Hospice Documentation
That Protects Your Reimbursement

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Today hospices are facing a great deal of scrutiny by the Centers for Medicare and Medicaid Services (CMS). Medicare administrative contractors (MACs) have increased their edits and are now asking hospices to send in documentation prior to payment through the Additional Document Request or Additional Development Request (ADR) process. This means your business is under the magnifying glass, and there's nothing on the horizon to indicate that this will be changing anytime soon. But, information is power – and the key to ensuring you get paid. This white paper outlines how to identify where you are at risk for an audit, and how to prepare for it and ensure that you have the necessary documentation in place to be able to pass it.

Kinnser thanks Annette Lee, RN MS HCS-D COS-S, for authoring this guide.

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ADR PROCESS

The foundation for the edits begins with the Progressive Corrective Action Plan, which is a process designed by CMS to ensure a logical and fair methodology for Medicare claim reviews. (To review the process in detail, refer to the Medicare Program Integrity Manual.) As part of this process, an ADR can be invoked, which simply means that an intermediary can suspend your claim and request additional documentation before you can be paid.

There are three kinds of edits that can be requested: widespread, provider-specific, and beneficiary- or patient-specific. Let’s take a look at each one.

Widespread Edits

Widespread edits are set up with parameters such as length of stay. When a vulnerability is identified, it is first validated by a “probe edit” which is where 100 claims are randomly picked and reviewed. If the findings prove to be significant, the edit will continue.

With widespread edits your agency will not go on a focused medical review – that is after you’ve been through your own analysis, when you’ve had multiple claims looked at. But widespread is more just luck of the draw.

Currently, if you bill to CGS there are five widespread edits already in existence:
1. **5037T**: This edit selects hospice claims with revenue code 0651 (Routine) and a length of stay of greater than 730 days.

2. **5048T**: This edit selects hospice claims based on a length of stay of 999 days.

3. **5057T**: This edit selects hospice claims with revenue code 0656 (General Inpatient Services [GIP]) with at least seven or more days in a billing period.

4. **5091T**: This edit selects hospice claims with HCPC codes Q5003 (Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)) and Q5004 (Hospice care provided in skilled nursing facility (SNF)), primary diagnosis of 799.3 (Debility, unspecified) and a length of stay greater than 180 days.

5. **59BX9**: This edit selects hospice claims due to previous denials for selected beneficiary.

Palmetto is also doing widespread edits and they are looking at non-cancer diagnoses of patients who live in facilities. There’s no length of stay noted here, they are just looking at patients with hospice diagnoses that are not cancer-related who reside in a nursing facility. NGS (and the former NHIC) is not currently conducting widespread edits. However, this could change.

So, how does the landscape of widespread edits look in the near future? While there has been some pushback on the MACs for the level of reviews being conducted, the evaluation of the length of stay will continue. Diagnoses related to debility or failure to thrive will be returned to provider for further details. And, local coverage determinations (LCDs) will need to be updated. A good resource for understanding what you might be facing is the Office of Inspector General’s (OIG) report. Of note, the OIG is focused on the level of general inpatient and relationships with nursing facilities due to feedback that hospices are gaining an unfair advantage because they can promise nursing facility continuous care. By law, this is illegal, but the OIG is looking at what those relationships are like. Also, the OIG also noted that 40% of the hospices in the nation have not had a survey in six years, which has raised a red flag. So, in the future be prepared that more hospices will be surveyed routinely.

There is also some buzz about the Recovery Administrative Contractor (RAC), which is a contractor that works partly on the pay that they recoup. This is a post-pay contractor, so it is different than the intermediary where they suspend the claim and ask you to prove the case before they pay you. The RAC can come in two to three years later and request documentation for an old case, and if they don’t feel the documentation is strong enough they can recoup the funds. CMS plans to have a new RAC contractor this year for hospice, home health and durable medical equipment (DME). So, it is an excellent idea to be prepared for an audit because you never know when it may happen.
Provider-Specific Edit
It is great if your outcomes such as national quality stand out. But when it comes to normal utilization, you definitely want to stay under the radar to avoid attention from the MACs. When they have a question regarding data, they may choose to do a probe edit where they will request 20 to 40 of your claims and request charts through the ADR. There are two possible outcomes to the edit; either they will say everything is ok and take you off of review, or they will indicate that they’ve found enough issues that you’re going on targeted review. This is calculated by an error rate, which is dollars billed versus dollars paid for what they looked at, and every intermediary has a different threshold. Palmetto is the tightest, allowing only 10% of error. NGS allows 15% and CGS allows 25%. So, it’s important to ensure you stay under those thresholds because exceeding them will ensure you will be placed on targeted review. And, a targeted review means you’ll be scrutinized every quarter until they are satisfied that things are as they should be.

