Responding to Hospice ADRs

Charles Canaan
Senior Provider Education Consultant

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

OKLAHOMA HOSPICE & PALLIATIVE CARE ASSOCIATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

PALMETTO GBA®
A CELERIAN GROUP COMPANY

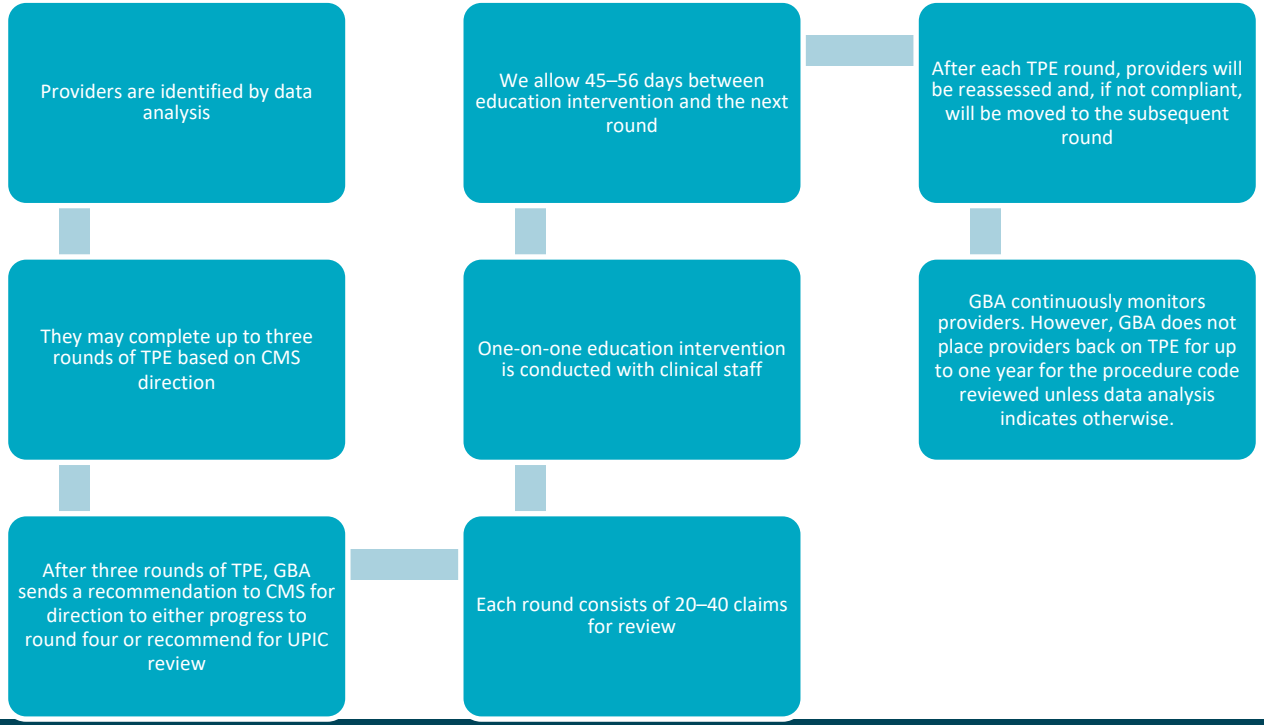
Targeted Probe and Educate (TPE)

Provider Specific Medical Review for Hospice

Code Type	Specific code	Edit Topic	Edit Description
Revenue Code	General Inpatient Care (GIP)	General Inpatient Care (GIP)	Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for Revenue Code 656 and place of service codes Q5004–Q5009
Revenue Code	ALL	New Hospice Providers	Review of claims for Hospice providers new to Medicare for all place of service codes

Targeted Probe and Educate Process

4



Additional Documentation Request (ADR)

Per the Social Security Act, Sections 1815(a), 1833(e), and 1862(a)(1)(A), providers are required to submit medical record documentation to support claims for Medicare services to the MAC program upon request

- **The requests are considered ADRs**

Point of Contact

- When submitting the requested medical record documentation in response to the ADR, submit the following information:
  - **Point of contact for the agency**
  - **Name and phone number**

- This allows for follow up during the review if missing documentation is identified

NPI			
PTAN			
Group/Practice Name			
Provider Name			
Contact Name			
Title			
Contact Number			
Hours of Availability		Time Zone	☐ Pacific ☐ Mountain ☐ Central ☐ Eastern

Submission Methods

eServices Portal

Visit our website at www.PalmettoGBA.com/eServices for more information

Electronic Submission of Medical Documentation (esMD)

