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**OBJECTIVES**

- Describe the current regulatory and reimbursement issues facing the hospice industry.
- Review key additional reporting requirements, diagnosis coding requirements and Medicare Part D medication coverage issues affecting hospice providers.
- Describe the relationship between the additional reporting requirements, diagnosis coding changes and Medicare Part D medication issues and the impact of these changes on the determination of “relatedness” of conditions and medications provided under the hospice benefit.

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**OBJECTIVES (CONTINUED)**

- Describe the key CMS Quality Reporting Requirements as outlined in the 2014 Wage Index Final Rule.
- Identify areas of scrutiny for hospice in 2014/15.
- Describe clinical operational strategies that hospices can use for successful implementation of these requirements.
- Utilize case study examples and audience participation to describe challenges associated with implementation of these requirements and identify additional solutions to meet these challenges.
- Questions/Answers

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**INTRODUCTION** **Simione**  
HEALTHCARE CONSULTANTS, LLC

- Team of home care and hospice experts with focus on solutions
  - Organizational
    - Operational Assessment, Strategic Planning, Compliance, Clinical Operations
  - Financial
    - Cost Reporting, Compliance, Revenue Cycle
  - Sales & Marketing
    - Assessment & Analysis, Referral Management, Training Resources, "Sales Boot Camp"
  - Technology
    - Assessment & Analysis, Guided System Search, Implementation Support, Process Engineering
  - Mergers & Acquisitions
    - Due Diligence, Business Valuation, Market Assessment
  - Simone Financial Monitor™
    - Benchmarking

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**THE SEA OF CHANGE FOR HOSPICE** **Simione**  
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**WHY DO WE NEED THESE NEW REQUIREMENTS?** **Simione**  
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- Affordable Care Act requires CMS to:
  - Collect data from claims and cost reports
  - Revise the payment system and rates for hospice services
    - May be a case mix based system, U shape or Tiered model
- Better Data:
  - Measure quality, safety and efficacy of care
  - Design payment systems and process claims for reimbursement
  - Prevent and detect healthcare fraud and abuse
  - Performance monitoring- P4P
  - Monitoring resource utilization

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**2014 REGULATORY ENVIRONMENT** 

- Hospice 2014 Wage Index Final Rule:
  - Diagnosis Coding Clarifications
  - Related Diagnosis Reporting on Claims
  - Related Conditions
  - Use of Debility/Adult Failure to Thrive/Alzheimer's Dementia
  - QAPI Quality Reporting Measures
    - Hospice Item Set
    - Hospice CAHPS
- Additional Data Reporting (CR8358)
- Medicare Part D
- ICD-10

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**MEDICARE HOSPICE REIMBURSEMENT** 

- National Rates based on hospice fiscal year October 1 to September 30
  - Wage Component portion
    - Subject to Wage Index for location of place of service
    - Wage Index changes annually October 1
  - Non-Wage Component
  - Adjusted wage component added to non-wage component
- All payments subject to CAP
- October 1, 2014 Preliminary National Payment Rates
  - Routine Home Care=\$159.18
  - Continuous Home Care=\$929.00
  - Inpatient Respite Care=\$164.65
  - General Inpatient Care=\$708.07
- Quality Reporting: Failure to report results in negative 2% adjustment to rate

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**OVERVIEW OF HOSPICE INDUSTRY REIMBURSEMENT TRENDS** 

- MedPAC Report June 2013
  - Accountability
- Reimbursement (Proposed in 2014):
  - U Shaped Payment
  - Tiered-Shaped Payment Model
  - Payment for Nursing Home
  - Rebasing Routine Home Care Rate
  - No Proposed Payment Model Changes in 2015 Proposed Rule
- ACOs
  - Bundling Post Acute Care
- Cost Report Changes (Expected date 10/1/14)
- 2014 Hospice Wage Index Final Rule/2015 Proposed Rule
- 2% Sequestration Adjustment still in effect

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**2015 CMS FISCAL YEAR PROPOSED RULE OVERVIEW** 

- Advance Copy Published May 2, 2014 (CMS 1609-P). Key Proposed Items (Published in Federal Register 5/8/14):
  - BNAF phase out
  - 2015 Payment update
  - Expedited CAP overpayment recovery
  - Definitions- "Terminal Illness" and "Related Conditions"
  - NOE filed within 3 days of election
  - Termination/Revocation filed within 3 days of discharge/revocation
  - Identification of the Attending Physician on the NOE
  - Medicare Part D
  - Codification of Hospice Quality Reporting Requirements
- Comments due July 1, 2014

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**HOSPICE INDUSTRY CHANGES** 

