Code**	**Denial Description**	**% of Claims Denied**
1	5PX06	The notice of election is invalid because it doesn't meet statutory/regulatory requirements	45.2%
2	5PM01	According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less	38.7%
3	5PX08	Face-to-Face Encounter requirements not met	5.6%
4	56900	Medical records were not received	3.3%
5	5PC01	The physician narrative statement was not present or was not valid	1.4%

Source: CGS

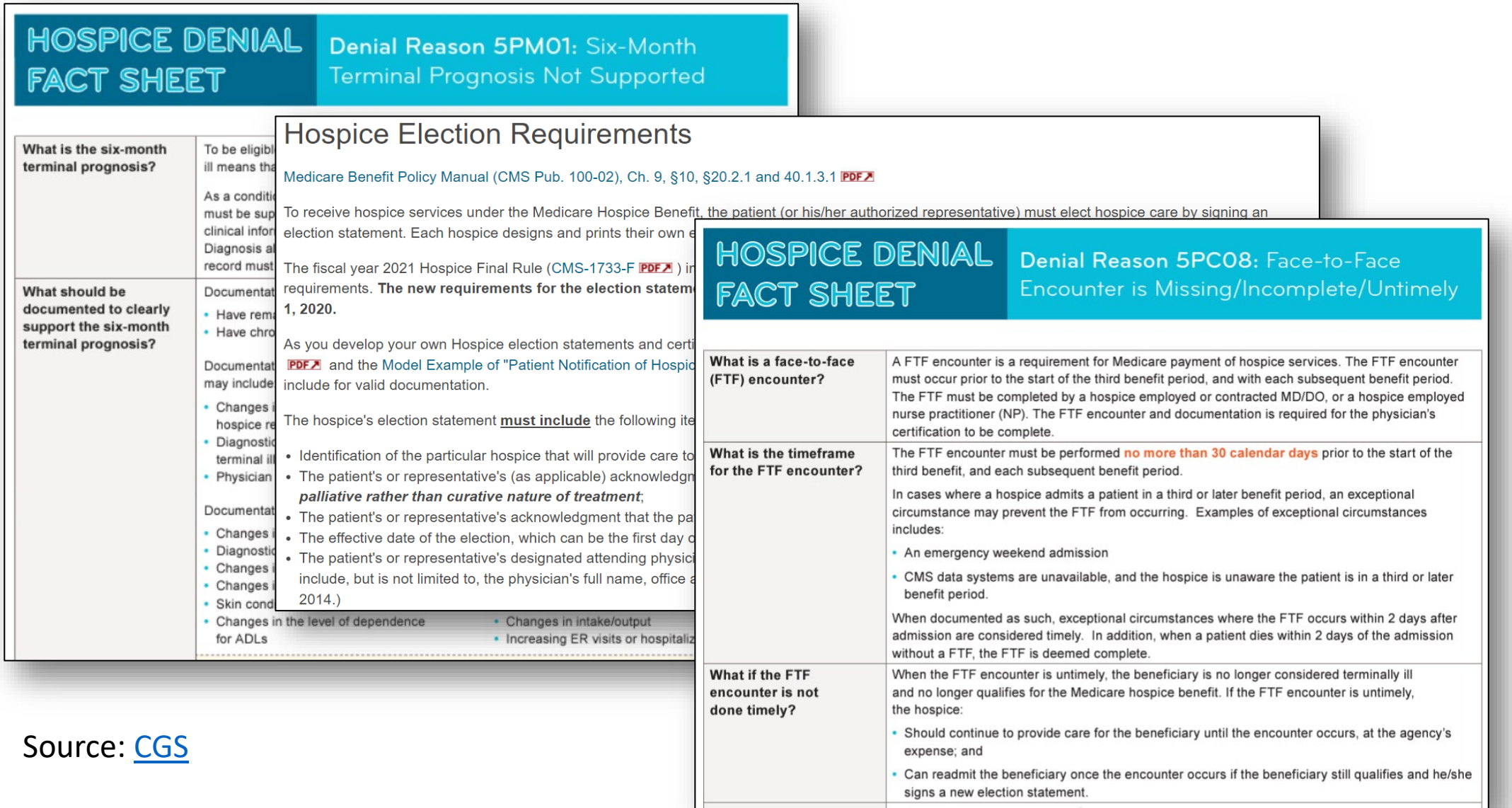
Audit Environment | TPE by State





Source: https://cgsmedicare.com/hhh/pubs/news/2024/05/cope156281.html

Environment | TPE



HOSPICE DENIAL FACT SHEET

Denial Reason 5PM01: Six-Month Terminal Prognosis Not Supported

What is the six-month terminal prognosis?	To be eligibl ill means tha As a conditi must be sup clinical infor Diagnosis al record must
What should be documented to clearly support the six-month terminal prognosis?	Documentat • Have rem • Have chro Documentat may include • Changes hospice re • Diagnostic terminal ill • Physician Documentat • Changes • Diagnostic • Changes • Changes • Skin cond • Changes in the level of dependence for ADLs • Changes in intake/output • Increasing ER visits or hospitaliz

Hospice Election Requirements

Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9, §10, §20.2.1 and 40.1.3.1 PDF

To receive hospice services under the Medicare Hospice Benefit, the patient (or his/her authorized representative) must elect hospice care by signing an election statement. Each hospice designs and prints their own e

The fiscal year 2021 Hospice Final Rule (CMS-1733-F PDF) i requirements. **The new requirements for the election statem 1, 2020.**

As you develop your own Hospice election statements and certi PDF and the Model Example of "Patient Notification of Hospic include for valid documentation.

The hospice's election statement **must include** the following ite

- Identification of the particular hospice that will provide care to
- The patient's or representative's (as applicable) acknowledgm ***palliative rather than curative nature of treatment***;
- The patient's or representative's acknowledgment that the pa
- The effective date of the election, which can be the first day c
- The patient's or representative's designated attending physici include, but is not limited to, the physician's full name, office a 2014.)

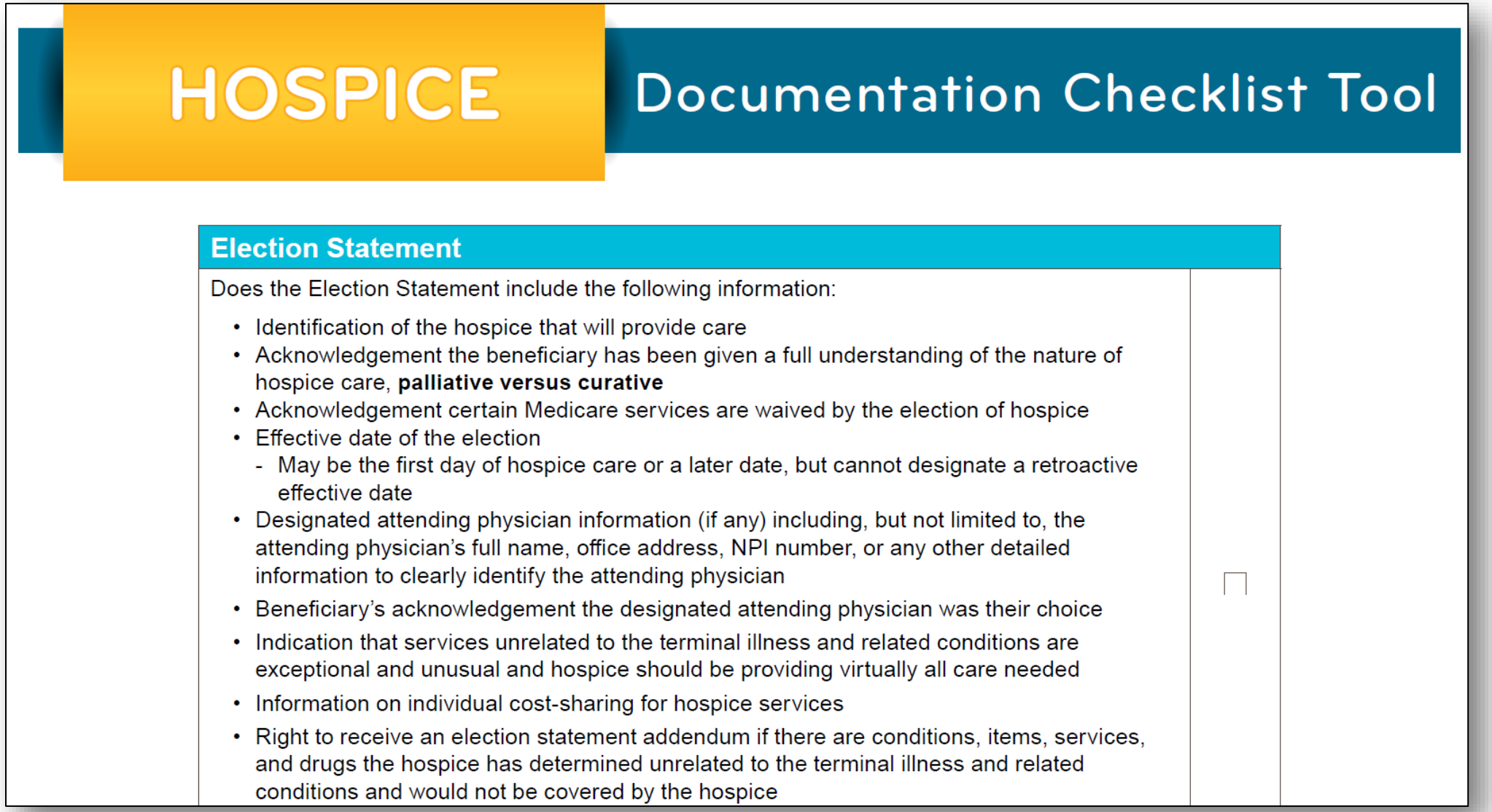
HOSPICE DENIAL FACT SHEET

Denial Reason 5PC08: Face-to-Face Encounter is Missing/Incomplete/Untimely

What is a face-to-face (FTF) encounter?	A FTF encounter is a requirement for Medicare payment of hospice services. The FTF encounter must occur prior to the start of the third benefit period, and with each subsequent benefit period. The FTF must be completed by a hospice employed or contracted MD/DO, or a hospice employed nurse practitioner (NP). The FTF encounter and documentation is required for the physician's certification to be complete.
What is the timeframe for the FTF encounter?	The FTF encounter must be performed **no more than 30 calendar days** prior to the start of the third benefit, and each subsequent benefit period. In cases where a hospice admits a patient in a third or later benefit period, an exceptional circumstance may prevent the FTF from occurring. Examples of exceptional circumstances includes: • An emergency weekend admission • CMS data systems are unavailable, and the hospice is unaware the patient is in a third or later benefit period. When documented as such, exceptional circumstances where the FTF occurs within 2 days after admission are considered timely. In addition, when a patient dies within 2 days of the admission without a FTF, the FTF is deemed complete.
What if the FTF encounter is not done timely?	When the FTF encounter is untimely, the beneficiary is no longer considered terminally ill and no longer qualifies for the Medicare hospice benefit. If the FTF encounter is untimely, the hospice: • Should continue to provide care for the beneficiary until the encounter occurs, at the agency's expense; and • Can readmit the beneficiary once the encounter occurs if the beneficiary still qualifies and he/she signs a new election statement.

Source: CGS

Environment | TPE



HOSPICE Documentation Checklist Tool

Election Statement	
Does the Election Statement include the following information: • Identification of the hospice that will provide care • Acknowledgement the beneficiary has been given a full understanding of the nature of hospice care, **palliative versus curative** • Acknowledgement certain Medicare services are waived by the election of hospice • Effective date of the election - May be the first day of hospice care or a later date, but cannot designate a retroactive effective date • Designated attending physician information (if any) including, but not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician • Beneficiary's acknowledgement the designated attending physician was their choice • Indication that services unrelated to the terminal illness and related conditions are exceptional and unusual and hospice should be providing virtually all care needed • Information on individual cost-sharing for hospice services • Right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined unrelated to the terminal illness and related conditions and would not be covered by the hospice	☐

Source: CGS

Audit Environment | TPE

Model Example of Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ **(Patient Name)** choose to elect the Medicare hospice benefit and receive Hospice services from _____ **(Name of Hospice Agency)** to begin on _____ **(Start of Care Date)**.

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Source: CMS, March 2024

Audit Environment | TPE

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician

☐ I acknowledge that my choice for an attending physician is:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Source: CMS , March 2024

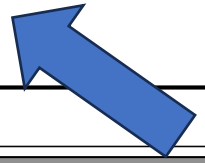
Audit Environment | TPE

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: _____

BFCC-QIO Phone Number or Website: _____



Source: CMS , March 2024

Audit Environment | TPE F2F Missed

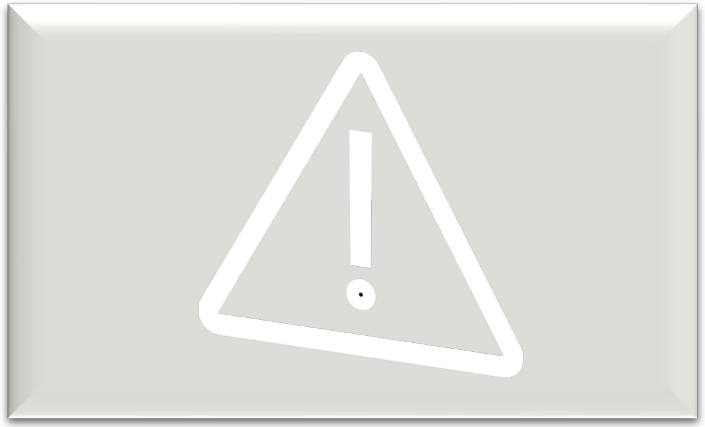
Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. The statute requires a complete certification or recertification in order for Medicare to cover and pay for hospice services. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.

The hospice must file written certification statements and retain them in the medical record. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

These requirements also apply to individuals who had been previously discharged during a benefit period and are being recertified for hospice care.

Source: CMS Benefit Policy Manual

Environment | RAC



TPE

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Environment | RAC

PERFORMANT

CMS APPROVED AUDIT ISSUES

ISSUE NAME	ISSUE NUMBER	REVIEW TYPE	PROVIDER TYPE	REGION	STATE	DATE APPROVED	DETAILS
Hospice Care-Extended Length of Stay: Medical Necessity and Documentation Requirements	_0221	Complex	Hospice	Region-5	Nationwide	12/1/2023	details
Hospice General Inpatient Care: Medical Necessity and Documentation Requirements	_0212	Complex	Hospice	Region-5	Nationwide	4/1/2023	details
Hospice Continuous Home Care: Medical Necessity and Documentation Requirements	_0201	Complex	Hospice	Region-5	Nationwide	2/1/2021	details

Environment | RAC

HOSPICE CARE- EXTENDED LENGTH OF STAY: MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENTS

ISSUE NAME: Hospice Care- Extended Length of Stay: Medical Necessity and Documentation Requirements

ISSUE NUMBER: _0221

REVIEW TYPE: Complex

PROVIDER TYPE: Hospice

REGION: Region-5

STATE: Nationwide

DATE APPROVED: 12/1/2023

DATES SERVICE: Claims having a "claim paid date" that is more than 3 years prior to the ADR date will be excluded.

DESCRIPTION: This review will determine if billed Hospice Care with Extended Lengths of Stay was reasonable and necessary. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment.
Affected codes:
REV Codes
- 0651- Routine Home Care
- 0652- Continuous Home Care
- 0655- Inpatient Respite Care
- 0656- General Inpatient Care

REFERENCES: 1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §§1812(a)(4), (a)(5), and (d)- Scope of Benefits.
2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1813(a)(4)(A)- Deductibles and Coinsurance.
3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, §1814(a)(7)- Conditions

Source: Performant

Environment | RAC

Issue Name	Review Type	Provider Type	MAC Jurisdiction	Date Approved
0105-Physician Services during Hospice Period: Unbundling	Automated	Professional Services	All A/B MACs	2018-08-07
0114-Durable Medical Equipment Billed during Hospice Period: Unbundling	Automated	DME Physician, DME Supplier	All DME MACs	2018-10-15
0122-Outpatient Service Related to Hospice Diagnosis: Unbundling	Automated	Outpatient Hospital	All A/B MACs	2018-11-06
0163-Ambulance Services Billed during Hospice: Unbundling	Automated	Laboratory/Ambulance	All A/B MACs	2019-07-02

Source: CMS

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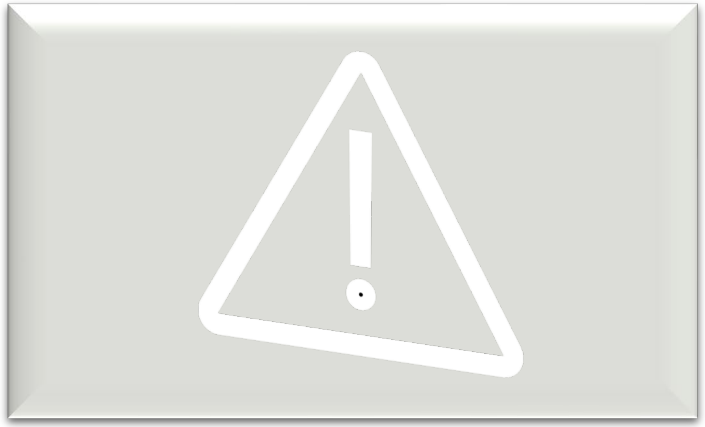
☐ I acknowledge that my choice for an attending physician is:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Source: CMS , March 2024

Environment | SMRC



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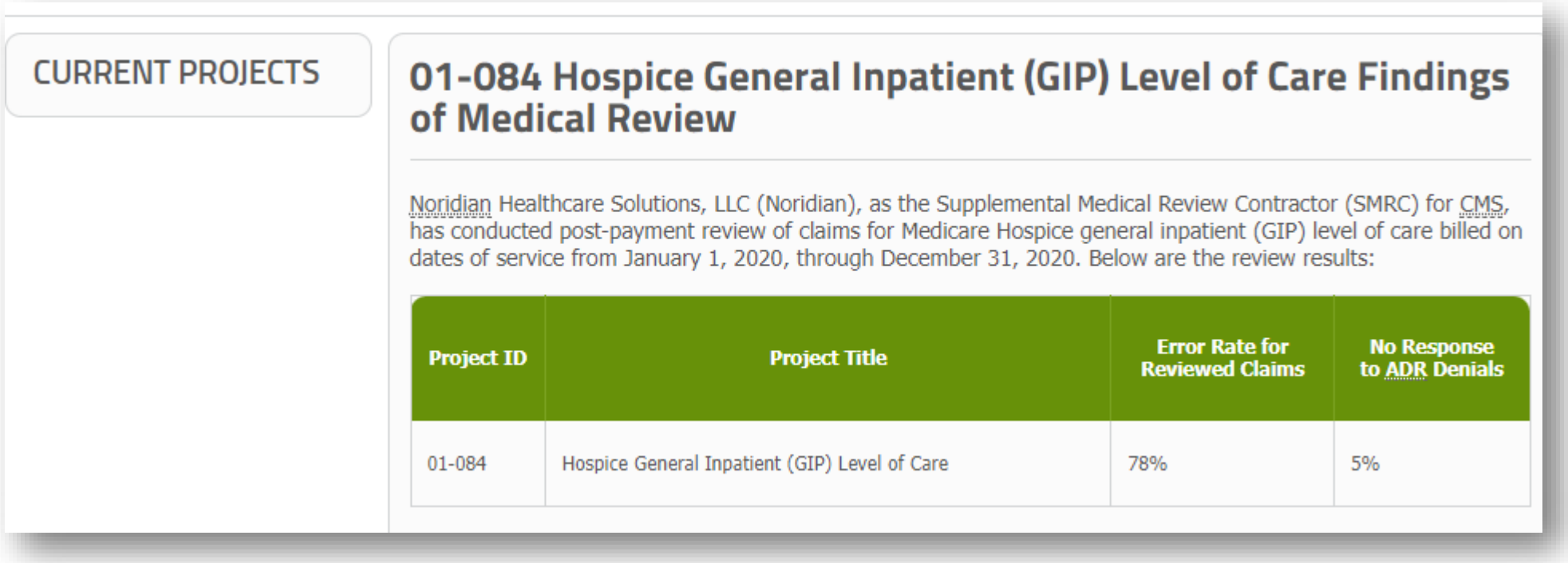


CURRENT PROJECTS

01-084 Hospice General Inpatient (GIP) Level of Care Findings of Medical Review

Noridian Healthcare Solutions, LLC (Noridian), as the Supplemental Medical Review Contractor (SMRC) for CMS, has conducted post-payment review of claims for Medicare Hospice general inpatient (GIP) level of care billed on dates of service from January 1, 2020, through December 31, 2020. Below are the review results:

Project ID	Project Title	Error Rate for Reviewed Claims	No Response to ADR Denials
01-084	Hospice General Inpatient (GIP) Level of Care	78%	5%

Common Denial Reason

- Medical Necessity
- Insufficient Documentation
- No Inpatient Facility Documentation

Source: Noridian

Audit Environment | SMRC

Background

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services published a portfolio report (OEI-02-16-00570) in July 2018 titled, "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity," which identified that Medicare paid hundreds of millions of dollars to hospices that billed inappropriately for higher levels of care when the beneficiary did not need it. Reviews were conducted of individual hospices and found improper payments ranging from $447,000 to $1.2 million for services not meeting Medicare requirements.

According to the Comprehensive Error Rate Testing (CERT) report, the projected improper payment amount for hospice during the 2021 report period was $1.7 billion, resulting in an improper payment rate of 7.8% for hospice services.

GIP care is one of the four levels of hospice care provided for pain control and symptom management. To be considered GIP, the care must be provided in an inpatient facility and cannot be managed in other outpatient settings. GIP level of care is intended to be short-term and may only be provided in a Medicare-certified hospice unit, hospital, or a skilled nursing facility (SNF).

