Providers Need to Be Aware of Key Hospice Risk Areas

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The landscape of audits and health care compliance has been impacted significantly by the enactment of the Patient Protection and Affordable Care Act (PPACA). Under PPACA, the Medicare hospice benefit underwent changes related to both documentation and billing requirements. It is important for providers to recognize these changes and adjust their procedures accordingly. Failure to comply with these new requirements may leave providers vulnerable to claim denials and overpayment recoupment in a future RAC or other Medicare audit.

Hospice Certification

In order for a patient to receive hospice care, a physician must certify that the patient is suffering from a terminal illness and that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. In 2009, CMS added a clinical narrative requirement to the certification process. In accordance with this requirement, the physician is required to prepare a narrative which outlines the clinical findings that support a life expectancy of no longer than six months in order to certify a patient for hospice. This narrative must be reflective of the patient's individual clinical conditions and cannot contain form language or check-box information. Further, the physician is required to attest that he or she wrote the narrative personally, based on examination or the patient's medical records. This additional measure is designed to ensure that the physician has personally diagnosed the patient's condition, and is not just signing off on what another clinician on the nursing staff has concluded. Increased physician and patient contact seems to be the trend in hospice care recently.

Recertification

Accordingly, PPACA also adopted several of the Medicare Payment Advisory Commission's (MedPAC) recommendations with respect to recertification. Specifically, Section 3132 of PPACA called for greater physician engagement in the recertification of hospice patients' eligibility to receive Medicare coverage for hospice services. The focus on increased physician engagement was memorialized in a Final Rule issued on November 17, 2010, which incorporated new legislative requirements for face-to-face encounters. The new regulations required that a hospice physician or nurse practitioner undertake a face-to-face encounter with all hospice patients prior to the 180-day recertification, and all subsequent recertifications, to determine a patient's continued eligibility for hospice. The face-to-face encounter is not required for certification of the first or second 90-day benefit period, but must be performed for patients entering their third (60-day) benefit period, and for any and all subsequent 60-day benefit periods. While nurse practitioners may conduct the face-to-face encounter, only a physician

may certify the patient's terminal illness. Thus, if a nurse practitioner conducts the encounter, he or she must certify that the clinical information was provided to the certifying physician.

The face-to-face encounter is required to take place no more than 30 days prior to the 180-day recertification and subsequent recertifications. Without a valid face-to-face encounter, Medicare will not cover the hospice stay. The face-to-face encounter requirements took effect on January 1, 2011 and all providers need to adopt protocols now to ensure that these encounters are taking place with the appropriate personnel and in the timeframe required, or risk potential claim denials.

Once a patient has been properly certified, level of care is another important consideration. Hospice care is provided in four different levels, which consist of routine home care, general inpatient, continuous home care and inpatient respite care. Each level has specific criteria in order to determine whether it is the appropriate level of care for the patient at issue, and each level has its own billing rate. Providers need to ensure that they are meeting all the requirements for the level of care billed in order to avoid any possible issues when and if their practice becomes the subject of a RAC or Medicare audit.

The audit and compliance environment continues to change at a rapid rate as new documentation and coverage requirements are implemented. Based on our experience, providers are facing key audits risk areas and claim denials related to: six month prognosis, level of care, continuous care, inpatient hospital admissions, hospice/nursing facility benefit, and technical denials for certifications. The best defense for a RAC or Medicare audit is to have a comprehensive compliance plan in place now that mitigates these and other potential audit risk areas. This is especially true in the hospice arena where CMS has recently implementing provisions of PPACA that directly affect hospice providers. While there is a no guarantee that a provider with a strong compliance program will not find him or her practice in the crosshairs of a Medicare auditor, it is one of the best ways to proactively prepare for the situation.