- Increase in Non-CA Diagnoses
- Increase in Hospice Providers
- Longer LOS
- Hospice in Nursing Homes and other Settings
- General Inpatient Level of Care
- Increased Scrutiny
- Palliative Care
- Medicare Care Choices Model (MCCM)
- Hospice Strategic Opportunities

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**MEDICARE CARE CHOICES MODEL** 

- MCCM will test improvements to certain Medicare beneficiaries' quality of life while they are receiving both curative and palliative care.
- CMS will study whether access to such services will result in improved quality of care and patient and family satisfaction, and whether there are any effects on use of curative services and the Medicare hospice benefit.
- Target Patient Population: Medicare beneficiaries who are:
  - Eligible for the Medicare Hospice Benefit.
  - Dual eligible beneficiaries who are enrolled in traditional Medicare and eligible for the Medicaid hospice benefit.
  - Beneficiaries must not have elected the Medicare or Medicaid Hospice Benefit (or the Medicaid hospice benefit) within the last 30 days prior to participating in the model.

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**MEDICARE CARE CHOICES MODEL** 

- Participation limited to beneficiaries with:
  - Advanced cancers
  - Chronic obstructive pulmonary disease (COPD)
  - Congestive heart failure
  - HIV/AIDS
- Sites and Enrollment:
  - At least 30 rural and urban Medicare certified and enrolled hospices.
  - Sites must have demonstrated experience with an established network of providers for referrals to hospice.
  - Preference will be given to hospices that can demonstrate experience in developing, reporting, and analyzing quality assurance and performance improvement data.
  - Expected enrollment of 30,000 beneficiaries during 3-year period.

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**MEDICARE CARE CHOICES MODEL** 

- Payment Model:
  - Participating hospices will provide services available under the Medicare hospice benefit for routine home care and inpatient respite levels of care that cannot be separately billed under Medicare Parts A, B, and D.
  - Available 24/7, 365 calendar days per year.
  - CMS will pay a \$400 per beneficiary per month fee for these services.
  - Providers and suppliers furnishing curative services to beneficiaries participating in Medicare Care Choices Model will be able to continue to bill Medicare for the reasonable and necessary services they furnish.

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**MEDICARE CARE CHOICES MODEL** 

- Applications due no later than June 19, 2014
- For More Information:  
<http://innovation.cms.gov/initiatives/Medicare-Care-Choices/>  
<http://innovation.cms.gov/initiatives/Medicare-Care-Choices/faq.html>

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**ADDITIONAL DATA REPORTING** 

- CR 8358-Additional Data Reporting on Hospice Claims
- Published July 26, 2013
- <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Transmittals-Items/Hospice-CR8358-R2747CP.html>
- Effective Dates
  - April 1, 2014: Mandatory reporting for claims with dates of service on or after 4/1/14.

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**ADDITIONAL DATA REPORTING** 

- Requirements
  - General Inpatient Care Visits (GIP)
  - NPI-Inpatient Facility Identification
  - Post-Mortem Visits
  - Injectable and Non-Injectable Drugs
  - Infusion Pumps

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**GENERAL INPATIENT (GIP) VISITS** 

- Hospice staff visit data for General Inpatient (GIP) level of care in SNFs and Hospitals:
  - Hospices must report all hospice staff - nursing, PT, OT, ST, Hospice Aide as well as Social Work (visits and telephone calls) in 15 minute increments for patients in hospitals and skilled nursing facilities receiving GIP level of care.
  - There are no changes to the GIP visit reporting requirements when the site of service is a hospice inpatient unit.

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**FACILITY IDENTIFICATION** 

- **NPI Number of Facility where Hospice Patient is Receiving Services:**
  - Hospices must report the NPI of a nursing facility, hospital and hospice facility where the patient is receiving services when the service is not performed at the same location as the billing hospice's location, regardless of level of care provided.
  - If the patient receives service in more than one facility in a month, the hospice must report the NPI of the facility where the patient was last treated.

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**FACILITY IDENTIFICATION** 

- Claims will be returned to provider (RTP'd) if missing
- **Applies to Q Codes:**
  - Q5003 (NF patient receiving unskilled care)
  - Q5004 (SNF patient receiving skilled care)
  - Q5005 (Inpatient hospital)
  - Q5006 (Only if providing in another hospice's facility)
  - Q5007 (Long term care hospital-LTACH)
  - Q5008 (Inpatient psychiatric facility)

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**POST MORTEM VISITS** 

- **Post Mortem Visits:**
  - All visits occurring on the same calendar day of the patient's death after the pronounced time of death will be billed with a PM modifier.
  - Visits that occur on a date subsequent to the date of death are not to be reported on the claim.
  - For patient deaths occurring during the visit, the visit should be split to report the time of the visit prior to death and the time of the visit after death.