Last Updated Nov 13, 2023

Source: Noridian

Environment | SMRC

CMS determines review topics and time frames, and assigns the focus project to the SMRC (Noridian) via a formal notification. Noridian sends affected providers/suppliers an Additional Documentation Request (ADR) letter and, upon receipt of returned medical records and/or supporting documents, conducts the review based on the analysis of national claims data and in accordance with statutory, regulatory and sub regulatory coverage, coding, payment, and billing requirements.

Project Review Types

- **Healthcare Fraud Prevention Partnership (HFPP) Support Review** – Review based on fraud, waste, and abuse trends identified by the HFPP
- **Program Integrity (PI) Support Review** – Claim review focused on possible falsification or other evidence of alterations of medical record documentation including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries; evidence that service billed for was actually provided and/or provided as billed; or, patterns and trends that may indicate potential fraud, waste, and abuse
- **Provider Compliance Group (PCG) Review** – Claim review based on evaluation of beneficiary's information and supporting medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements

Access current projects below.

If the project is not listed, please see the Completed Projects.

NOTE: At CMS discretion, not all projects will be made available on this website.

Project ID	Project Title
01-116	OIG Epidural Steroid Injections
01-119	Home Health Second Certification Period
01-121	Nail Avulsions
01-123	Nerve Block Injections
01-125	Cataract Surgery
01-127	Outpatient Therapy Reviews Below the Threshold
12-001	CAA Telehealth Services

Source: [Current Projects - Noridian - SMRC (noridiansmrc.com)]

Audit Environment | SMRC

01-099 Hospice 90 Day Stay Findings of Medical Review

Noridian Healthcare Solutions, LLC, (Noridian), as the Supplemental Medical Review Contractor (SMRC) for the CMS, has conducted post-payment review of claims for Medicare Part A hospice billed on dates of service from January 1, 2021, through December 31, 2021. Below are the review results:

Project ID	Project Title	Error Rate for Reviewed Claims	No Response to ADR Denials
01-099	Hospice 90 Day Stay	16%	11%

Source: Noridian

Last Updated Mar 19, 2024

Audit Environment | SMRC

Background

Hospice is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus of care from curative to comfort care for pain relief and symptom management of a beneficiary's terminal illness.

Routine home care (RHC) is one of four levels of hospice care and is provided within the beneficiary's home when the beneficiary is not in crisis. To be eligible for hospice, the beneficiary must be entitled to Medicare Part A, elect hospice care, and be certified as terminally ill, with a prognosis life expectancy of six months or less if the terminal illness runs its normal course.

According to the 2022 Medicare Fee-for-Service Supplemental Improper Payment Data report, the projected improper payment amount for hospice was $2.9 billion, resulting in an improper payment rate of 12.0 percent. In addition, CMS internal data has identified a potential area of vulnerability, beginning with the second benefit period, or 91st day in hospice.

Source: Noridian

Last Updated Mar 19, 2024

Audit Environment | SMRC

Reason for Review

The SMRC was tasked to perform data analysis and conduct medical record review activities. The SMRC performed medical record review on Part A hospice claims, specifically the second benefit period, with dates of service (DOS) January 1, 2021, through December 31, 2021.

The SMRC conducted medical record reviews in accordance with applicable waivers, flexibilities, statutory, regulatory, and sub-regulatory guidance.

Source: Noridian

Last Updated Mar 19, 2024

Audit Environment | SMRC

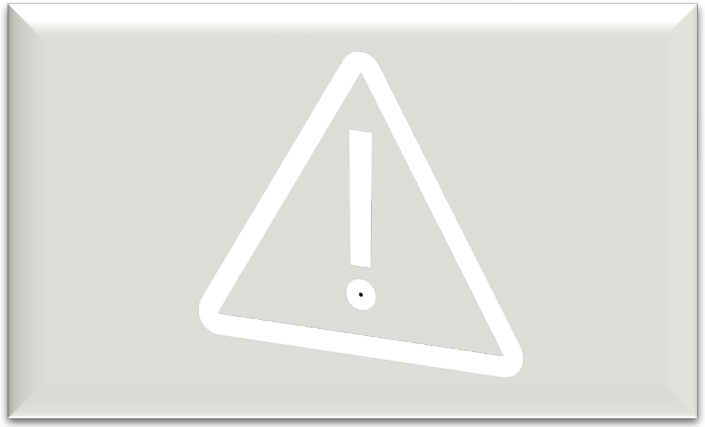
Common Reasons for Denial

- **Medical Documentation Not Received**
  - **Invalid Election Statement**
    - Section 418.24 of 42 CFR, contains requirements for a valid election statement including the hospice providing the beneficiary's care, the beneficiary's or representative's (as applicable) acknowledgement of receipt of a full understanding that hospice is palliative rather than curative care, the beneficiary's or
  - **Election Statement Not Received**
    - Social Security Act 1861(d)(1) requires a valid election statement for admission to hospice. Also refer to 42 CFR, § 418.24 and 424.5(a)(6). "The election statement for this beneficiary was not received as requested." Documentation submitted did not include an election statement to support the claim.

Source: Noridian

Last Updated Mar 19, 2024

Environment | OIG



TPE

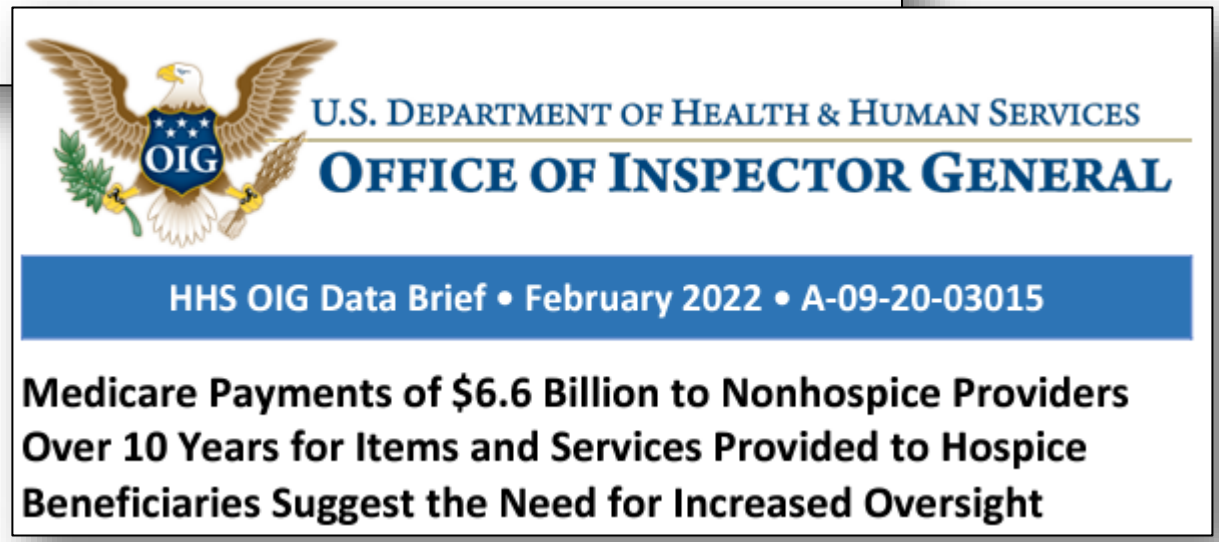
RAC

SMRC

OIG

UPIC

Environment | OIG



Source: OIG

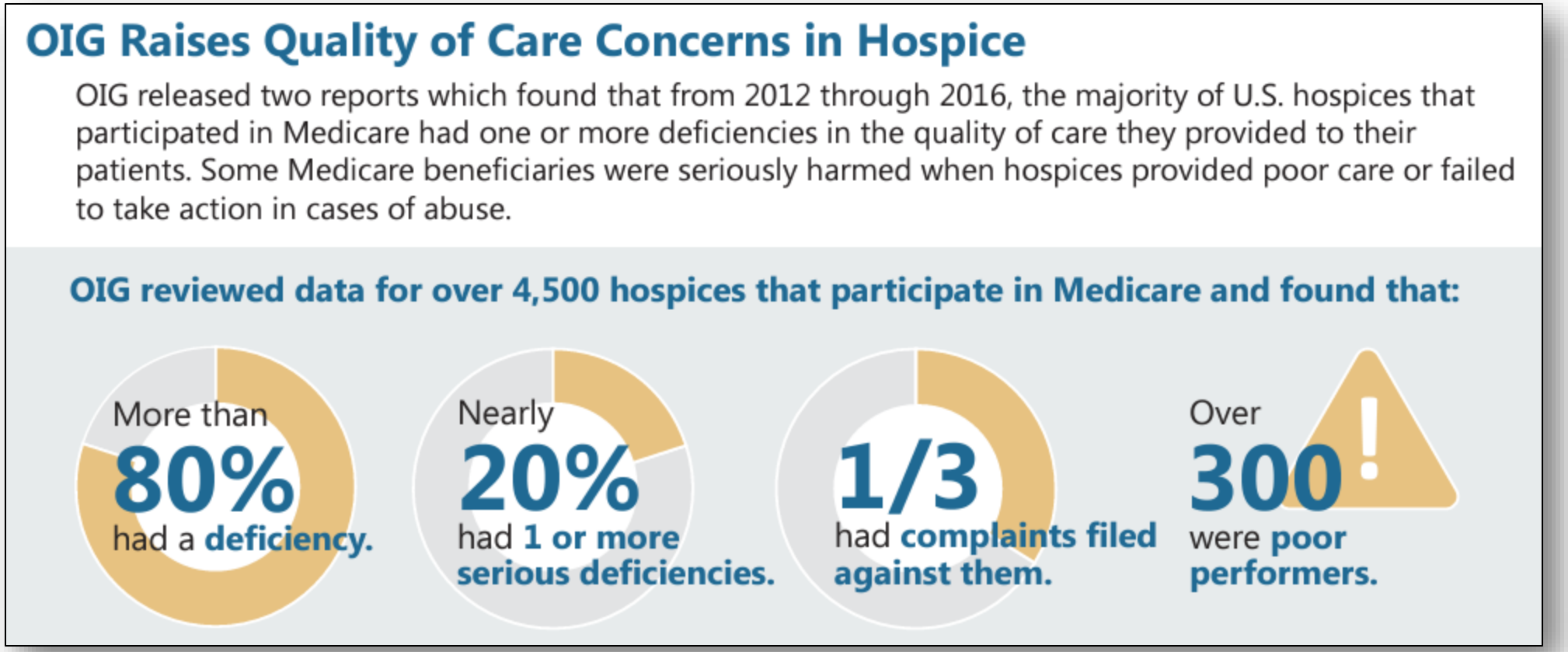
Environment | OIG

Review of Hospices: Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. 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 and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Source: OIG

Audit Environment | OIG



Source: OIG

Audit Environment | OIG

Review of Hospices: Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. 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 and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Source: OIG

Audit Environment | OIG

Month/ Year	Hospice Provider	OIG Overpayment Estimate
11/2020	Hospice Compassus of Payson, Arizona	$1,800,000
12/2020	Hospice Compassus of Tullahoma, Tennessee	$3,400,000
05/2021	Suncoast Hospice	$47,400,000
05/2021	Alive Hospice	$7,300,000
05/2021	Ambercare Hospice	$24,600,000
05/2021	Franciscan Hospice	$13,000,000
06/2021	Professional Healthcare at Home	$3,300,000
06/2021	Northwest Hospice	$3,900,000
07/2021	Partners in Care	$11,200,000
07/2021	Mission Hospice & Home Care	$10,500,000
07/2022	Vitas Healthcare Corporation of Florida	$140,000,000
09/2022	Hospice of Palm Beach County	$42,300,000

Source: OIG

Audit Environment | OIG

Audit of Selected, High-Risk Medicare Hospice General Inpatient Services

Medicare pays hospices a daily reimbursement rate for each day an individual is enrolled to receive the hospice benefit. The reimbursement rate for hospice general inpatient (GIP) care is the second-highest daily rate that Medicare pays for hospice services. GIP care is provided only for pain control or acute or chronic symptom management that cannot be managed in other settings. It is intended to be short-term care. For this audit, we will focus on claims for enrollees who were transferred to GIP care immediately after an inpatient hospital stay for a period during which the enrollee's inpatient stay reached or exceeded the geometric mean length of stay for the assigned diagnosis-related group. These hospice GIP claims are at high risk for inappropriate billing because GIP care may exceed an enrollee's needs or may not be provided. We will determine whether hospice providers that billed for GIP care complied with Medicare requirements.

Expected Issue Date (FY)
2025

Source: OIG

Audit Environment | OIG

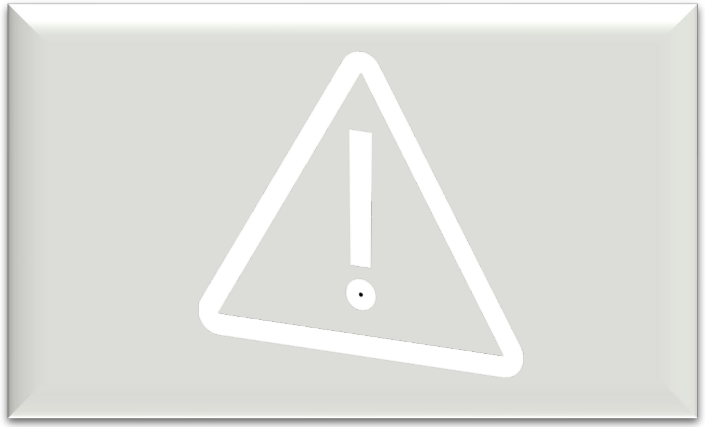
Nationwide Review of Hospice Beneficiary Eligibility

Hospice care can provide comfort to beneficiaries, families, and caregivers at the end of beneficiaries' lives. To be eligible for hospice care, they must be entitled to Medicare Part A and be certified as being terminally ill. The certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group, and the beneficiaries' attending physician, if they have one, regarding the normal course of their illness. OAS has performed several compliance audits of individual hospice providers in recent years, and each of those audit reports identified findings related to beneficiary eligibility. We will perform a nationwide review of hospice eligibility, focusing on those hospice beneficiaries that haven't had an inpatient hospital stay or an emergency room visit in certain periods prior to their start of hospice care.

Expected Issue Date (FY)
2024

Source: OIG

Environment | UPIC



TPE

RAC

SMRC

OIG

UPIC

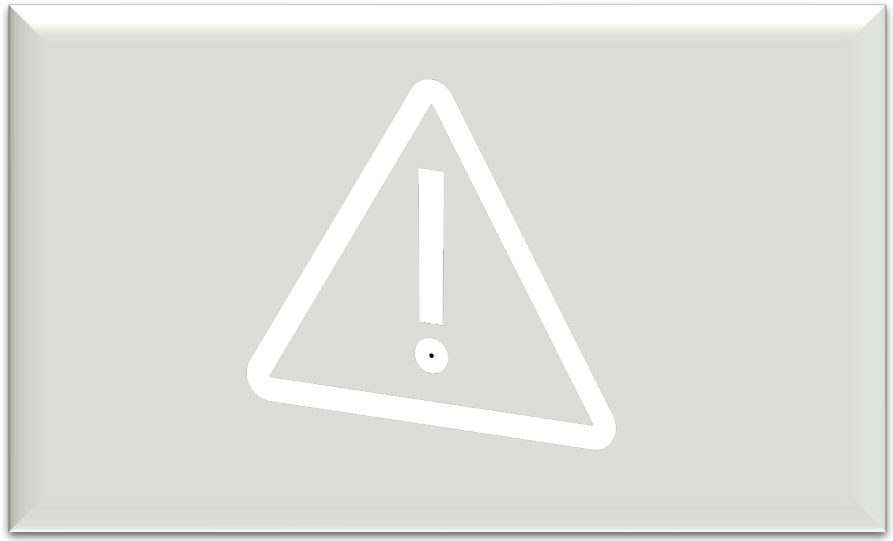
Environment | UPIC

Re: Provider Education Letter
Provider Specialty: Home Health
Date of Service Range: 03/17/2022-10/12/2022
Number of Claims Reviewed: 15
Number of Claims Denied: 11
Error Rate: 73.3%

Dear xxxxxx:

In order to fulfill its contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Qlarant Integrity Solutions, LLC ("Qlarant"), the Unified Program Integrity Contractor, performs analyses and/or reviews to determine whether the services billed by and paid to providers/suppliers are reasonable and necessary. All billed services should be in full compliance with the qualifying criteria for Medicare coverage of services to eligible beneficiaries by appropriately qualified and licensed providers/suppliers.

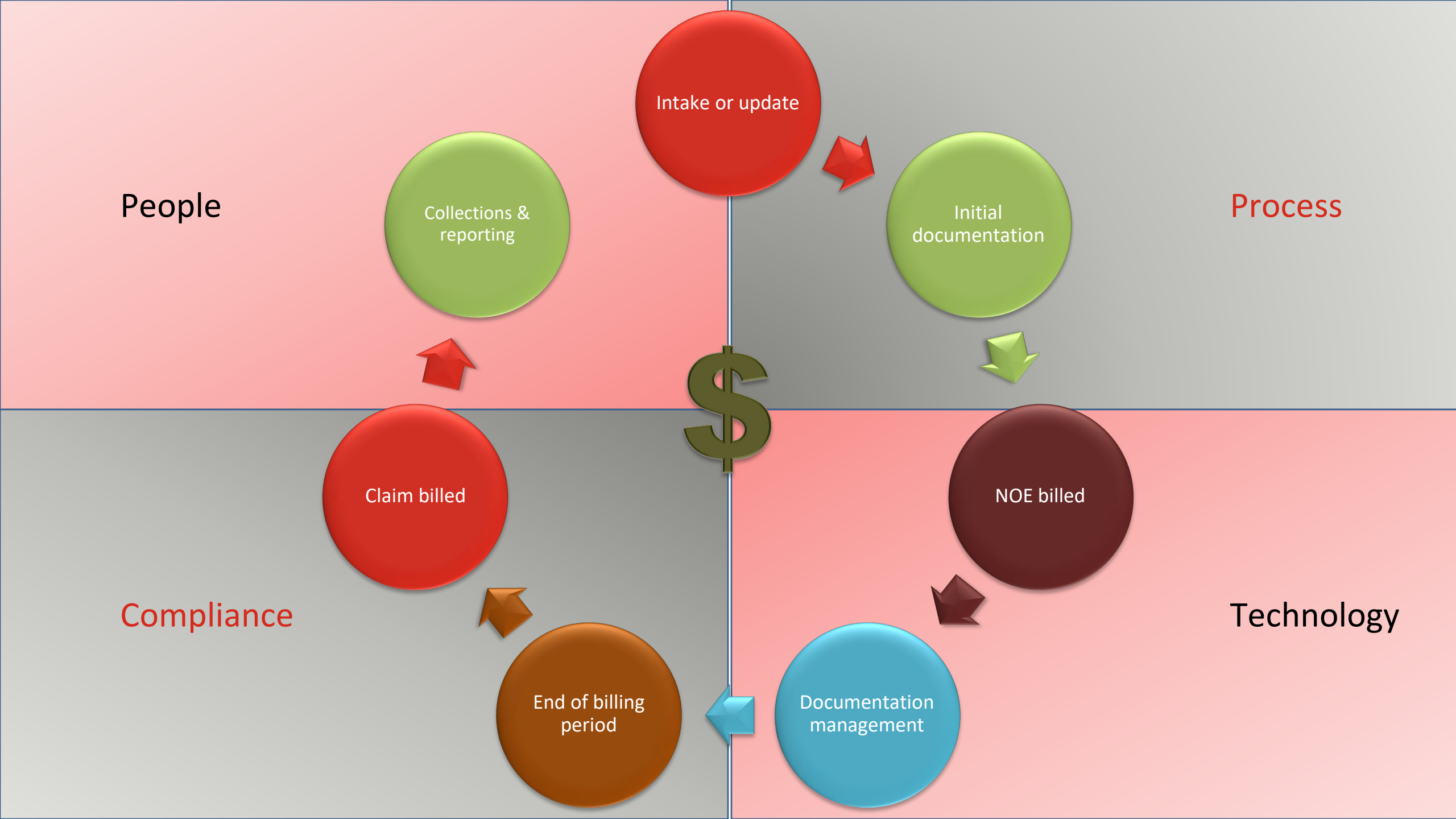
Based on findings from medical review of your claims with dates of service 03/17/2022-10/12/2022, Qlarant has identified a pattern of claim denials. The submitted documentation failed to meet the Medicare coverage guidelines for home health. The documentation did not support the beneficiary was in need of intermittent skilled nursing services or training and/or insufficient documentation to support the homebound status; and/or face-to-face encounter requirements were not met.