Include a copy of the ADR with your documents

More information on esMD can be found at www.cms.gov/esMD

Fax

JM HHH: (803) 699–2436

Include a copy of the ADR with your documents

Submission Methods Home Health

- Please include a copy of your ADR with all document submissions
- Via fax: (803) 699–2436
- Via mail:

U.S. MAIL	OVERNIGHT MAIL
Palmetto GBA HHH Medical Review Mail Code: AG-230 P.O. Box 100238 Columbia, SC 29202-3238	Palmetto GBA HHH Medical Review Mail Code: AG-230 2300 Springdale Drive, Bldg. 1 Camden, SC 29020

Results and Education

During the probe review, the reviewer may contact the designated POC for any missing information or to provide education on a specific claim or issue identified

If you have submitted a complete documentation package, or no education requirement was identified during the probe, the reviewer will not contact you during the probe

Providers will receive an education letter at the conclusion of each reviewed claim with the individual claim specific results and any applicable education

Missing Documentation

Some examples of missing documentation most frequently requiring contact, may include (but not limited to):

- No Hospice Election Statement
- No or incorrect certification for DOS billed
- Missing face-to-face
- Missing point of contact
- No physician's narrative
- No POC/Interdisciplinary doc for DOS billed
- Missing documentation to support the level of care billed:
  - Rev code 0656 — General Inpatient Care

Results and Education

Upon completion of the 20–40 claim sample, Medical Review will provide you written notification to include your probe results

This letter will include the number of claims reviewed, the number of claims allowed in full, the number of claims denied in full or in part and education on the results

After the written notification has been issued, the Reviewer or Clinical Educator will contact you to schedule a 1:1 educational session via teleconference regarding any errors noted during the claim review

Is There a Documented Threshold to Determine if the Provider Should Move to the Next Round?

Each MAC evaluates the TPE probe claim denial or charge denial rate against an established threshold at the conclusion of each probe round

Providers with error rates that exceed the established threshold may be progressed to the next round

- *This information is communicated to the provider via the probe results information that all providers are issued at the conclusion of the 20–40 claim review for each probe*

Prior to the start of the next TPE probe round, all completed appeals and reopens are considered prior to transitioning a provider to the next probe

If the new claim and charge denial rates are 20% or less, a new TPE results letter will be issued, and the provider will be removed from progressing to the next probe

Auto Denial/No Response Errors Requested Records Not Submitted

- Monitor your claim status on Direct Data Entry (DDE). If the claim is in status/location SB6001, the claim has been selected for review and records must be submitted
- To ensure you are receiving ADRs, please ensure you update enrollment with any address changes promptly
- For your convenience, all providers enrolled in **eServices** will automatically receive the ADR by eDelivery
  - **Palmetto GBA's eServices is an internet-based, provider self-service secure application**
  - **Palmetto GBA's goal is to give the provider secure and fast access to their Medicare information seamlessly via our website through the eServices application**

https://www.palmettogba.com/eServicesUserGuide

Auto Denial/No Response Errors Requested Records Not Submitted (continued)

Aim to submit medical records within 30 days of the ADR date. The ADR date is in the upper left corner of the ADR request. The claim will auto deny by the system on day 46.

Gather all information needed for the claim and submit it all at one time.

Attach a copy of the ADR request to each individual claim.

If responding to multiple ADRs, separate each response and attach a copy of the ADR to each individual set of medical records.

- *Ensure each set of medical records is bound securely so the submitted documentation is not detached or lost.*

If mailing, please return the medical records to the address on the ADR. Be sure to include the appropriate mail code. This ensures your responses are promptly routed to the Medical Review department.

Certification of Terminal Illness

The hospice-

- Must obtain written certification of terminal illness for each of the periods
- Must obtain the written certification before it submits a claim
  - **Certifications may be completed no more than 15 calendar days prior to the effective date of election.**
  - **Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period**

Face-to-Face Encounter

- Hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay is anticipated to reach the 3rd benefit period
- The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care

Certification

- Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness
- The certification must conform to the following requirements:
  - **The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course**
  - **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**

Admission to Hospice Care

- The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician

- In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

  - **Diagnosis of the terminal condition of the patient**

  - **Other health conditions, whether related or unrelated to the terminal condition**

  - **Current clinically relevant information supporting all diagnoses**

Content of Written Certifications

- The statement that the individual's medical prognosis is that the beneficiary's life expectancy is 6 months or less if the terminal illness runs its normal course
  - **Guidance: A simple statement on the certification/recertification that states, the beneficiary has a medical prognosis of 6 months or less if the terminal illness runs its normal course**
- Patient-specific clinical findings and other documentation supporting a life expectancy of 6 months or less
  - **Guidance: The certification should give specific clinical findings, for example, signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake**
- The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers