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**INJECTABLE AND NON-INJECTABLE PRESCRIPTION MEDICATIONS** 

- Reporting Injectable and Non-Injectable Prescription Drugs:
  - Injectable prescription drugs that are being billed through the hospice are reported on a line item basis per fill using appropriate revenue code and the applicable HCPCS code.
  - Non-Injectable Prescription Drugs are reported on a line item basis per fill using the appropriate revenue code the applicable National Drug Code (NDC).
  - Over the Counter medications are not required to be reported on the claim.
  - Only applies to hospice covered medications for which hospice is financially responsible.

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**INFUSION PUMPS** 

- Reporting Infusion Pumps:
  - Hospices must report infusion pumps on a line-item basis for each pump order using revenue code 029X and the appropriate HCPCS code.
  - Hospices must report the infusion medication on a line-item basis for each fill using revenue code 0294 along with the appropriate HCPCS code.
  - DME other than infusion pumps are not to be reported at this time.
  - Excludes OTC drugs and nutrition (TPN).

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**CLARIFICATIONS** 

- Dispenser Type Medications are to be reported per month
- Comfort packs – each medication is reported per fill
- Compounded medications – Each ingredient of compound must be reported along with each NDC and appropriate units of measure per fill
- Infusion pump charge for time period of claim (per month)

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**OPERATIONAL ISSUES FOR NEW CLAIM REQUIREMENTS** 

- IT systems are not ready and tested
  - Responsibility for new codes IT vendor or hospice?
- Obtaining needed medication information from pharmacies and IV Vendors and contracted facilities
- Obtaining required data from contracted facilities
  - Requires working with the facilities – potential contract changes
- Staff training on billing requirements or changed visit reason/coding
- New processes and Information flow
  - Post mortem coding
  - Facility location of patient
  - Data Entry
- Potential for delayed billing impact to cash flow

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**HOSPICE CODING HOW DID WE GET HERE?** 

- For the past three years CMS has been reminding Hospices that it must use appropriate coding guidelines. These notices were buried in the annual Wage Index Adjustment notices, and had no payment or COP penalties attached.
- The 2014 notice (issued in 2013) carried weight indicating that claims coded with primary diagnosis as Debility or Adult Failure to Thrive will be returned to provider beginning October 1, 2014.

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**JULY 2012 HOSPICE WAGE INDEX** 

CMS said:

" To adequately account for any clinical complexities a given patient might have as a result of related co-morbidities, those co-morbidities must be included on the Medicare hospice claim. While some Hospice providers are reporting additional or co-existing diagnoses on claims, a majority are not. As such, the current claims data do not allow us to appropriately analyze whether a case mix adjustment would or would not be a reasonable approach to, or part of payment reform."

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**REQUIREMENTS FOR HOSPICE DIAGNOSIS CODING** 

- Medicare Claims Processing manual chapter 11 - Processing hospice claims
  - Hospices are to be coding diagnoses on claims following the ICD-9 CM Guidelines
    - Require reporting of all additional or co-existing diagnoses
- HIPAA Requirement to adhere to the ICD-9 diagnosis and procedure codes

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**CONFUSION** 

- Hospices have been up in arms in regard to the idea that they would have to discharge all the patients with Debility and Failure to Thrive diagnoses.....  
*Actually...not really...*
- The Local Coverage Determinations (LCDs) for Hospice **have** Debility and Failure to Thrive.....
- Interchangeable use of Co-morbid; Related and Not-Related; Co-existing; Additional Diagnosis (*what are they talking about?*)
- *"this is hospice....we don't have to do that"*

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**SUPPORT THE TERMINAL CONDITION** 

- Debility and Failure to Thrive are defined as "signs, symptoms and ill-defined conditions". According to coding guidelines these diagnoses are not to be used as a *primary diagnosis*
- Use the codes available to help support the terminal illness - and help to *"paint the picture"* of eligibility
- Continue to use the LCDs to assist in determining *prognosis*

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**CODING CONVENTIONS** 

- Following coding conventions can assist to establish and support hospice eligibility
- Required to use the full ICD-9 Diagnosis Codes
- Principal Diagnosis is established after study to be chiefly responsible for the Terminal Illness
- Hospices can use V Codes - but not as primary
- V-Codes can assist in describing the patient's condition and terminal status

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**SAMPLE CODING** 

- Referral received for an elderly patient - 97, declining status, weight loss and not eating. Had a hospitalization for unresponsive episode lasting two days. Past history of CAD, Arthritis; HTN and MI in distant past. Has improved but wants to die at home.
- Nurse initial assessment visit finds weight loss with little appetite; BMI is 25. Pt. spends most of day sleeping in bed, PPS Scale 40%; Pt is a DNR. BP is 120/80; mildly SOB. NY Heart Scale is a 2.