Environment

Risks

Strategies


People
Process
Compliance
Technology
Intake or update
Initial documentation
NOE billed
Documentation management
End of billing period
Claim billed
Collections & reporting
$

Risks

Election statements

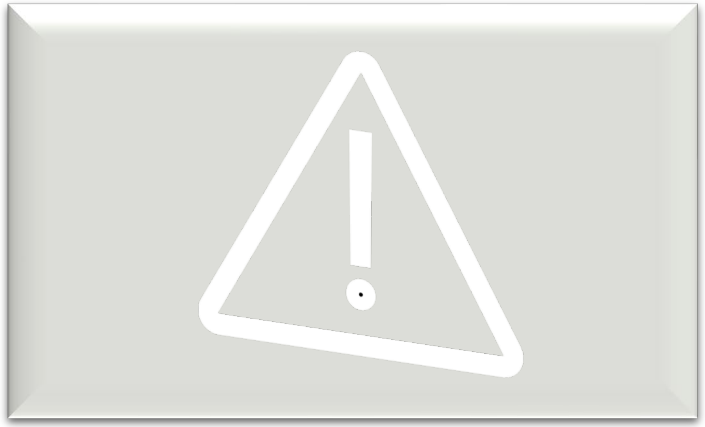
FTF

Certifications

Terminal prognosis

GIP

Risks | Election Statements



Election statements

FTF

Certifications

Terminal prognosis

GIP

Risks | Election Statements

- Example 1 – BFCC-QIO information

REMARKS

55H1R- THIS CLAIM WAS DENIED AFTER REVIEW BECAUSE THE ELECTION STATEMENT IS INVALID BECAUSE IT DOESN'T MEET STATUTORY/REGULATORY REQUIREMENTS. THE ELECTION STATEMENT DID NOT CONTAIN THE CONTACT INFORMATION FOR THE LOCAL BENEFICIARY AND FAMILY-CENTERED CARE QUALITY ORGANIZATION (BFCC-QIO). HOSPICES ARE REQUIRED TO PROVIDE THE BENEFICIARY WITH THE CONTACT INFORMATION FOR THE BFCC-QIO THAT SERVICES THEIR AREA. THE ELECTION STATEMENT MUST ALSO INCLUDE ALL COMPONENTS IDENTIFIED IN CMS PUBLICATION 100-2, CHAPTER 9, SECTION 20.2.1 AND COMPLY WITH THE CODE OF FEDERAL REGULATIONS, TITLE 42, PART 418.24. YOU MAY ALSO REFERENCE THE CMS MODEL EXAMPLE OF HOSPICE ELECTION STATEMENT FOR MORE INFORMATION

Risks | Election Statements

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

Patient Notification of Hospice Non-Covered Items, Services, and Drugs

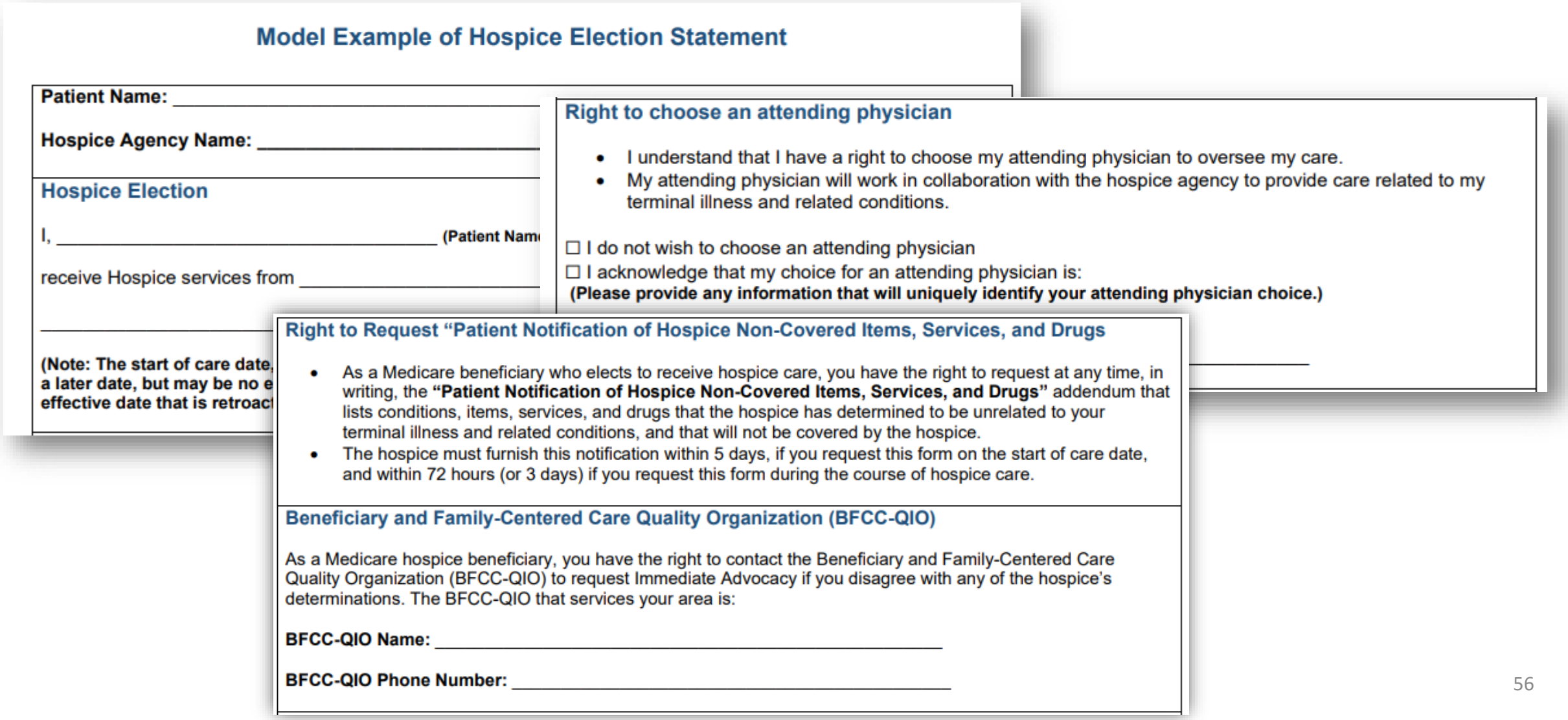
Please visit this website to find the BFCC-QIO for your area: https://qioprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048

Risks | Election Statements

- Example 2 – Beneficiary & attending physician identification

*0701-073122.FULL DENIAL. DENY 31 RHC (0651) 0701-0731. THE HOSPICE ELECTION STATEMENT DID NOT MEET STATUTORY/REGULATORY REQUIREMENTS. THE NAME OF THE BENEFICIARY ELECTING HOSPICE CARE WAS NOT ON THE ELECTION STATEMENT. THE ATTENDING PHYSICIAN OF CHOICE WAS LEFT BLANK. REFER TO CMS MANUAL SYSTEM, PUB 100-02, MEDICARE BENEFIT POLICY MANUAL, CHAPTER 9, SECTION 20.2.1 AND CODE OF FEDERAL REGULATIONS, 42 CFR - SECTIONS 418.24.

Risks | Election Statements



Model Example of Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ **(Patient Nam**

receive Hospice services from _____

_____

(Note: The start of care date,
a later date, but may be no e
effective date that is retroac

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

_____

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

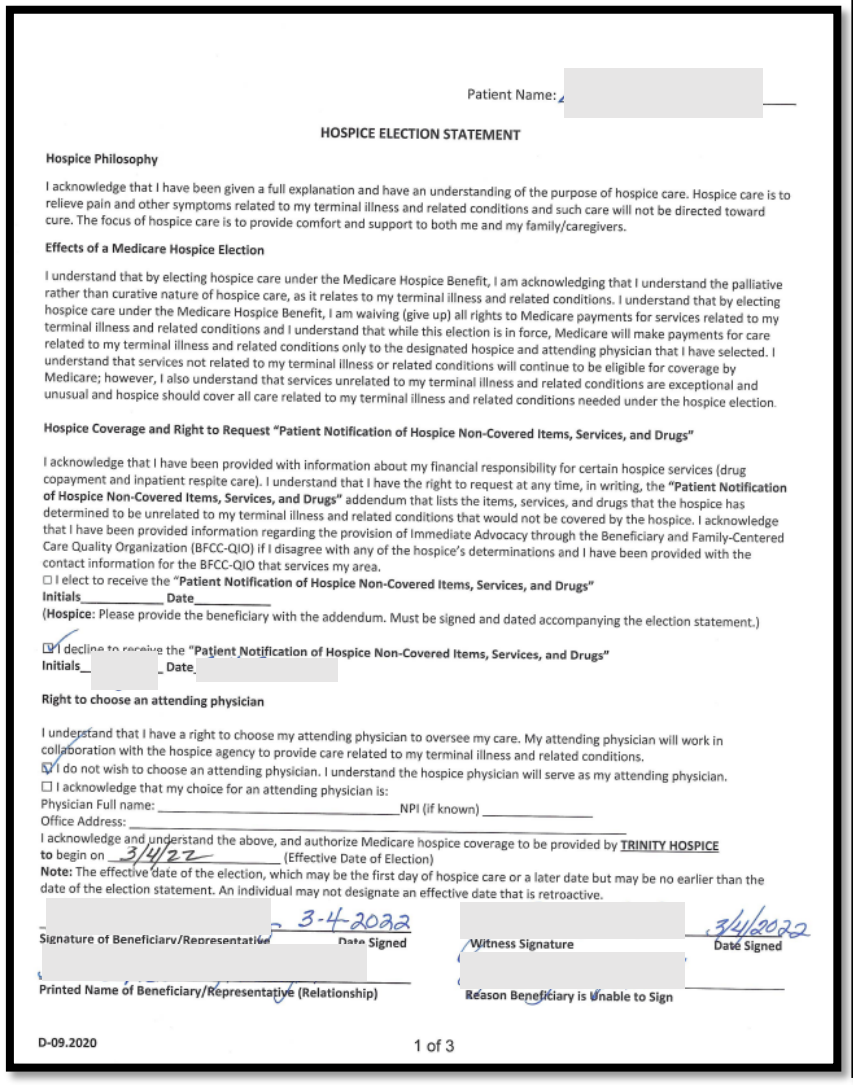
BFCC-QIO Name: _____

BFCC-QIO Phone Number: _____

Risks | Election Statements

- Identification of the particular hospice that will provide care to the patient;
- The patient's or representative's (as applicable) acknowledgment that the patient has been given a full understanding of hospice care, ***particularly the palliative rather than curative nature of treatment***;
- The patient's or representative's acknowledgment that the patient understands that certain Medicare services are waived by the election;
- The effective date of the election, which can be the first day of hospice care or a later date, but cannot be a retroactive date;
- The patient's or representative's designated attending physician (if they have one). Include enough detail to clearly identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or National Provider Identifier (NPI).
- The patient's or representative's acknowledgement that the designated attending physician was their choice.
- The signature of the patient or their representative.
- Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- A statement that, although it would be rare, there could be some necessary items or services that will not be covered by the hospice because the hospice has determined that these items or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- The statement would also include information about possible beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that expedited advocacy is available through the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) review if the beneficiary (or representative) disagrees with the hospice's determination.

Risks | Election Statements



Patient Name:

HOSPICE ELECTION STATEMENT

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicare Hospice Election

I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand the palliative rather than curative nature of hospice care, as it relates to my terminal illness and related conditions. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and hospice should cover all care related to my terminal illness and related conditions needed under the hospice election.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

☐ I elect to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_____ **Date**_____
(**Hospice**: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

☑ I decline to receive the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"**
Initials_____ **Date**_____

Right to choose an attending physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☑ I do not wish to choose an attending physician. I understand the hospice physician will serve as my attending physician.
☐ I acknowledge that my choice for an attending physician is:
Physician Full name: _____ NPI (if known) _____
Office Address: _____
I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by **TRINITY HOSPICE** to begin on 3/4/22 (Effective Date of Election)
Note: The effective date of the election, which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Signature of Beneficiary/Representative — Date Signed 3-4-2022
Witness Signature — Date Signed 3/4/2022
Printed Name of Beneficiary/Representative (Relationship)
Reason Beneficiary is Unable to Sign

D-09.2020 1 of 3

Patient Name:

INFORMED CONSENT FOR HOSPICE SERVICE/RELEASE OF RECORDS

I have been informed that TRINITY HOSPICE, referred to as the Agency or the Hospice in this document) offers hospice care under the Medicare/Medicaid Hospice Benefit program. I understand the following explanation of the Medicare/Medicaid Hospice Benefit.
Admission Information: The Agency will admit you only if the Agency is able to provide care appropriate to your needs. If the Agency is unable to meet your needs, the Agency will assist you and your representative in locating resources of your choice that can provide the needed services.
After Hours Access/Inpatient Care: A nurse is scheduled to respond after hours to patient calls, while the Agency's office is closed. If a nurse is needed after hours, call the Agency's phone number **(469) 726-4402.** The call will either be answered by a nurse or routed to a nurse via an answering service. If inpatient palliative support is needed, the Agency will provide and coordinate inpatient care at a contracted facility based on the needs of the patient as approved by the medical director and interdisciplinary team members. I understand that if I call 911, go to the hospital, or choose care for any conditions related to my admitting hospice diagnosis, without preauthorization from the Hospice, I may be responsible for those associated costs.
Clinical Records: It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons. I authorize the Agency to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations, as appropriate. It is the policy of the Agency to protect all clinical records against loss, defacement, tampering and use by unauthorized persons.
I authorize the release of the Plan of Care and Discharge Summary if I transfer to another health care entity or facility. If I transfer to another health care entity or facility, the Plan of Care, Discharge Summary and medical record, if requested, may be released to the new service providers.

SERVICES/RIGHTS/HOTLINE/POLICIES/PROCEDURES

I understand that a Registered Nurse will case manage all services and I have accepted the following services:
☑ RN/LPN or LVN ☐ Hospice Aide ☑ Social Worker ☑ Chaplain ☐ Dietician ☐ Volunteer ☐ PT ☐ OT ☐ SP ☐
Other:_____
I have been notified of my right to voice a complaint to the Agency Administrator or designee at **(469) 726-4402.** An investigation of the complaint will be initiated within 10 calendar days and resolved within 30 calendar days of receipt. I may also contact Texas Health and Human Services, HHS, Consumer Rights and Services Division, Mail Code E249, PO Box 149030, Austin, TX 78714-9030, or by calling 1-800-458-9858. The line is open 24 hours a day. This includes a complaint regarding advance directives. For any complaints regarding discrimination, I understand that I may contact the Office of Civil Rights within 180 days of when the situation occurred. The complaint must be filed in writing by mail, fax, e-mail, or via the OCR Complaint Portal. Complaints regarding any health insurance services can be mailed to MC 111 IA, Consumer Protection, Texas Department of Insurance, PO Box 149091, Austin, TX 78714, or by calling the Consumer Help Line at 1-800-252-3439, online at http://www.tdi.texas.gov/consumer/complfrm.html, or by email to ConsumerProtection@tdi.texas.gov
I acknowledge I have received a copy along with a verbal explanation of the following:

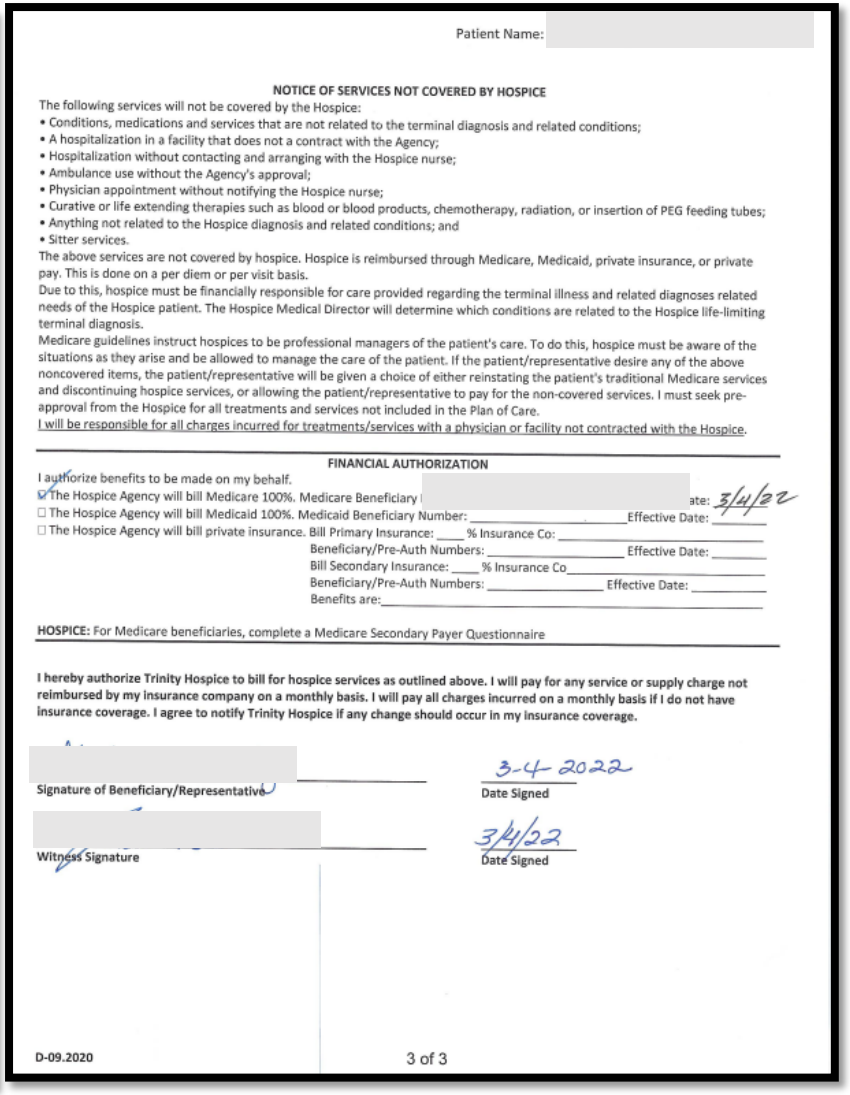
- Patient Rights and Responsibilities and Patient Choice Statement
- Advance Directive Information
- Abuse/Neglect/Exploitation Policy
- Home Safety Information
- Medicare Part D Information
- Infection Control Education
- Disposal of Controlled Substances and Medication Disposal Policies
- Rights of the Elderly
- HIPAA/Notice of Privacy Practices Information
- Emergency Preparedness/Natural Disaster Information
- Expected Death (At Home) Policy
- Home Hazardous Waste Disposal Information
- Agency's Drug Testing Policy

I have received education on completing an emergency preparedness plan for myself and my family. I understand the importance of completing this plan and know that the Agency staff may assist in this process.

I consent to the Agency's use and/or disclosure of protected health information for payment, treatment and the Agency's health care operations.
I have been informed of the availability of clergy and spiritual counseling services.
I understand that it is my right and responsibility to be involved in my care and that I will be informed as to the nature and purpose of any procedures. I also understand that I must have a primary caregiver.

I have ✓ or have not ____ signed a ✓ Directive to Physician/Living Will ☑ Medical Power of Attorney ☐ Out of Hospital DNR.
I am ✓ am not ____ providing a copy for my hospice record.
Designated Medical Power of Attorney: _____ Phone: _____
Signature of Beneficiary/Representative — Date Signed 3-4-2022
Witness Signature — Date Signed 3/4/22

D-09.2020 2 of 3



Patient Name:

NOTICE OF SERVICES NOT COVERED BY HOSPICE

The following services will not be covered by the Hospice:

- Conditions, medications and services that are not related to the terminal diagnosis and related conditions;
- A hospitalization in a facility that does not a contract with the Agency;
- Hospitalization without contacting and arranging with the Hospice nurse;
- Ambulance use without the Agency's approval;
- Physician appointment without notifying the Hospice nurse;
- Curative or life extending therapies such as blood or blood products, chemotherapy, radiation, or insertion of PEG feeding tubes;
- Anything not related to the Hospice diagnosis and related conditions; and
- Sitter services.

The above services are not covered by hospice. Hospice is reimbursed through Medicare, Medicaid, private insurance, or private pay. This is done on a per diem or per visit basis.
Due to this, hospice must be financially responsible for care provided regarding the terminal illness and related diagnoses related needs of the Hospice patient. The Hospice Medical Director will determine which conditions are related to the Hospice life-limiting terminal diagnosis.
Medicare guidelines instruct hospices to be professional managers of the patient's care. To do this, hospice must be aware of the situations as they arise and be allowed to manage the care of the patient. If the patient/representative desire any of the above noncovered items, the patient/representative will be given a choice of either reinstating the patient's traditional Medicare services and discontinuing hospice services, or allowing the patient/representative to pay for the non-covered services. I must seek pre-approval from the Hospice for all treatments and services not included in the Plan of Care.
I will be responsible for all charges incurred for treatments/services with a physician or facility not contracted with the Hospice.

FINANCIAL AUTHORIZATION

I authorize benefits to be made on my behalf.
☑ The Hospice Agency will bill Medicare 100%. Medicare Beneficiary ... ate: 3/4/22
☐ The Hospice Agency will bill Medicaid 100%. Medicaid Beneficiary Number: _____ Effective Date: _____
☐ The Hospice Agency will bill private insurance. Bill Primary Insurance: ____ % Insurance Co: _____
Beneficiary/Pre-Auth Numbers: _____ Effective Date: _____
Bill Secondary Insurance: ____ % Insurance Co _____
Beneficiary/Pre-Auth Numbers: _____ Effective Date: _____
Benefits are: _____

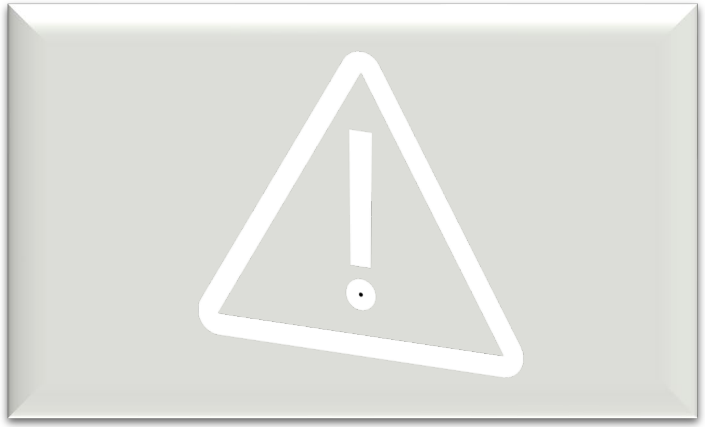
HOSPICE: For Medicare beneficiaries, complete a Medicare Secondary Payer Questionnaire

I hereby authorize Trinity Hospice to bill for hospice services as outlined above. I will pay for any service or supply charge not reimbursed by my insurance company on a monthly basis. I will pay all charges incurred on a monthly basis if I do not have insurance coverage. I agree to notify Trinity Hospice if any change should occur in my insurance coverage.