Beneficiary-Specific Edit
A beneficiary edit occurs after a reviewer has made a denial based on seeing vulnerability for a next claim. For example, if you have a patient with heart failure on their third year of hospice and your documentation indicates that the patient has some shortness of breath but is up and gardening, the reviewer is going to think that there’s not going to be that much of a decline from one month to the next. This will lead them to ask to see billing for the next few months. Once the beneficiary edit has been turned on – all of the intermediaries will have a B in the edit name, which you can look up in the Fiscal Intermediary Standard System (FISS) – that patient will always be selected. You might as well copy the chart when you send in the bill, because you will always have to prove your case on that patient. The only time a beneficiary edit is removed is when the claim is paid by the medical review or on the first level of appeal.
FINDING ADRS

So how do you know if you have an ADR? If you bill through a third party like Ability you can access reports that will provide that information. You can also go directly to FISS and look for claims that are in this status location as first suspended and then B6001. That is consistent for all intermediaries because it is a national system, and they recommend that you check on a weekly basis for ADRs. However, one of the best resources out there is the CGS ADR Process webpage, which provides an algorithm that will walk you through the different steps such as what to do if you see a suspended claim. There’s also a checklist that the intermediary will provide for you on Claim Page 8.

You certainly will want a clinician to review this and when they do, they might want to include additional documentation from dates prior to this month and after this month, because it’s necessary to show is the big picture. In hospice, this is particularly pertinent because a lot of times it’s either the acuity of the disease or the trajectory of it that shows the downhill slide. It also can be really helpful for the clinician to write an outline or letter pointing to specific dates or page numbers of primary supportive documentation.
MEDICAL REVIEWS

So when an intermediary reviews your charts, what do they base their review on? This is an area where the government really has two separate sides – quality and payment. The quality side is the domain of the state surveyors or, if you’re accredited, the Community Health Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC), and the Joint Commission. The payment folks rely heavily on the Medicare Benefit Policy Manual.

The intermediaries also have a Local Coverage Determination (LCD). The LCD for NGS and CDS allows for the patient’s decline and specific diagnoses. Palmetto does it a little differently, with separate LCDs for each diagnosis, which allows for different documentation with a focus on decline. So although the criteria for the intermediaries are similar, they do have some differences, especially with Palmetto. The key takeaway here is that you must know all of your specific LCDs.

The LCDs provide pertinent information about the symptoms that will support a six-month prognosis, but there are additional things you must provide.

When a chart is reviewed this is the hierarchy they will use. The reviewer will first look to see if there is a valid election statement in the chart. They will also look for some specifics such as signature and date, and an explanation of what hospice means. Then they will look for the certification for those dates of service. And, if this is a 60-day certification or you’re into the third benefit period or later, the face-to-face will be included as well. If all of that is passed, then the next step is to see if the documentation shows that the patient is right for hospice, meaning a) that the

**Diagram:**
- Physician visits
- Non-Routine care supported?
- POC Update every 15 days
- Disease Acuity or Trajectory supports terminal 6 months prognosis
- Technical Components: Certification/FTF if 3rd or later benefit period
- Valid Election Statement with Effective Date
acuity of the disease shows that there is no question the patient is not going to live for another six months, or b) that it shows a longer trajectory but still points again to a six-month prognosis. The last thing they will look at is to see if the plan of care is updated every 15 days. This is all that’s needed to pay a typical hospice claim. The last two things on this hierarchy are for specialized claims. If non-routine care was provided or physician visits occurred you must include that documentation in your chart.

While this seems pretty straightforward, claim denials are occurring. **The top denial codes from CGS include:**

1. **5PTER:** Six-month terminal prognosis not supported
2. **5PCER:** Missing, incomplete, untimely certification/recertification
3. **5PPOC:** Plan of care requirements not met
4. **5PNOE:** Election statement incomplete/untimely
5. **5PRLM:** Reduced level of care (medical necessity)

The number one denial at CGS is that the patient didn’t look like they had a six-month prognosis, which means one of two things has happened: A) the patient really isn’t right for hospice, or B) the prognosis wasn’t captured in the documentation somehow. From here the denials focus more on the technical aspects of the claim with the certification and election, plan of care, and GIP.