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**SAMPLE CODING** 

- Primary Diagnosis (as defined by IDG/Medical Director)
  - 414.9 CAD
  - 419.0 Hypertension
  - 783.21 Loss of Weight
  - V49.84 Confined to bed
  - 780.79 Malaise and Fatigue
  - 799.3 Debility
  - V66.7 Encounter for Palliative Care
  - V49.86 Do Not Resuscitate Status

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**A WORD ABOUT DEMENTIAS AND ALZHEIMER'S** 

- Need to follow coding guidelines - use of "buddy" codes which further classify the Alzheimer's and Dementia
- Second code should be used to show the dementia and behaviors present with Alzheimer's 331.0
- Use the additional code 294.1X in Dementias to code the behavior disturbances

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**USING CLINICAL FINDINGS TO SUPPORT DIAGNOSIS CODING** 

- History and Physical reports; Hospital records and reports from primary MD should be used to assist in determining current condition and related diagnosis.
- Also use clinical findings on assessments to assist in supporting terminal status of the patient. Functional status, DNR Status, Nutritional status, Pain status. All of which are gathered on hospice assessments.
- Remember - accurate and comprehensive coding now, will influence payment in the future.

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**MOVING TO ICD 10** 

- ICD-9 code set is 25 years old
  - Has not kept up with changes in medicine
  - New conditions identified
  - New treatments
- ICD-10 provides
  - Detailed info on condition through specific diagnosis
  - More specific approach to classifying inpatient hospital procedures
  - Delayed until 2015

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WHAT IS DIFFERENT?		Simione
	ICD 9 CM	ICD 10 CM
Characters	3-5	3-7
Number	14,000	68,000
Procedure codes	4,000	87,000
First digit	Alpha (E,V) or numeric	Alpha
V and E codes	Used for "factors influencing" and "external causes"	Incorporated into main classification rather than separate
Character "X"	None	<ul style="list-style-type: none"> <li>Used as 5<sup>th</sup> character placeholder in certain 6 character codes to allow for future expansion</li> <li>Fill in other empty characters when a code that is less than 6 characters requires a 7<sup>th</sup> character</li> </ul>

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QUICK HOSPICE CODING SAMPLES AND ICD- 10 CONVERSIONS		Simione	
Diagnosis Name	Use	ICD 9 2014	ICD- 10 Conversion
CAD	Primary	414.9	I25.9
CHF	Primary	428.0	I50.9
COPD	Primary	496.0	J44.9
Alzheimer's	Primary	331.0	G30.9
Dementia Uncomplicated (code for related conditions/behavioral presentations)	Primary	290.X	F03.90
Cancer of Lung (unspecified) Code the Metastatic cancer as secondary	Primary	162.9	C34.90
Pain (malignant)	Primary	338.3	G89.3

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- | CODING CONSIDERATIONS   | Simione |
|---|---------|
| <ul style="list-style-type: none"> <li>Important that coding be done correctly – will impact future payment models</li> <li>Appropriate use of codes will assist in supporting patient's terminal state and decline</li> <li>Use staff trained to code – consider outsourcing</li> <li>If using home care coders pay attention to:                             <ul style="list-style-type: none"> <li>Home care codes for payment and what is being addressed on the Plan of Care</li> <li>Hospice codes for what is related to the terminal illness</li> </ul> </li> </ul> |         |
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**CODING CONSIDERATIONS** 

- Have a formal process with Medical Director or hospice physician to approve the diagnoses and related conditions - (signed and dated).
- Have a process to review coding with care plan reviews and update to reflect changing condition – at least monthly prior to billing.

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**RELATED AND NOT RELATED DIAGNOSIS** 

**CMS States:**

- "unless there is clear evidence that a condition is unrelated to the terminal illness, all conditions would be considered related.....it is the responsibility of the hospice physician to document why the patient's medical needs would not be related to the terminal illness."
  - Hospices are required to cover the care and services needed to treat the terminal illness and related conditions.
  - 2015 Hospice Wage Index Proposed Rule definitions further support this statement-very broad.