Signature of Beneficiary/Representative — Date Signed 3-4-2022
Witness Signature — Date Signed 3/4/22

D-09.2020 3 of 3

Risks | FTF



Election statements

FTF

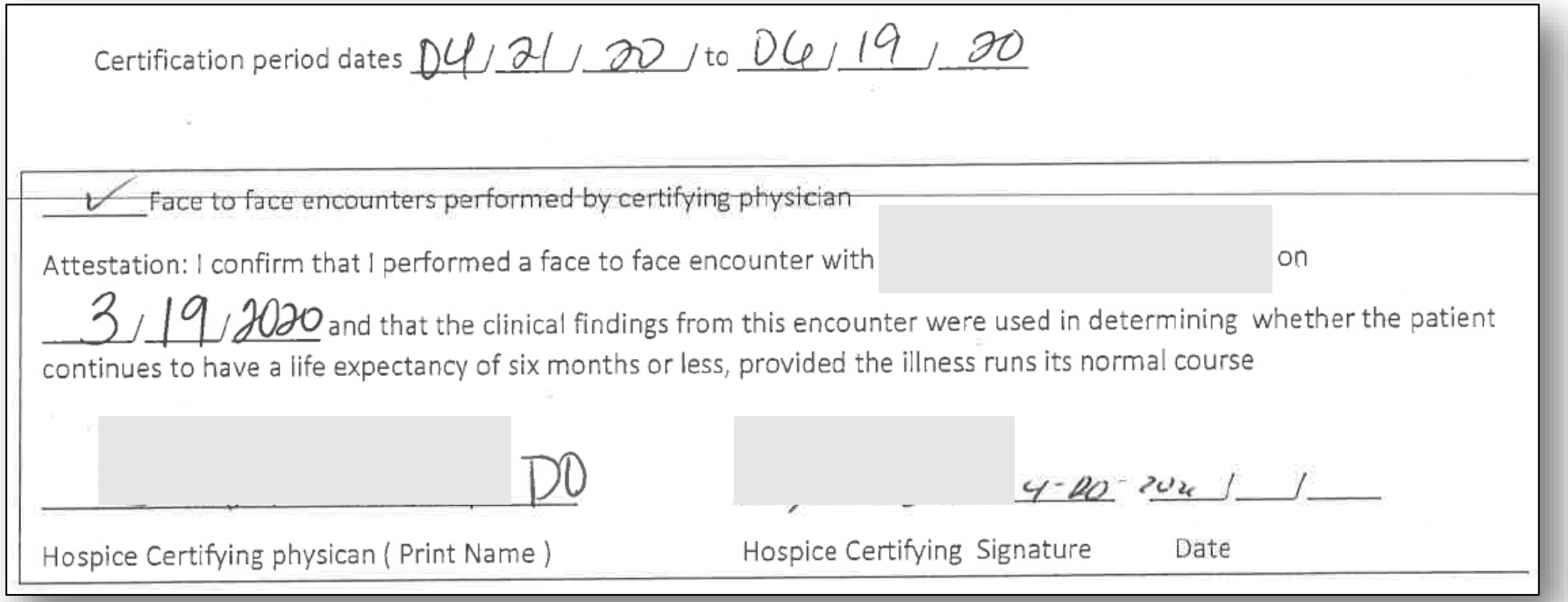
Certifications

Terminal prognosis

GIP

Risks | FTF

- Example 3 – Untimely FTF



Certification period dates 04/21/20 to 06/19/20

✓ Face to face encounters performed by certifying physician

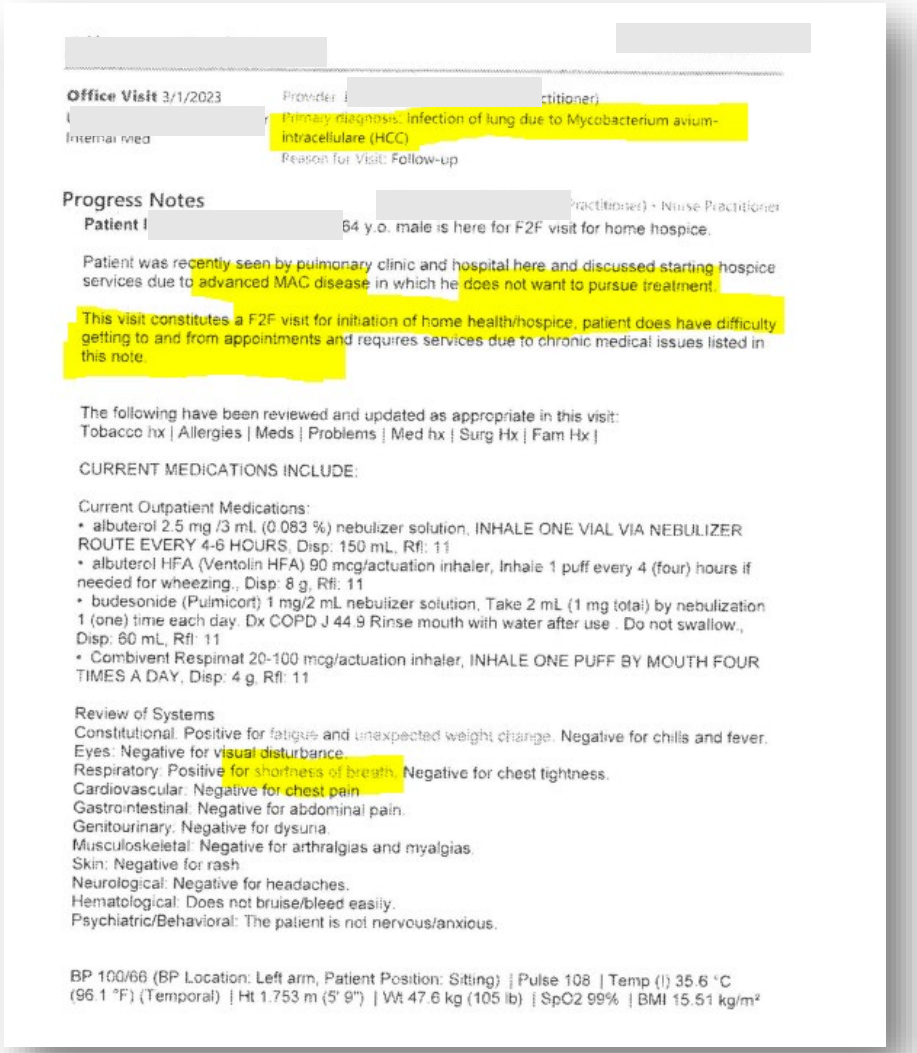
Attestation: I confirm that I performed a face to face encounter with [redacted] on 3/19/2020 and that the clinical findings from this encounter were used in determining whether the patient continues to have a life expectancy of six months or less, provided the illness runs its normal course

[redacted] DO — [redacted] 4-20-20 / /

Hospice Certifying physican (Print Name) | Hospice Certifying Signature | Date

Risks | FTF

- Example 4 – FTF done by NP not employed by hospice



Office Visit 3/1/2023

Primary diagnosis: Infection of lung due to Mycobacterium avium-intracellulare (HCC)

Reason for Visit: Follow-up

Progress Notes

Patient I 64 y.o. male is here for F2F visit for home hospice.

Patient was recently seen by pulmonary clinic and hospital here and discussed starting hospice services due to advanced MAC disease in which he does not want to pursue treatment.

This visit constitutes a F2F visit for initiation of home health/hospice, patient does have difficulty getting to and from appointments and requires services due to chronic medical issues listed in this note.

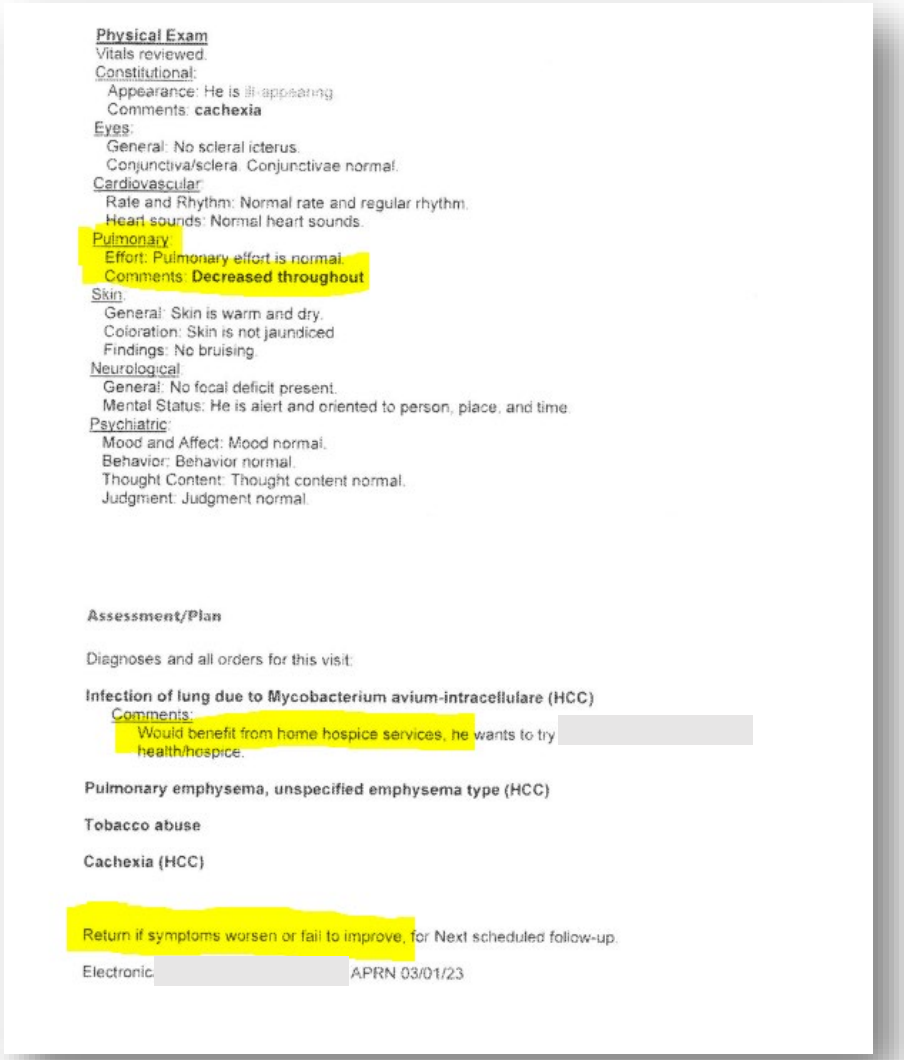
The following have been reviewed and updated as appropriate in this visit:
Tobacco hx | Allergies | Meds | Problems | Med hx | Surg Hx | Fam Hx |

CURRENT MEDICATIONS INCLUDE:

Current Outpatient Medications:
- albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution, INHALE ONE VIAL VIA NEBULIZER ROUTE EVERY 4-6 HOURS, Disp: 150 mL, Rfl: 11
- albuterol HFA (Ventolin HFA) 90 mcg/actuation inhaler, Inhale 1 puff every 4 (four) hours if needed for wheezing., Disp: 8 g, Rfl: 11
- budesonide (Pulmicort) 1 mg/2 mL nebulizer solution, Take 2 mL (1 mg total) by nebulization 1 (one) time each day. Dx COPD J 44.9 Rinse mouth with water after use . Do not swallow., Disp: 60 mL, Rfl: 11
- Combivent Respimat 20-100 mcg/actuation inhaler, INHALE ONE PUFF BY MOUTH FOUR TIMES A DAY, Disp: 4 g, Rfl: 11

Review of Systems
Constitutional: Positive for fatigue and unexpected weight change. Negative for chills and fever.
Eyes: Negative for visual disturbance.
Respiratory: Positive for shortness of breath. Negative for chest tightness.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain.
Genitourinary: Negative for dysuria.
Musculoskeletal: Negative for arthralgias and myalgias.
Skin: Negative for rash.
Neurological: Negative for headaches.
Hematological: Does not bruise/bleed easily.
Psychiatric/Behavioral: The patient is not nervous/anxious.

BP 100/66 (BP Location: Left arm, Patient Position: Sitting) | Pulse 108 | Temp (I) 35.6 °C (96.1 °F) (Temporal) | Ht 1.753 m (5' 9") | Wt 47.6 kg (105 lb) | SpO2 99% | BMI 15.51 kg/m²



Physical Exam
Vitals reviewed.
Constitutional:
Appearance: He is ill-appearing.
Comments: **cachexia**
Eyes:
General: No scleral icterus.
Conjunctiva/sclera: Conjunctivae normal.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal.
Comments: **Decreased throughout**
Skin:
General: Skin is warm and dry.
Coloration: Skin is not jaundiced.
Findings: No bruising.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.
Thought Content: Thought content normal.
Judgment: Judgment normal.

Assessment/Plan

Diagnoses and all orders for this visit:

Infection of lung due to Mycobacterium avium-intracellulare (HCC)
Comments:
Would benefit from home hospice services, he wants to try health/hospice.

Pulmonary emphysema, unspecified emphysema type (HCC)

Tobacco abuse

Cachexia (HCC)

Return if symptoms worsen or fail to improve, for Next scheduled follow-up.

Electronic APRN 03/01/23

Risks | FTF

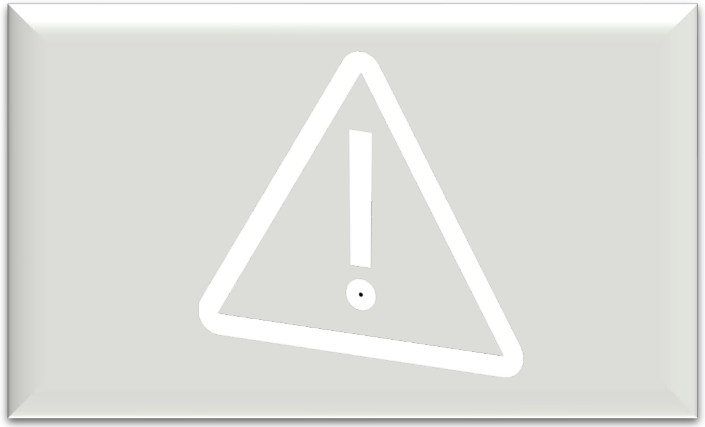
- **Time Frame for the Encounter**
- The FTF encounter must occur within 30 calendar days prior to the start of the 3rd benefit period and each subsequent recertification. In documented exceptional circumstances, for a new hospice admission in the third or later benefit period, the FTF encounter is considered to be timely when performed within 2 days after admission. Examples include:
- An emergency weekend admission and the patient cannot be seen by the hospice physician or the nurse practitioner (NP) until the following Monday.
- Unavailable CMS data systems resulting in the inability for the hospice to determine if the patient is in the 3rd benefit period.
- In addition, if the patient dies within 2 days of admission, a FTF encounter is considered to be complete.

- **Untimely Face-to-Face Encounter**
- When a required face-to-face (FTF) encounter does not occur timely, the beneficiary is no longer certified as terminally ill, and therefore, is not eligible for the Medicare hospice benefit. In these cases, the hospice must discharge the beneficiary from the Medicare hospice benefit because he/she is no longer considered terminally ill for Medicare purposes. When a discharge occurs due to failure to perform a required FTF encounter timely, the claim should include appropriate billing information. For additional information about how to bill correctly, refer to the CGS "Untimely Face-To-Face Encounter" Web page.

Risks | FTF

- **Who Performs and Signs the FTF Encounter**
- The FTF encounter must be performed by a hospice physician or a hospice NP. The hospice physician must be employed by the hospice, a volunteer, or working under contract. The hospice NP must be employed by the hospice (receives a W-2 form from the hospice or volunteers for the hospice).
- **FTF Requirements**
- The hospice physician or NP must attest in writing that he or she had a FTF encounter with the patient, including the date of the encounter. The attestation, which must be a separate and distinct part of the recertification, or as an addendum to the recertification associated with the 3rd benefit period, must meet the following criteria:
- Clearly titled.
- Accompanying signature, and date signed by the individual who performed the visit.
- Date of the visit.
- Clinical findings to determine continued hospice eligibility.
- When the hospice NP/non-certifying physician performs the FTF, the attestation must also state that the clinical findings were provided to the certifying physician.

Risks | Certifications



Election statements

FTF

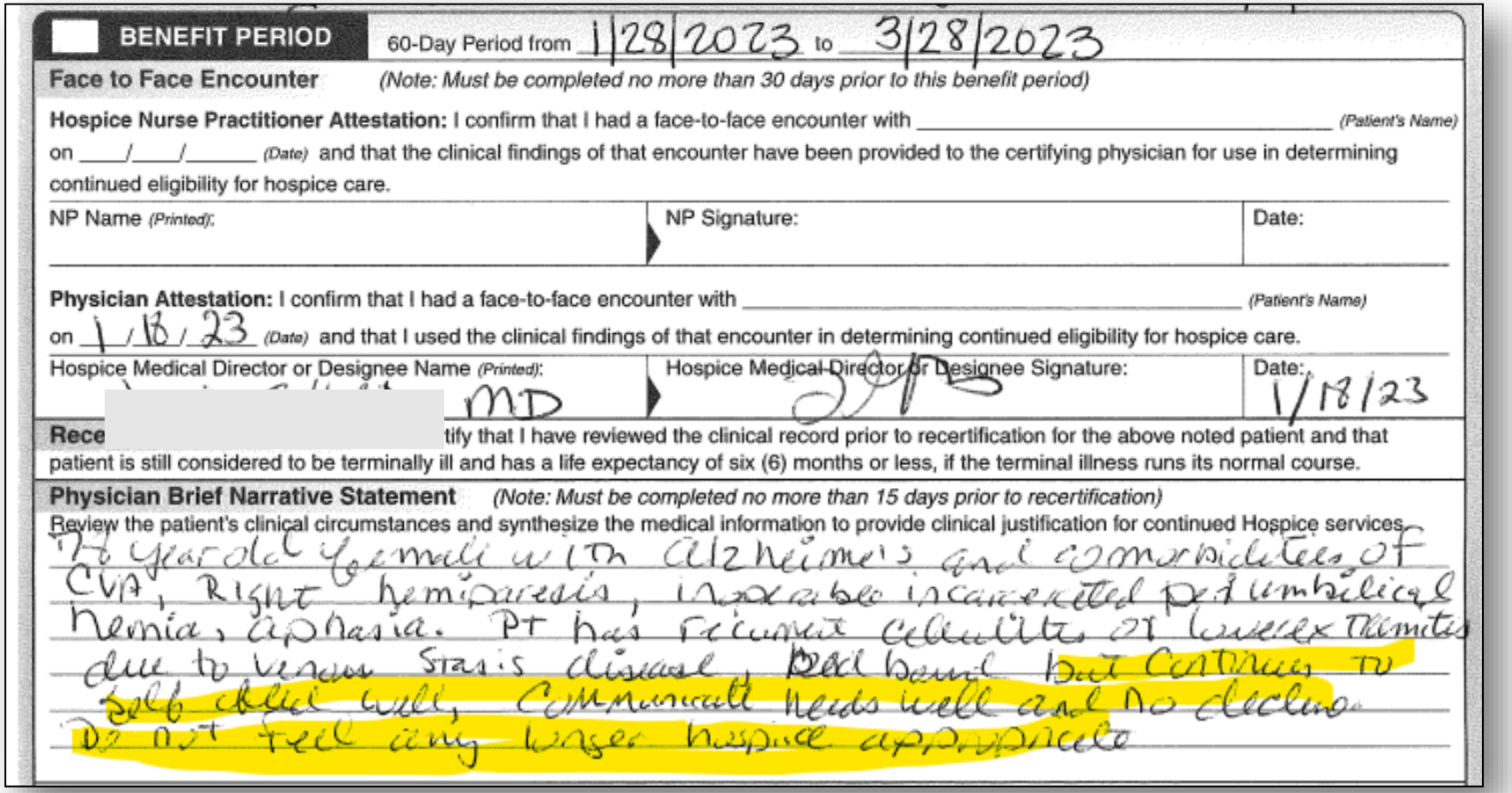
Certifications

Terminal prognosis

GIP

Risks | Certifications

- Example 5 – Physician narrative



BENEFIT PERIOD 60-Day Period from 1/28/2023 to 3/28/2023

Face to Face Encounter *(Note: Must be completed no more than 30 days prior to this benefit period)*

Hospice Nurse Practitioner Attestation: I confirm that I had a face-to-face encounter with _____ *(Patient's Name)* on ___/___/_____ *(Date)* and that the clinical findings of that encounter have been provided to the certifying physician for use in determining continued eligibility for hospice care.

NP Name *(Printed)*:	NP Signature:	Date:

Physician Attestation: I confirm that I had a face-to-face encounter with _____ *(Patient's Name)* on 1/18/23 *(Date)* and that I used the clinical findings of that encounter in determining continued eligibility for hospice care.

Hospice Medical Director or Designee Name *(Printed)*:	Hospice Medical Director or Designee Signature:	Date:
MD		1/18/23

Rece[redacted]tify that I have reviewed the clinical record prior to recertification for the above noted patient and that patient is still considered to be terminally ill and has a life expectancy of six (6) months or less, if the terminal illness runs its normal course.

Physician Brief Narrative Statement *(Note: Must be completed no more than 15 days prior to recertification)*

Review the patient's clinical circumstances and synthesize the medical information to provide clinical justification for continued Hospice services.