Examples of the Narrative for a Physician Certification

- I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates: 1/1/20XX to 3/30/20XX
- Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78-year-old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy, but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over past 2 weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath

Recertification of Terminal Illness (At 90 days and each subsequent 60 days)

- I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course.
- Certification period dates: 3/31/20XX to 6/28/20XX
- Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78-year-old male with a diagnosis of stage 4 lung cancer who has been receiving hospice services since 1/1/2016. Oxygen dependent and has been increased to 6LNC. Increasing somnolence and is only out of bed for short periods of time with max assist. Poor appetite and is only taking small sips of water and broth. Evident cachexia. Receiving morphine every 2 hours for pain.
- Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Recertification of Terminal Illness (At 90 days and each subsequent 60 days

- Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative & Face-to-Face attestation included)
- I certify that Jane Smith is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.
- Certification period dates: 6/29/2016 to 8/27/2016 Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services).
- 83-year-old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.
- Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one)

Common Hospice Certification Errors

- Predating physician(s) certification signatures
- Not having both the hospice medical director and attending physician (if applicable) sign the initial certification as required
- The physician narrative is missing
- The attestation statement is missing
- Not having verbal certifications by both the medical director and attending physician (if applicable)

Common Hospice Certification Errors

- No physician(s) signatures
- Illegible physician signatures
- Physician did not date his/her signature
- Not clearly stating the dates the certification period encompasses

Certification Denial Reasons

- No certification for dates billed
- Certification not signed
  - **Initial**
  - **Subsequent**
- Certification not signed timely
  - **Initial**
  - **Subsequent**

No Certification for Dates Billed

The documentation submitted for review did not include a certification covering all the dates billed.

- Dates of service billed: 11/01/21 – 11/30/21
- Initial benefit period:
- 8/15/21 – 11/12/21
- Second benefit period 11/13/21 – 02/12/22
  - The provider did not submit the second certification
  - Services non-covered 11/13/21 – 11/30/21

Certification Not Signed

The documentation submitted for review did not include a certification that was signed and/or dated by the medical director (and attending physician for initial)

I certify Mr. Patient to be terminally ill with a prognosis of six months or less to live if the disease follows its normal course

John Doe MD _____

Physician Signature Date

Certification Not Signed Timely

The documentation submitted for review did not include a certification that was signed **timely** by the medical director (and attending physician on initial)

Start of Care is March 1, 2021

- Attending physician signs March 1, 2021
- Hospice medical director signs March 10, 2021 (no verbal certification present)

Face to Face Encounter Requirements Not Met

- The services billed were not covered because the documentation submitted for review did not include documentation of a face-to-face encounter.
- **How to prevent this denial:**
  - **The face-to-face encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter.**
  - **Specific documentation related to face-to-face encounter requirements must be submitted for review. This includes, but is not limited to, the following:**
    - The hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.
    - When a nurse practitioner performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course

General Inpatient Services Not Reasonable and Necessary

- The hospice services billed for general inpatient care days were not covered, as submitted documentation did not support medical necessity
- Therefore, the general inpatient care days were reduced to routine care days

General Inpatient Services Not Reasonable and Necessary

Documentation should include the following:

- Name of the contract facility in which the patient is receiving general inpatient care.
- Explanation for admission to the inpatient facility.
- Hospice interdisciplinary notes during the general inpatient stay and the physician's discharge summary.
- Documentation of the patient's condition during the inpatient stay.
- Hospitalization must be on a short-term basis and must be related to complications attributable to the terminal diagnosis such as pain control or symptom management which cannot be provided in other settings

General Inpatient Services Not Reasonable and Necessary

Documentation submitted must include the following:

- Need for pain control or symptom management that is not feasible in other settings
- Skilled care required when home support has broken down and it is no longer feasible to furnish needed care in the home setting
- Patient's need for medication adjustment, observation or other stabilizing treatments, which cannot be furnished in home

Not Hospice Appropriate

- The claim has been fully or partially denied because the documentation submitted for review did not support prognosis of six months or less
- How to prevent this denial:
  - **Ensure a legible signature is present on all documentation necessary to support six-month prognosis**
  - **Submit documentation for review to provide clear evidence the beneficiary has a six-month or fewer prognoses which supports hospice appropriateness at the time the benefit is elected, and continues to be hospice appropriate for the dates of service billed**

Not Hospice Appropriate

- Palmetto GBA has a Local Coverage Determination (LCD) for some non-cancer diagnoses. Submit documentation which supports the coverage criteria outlined in the policy. LCDs may be viewed on the Palmetto GBA Web site at www.PalmettoGBA.com/HHH .
- Document any co-morbidity, which may further support the terminal condition of the beneficiary and the continuing appropriateness of hospice care