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**HOW COULD YOU?** 

- Consider – how could you demonstrate your decisions for related and not related medications, hospitalizations and treatments last year?
  - Is the documentation in the record?
  - Does it support the decision?
  - Could you end up paying for those items or services?
- Review practices and documentation

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**UNRELATED CONDITIONS** 

- **Unrelated conditions, treatments and medications**
  - Defined with reason by Medical Director/Hospice MD
    - This is not a nursing or management decision
  - Be clearly documented and distinguishable component in the record
  - Signed and dated by Medical Director/Hospice MD
  - Started on admission with diagnoses and updated as new medications and treatments are added or patient condition changes
  - Integrate this discussion into operations
- **Unrelated conditions should NOT appear on the claim**

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Hospice Patient Name \_\_\_\_\_ Admit date \_\_\_\_\_ 

Primary Diagnosis (What is causing the terminal illness - do not use Delirium or FTT these are secondary conditions)

Secondary Diagnosis or Condition **RELATED** to Terminal Diagnosis (Consider Palliative Care Code Status, Weight loss, SOB, Functional status, etc. up to 14)

Hospice Coverage for Medications/Other Supplies: List Medications and Treatments NOT covered & Reason (Attach Med list with C (Covered) NC (Not Covered))

Item \_\_\_\_\_ Reason Not Covered \_\_\_\_\_

List Co-Morbidities which are not related to the terminal illness. (\*DO NOT CODE these on Claims)

Treas Signature (Require Nurse & MD)

44 Name \_\_\_\_\_ Date \_\_\_\_\_ Hospice MD \_\_\_\_\_ Date \_\_\_\_\_ *The way is in sight™*

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**Medicare Part D Billing For Hospice Enrollees** 

**Background**

- **2012 OIG Report Published**
  - CMS concerns regarding medications billed to Part D for hospice patients (\$13 million in analgesics paid by Part D in 2010 for hospice enrollees).
  - Continued review by CMS Program Integrity for 2011-2012 analgesic usage
- **June 2013**
  - CMS Directive to Medicare Part D plan sponsors to recoup all money paid by Part D for hospice enrollees for analgesics
- **October 2013**
  - Additional guidance to Medicare Part D plans
- **December 2013**
  - Proposed guidance published with comment period
- **March 10, 2014**
  - Final Guidance Published-IMPLEMENTATION DATE 5/1/14

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**MEDICARE PART D AND HOSPICE** 

- CMS Proposed Guidance Issued 12/6/13:
  - CMS belief that virtually all drugs are “related” to the terminal illness and related conditions and should be paid by hospice

“a key component of hospice care is symptom control. These symptoms can be physical, emotional, psychosocial, and/or spiritual. Thus, when we refer to “pain and symptom relief”, or “palliation and management of the terminal illness and related conditions”, this encompasses all medical supplies and drugs needed to manage all the patient’s health conditions related to the terminal prognosis, to minimize symptoms and maximize comfort and quality of life. The focus is not limited to pain medications or a narrow definition of palliative care, but is broad and holistic.”

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**COORDINATION WITH PART D** 

“As a general rule, hospice providers are expected to cover virtually all drugs for hospice beneficiaries during the hospice election. **The hospice provider will be responsible for coordinating with Part D plan sponsors for those drugs they believe are completely unrelated to the terminal illness and/or related conditions to determine payment responsibility.**”

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**MEDICARE D SPONSOR PA** 

- The Medicare D sponsor will issue a Prior Authorization (PA) process for all patients with an active hospice election
  - Prior to coverage of any medications
  - Responsibility of the hospice to provide the documentation that the medications are not related to the terminal status or related conditions
  - Sponsor will have the right to seek a independent review if have concerns with coverage issues

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**PATIENTS AND FORMULARIES** 

- Hospices can continue to use formularies.
- If patient wishes to have a drug not on the formulary, and hospice IDG has determined that drug on formulary is effective. Patient may get drug, but will have to pay out of pocket. Medicare D would not cover.
- If hospice is not covering a medication and provides it to patient and bills the patient; an ABN would be required.

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**EXAMPLE – PATIENT SCENARIO** 

Patient with metastatic breast cancer with a long standing cardiac history. Medications are analgesics for pain, Digoxin and Lasix. Hospice has determined that the Digoxin and Lasix are not related to the terminal condition and are not covering the meds. The patient/family want to stay on the medications after a discussion with the physician.

- Hospice has to provide Medicare D sponsor with documentation of related/unrelated diagnosis and rationale.

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**PATIENT SCENARIO CONTINUED** 

- If the patient decides she wants off formulary analgesic – but hospice MD determines formulary medication is adequate to meet the patient’s needs and won’t cover the off formulary medication:
  - The patient would have to pay out of pocket
  - If hospice provides the medication through its pharmacy – and bills the patient. An ABN would be required
  - The patient can appeal hospice’s decision to CMS

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**OPERATIONAL CONCERNS** 

- Documentation in record of reason's not covered signed and dated by hospice physician
- Implement processes to communicate to patient's sponsor or pharmacy & provide documentation. Be proactive! Start now!
- Obtain Information regarding Part D coverage on admission.
- Issuing ABN – when and how to issue (update Policy & Procedures)
- Ensure staff educated – can clearly represent Hospice and explain process to patient and family; some drugs may not be covered
- Stay updated on guidance