76 year old female with Alzheimer's and comorbidities of CVA, Right hemiparesis, incarcerated peri umbilical hernia, aphasia. PT has recurrent cellulitis of lower extremities due to venous stasis disease, bed bound but continues to take adequate fluids, communicates needs well and no decline. Do not feel any longer hospice appropriate

Risks | Certifications

- Example 6 – Physician narrative

2. Patient-specific clinical findings and other documentation supporting a life expectancy of 6 months or less

Guidance: The certification should give specific clinical findings, for example, signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake.

Certification of Terminal Illness

Hospice Physician: **Attending Physician:**

Attending is Also the Hospice Physician

Type of Certification:
90 Day Recertification: Second Certification Period (90 days)

Benefit Period:
02/06/2023 - 05/06/2023

Terminal Diagnosis:
I25.10 Athscl heart disease of native coronary artery w/o ang pctrs

Comorbidities:
R13.12 Dysphagia, oropharyngeal phase, R00.1 Bradycardia, unspecified, F33.1 Major depressive disorder, recurrent, moderate, R27.8 Other lack of coordination, I69.310 Attention and concentration deficit following cerebral infrc, I69.311 Memory deficit following cerebral infarction, R41.841 Cognitive communication deficit, R41.841 Cognitive communication deficit, M15.0 Primary generalized (osteo)arthritis, R47.89 Other speech disturbances, M15.9 Polyosteoarthritis, unspecified, R26.81 Unsteadiness on feet, R09.89 Oth symptoms and signs involving the circ and resp systems, F34.9 Persistent mood [affective] disorder, unspecified, M54.50 Low back pain, unspecified, R26.89 Other abnormalities of gait and mobility, M25.551 Pain in right hip, M62.58 Muscle wasting and atrophy, NEC, oth site, G30.1 Alzheimer's disease with late onset, I67.89 Other cerebrovascular disease, I95.1 Orthostatic hypotension

Composed By:
Hospice Physician

Physician Narrative

see attached narrative

I certify that [redacted] is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Physician Narrative Attestation

I confirm that I composed this narrative statement and that it is based on my review of the patient's medical record and/or examination of the patient.:

Signature: [redacted] Date: 1/24/23

Patient has advanced coronary artery disease.
He is not willing to undergo any additional treatment
Life expectancy less than 6 month

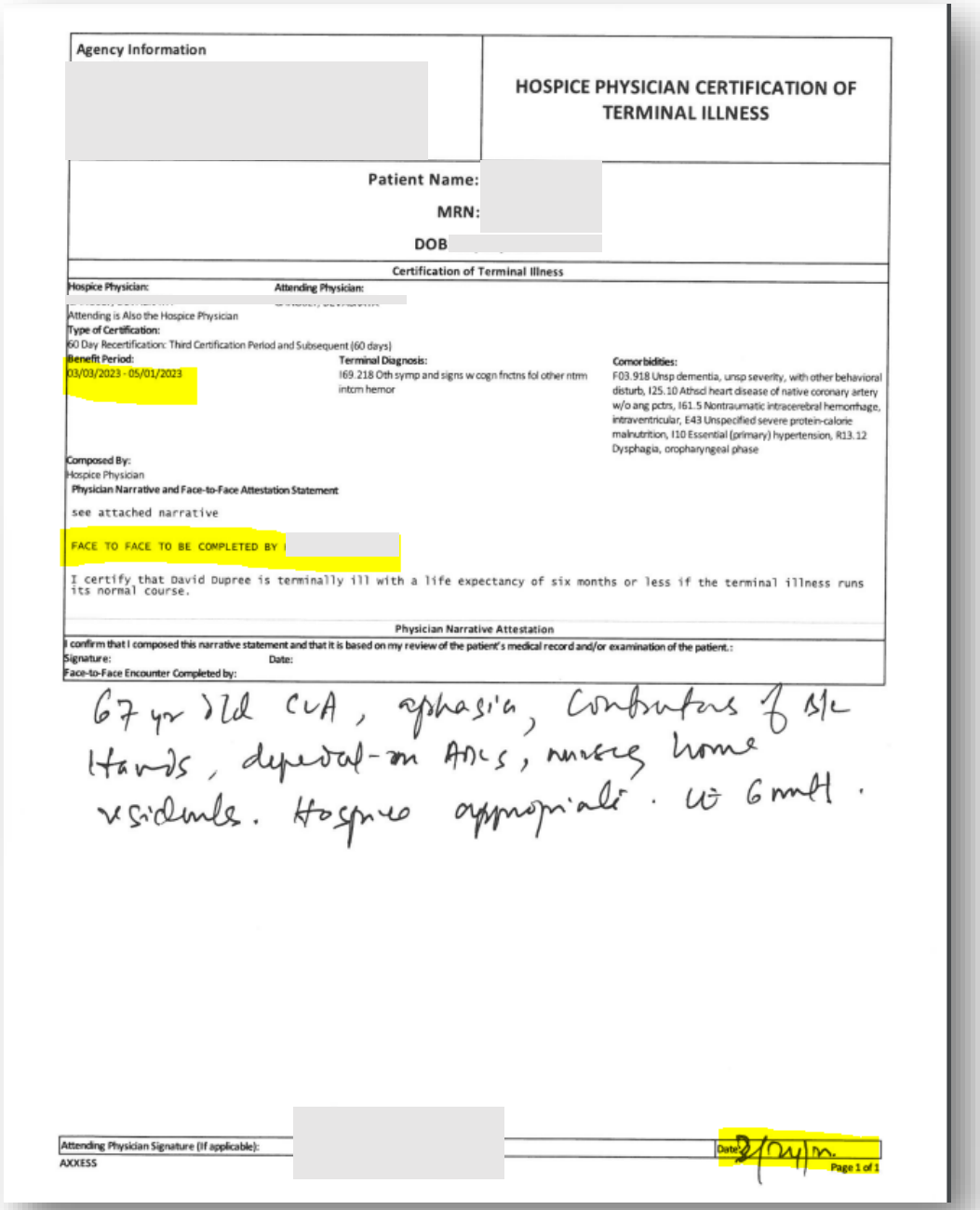
Date 1/24/23

Attending Physician Signature (If applicable): [redacted] Date: 1/24/23

Risks | Certifications

- Example 7—Cert without FTF


Composed By:
Hospice Physician
Physician Narrative and Face-to-Face Attestation Statement
see attached narrative
FACE TO FACE TO BE COMPLETED BY


Agency Information

HOSPICE PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS

Patient Name:
MRN:
DOB

Certification of Terminal Illness

Hospice Physician: Attending Physician:

Attending is Also the Hospice Physician
Type of Certification:
60 Day Recertification: Third Certification Period and Subsequent (60 days)
Benefit Period: 03/03/2023 - 05/01/2023
Terminal Diagnosis: I69.218 Oth symp and signs w cogn fnctns fol other ntrm intcrn hemor
Comorbidities: F03.918 Unsp dementia, unsp severity, with other behavioral disturb, I25.10 Athscl heart disease of native coronary artery w/o ang pctrs, I61.5 Nontraumatic intracerebral hemorrhage, intraventricular, E43 Unspecified severe protein-calorie malnutrition, I10 Essential (primary) hypertension, R13.12 Dysphagia, oropharyngeal phase

Composed By:
Hospice Physician
Physician Narrative and Face-to-Face Attestation Statement
see attached narrative
FACE TO FACE TO BE COMPLETED BY
I certify that David Dupree is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Physician Narrative Attestation

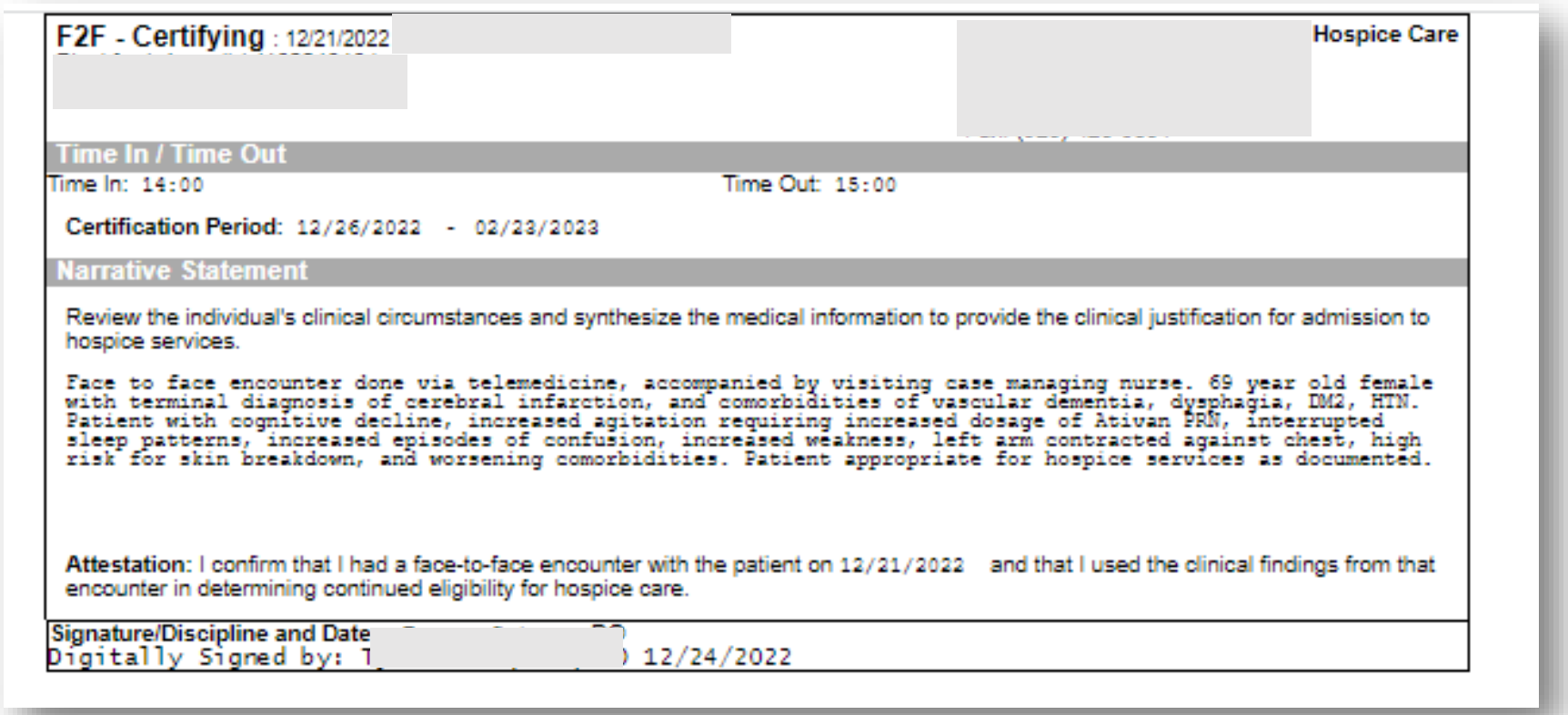
I confirm that I composed this narrative statement and that it is based on my review of the patient's medical record and/or examination of the patient.:
Signature: Date:
Face-to-Face Encounter Completed by:

67 yr old CVA, aphasia, contractures of b/l hands, dependent on ADLs, nursing home residents. Hospice appropriate. W 6 mth.

Attending Physician Signature (If applicable): Date:
AXXESS
Page 1 of 1

Risks | Certifications

- Example 8 – Compliant example



F2F - Certifying : 12/21/2022 [redacted] **Hospice Care**

[redacted]

Time In / Time Out

Time In: 14:00 Time Out: 15:00

Certification Period: 12/26/2022 - 02/23/2023

Narrative Statement

Review the individual's clinical circumstances and synthesize the medical information to provide the clinical justification for admission to hospice services.

Face to face encounter done via telemedicine, accompanied by visiting case managing nurse. 69 year old female with terminal diagnosis of cerebral infarction, and comorbidities of vascular dementia, dysphagia, DM2, HTN. Patient with cognitive decline, increased agitation requiring increased dosage of Ativan PRN, interrupted sleep patterns, increased episodes of confusion, increased weakness, left arm contracted against chest, high risk for skin breakdown, and worsening comorbidities. Patient appropriate for hospice services as documented.

Attestation: I confirm that I had a face-to-face encounter with the patient on 12/21/2022 and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

Signature/Discipline and Date [redacted]

Digitally Signed by: T[redacted] 12/24/2022

Risks | Certifications

- **Common Hospice Certification Errors**
- Medicare cannot make appropriate payment without correct dates, signatures and identifying roles of the physician(s). The following list identifies the common types of missing and inadequate information:
- Predating physician(s) certification signatures
- Not having both the hospice medical director and attending physician (if applicable) sign the initial certification as required
- The physician narrative is missing
- The physician's narrative does not include a statement attesting that it was composed by the physician
- The attestation statement is missing
- Not having verbal certifications by both the medical director and attending physician (if applicable)
- No physician(s) signatures
- Illegible physician signatures
- Physician did not date his/her signature
- Not clearly stating the dates the certification period encompasses

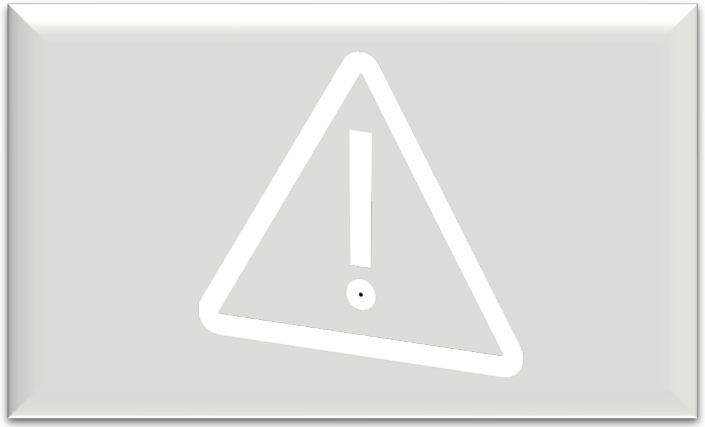
Risks | Certifications

- **Timeframe for Certification/Recertification**
- The hospice must obtain ***verbal or written certification*** of the terminal illness, ***no later than 2 calendar days*** (by the end of the third day) after the start of each benefit period (initial and subsequent). Initial certifications may be completed ***up to 15 days before*** hospice care is elected. Recertifications may be completed ***up to 15 days before*** the start of the next benefit period.
- If written certification/recertification cannot be obtained within 2 calendar days, verbal certification must be obtained. The hospice must determine who may accept verbal certification from a physician in compliance with state and local law regulations.
- In addition, the hospice must ensure the written certification/recertification is signed and dated prior to billing Medicare, or their claim(s) may be denied.

Risks | Certifications

- **Content of the Certification/Recertification**
- The certification should be based on the clinical judgment of the hospice medical director (or physician member of the interdisciplinary group (IDG), and the patient's attending physician, if he/she has one. Nurse practitioners and physician assistants cannot certify or recertify an individual is terminally ill. If the patient's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.
- In addition to the initial certification for hospice, the patient must be recertified for each subsequent hospice benefit period.
- The written certification/recertification must include:
- The statement that the patient's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course
- A brief narrative, written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of six months or less. This narrative can be a part of the certification/recertification form or as an addendum to the form.
    - If the narrative is part of the form, it must be located immediately above the physician's signature.
    - If the narrative is an addendum, the physician must also sign the addendum immediately following the narrative.
    - Do not include check boxes or standard language used for all patients. The narrative cannot be completed by other hospice personnel; it must be completed by the certifying physician.
    - The narrative shall include a statement, located above the physician signature and date, that attests to the fact that by signing the form, the physician 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.
- The benefit period dates that the certification or recertification covers.
- Effective for recertifications on/after January 1, 2011, narratives associated with the third benefit period and subsequent benefit periods must explain why the clinical findings of the face-to-face encounter support a life expectancy of six months or less. Documentation must include the date of the encounter, an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary. If the encounter was done by a nurse practitioner, he/she must attest that clinical findings were provided to the certifying physician.

Risks | Terminal Prognosis



Election statements

FTF

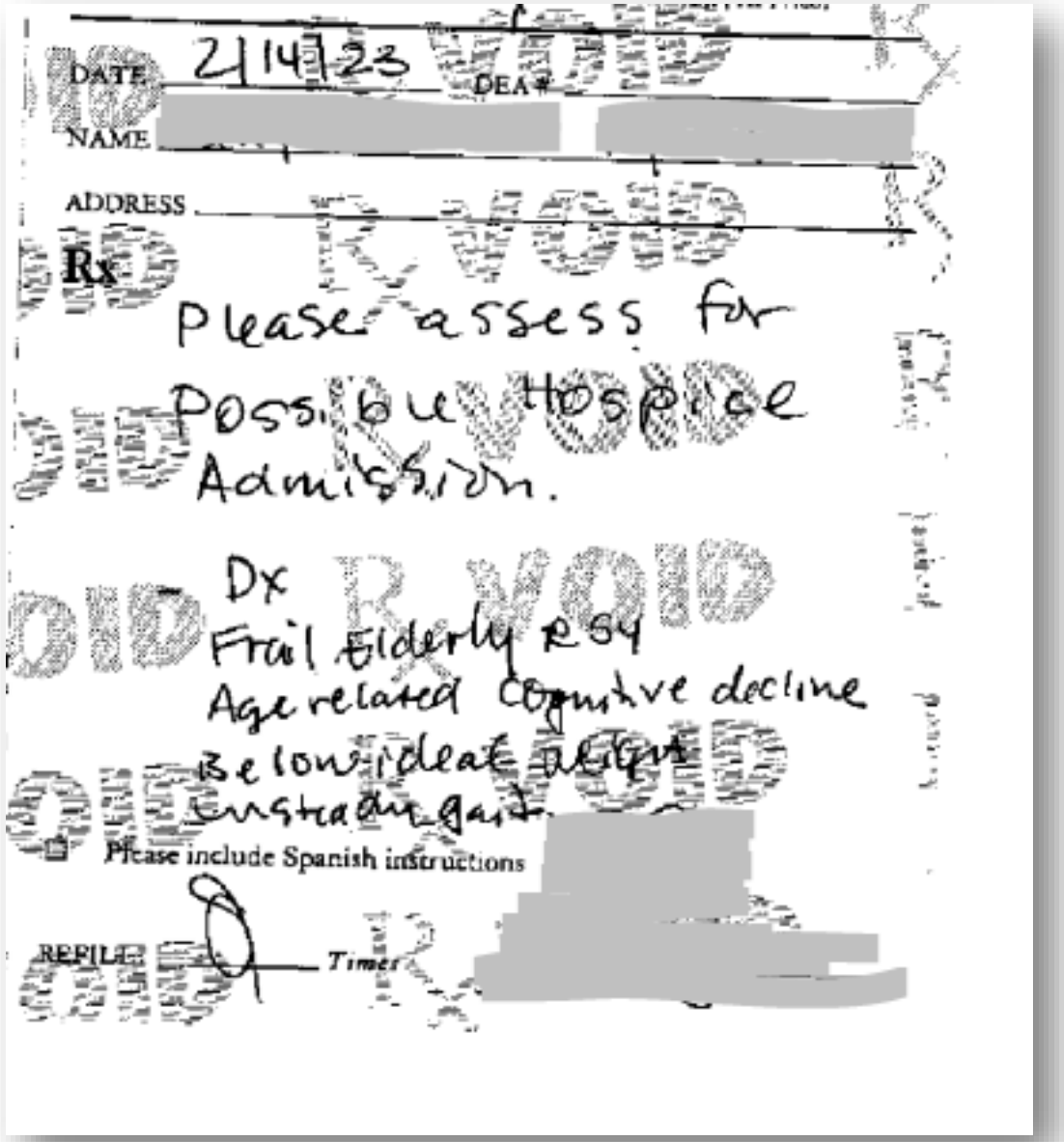
Certifications

Terminal prognosis

GIP

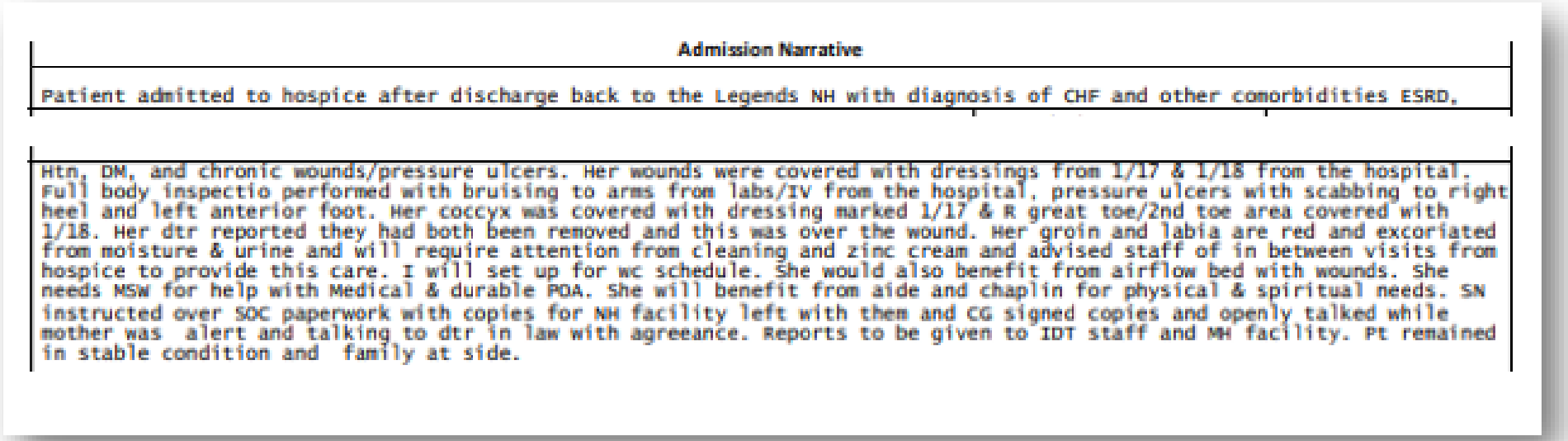
Risks | Terminal Prognosis

- Example 9—Vague referrals



Risks | Terminal Prognosis

- Example 10—Poor admission summary



Admission Narrative

Patient admitted to hospice after discharge back to the Legends NH with diagnosis of CHF and other comorbidities ESRD, Htn, DM, and chronic wounds/pressure ulcers. Her wounds were covered with dressings from 1/17 & 1/18 from the hospital. Full body inspectio performed with bruising to arms from labs/IV from the hospital, pressure ulcers with scabbing to right heel and left anterior foot. Her coccyx was covered with dressing marked 1/17 & R great toe/2nd toe area covered with 1/18. Her dtr reported they had both been removed and this was over the wound. Her groin and labia are red and excoriated from moisture & urine and will require attention from cleaning and zinc cream and advised staff of in between visits from hospice to provide this care. I will set up for wc schedule. She would also benefit from airflow bed with wounds. She needs MSW for help with Medical & durable POA. She will benefit from aide and chaplin for physical & spiritual needs. SN instructed over SOC paperwork with copies for NH facility left with them and CG signed copies and openly talked while mother was alert and talking to dtr in law with agreeance. Reports to be given to IDT staff and MH facility. Pt remained in stable condition and family at side.

