PROVIDER COMPLIANCE TIPS FOR HOSPITAL BASED HOSPICE

PROVIDER TYPES AFFECTED

Medicare certified hospital based hospice programs

BACKGROUND

The Medicare Fee-For-Service (FFS) improper payment rate for hospital based hospice programs for the 2018 reporting period was 19.3 percent, accounting for 0.9 percent of the overall Medicare FFS improper payment rate in 2018. The projected improper payment amount for hospital based hospice during the 2018 report period was $275,887,344.[1]

REASONS FOR DENIAL

For the 2018 reporting period, insufficient documentation accounted for 83.4 percent of hospital based hospice improper payments. Additional types of errors for hospital based hospice claims in 2018 reporting period were incorrect coding (14.1 percent), medical necessity (1.4 percent) and no documentation (1.1 percent).[1]

TO PREVENT DENIALS

When billing Medicare for hospital based hospice services it is important to keep the following certification requirements in mind:

- For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG), and the individual's attending physician if the individual has an attending physician.
- Initial certifications may be completed up to 15 days before hospice care is elected. Payment normally begins with the effective date of election, which is the same as the admission date. If the physician forgets to date the certification, a notarized statement or some other acceptable documentation can be obtained to verify when the certification was obtained.
- For the subsequent periods, recertifications may be completed up to 15 days before the next benefit period begins. For subsequent periods, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG. If the hospice cannot obtain written certification within 2 calendar days, it must obtain oral certification within 2 calendar days.
- The hospice must obtain written certification of terminal illness for each benefit period, even if a single election continues in effect.

1 2018 Medicare Fee-for-Service Supplemental Improper Payment Data
2 Medicare Benefit Policy Manual, Chapter 9

- A written certification must be on file in the hospice patient's record prior to submission of a claim to the A/B MAC (HHH). Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

A complete written certification must include:

1. The statement that the individual's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course
2. Specific clinical findings and other documentation supporting a life expectancy of 6 months or less
3. The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers
4. As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms
    - If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.
    - If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
    - The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
    - The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.
    - For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.
5. Face-to-face encounter (see below for additional requirements related to the face-to-face encounter)

Face-to-face encounters

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in the Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

When billing Medicare for hospital based hospice services it is important to keep the following recertification requirements in mind:

- 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.

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
2018 Medicare Fee-for-Service Supplemental Improper Payment Data	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2018MedicareFFSSuplementalImproperPaymentData.pdf
Medicare Benefit Policy Manual, Chapter 9	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html