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**Communication With Plan Sponsor** 

- Draft form developed to expedite communication with Part D sponsor developed by National Council of Prescription Drug Plans (NCPDP) Hospice Task Group
- “Hospice Status and Plan of Care for Medicare Part D A3 Reject Override”

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**What Hospices Can Do Now** 

- Stay Informed – clarifications and updates
- Work with Software Vendors
- Work with Pharmacy Vendors
- Staff and Manager/IDG Education
- Patient/Family Education
- Evaluate current hospice operations – admission, medication management
- Evaluate impact on Compliance, Billing Functions and QAPI
- Develop Implementation Plan – review and change

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**CMS QUALITY MEASURES** 

- **Quality Reporting Measures-Changes:**
  - Eliminated #0209 Comfortable Dying and Structural Measures beginning with FY 2016 payment determination year. Last submission for CY 2013 data was 4/1/14.
- **Hospice Item Set - Effective 7/1/2014**
  - Will affect FY 2016 payment determination year
  - 7 outcome measures - approved by CMS
  - Public Reporting – not yet determined
- **Hospice Experience of Care Survey (Hospice CAHPS)**
  - Effective 2015
  - Will effect FY 2017 payment determination year

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**HOSPICE INFORMATION SET (HIS)** 

The HIS is a set of data elements that can be used to calculate 7 quality measures – 6 NQF-endorsed measures and 1 modified NQF-endorsed measure:

- NQF #1641 – Treatment Preferences
- Modified NQF #1647 – Beliefs/Values Addressed
- NQF #1634 & NQF #1637 – Pain Screening and Pain Assessment
- NQF #1639 & NQF #1638 – Dyspnea Screening and Dyspnea Treatment
- NQF #1617 – Patients Treated with an Opioid who are Given a Bowel Regimen

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**HIS QUESTIONS** 

- Answered on admission and discharge of the patient (within 14 days of admission, 7 days of discharge)
- NOT an assessment instrument, although the questions may be incorporated into the nursing assessment process.
- These will be submitted to CMS (OASIS, MDS) within 30 days.
- Component of public reporting in the future (Not yet defined)
- Reports available to hospices on results
- Data collection to begin July 2014

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**HIS QUESTIONS (CONTINUED)** 

- All patients admitted will need HIS completed, regardless of age, level of care or LOS.
- CMS will carve out patients under age 18 and LOS less than 7 days but data is still required to be collected and submitted on these patients.

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**HIS TECHNICAL IMPLEMENTATION** 

- HIS User Manual available now
  - <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html>
- Technical Manual available in April 2014
  - <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HIS-Technical-Information.html>
- Registration for user IDs will begin 5/19/14
  - Two IDs needed:
    - Data Submission
    - Retrieval
- CMS Data submission training modules are now available
- CMS plans a “dry run” window for providers-not scheduled yet.

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**PLANNING FOR HIS** 

- Readiness of information system
  - Testing and test submission
  - Plan for internal processes (submission, validation)
  - Determine responsibility internally for validation and submission of the data to CMS
- Train staff using the HIS User Manual as a guide—remember that the correct use of the data set will have an impact on hospice’s future
  - Public reporting
  - Payment reforms

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**Section J Health Conditions**

**Respiratory Status**

**J2030. Screening for Shortness of Breath**

Enter Code

A. Was the patient screened for shortness of breath?  
 0. No → Skip to N0500, Scheduled Opioid  
 1. Yes

B. Date of first screening for shortness of breath:  
 Month [ ] Day [ ] Year [ ]

C. Did the screening indicate the patient had shortness of breath?  
 0. No → Skip to N0500, Scheduled Opioid  
 1. Yes

**J2040. Treatment for Shortness of Breath**

Enter Code

A. Was treatment for shortness of breath initiated? - Select the most accurate response  
 0. No → Skip to N0500, Scheduled Opioid  
 1. No, patient declined treatments offered → Skip to N0500, Scheduled Opioid  
 2. Yes

B. Date treatment for shortness of breath initiated:  
 Month [ ] Day [ ] Year [ ]

C. Type(s) of treatment for shortness of breath initiated:

Check all that apply

1. Opioids  
 2. Other medication  
 3. Oxygen  
 4. Non-medication

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**Section N Medications**

**N0500. Scheduled Opioid**

Enter Code

A. Was a scheduled opioid initiated or continued?  
 0. No → Skip to N0510, PRN Opioid  
 1. Yes

B. Date scheduled opioid initiated or continued:  
 Month [ ] Day [ ] Year [ ]

**N0510. PRN Opioid**

Enter Code

A. Was a PRN opioid initiated or continued?  
 0. No → Skip to N0520, Bowel Regimen  
 1. Yes

B. Date PRN opioid initiated or continued:  
 Month [ ] Day [ ] Year [ ]

**N0520. Bowel Regimen**  
 Complete only if N0500A or N0510A = 1

Enter Code

A. Was a bowel regimen initiated or continued? - Select the most accurate response  
 0. No → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
 1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip to Z0400, Signature(s) of Person(s) Completing the Record  
 2. Yes