Risks | Terminal Prognosis

Certified by physician as terminally ill

Prognosis for life expectancy six months

Risks | Terminal Prognosis

Hospice Local Coverage Determination (LCD)

LCDs provide guidance in determining medical necessity of services. CGS has developed a hospice LCD, ID# L34538 titled Hospice Determining Terminal Status

The LCD:

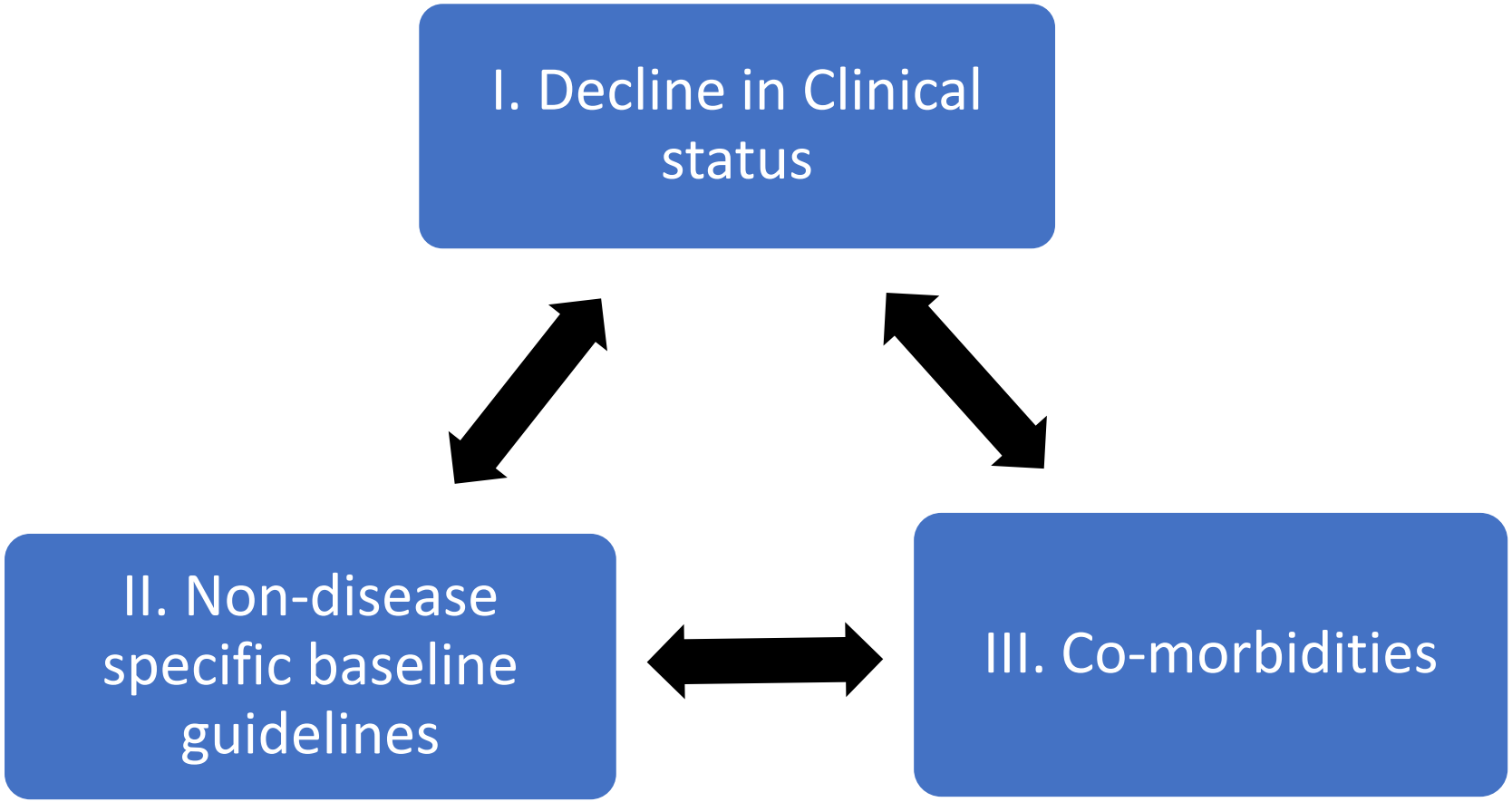
- Allows for the decline of a beneficiary to be a factor in determining prognosis.
- Consists of three parts, and a disease specific appendices:
  - Part I is related to the decline in a beneficiary predictive of a six month prognosis.
  - Part II is related to the functional limitations of a beneficiary, and is used in conjunction with the disease specific appendices. Part II does not stand alone in prediction of a limited prognosis.
  - Part III discusses co-morbidities that may be helpful in predicting and documenting a six-month prognosis.
  - Is used by CGS Medical Review staff as a guideline to aide in consistency of reviews.

Reviewed: 12.08.21

CGS

FORVIS

Risks | Terminal Prognosis



Risks | Terminal Prognosis

- Example 11—Hospital documentation/good admission narrative

Hospital Course

.

Brief HPI:

Patient is a 86 y.o. female with PMH significant for failure on 2 L of oxygen, COPD/centrilobular emphysema, pulmonary hypertension, hypothyroidism, DM2, AAAadmitted on 3/23/2023 with pressure injury on her sacrum. The patient was recently admitted twice in February for acute COPD exacerbation with concurrent pneumonia and left hip fracture. She was discharged on 2/23/2023 to [redacted] and rehab with a Foley. Since her stay at [redacted] health and rehab the patient developed a stage III sacral ulcer. Her daughter was concerned so she brought her to the ED for further evaluation and treatment.

Acute on chronic hypoxic hypercapnic respiratory failure, on 2L NC baseline
Acute on chronic diastolic heart failure
GPC and GNR pneumonia POA
Bilateral pneumonia left more than right, suspect healthcare associated
Covid 19 pneumonia with superimposed bacterial pneumonia
COPD exacerbation: Presumed COPD. No PFTs on file.
-Completed dexamethasone , not a candidate for remdesivir due to acute infection. No Actemra due to high flow oxygen need.
-Baseline 2L NC -> Oxygen requirements have improved to 2-3L NC from HFNC
-Good response to Lasix IV 20mg BID, switch to 20 mg daily on discharge
-Completed antibiotics vancomycin, ceftriaxone on 4/1/2023; s/p cefepime, Zosyn and Zithromax

Risks | Terminal Prognosis

Visit Notes/Ongoing Comprehensive Assessment 86 year old caucasian female patient being admitted with End Stage Respiratory Failure

Comorbidities: Protein Calorie Malnutrition, CAD, HTN, CKD IIIA, Chronic Respiratory failure, Emphysema, Pulmonary HTN, Hypothyroidism, DMII, AAA, Pressure Ulcer to sacrum with MRSA, COVID, Cerebral Artery Occlusion with cerebral infarct, Bacterial Pneumonia, Left hip fracture, Acute on chronic diastolic CHF, COPD, Sepsis pneumonia

PPS: 30, LMAUC: 33.3, Height: 62", Weight: 171.8, BMI 33.55

Why hospice: Patient has been hospitalized 5 times in the past 6 months. 2/09/2023- 02/17/2023 for Pneumonia, 02/19/2023 - 02/23/2023 for left hip fracture. She was receiving PT at [redacted] Health and Rehab and went to for follow up for hip fracture on 03/23/2023 and found to have a pressure ulcer to sacrum that was positive for MRSA. While hospitalized found to have COVID and COVID pneumonia superimposed with bacterial pneumonia, Acute on chronic diastolic CHF and respiratory failure. She was found to have albumin of 2.9 and was treated with midodrine and Albumin and LR. Albumin levels improved to 3.1. She was treated with antibiotics and steroids for pneumonia. While hospitalized she declined and was transferred to ICU and placed on BiPap. Patient was weaned off but now requires 2L O2 continuously. Since hospitalization the patient's PO intake declined and she was only eating bites of food with sips of liquids. After discussing options the patient verbalized that she did not wish to return to therapy and wanted to go home and no longer seek aggressive treatment.

Mental Status: 6 months ago the patient was AOx3-4. Able to have a meaningful conversation and make her basic needs known. She was able to make her own decisions. This remains the same. She was slow to answer questions but was able to make her needs known and participate in own care decisions.

Functions: 6 months ago the patient was high functioning. She was able to stand independently and was ambulatory in her home with walker for stability. She required wheelchair for mobility outside of home related to SOB. She was continent of bowel and bladder with intermittent stress urinary incontinence. She was able to toilet herself, shower and dress herself. She was able to participate in ADLs. Now patient is bed bound. She is minimally able to assist with turning. She becomes easily fatigued with minimal exertion. She appears weak. She has a foley catheter in place with light yellow urine output. She now has chronic constipation. Daughter reports she had to be disimpacted on 04/02/23. She requires total care with ADLs.

Respirations: 6 months ago the patient had a history of COPD and Emphysema. She had shortness of breath with minimal exertion and talking. She required 2L O2 intermittently during the day for dyspnea and at night while sleeping. She had a chronic cough. Now the patient requires 2L O2 continuously. Her lung sounds are diminished to bases and clear to upper lobes. She becomes easily short of breath with any exertion and with talking. O2 sats at 94% at rest with O2 and dropped with 92% with talking.

Cardiac: 6 months ago the patient had a history of HTN and CAD. She was diagnosed with AAA in September. Her family reports she would have intermittent swelling of her feet and ankles. Now the patient has 1+ generalized edema. Her heart rate is sluggish at 50 BPM. Her hands and feet are warm to touch. Pedal pulses were palpable.

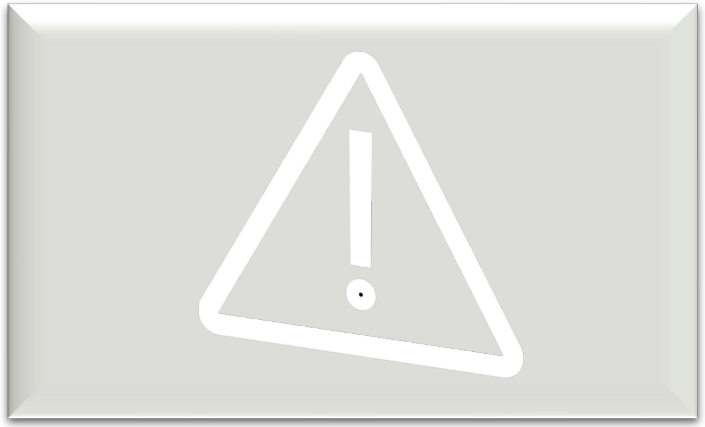
Sleeping: 6 months ago the patient was sleeping 10-12 hours per day and taking no naps. Now the patient is sleeping 14-16 hours per day in 3-4 hour increments.

Eating: 6 months ago the patient was eating 3 small meals per day. She was able to feed herself with setup assist. Now the patient is only taking bites of food with sips of liquids. She has been drinking Ensure for supplements. She has visible muscle wasting. She appears fluid overloaded.

Skin: 6 months ago the patient had no skin issues. Now the patient has an unstageable wound to her sacrum measures 5.5 X 5.8 X 3.5 with excoriation to surrounding tissues. She has large number of scattered bruises to arms. She has a 4.0 X 3.2 skin tear to her left upper arm. Her skin is pale with poor turgor.

Pain: 6 months ago the patient had chronic pain to lower back. Now the patient has pain to her left hip related to previous fracture. Continues to have chronic lower back pain

Risks | GIP



Election statements

FTF

Certifications

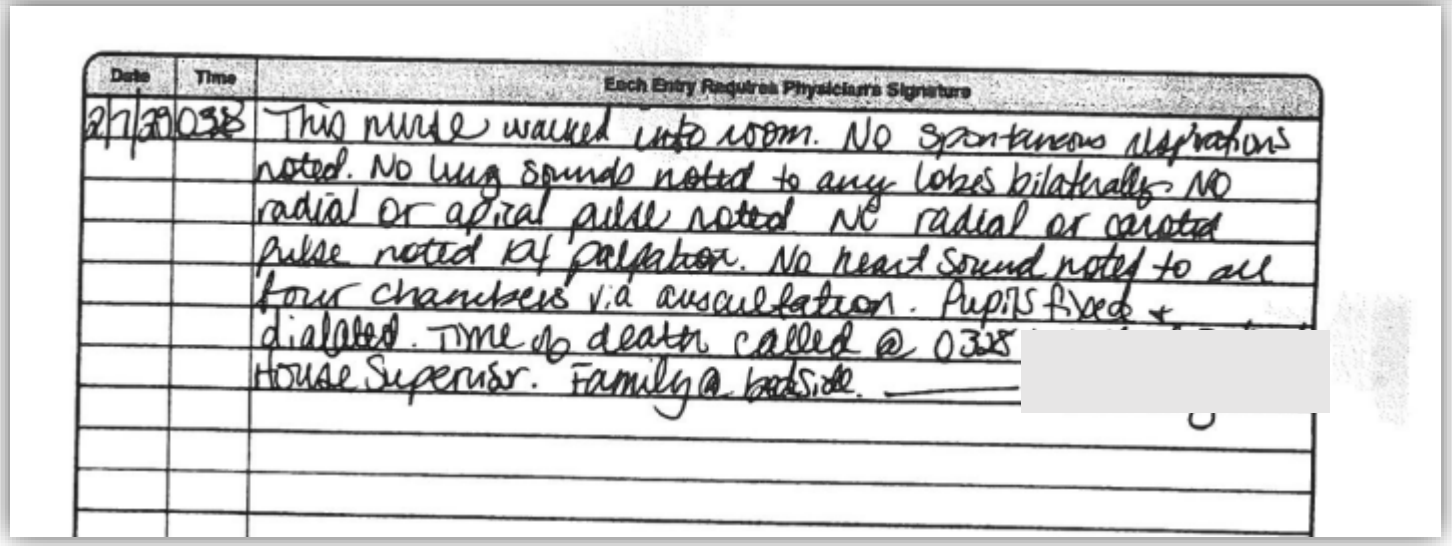
Terminal prognosis

GIP

Risks | GIP

- Example 12—What symptoms?

Patient is an 80 year old female who was living in her home independently 2 weeks ago. She presented to the ER on 1/26/2023 after having a thyroid ablation 2 weeks prior with hallucinations and overall change in mental status. She has went in and out of consciousness for the past week. Current non-responsive x 24 hrs. Nothing to eat in 6 days but has been receiving IV hydration. Her daughter is in the room with her on admission and comfortable with the decision for comfort care. She will be the primary caregiver at home when patient symptoms are managed well enough to be transferred home. Currently her HR is 140-150, temp is over 100, and secretions in airway requiring suction. First dose of morphine was give just prior to SN arrival and she seemed to be resting comfortable. Plan of care orders taken from [redacted] reviewed with patients daughter, and facility staff. No skin breakdown noted today. Plan to see patient daily.



Date	Time	Each Entry Requires Physician's Signature
2/7/23	0338	This nurse walked into room. No spontaneous respirations noted. No lung sounds noted to any lobes bilaterally. NO radial or apical pulse noted. NO radial or carotid pulse noted by palpation. No heart sound noted to all four chambers via auscultation. Pupils fixed & dialated. Time of death called @ 0338 [redacted] House Supervisor. Family @ bedside.

Risks | GIP

- Example 13—IV medications

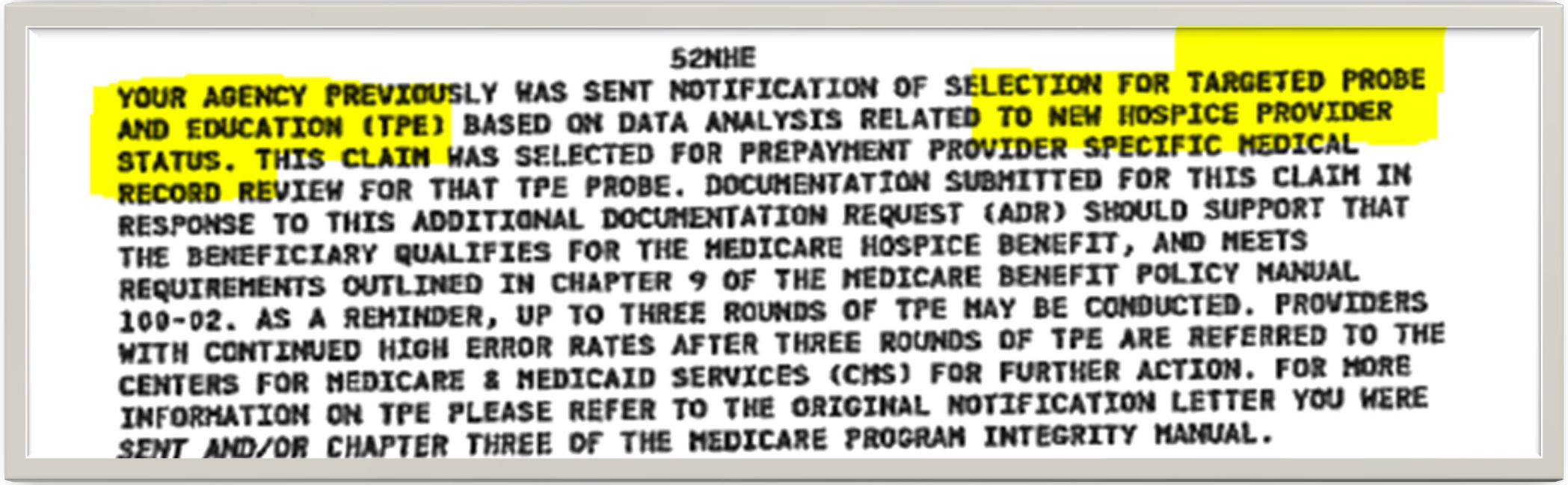
History of Present Illness
Admission date: Feb 19, 2023
Chief Complaint: Desatting O2
History of Present Illness
M is a chronically ill 76-year-old male who resides at still house. Recently admitted for right humerus fracture. Medical history includes metastatic squamous cell carcinoma status post left neck dissection, chronic pain, hypertension, CAD, depression patient current everyday smoker ambulation wheelchair-bound. Most history obtained from chart and son at bedside patient is unable to answer questions meaningful at this time. Patient presented to the ER tonight via EMS from still house due to desatting nursing home staff states patient sats were in the 80s patient on BiPAP patient temperature 102 patient been hypotensive 94/57 it appears patient may have aspiration pneumonia.

Indicate patient's decline with terminal diagnosis as well as comorbidities in the last 2-6 months, including measurable changes in PPS/KPS, weight/MAC/BMI, wound measurements, FAST, hours of sleep, medications, DME, visit frequencies, level of care, and ADL assistance needs.

76 year old male admitted GIP at PRMC with dx of metastatic squamous cell carcinoma and patient is imminent at time of admit. He is unresponsive and has had no oral intake since Friday. He has elevated heart rate, increased respiratory rate, temperature and edema. Patient is requiring IV ativan and morphine to keep him comfortable. He is total care with all ADL's and he is taking nothing by mouth, oral care only. He has surgical wounds to bilateral upper arms with staples from surgeries to repair femur fractures in both arms without injuries. He has a stage 3 pressure sore to his coccyx. He is mouth breathing and dry mucous membranes. He has been on bipap and then no longer could keep his sats up and he is now on a nasal cannula at 15L that is placed across his mouth due to mouth breathing. Patients death is imminent and has had a rapid decline since Friday. Family wants comfort measures only and patient is a DNR.