**The Palmetto denial codes include:**

1. **56900:** Auto Deny - Requested Records not Submitted
2. **5CFNP:** No Plan of Care Submitted
3. **5CF36:** Not Hospice Appropriate
4. **5T009:** Claim Level Denial for Multiple Line Denials
5. **5CFTF:** Face to Face Encounter Requirements Not Met
6. **5CFH9:** Physician Narrative Statement Not Present or Not Valid
7. **5CN0E:** No Valid Election Statement Submitted
8. **5CFH6:** Initial Certification Not Timely

Palmetto’s denials are quite different from CGS. The top denial at Palmetto is because the records were not sent in on time, followed by a plan of care not being submitted. The number three denial is that the patient is not right for hospice. With regard to that, it’s important to remember that the reviewer is sitting in a world of cubicles and looking at your documentation as if it’s black and white, and that is often not the case. So when you get feedback that they’re
denying a claim, take look at the documentation and talk with the team that cares for the patient to see if it's problem with the documentation or an issue with the team not identifying that the patient has been stable for too long.

If you get a full-blown denial, meaning they deny the whole 30 days, then a patient-specific edit will more than likely be invoked and it's going to be reviewed every time you submit a claim. The best way to document terminal prognosis is to rely heavily on your LCD. Here is a list of links to the LCDs for CSG, NGS, and Palmetto.

- [http://www.cgsmedicare.com/hhh/coverage/](http://www.cgsmedicare.com/hhh/coverage/)
- [www.ngsmedicare.com](www.ngsmedicare.com)
- [www.palmettogba.com](www.palmettogba.com)

So what other things can be done to support your case? The history and physical information (past medical information) can be just as pertinent as the current medical information, so try to obtain as much of it as you can. Be sure to use a functional scale (Karnofsky or Palliative). Show how it changed as care moves through its process. It will be important to use the plan of care and the Interdisciplinary Group (IDG) process to ensure that you're showing what is being done to maintain the patient. Rely heavily on your physicians; they can help you paint a clear picture that the patient definitely needs hospice.

The LCDs are key because they allow the client's clinical decline to be a component of terminal prognosis. And, if you base your documentation as much as you can on the LCD requirements, that will save the day every time. The CGS and NGS LCDs consist of three parts:

PART 1: Decline

PART 2: General guidelines (to be used as a gateway to diseases in appendix)

PART 3: Co-morbidities (specific disease processes including cardiac, Alzheimer’s, pulmonary disease, etc.)

Palmetto differs in that it provides a separate diagnosis for each LCD. International Classification of Functioning (ICF) is also considered.
TYPES OF DENIALS
Let’s take a closer look at the top four denials.

Certification Denial
Make sure that you have a clear range of dates on the certification. You must have the date range spelled out (e.g., August 1 to October 29, 2014). And, it must be signed and dated by the physician, both attending and the medical director on the initial benefit (if attending is designated). Ensure the narrative tells a nice, objective story with symptoms and progression to support prognosis. The narrative must be completed, signed and dated prior to the billing. The certification must be obtained within two days; it can be verbal but ensure that it’s signed and dated before you put in the final bill for the month.

Plan of Care Update Denial
This is an area where the denials are growing, and it is a condition of participation and payment. What the reviewer is looking for is that the core IDG – the physician, nurse, social worker and chaplain – are all involved every 15 days to review the plan of care and update it when necessary. The key to avoid this denial is to include the POC and documentation that shows updates at a minimum of every 15 days. The documentation can be signatures of the core IDG on update, minutes of the IDG when updates are made and core IDG members are noted (or signed in) as present, or documented by the RN/case manager.

Election Statement Denial
Review your election statements, especially if you have changed forms recently, to ensure they include:

- The name of hospice with whom electing
- A palliative vs. curative model understanding
- Waiving of traditional Medicare for terminal conditions
- Effective date
- Signature

GIP Not Supported Denial
With regard to GIPs, things may look appropriate at the beginning – there are a lot of symptoms and the crisis is clearly defined – but several days later everything is working great and the documentation says the patient is resting quietly so there’s nothing to show that they continue to need that high level of care. When the reviewer sees bills that have seven days or more,
they are often paying the first three or four days and the last few are being denied. Education is key here. The benefit for general inpatient is supposed to be short-term for management of symptoms that they can’t get under control at home, so the key here is to show what you’ve tried to do before and, on an ongoing basis, show the needed assessment and modifications or changes to their current meds so you can demonstrate that this was a needed level of care to get these symptoms under control.