B. Date bowel regimen initiated or continued:  
 Month [ ] Day [ ] Year [ ]

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**Section Z Record Administration**

**Z0400. Signature(s) of Person(s) Completing the Record**

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information will lead to a 2 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of Person Verifying Record Completion**

A. Signature: \_\_\_\_\_ B. Date: \_\_\_\_\_  
 Month [ ] Day [ ] Year [ ]

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**HIS DISCHARGE FORM** **Simione**  
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Hospice Item Set - Discharge

**Section A Administrative Information**

A0010. Type of Record  
 1. Admit new record  
 2. Modify existing record  
 3. Duplicate existing record

A0100. Facility Provider Numbers - Enter code as listed provided

A. National Provider Identifier (NPI)

B. NPI Certification Number (CN)

A0120. Admission Date

A0130. Reason for Record  
 01. Admission  
 02. Discharge

A0170. Discharge Date

A0190. Legal Name of Patient

A. Full name

B. Middle initial

C. Last name

D. Suffix

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**HIS ADMINISTRATIVE INFORMATION** **Simione**  
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**Section A Administrative Information**

A0600. Social Security and Medicare Numbers

A. Social Security Number

B. Medicare number (or comparable railroad insurance number)

A0700. Medicaid Number - Enter "\*" if pending, "N" if not a Medicaid recipient

A0800. Gender  
 1. Male  
 2. Female

A0900. Birth Date

A2115. Reason for Discharge  
 01. Expired  
 02. Revoked  
 03. No longer terminally ill  
 04. Moved out of hospice service area  
 05. Transferred to another hospice  
 06. Discharged for cause

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**HIS RECORD ADMINISTRATION** **Simione**  
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**Section Z Record Administration**

Z0100. Signatures of Persons Completing the Record

Verify that the accompanying information accurately reflects patient assessment information for this patient and that collected or corroborated collection of this information on the date specified. To the best of my knowledge, the information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. Further, I understand that failure to report such information will lead to a percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility as to listed.

	Signature	Title	Section	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				
M.				
N.				
O.				
P.				
Q.				
R.				
S.				
T.				
U.				
V.				
W.				
X.				
Y.				
Z.				

Z0200. Signature of Person Verifying Record Completion

A. Signature  B. Date

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**HOSPICE CAHPS SURVEY** 

- Hospice Consumer Assessment of Healthcare Providers and Systems (Hospice CAHPS).
- CMS is planning the future implementation of measures based on an experience of care survey, similar to the Family Evaluation of Hospice Care (FEHC) survey.
- Similar to other provider requirements (Home Care, Hospitals, SNFs etc).

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**HOSPICE CAHPS SURVEY** 

- Based on patient location
  - Facility- Hospital
  - Nursing home
  - Home
- Use of outside vendor to administer survey
  - Expect similar processes as with home care survey
- Use is scheduled to begin in early 2015 with a testing period from Jan to March 2015 and full implementation in April 2015.

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**WHAT CAN HOSPICES DO NOW?** 

- Review current Hospital and Home Health CAHPS processes
  - <http://www.hcahponline.org/home.aspx>
  - <https://homehealthcahps.org/>
- Begin initial vendor review/selection process
  - Available vendors (for Hospices with Home Health Agencies or who are part of a hospital system).
  - Cost
  - Options for survey
- Educate Staff regarding HIS and Hospice CAHPS questions
- Patient/family education on admission
- Customer service is key

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**HOSPICE COMPLIANCE** 

- Long-Time Government Focus on Hospice in SNFs and General Inpatient Level of Care.
- OIG Reports
- OIG Work Plan 2014:
  - Hospice in ALF
  - Hospice General Inpatient Care (Quality and Safety)
- Hospice Compliance: Learn Your Alphabet Soup:
  - CMS Contractor Audits (ADR, ZPIC, CERT, PERM, RAC)

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**PRIMARY COMPLIANCE ISSUES** 

- LOS greater than 180 days
- LOS greater than 365 days
- Hospice/SNF
- GIP utilization
- Live Discharges
- Eligibility
- Attestation Documentation
- Other

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**INCREASED SCRUTINY** 

- Hospice Compliance: What should hospice providers be doing?
  - Hospices must be vigilant in ensuring that the documentation thoroughly tells the story of the patient's eligibility and the need for continuation of hospice services.
  - Constant review of patients with length of stays over 180 days is essential.
  - Patients MUST demonstrate a significant decline in health status that shows terminal prognosis rather than chronic illness.
  - Close monitoring of documentation for patients receiving General In-Patient (GIP) level of care or care in SNF/ALF.

