RAC MONITOR

Impact of an Untimely Hospice Face-to-Face Encounter: An Update

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A hospice provider's failure to comply with the timing requirements for the newly required face-to-face encounter may lead to claim denials in future audits. Hospice providers are advised to take heed of the recent MLN Matters article issued by the Centers for Medicare and Medicaid Services (CMS) addressing claim processing issues when the required face-to-face encounter does not occur timely.

To be eligible for the Medicare hospice benefit, a physician is required to certify the beneficiary as terminally ill. This certification must be in writing and on file prior to claim submission. The Medicare Benefit Policy Manual requires specific elements as part of a hospice certification or recertification including: (1) a statement that the individual's medical prognosis is a life expectancy of 6 months or less if the terminal illness runs its normal course; (2) specific clinical findings and other documentation supporting the life expectancy of 6 months or less; (3) the physician's signature; and (4) a brief physician narrative of the clinical findings that supports a life expectancy of 6 months or less.

In addition, Section 3132(b) of the Affordable Care Act of 2010 (ACA) added the requirement that a hospice physician or nurse practitioner conduct a face-to-face encounter with each hospice patient prior to the beginning of the 180-day recertification (i.e. third benefit period), and prior to the start of each subsequent benefit period. Effective January 1, 2011, the required face-to-face encounter must occur no more than 30 calendar days prior to the start of the third benefit period. This same timeframe must also be met for every benefit period subsequent to the third benefit period.

Specifically, the recertification form must include a written attestation by the hospice physician or nurse practitioner that performed the face-to-face encounter. In cases where the encounter is performed by a nurse practitioner, the attestation must evidence that the clinical findings of the encounter visit were provided to the certifying physician. The attestation, along with an accompanying signature and the date signed, is required to be a separate and distinct section of the recertification form.

If all the requirements are met, including face-to-face encounters as applicable within the required time frames discussed above, then the beneficiary will be eligible for the Medicare hospice benefit. CMS recently released MLN Matters (MM7478) and Change Request 7478, which advises hospice providers of the impact of the failure to meet the face-to-face requirements within the required timeframe. When the required face-to-face encounter does not occur within prescribed timeframes, it is considered untimely and will cause the beneficiary to no longer be classified as terminally ill. Without the terminally ill designation, the beneficiary will no longer be eligible for the hospice benefit.

If the beneficiary is ineligible for the hospice benefit because of the lack of terminally ill status, the hospice must discharge the patient from the Medicare hospice benefit. However, the hospice can re-admit the patient to the Medicare hospice benefit if the patient later receives the face to face encounter and meets other eligibility requirements.

In cases where the patient is discharged from the hospice due solely to the untimely face-to-face encounter, CMS expects the hospice would continue to service the patient at its own expense until the face-to-face encounter requirement has been met. By doing so, the hospice will be able to more readily reestablish Medicare eligibility. This assertion by CMS suggests a potential focus for future audit reviews because hospice beneficiaries with delayed face to face documentation could have a lapse in coverage which would be considered an overpayment to the hospice provider. Because of the new requirement under the Patient Protection and Affordable Care Act (PPACA) Section 6402, hospice providers have an affirmative duty to report and return any such overpayments.

The likelihood of such audits seems probable based on the scrutiny with which CMS audit contractors currently view hospice providers with regard to other requirements such as certification requirements, level of care, and six month prognosis. The RACs have also taken aim at certain hospice related issues on their current approved issues lists. For instance, HealthDataInsights, the RAC for Region D, has approved review of hospice related services, specifically services related to a hospice terminal diagnosis provided during a hospice period, which are included in the hospice payment and are not separately payable.

Hospice providers are advised to develop and maintain effective policies and systems to ensure that the face-to-face encounters are conducted timely and documented appropriately. It is important to educate clinicians, coding and billing staff, and referring providers of the applicable timeframes and documentation requirements surrounding the face-to-face encounter. Failure to have such policies in place could lead to future claim denials, as well as place the provider at the risk of overpayment liability. These risks can be effectively minimized by reviewing and understanding the recent guidance issued by CMS and its contractors. Hospice providers must also be cognizant of the requirement to report and return any known overpayment, including those overpayments related to untimely face-to-face encounters.

LINKS:

MLN Matters MM7478: https://www.cms.gov/MLNMattersArticles/downloads/MM7478.pdf

Change Request 7478: https://www.cms.gov/MLNMattersArticles/downloads/MM7478.pdf