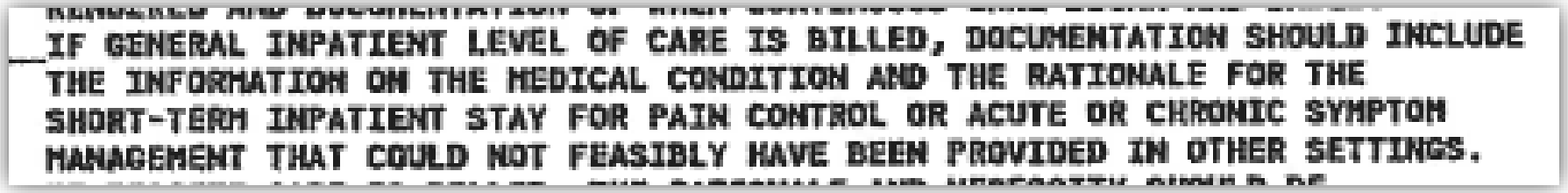
Risks | GIP

- New Hospice Provider GIP



52NHE

YOUR AGENCY PREVIOUSLY WAS SENT NOTIFICATION OF SELECTION FOR TARGETED PROBE AND EDUCATION (TPE) BASED ON DATA ANALYSIS RELATED TO NEW HOSPICE PROVIDER STATUS. THIS CLAIM WAS SELECTED FOR PREPAYMENT PROVIDER SPECIFIC MEDICAL RECORD REVIEW FOR THAT TPE PROBE. DOCUMENTATION SUBMITTED FOR THIS CLAIM IN RESPONSE TO THIS ADDITIONAL DOCUMENTATION REQUEST (ADR) SHOULD SUPPORT THAT THE BENEFICIARY QUALIFIES FOR THE MEDICARE HOSPICE BENEFIT, AND MEETS REQUIREMENTS OUTLINED IN CHAPTER 9 OF THE MEDICARE BENEFIT POLICY MANUAL 100-02. AS A REMINDER, UP TO THREE ROUNDS OF TPE MAY BE CONDUCTED. PROVIDERS WITH CONTINUED HIGH ERROR RATES AFTER THREE ROUNDS OF TPE ARE REFERRED TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) FOR FURTHER ACTION. FOR MORE INFORMATION ON TPE PLEASE REFER TO THE ORIGINAL NOTIFICATION LETTER YOU WERE SENT AND/OR CHAPTER THREE OF THE MEDICARE PROGRAM INTEGRITY MANUAL.



IF GENERAL INPATIENT LEVEL OF CARE IS BILLED, DOCUMENTATION SHOULD INCLUDE THE INFORMATION ON THE MEDICAL CONDITION AND THE RATIONALE FOR THE SHORT-TERM INPATIENT STAY FOR PAIN CONTROL OR ACUTE OR CHRONIC SYMPTOM MANAGEMENT THAT COULD NOT FEASIBLY HAVE BEEN PROVIDED IN OTHER SETTINGS.

Risks | GIP

- Example 14 – New hospice provider GIP TPE summary

admitted to GIP level of care for a terminal diagnosis of nontraumatic intracranial hemorrhage, end stage disease. Patient was admitted to Hospice on January 29,2023. was certified for eligibility for hospice by Hospice medical director. His comorbidities include Fall on same level, unspecified, initial encounter, Cerebral aneurysm, non-ruptured, Other nonspecific abnormal finding of lung field, Essential (primary) hypertension. At the time of admission in January, , met criteria for General Inpatient Hospice at Patient presented to ER after ground level fall. Reports leg weakness and fell to knees. RLE weakness remained. Upon work up pt found to have intracranial bleed also has neoplastic mass in lungs. Pt had craniotomy performed. Unable to wean from vent. Continues to require sedation and mechanical ventilation. Requiring pressors to keep his blood pressure up. Continued to decline despite aggressive treatment. Patient remains un-responsive. Ventilator in place. Patient over breathing ventilator. Labored respirations. Large amount of family members present. All family except immediate family says final goodbyes and leaves room. Family grieving appropriately. Hospital to proceed with extubation and providing comfort measures. PPS 10%, KPS 10% his family have made the decision to seek Hospice Care via GIP versus aggressive treatment for conditions related end Cerebral Infarction.

Prior to GIP Admission Requested Documentation Period

- Documented a rapid decline in health status
- Documented PPS 10% and KPS 10%
- Documented Intubated on Ventilator (On 01/20/2023)
- Documented Acute Intra-Axil Hematoma Lung Mass with pneumonia Measuring 4cmX4cmX4.4cm w/subarachnoid hemorrhage
- Documented Right Sided Weakness
- Documented increased sleeping 20 to 24 hours.
- Documented nutritional status is poor due to NPO.
- Documented orientation (Unresponsive).
- Documented Dependent of 6/6 ADLs, requires supervision, dependent with dressing, bathing, incontinence of bowel and bladder, transfer and is bedbound.
- Small Renal Cyst Noted

Based on the information, we believe that all services billed to were reasonable and necessary and met all requirements for Medicare coverage.

Risks | GIP

Supportive Documentation for GIP

Upon transfer to GIP level of care, documentation should include both:

- A precipitating event (onset of uncontrolled symptoms or pain)
- The interventions tried in the home that have been unsuccessful at controlling the symptoms

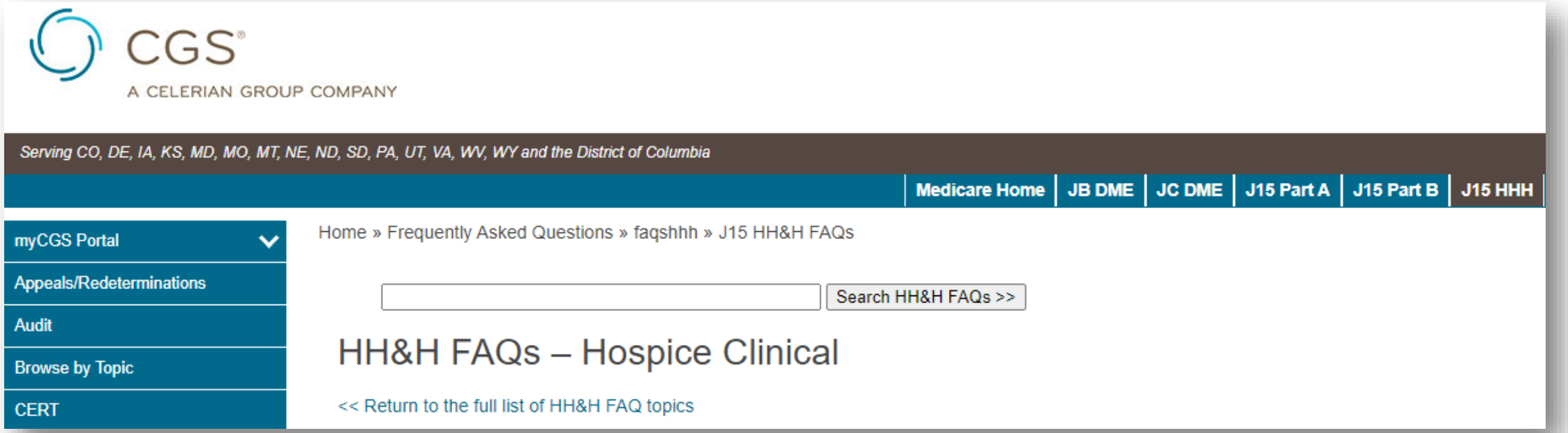
Supporting documentation for pain control may include:

- Frequent evaluation by a doctor or nurse
- Frequent medication adjustment
- IVs that cannot be administered at home
- Aggressive pain management
- Complicated technical delivery of medication

Supporting documentation for symptom control may include:

- Sudden deterioration requiring intensive nursing intervention
- Uncontrolled nausea or vomiting
- Pathological fractures
- Open wounds requiring frequent skilled care
- Unmanageable respiratory distress
- New or worsening delirium

Risks | GIP



5. If a patient is actively dying, is general inpatient level of care appropriate?

A patient is appropriate for general inpatient level of care only if there are symptoms (such as out of control pain) that cannot be brought under control in their current setting. (CMS Pub. 100-02, Ch. 9 §40.1.5) PDF .

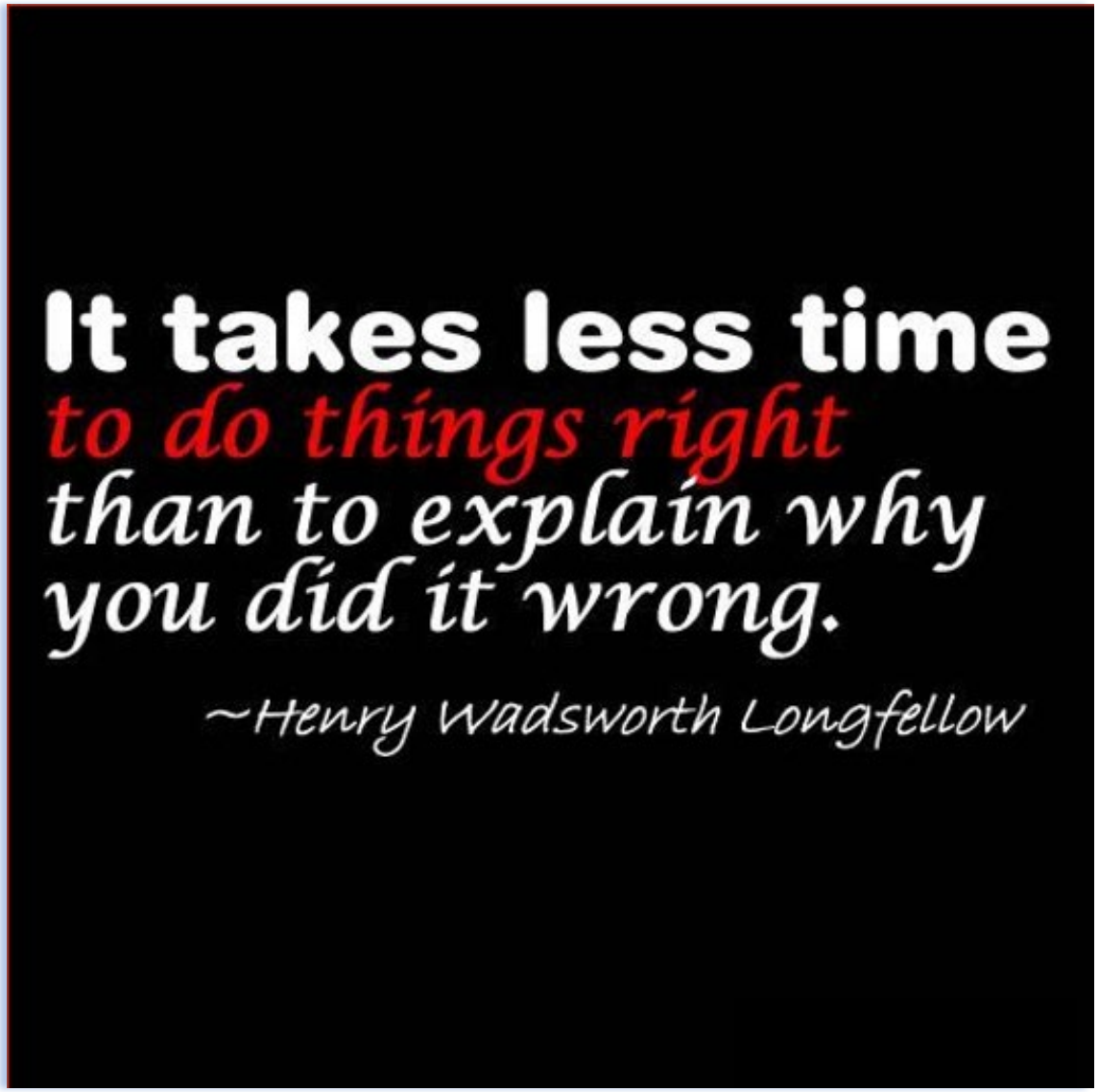
Risks | GIP

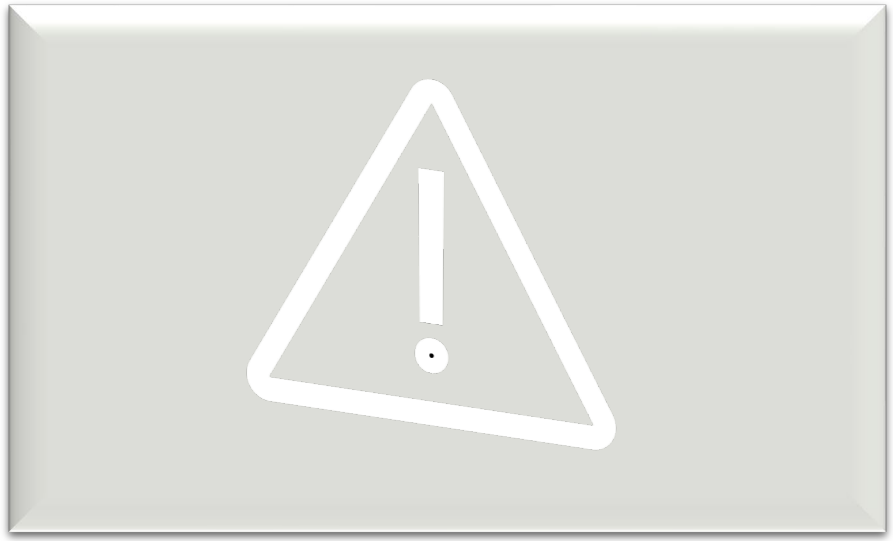
HPI: Veteran is 101y/o here as new patient.

Son states pt does not eat enough. Receives meals on wheels twice a week. Only eats the sweets- cakes, cupcakes. Has been like this most of his life.

He's also an ex-smoker and only has Hypothryoidism and a history of a heart attack in the 80's 😳

Risks | Mitigation





Environment

Risks

Strategies

Pre-Audit Strategies

PEPPER

Compliance assessment

Pre-Audit Strategies | PEPPER

PEPPER

Compliance assessment

Pre-Audit Strategies | PEPPER

PEPPER
Program for Evaluating Payment Patterns Electronic Report

What is PEPPER?

PEPPER summarizes Medicare claims data statistics for one provider in "target areas" that may be at risk for improper Medicare payments.

PEPPER compares the provider's Medicare claims data statistics with aggregate Medicare data for the nation, jurisdiction, and the state.

PEPPER cannot identify improper Medicare payments!

There will be a temporary pause in distributing CBRs and PEPPERs as CMS works to improve and update the program and reporting system. This pause will remain in effect through the fall of 2024. We recognize the importance of these reports to your practice. Therefore, during this time, CMS will be working diligently to enhance the quality and accessibility of the reports. In fulfilling this commitment, your feedback is requested. In the near future, CMS will release a Request for Information (RFI) to obtain information from you, the provider community, about how the program can better serve you.

Source: PEPPER

Pre-Audit Strategies | PEPPER

Hospice PEPPER Target Areas

- *Live Discharges No Longer Terminally Ill*
- *Live Discharges – Revocations*
- *Live Discharges LOS 61 – 179 Days*
- *Long Length of Stay*
- *Continuous Home Care Provided in an Assisted Living Facility*
- *Routine Home Care in Assisted Living Facility*
- *Routine Home Care in Nursing Facility*
- *Routine Home Care in Skilled Nursing Facility*

Hospice PEPPER Target Areas, Cont'd

- *Claims with Single Diagnosis Coded*
- *No General Inpatient Care or Continuous Home Care*
- *Long General Inpatient Stays*
- *Average Number of Medicare Part D Claims for Beneficiaries Residing at Home*
- *Average Number of Medicare Part D Claims for Beneficiaries Residing in an Assisted Living Facility*
- *Average Number of Medicare Part D Claims for Beneficiaries Residing in a Nursing Facility*

Source: PEPPER

Pre-Audit Strategies | PEPPER

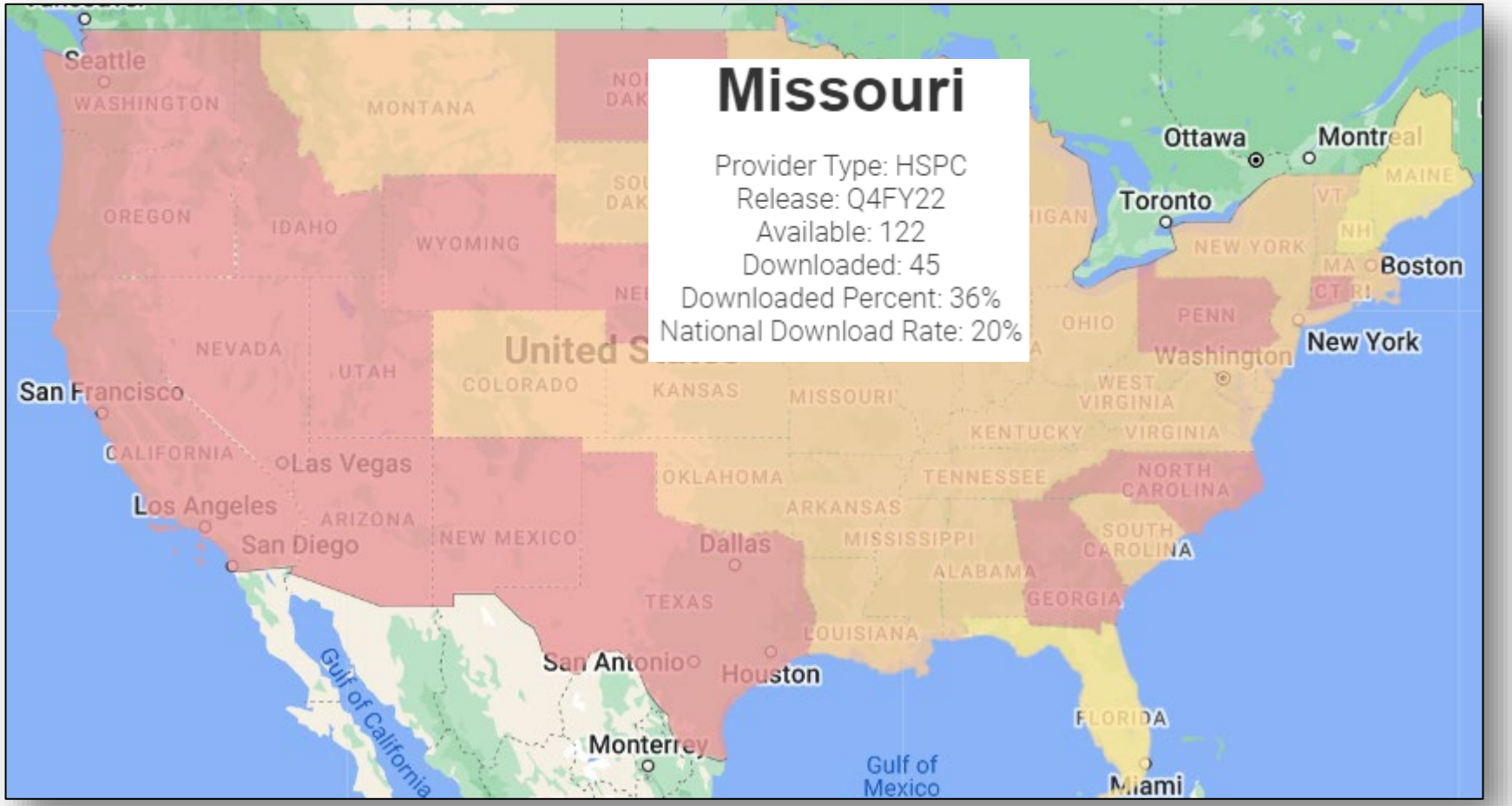
New *Hospice PEPPER* Target Areas

- *Average Number of Medicare Part B Claims for Beneficiaries Residing at Home*
  - New as of Q4FY22 release
- *Average Number of Medicare Part B Claims for Beneficiaries Residing in an Assisted Living Facility, Nursing Facility, or Skilled Nursing Facility*
  - New as of Q4FY22 release