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**INCREASED SCRUTINY** 

- **Hospice Compliance: What should hospice providers be doing?**
  - Don't discharge patients just because of audits – just make sure that you can justify the need
  - Educate your staff
  - Document appropriately
  - Make sure there is adequate supervision and review of documentation
    - Team Leader, QA nurse
    - Especially at admission, re-certification and before billing!

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**INCREASED SCRUTINY** 

- **Hospice Compliance: What should hospice providers be doing?**
  - ADRs: Need to be proactive and monitor!
    - Log onto FISS/DDE
    - Select 1 Inquiry
    - Select 12 Claims
    - Enter NPI number
    - Tab down to S/Loc and enter S B6000
    - A List of ADRs is visible

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**INCREASED SCRUTINY** 

- **Hospice Compliance: What should hospice providers be doing?**
  - ADRs: Need to be proactive and monitor!
    - There is a 30 day turnaround time frame
    - Staff assigned to collect ADRs: both clinical and financial leadership need to be alerted and track activity
      - **Clinical:** Technical denials and poor documentation
        - If patient truly eligible "attestations" & "summaries"
        - If not truly eligible discharge!
        - Appeals processes: Redetermination, Reconsideration, Administrative Law Judge
      - **Financial:** Track what was billed, what was paid, what was denied
        - Cross check with clinical
        - Understand what **not** to bill

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**INCREASED SCRUTINY** 

- **Certification of Terminal Illness/Attestation:**
  - One of the requirements of the certification/recertification form is the physician narrative and attestation statement. The CMS Benefit Policy Manual, Pub. 100-02, Chapter 9, section 20.1
  - States 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.

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**CERTIFICATION OF TERMINAL ILLNESS/ATTESTATION:** 

Statements such as:

“I confirm that this narrative is based on my review of the patient’s medical record and/or examination of the patient”

- Do not specifically indicate that the physician actually **composed** the narrative. These are being denied.

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**RISKS ON THE ATTESTATION OPERATIONAL CONCERNS** 

- Missing the required language on the attestation – “composed”
- Some software and forms have been identified as being incorrectly worded
- Claims are being denied
- Verify all forms and computer generated/formatted forms to ensure correct wording

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**COMPLIANCE CHECKLIST** 

- Hospice Patients: How many, what percentage?
  - Long lengths of stay (>180 days)
  - Live discharges
  - Non-cancer diagnosis
  - Nursing home patients
  - Process used to review records and ensure eligibility and excellence in documentation
- Hospice Plan of Care is current with updates to include all services needed for the palliation and management of the terminal illness and related conditions
  - Includes Medications

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**COMPLIANCE CHECKLIST-DIAGNOSES** 

- Debility and AFTT should no longer be the primary terminal diagnosis
- Appropriate use of Alzheimer's/Dementia diagnosis codes
- Hospice MD and IDG must have determined the most appropriate primary terminal diagnosis
- All co-morbid, secondary and related diagnoses are listed after the terminal diagnosis
- The terminal and all related diagnoses are properly listed on the billing claim
- Any unrelated disease:
  - Is not listed on the claim form
  - Is documented by the hospice MD in the clinical record as to why it is unrelated

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**COMPLIANCE CHECKLIST-DRUGS** 

- All medications the patient is taking are listed on the med list.
- Each medication has an indication of covered by hospice or non-covered after careful review by RN and MD to determine the relationship to disease and possible palliative effects.
- Those medications deemed 'non-covered' are documented by MD as to why they are unrelated.
- Lists of medications is reviewed and updated with caregivers, pharmacy and nursing home along with education to same to not bill Medicare Part D for covered medications.

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**COMPLIANCE CHECKLIST-DRUGS CONTINUED**

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- Monthly claims reviewed to ensure that only medications provided to the patient that are related to the terminal illness are included on the Medicare claim.
- Non-formulary medications (if a hospice uses a formulary) that are deemed necessary for palliation and/or management of the terminal illness and related conditions are covered by the hospice.

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**Questions?**



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<b>Julia Maroney, RN, MHA, CHCE</b> 4130 Whitney Avenue Hamden, CT 06518  203-287-0388 800.653.4043 <a href="mailto:jmaroney@simione.com">jmaroney@simione.com</a>	<b>Kim Skehan, RN, MSN</b> 4130 Whitney Avenue Hamden, CT 06518  203.287.9288 800-949-0388 <a href="mailto:kskehan@simione.com">kskehan@simione.com</a>
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