**Winning Denials**

If you’ve had ADRs and/or denials, the big key to be successful in your appeal is to watch the timeframes because if you miss them, you’re basically out of luck.

- **Redetermination**: 120 days to file; decision in 60 days
- **Reconsideration**: 180 days to file; decision in 60 days
- **ALJ Hearing**: 60 days to file; decision in 90 days
- **Appeals Council Review**: 60 days to file; decision in 90 days
- **Final Judicial Review**: 60 days to file

The first level of appeal for any CMS audit is sent to your MAC, and you have 120 days from the original denial to appeal it. The next one goes to a Qualified Independent Contractor (QIC). So, when you get a letter back from the MAC saying they’re still going to deny your appeal, you have 180 days to appeal that next level. Sometimes there are so many ADRs happening that the QICs cannot keep up, so they will send a letter saying they can’t respond within the 60-day window. If you get one of those letters, you can do one of two things – either do nothing and wait for the QIC or, if you want to move things along, you can escalate it to the ALJ. Interestingly, this is actually a very successful level of appeal as about 70% of all ALJ hearings are paid. You cannot, however, provide any additional documentation at this level so it is important to send anything that happens to that patient to demonstrate that they’re getting worse in the first two levels of appeal. It is helpful to have your case manager at this review, along with some leadership support and your medical director.
AUDIT STRATEGIES

There are some specific tools you can use to avoid audits. First of all, information is power. Share what you’ve learned from this white paper with your staff, especially about how to make decisions about a patient’s appropriateness for hospice. Knowing the LCDs inside and out is key. Guide decisions and empower clinicians with coverage criteria. Ensure you have oversight of your documentation; identify who’s doing that at your agency. This could even be a non-clinician, but someone needs to be always checking the documentation before billing.

Benchmarking is also a great tool. Use benchmarking vendors and your Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER). Be sure to understand what your average and median LOS are. If you use GIP, what is your average GIP utilization and do you stand out with any specific diagnoses or with the percentage of patients that are in nursing facilities? Remember that if you stand out in any of these areas you are more prone to audits. If this is just your population and you feel it’s totally appropriate, just be clear in your documentation and diligently cover all of your bases because you know your risk is high. One of the ways to do that is through an internal audit. Look at your chart in the same manner as if someone was going to actually review it.

Utilize the ADR tool to ensure all components are there prior to an ADR. If you do receive an ADR use the tool to ensure the medical record is complete prior to sending it. Again, LCDs are a great help here.
SPECIAL AUDIT CASES

Debility and Failure to Thrive
Clarification was published regarding the use of Debility, Adult Failure to Thrive classification. CMS was instructed not to use these as a primary diagnosis, so they will be returning to provider (RTP) any claims with these diagnoses as primary conditions as of 10/1/2014. Agencies should not use Debility or Adult FTT on new admins, and have a plan in place to ensure all patients have a more specific diagnosis as a primary DX. Use IDG for recertification (or sooner) to identify an appropriate primary diagnosis.

Dementias
Avoid using 290.x-294.x, or any of the dementias that state “Code the underlying diagnosis” as a primary. These should be used as a secondary/related. Instead, use the dementias from the Neuro chapter.

Hospice Supportive V Codes
These codes can be used, but not as a primary:

- V66.7 Encounter for palliative care
  - End-of-life care
  - Hospice care
  - Terminal care
- V49.86 Do Not Resuscitate (DNR) status
- V49.84 Bed confinement status
- V45.87 Transplanted organ removal status
- V49.83 Awaiting transplant
- V46.3 Wheelchair dependence

In Summary
While hospices will continue to be scrutinized by CMS and MACs, you do have the information and tools in your hands today to successfully deflect and/or win audits and, most importantly, get paid. If you’d like to increase your odds even more, home health software solutions such as Kinnser are a great place to start. To learn more about Kinnser’s leading hospice software solution, please visit Kinnser.com/hospice or contact us today at 877.399.6538.
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