Source: PEPPER

Pre-Audit Strategies | PEPPER

PEPPER
Program for Evaluating Payment Patterns Electronic Report

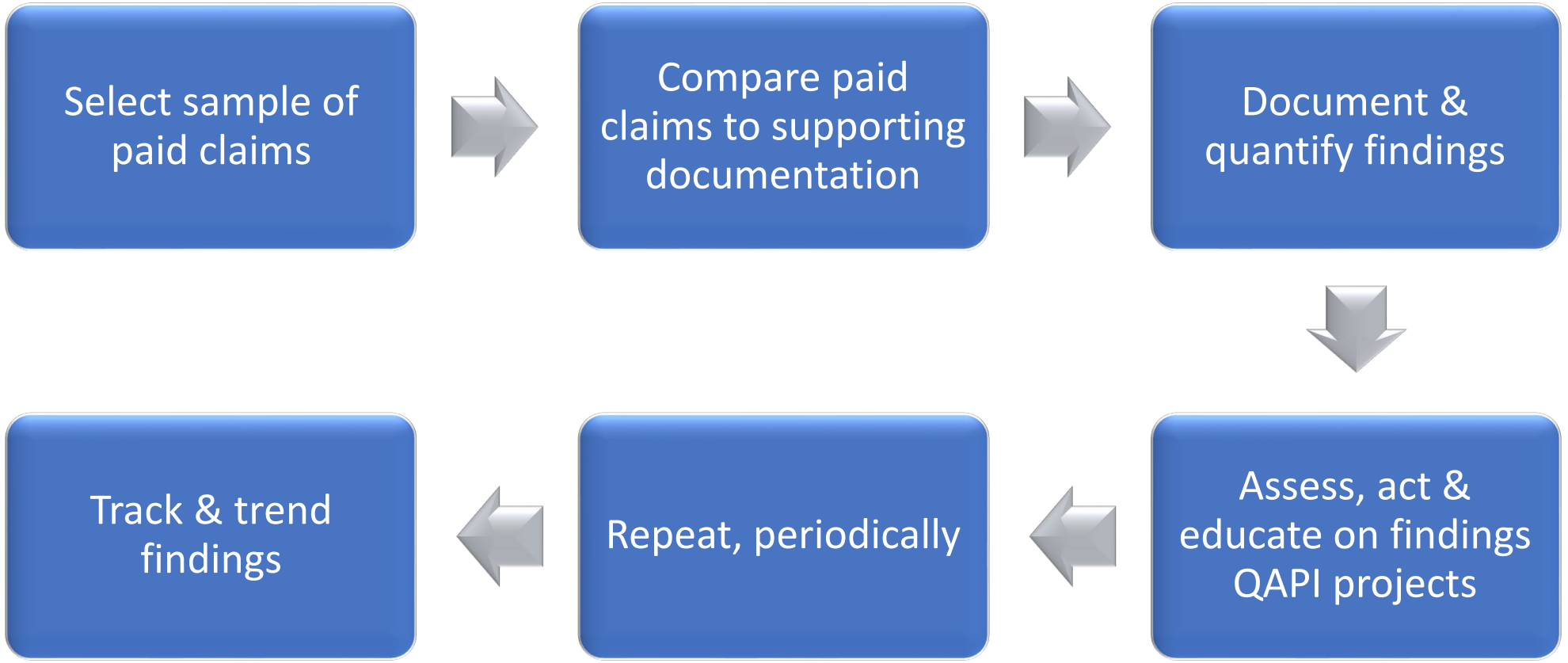


Pre-Audit Strategies | Compliance Assessment

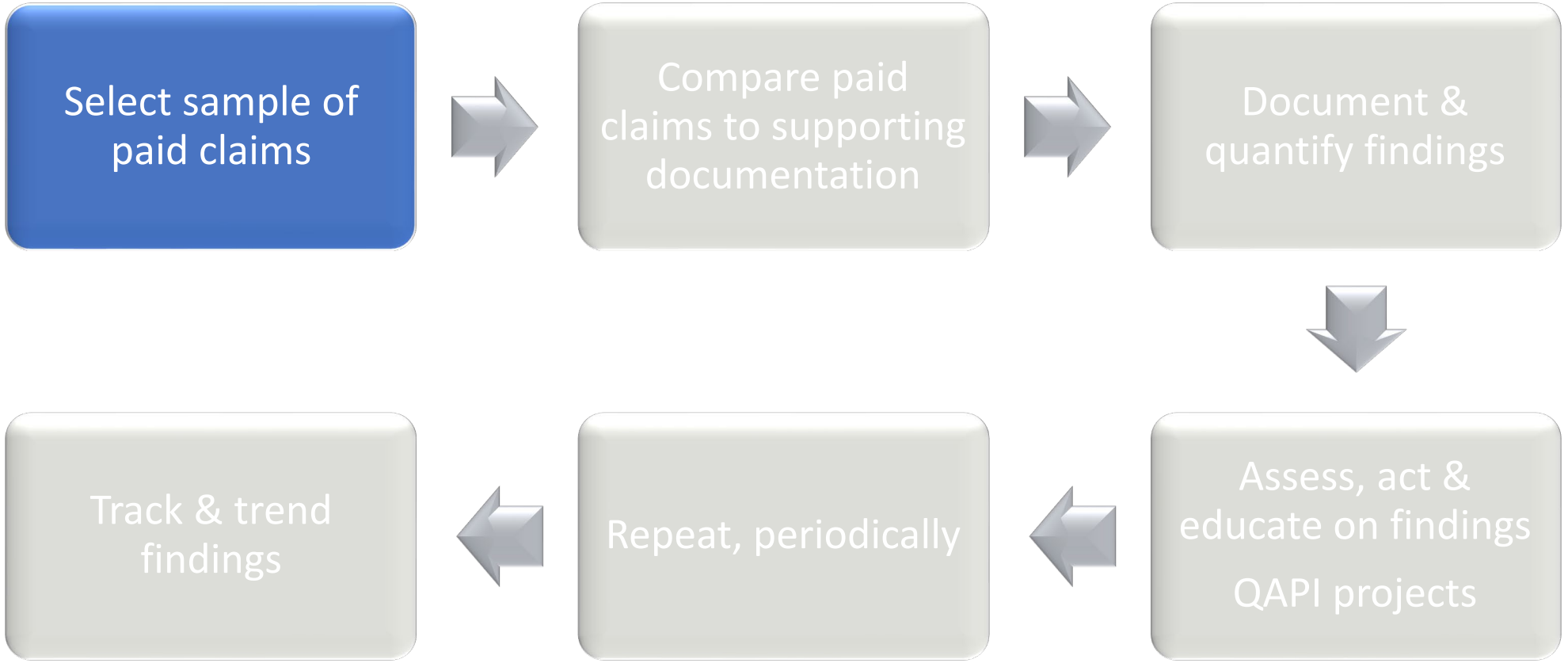
PEPPER

Compliance assessment

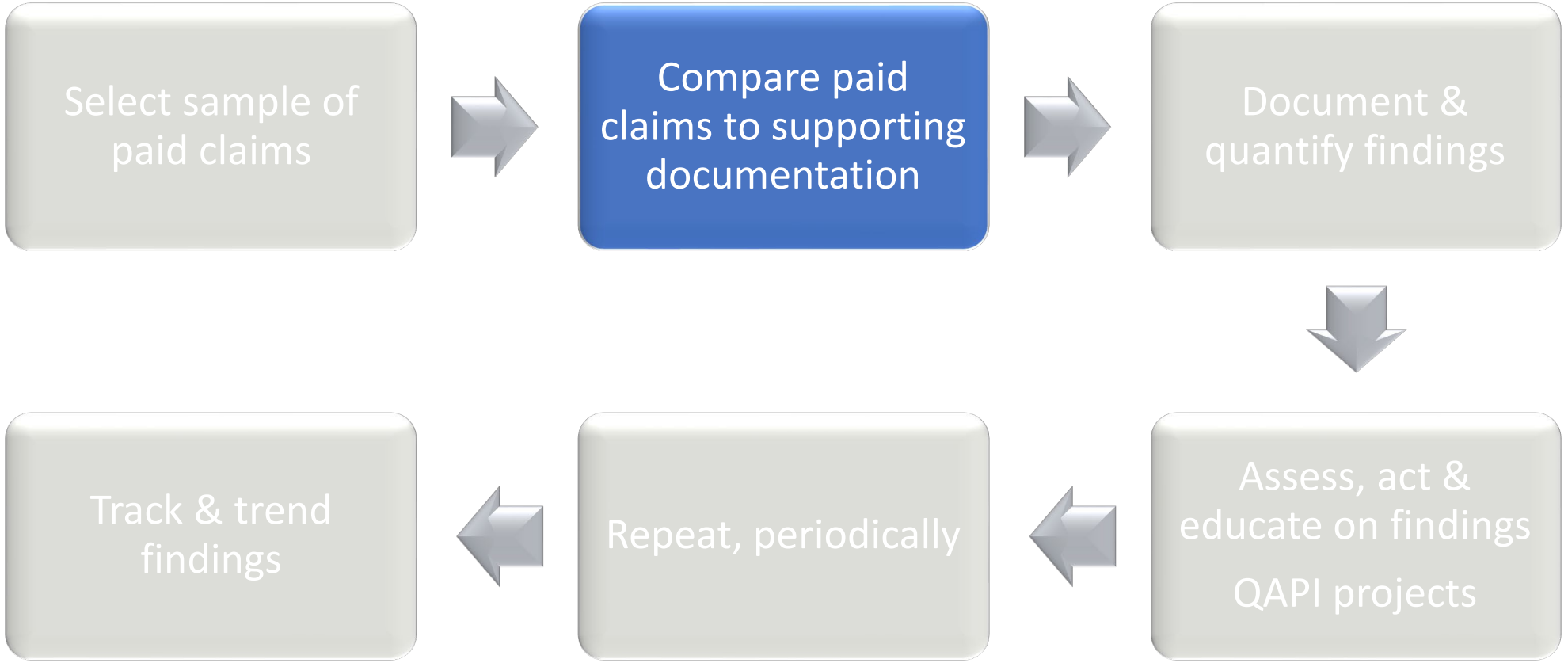
Pre-Audit Strategies | Compliance Assessment



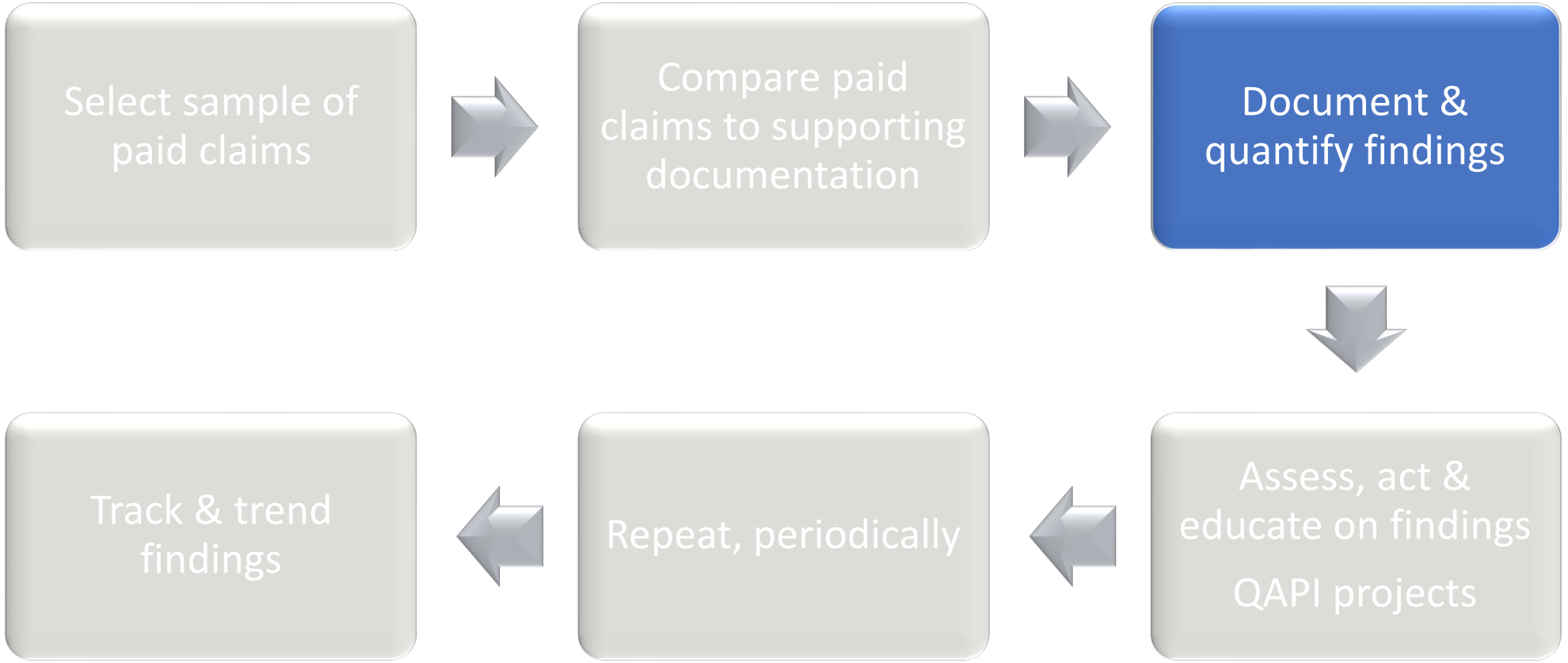
Pre-Audit Strategies | Compliance Assessment



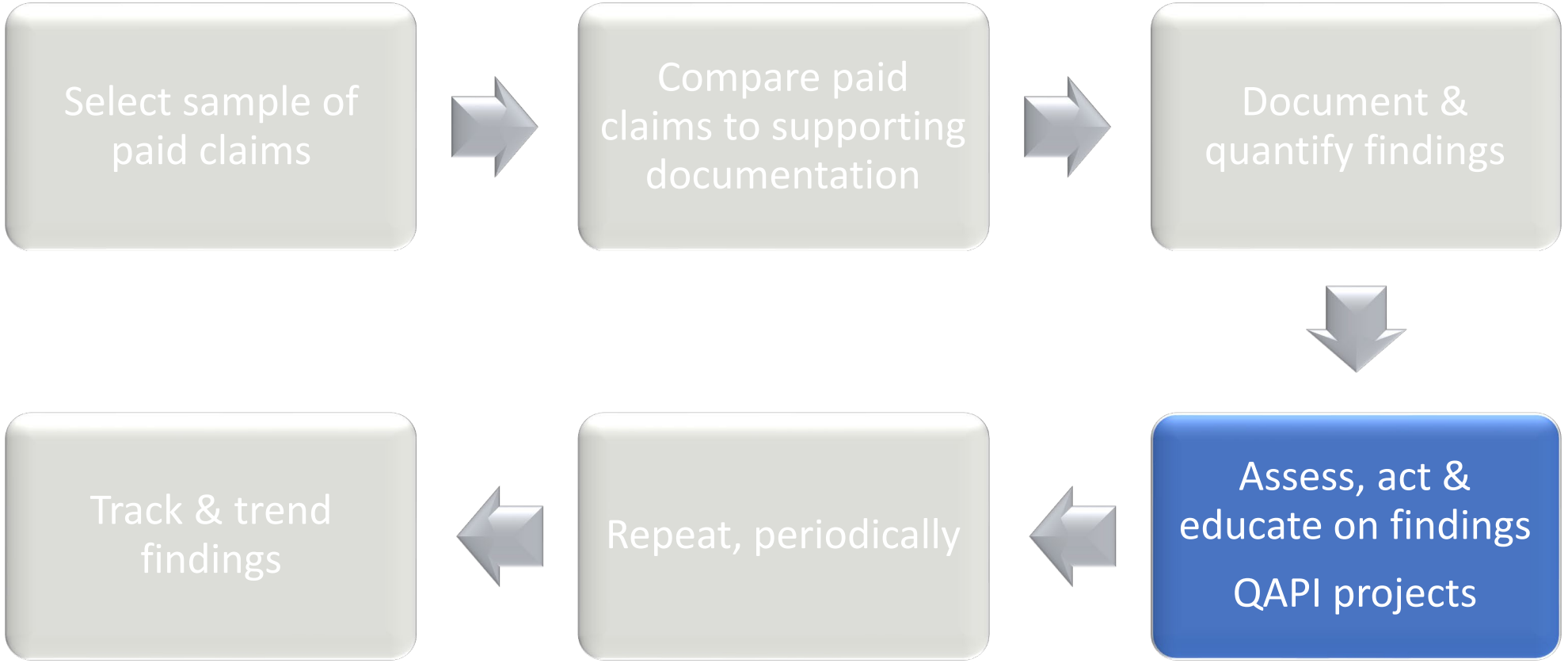
Pre-Audit Strategies | Compliance Assessment



Pre-Audit Strategies | Compliance Assessment



Pre-Audit Strategies | Compliance Assessment



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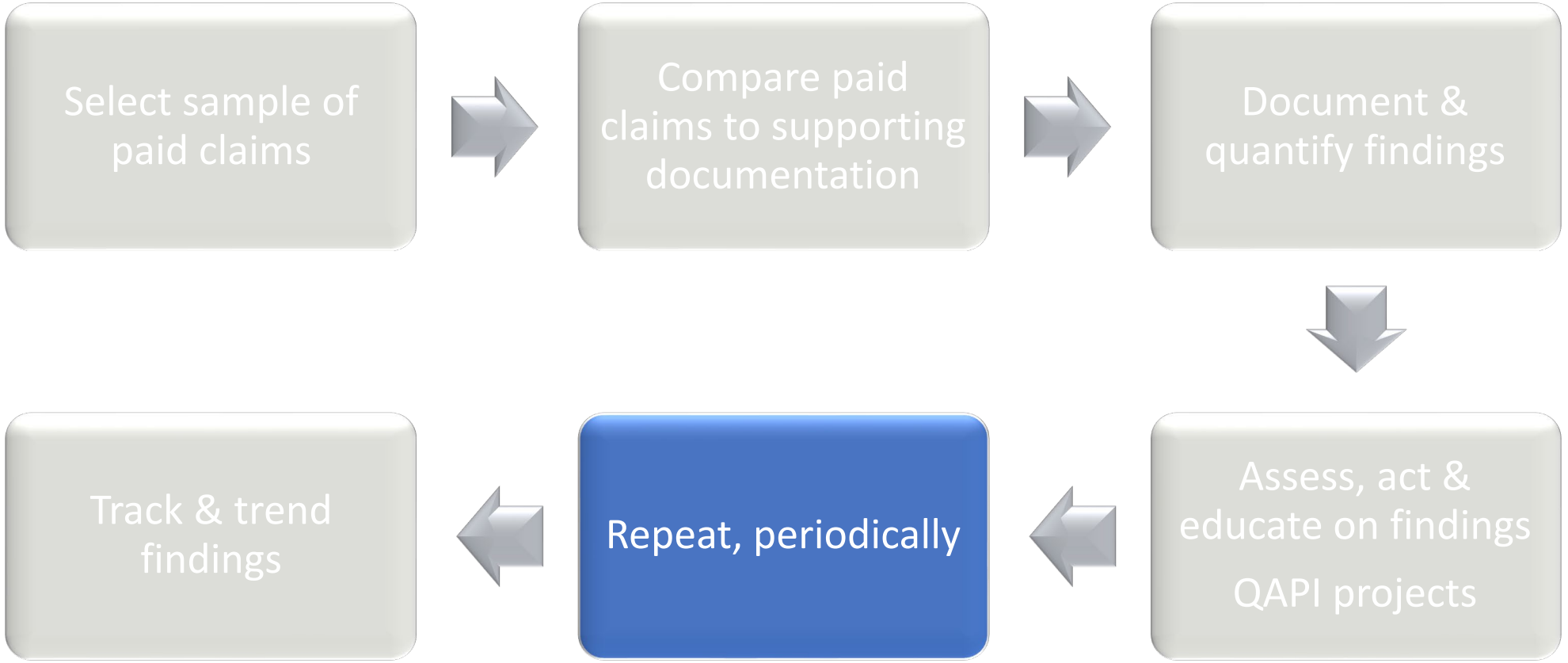

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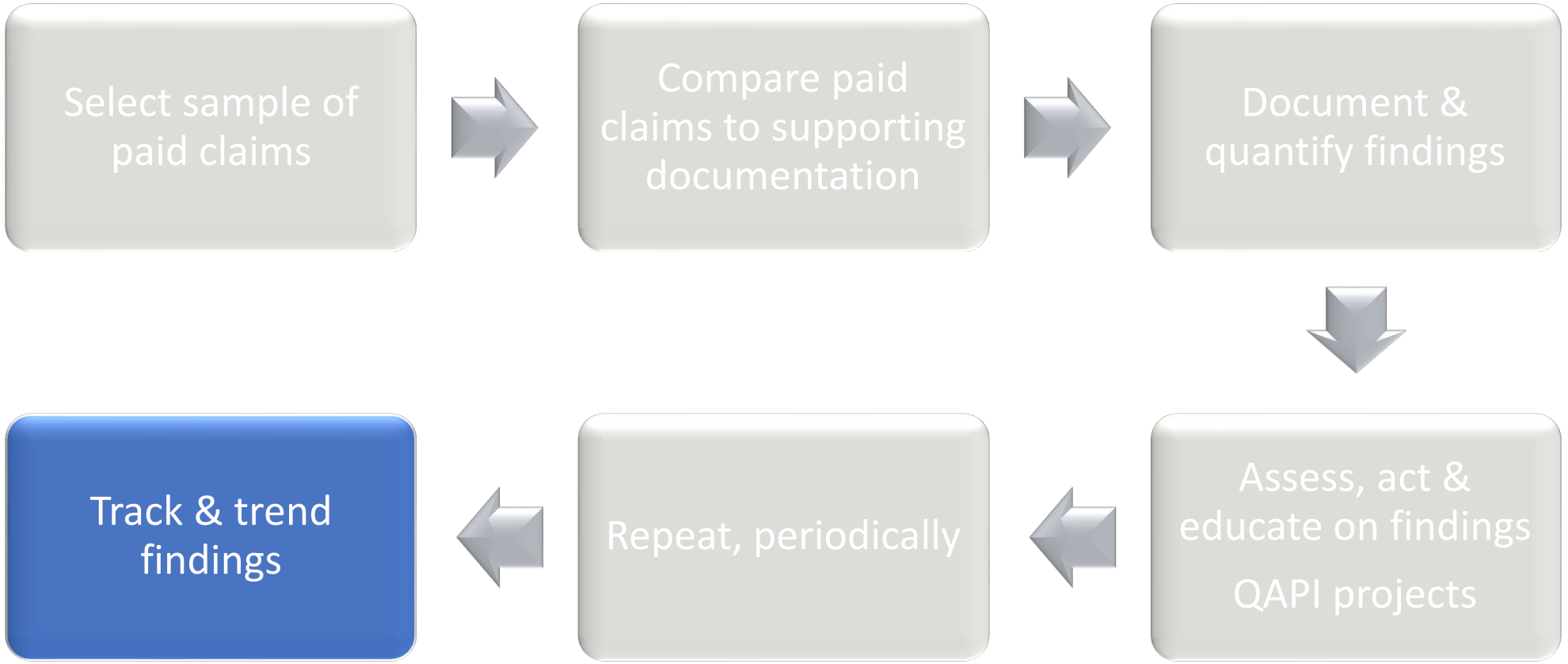

During Audit Strategies | People

- People
  - Who in your agency would get these letters
  - Who in your agency would know if claims are marked for ADR?
  - Who do they notify in your agency?
  - Who do you need to engage?
    - Financial
    - Clinical
    - Outside – legal & consultant

During - Audit Strategies | Processes

- Processes
  - Assemble a team
    - Outside assistance
  - Establish a process bases on audit type
  - Clinical review of every record
  - Organize records
  - Make it easy for the reviewer
  - Send electronically
  - Tracking

Understand environment

Know your risks

Apply practical strategies

Questions?

Angela Huff, RN
Senior Managing Consultant
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Acronyms

- **BFCC-QIO** Beneficiary & Family Centered Care-Quality Improvement Organization
- **CERT** Comprehensive Error Rate Testing contractor
- **FTF** Face-to-face
- **GIP** General inpatient care
- **MAC** Medicare Administrative Contractor
- **RAC** Recovery Audit Contractor
- **SMRC** Supplemental Medical Review Contractor
- **TPE** Targeted Probe & Educate
- **UPIC** Unified Program Integrity Contractor