Activity Limitations

ADLS

- Ambulation
- Continence
- Transfer
- Dressing
- Feeding
- Bathing

Co-Morbidities

- COPD
- CHF
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease
- Renal Failure
- Liver Disease
- Neoplasia
- AIDS/HIV
- Dementia

Signs/Symptoms

- Recurrent infections (e.g., pneumonia, sepsis, pyelonephritis)
- Pain requiring increasing doses of major analgesics
- Nausea/vomiting
- Poorly responsive to treatment
- Intractable Diarrhea
- Dyspnea with increasing respiratory rate
- Intractable Cough

Signs/Symptoms

- Weight loss (≥10% body weight in prior 6 months)
- ↓ anthropomorphic measurements (e.g., mid-arm circ, abdominal girth)
- Observation of ill-fitting clothes, ↓in skin turgor, ↑ skin folds
- ↓ serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake

Signs/Symptoms

- Change in Functional status
  - **Decline in PPS score**
  - **Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST)**
- Progressive stage 3-4 pressure ulcers
- History of increasing ER visits
- Hospitalizations or physician visits related to the hospice primary diagnosis prior to election of hospice

Documentation Tips

- Structural impairments
- Functional impairments
- Activity limitations
- Co-morbid conditions
- Secondary conditions

Invalid Plan of Care Submitted

- Claim has been fully or partially denied as the documentation submitted for review did not include a valid plan of care for all or some of the dates billed
- For a beneficiary to receive hospice care covered by Medicare, a POC must be established before services are provided
- POC is developed from the initial assessment and comprehensive assessment and services provided must be consistent with the POC

Invalid Plan of Care Submitted

How to prevent a denial:

- POC must contain certain information to be considered valid. This includes:
  - **a) Scope and frequency of services to meet the beneficiary's/family's needs**
  - **b) Beneficiary specific information, such as assessment of the beneficiary's needs, management of discomfort and symptom relief c) Services that are reasonable and necessary for the palliation and management of the beneficiary's terminal illness and related conditions**
- POC must be reviewed, revised and documented as frequently as the beneficiary's condition requires, but no less frequently than every fifteen (15) calendar days.

The Notice of Election Statement Is Invalid Because It Doesn't Meet Statutory/Regulatory Requirements/No Valid NOE Submitted

The services billed were not covered, as there was no valid signed NOE statement included with the documentation submitted for review.

- How to Prevent This Denial
  - A Medicare beneficiary must complete a NOE statement before the Hospice Medicare Benefit can begin. A beneficiary who meets the eligibility requirement in the Code of Federal Regulations 42 CFR — Part 418.20 may file a NOE statement with a particular hospice. The representative for this beneficiary may file the NOE if the beneficiary is physically or mentally incapacitated. The NOE statement must be signed no later than the first day for which the payment is claimed. It must also be signed if the beneficiary is reelecting the hospice Medicare benefit after a revocation or discharge from hospice.
  - The provider must submit a NOE statement to the intermediary for every beneficiary who elects the Hospice Medicare Benefit. A beneficiary (or his/her representative) must elect hospice care to receive it. Once the decision to receive hospice care is made, a NOE statement must be filed with a particular hospice.

The Notice of Election Statement Is Invalid Because It Doesn't Meet Statutory/Regulatory Requirements/No Valid NOE Submitted

How to Prevent This Denial

- All NOE statements must include the following information:
  - Identification of the particular hospice which will provide care
  - Acknowledgement the individual/representative has a full understanding of hospice, particularly the palliative vs curative nature of treatment
  - Acknowledgement that certain Medicare services are waived by the election
  - Effective date of the election
  - Individual's designated attending physician (if any)
  - Individual's acknowledgement the designated attending physician is their choice
  - Information on cost sharing / notification of the right to receive an election statement addendum / information on the BFCC-QIO, including the right to immediate advocacy
  - Signature of the individual / representative
- The duration of the NOE statement will be considered to continue through the initial election period and through the subsequent election periods without a break in care if the beneficiary remains in the care of a hospice and does not revoke the election under the provision of Code of Federal Regulations, 42 CFR — Section 418.28
- When a Medicare beneficiary or authorized representative elects the hospice Medicare benefit, a NOE statement must be submitted to the MAC prior to the submission of the first bill

References and Resources

Medicare Program Integrity Manual

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

Hospice Documentation Audit Tool

- https://www.palmettogba.com/Palmetto/Providers.Nsf/files/Hospice_Documentation_Audit_Tool.pdf/$File/Hospice_Documentation_Audit_Tool.pdf

Notice of Election

- https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6KPD3187

Certification

- https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/9CWSWZ3714

GIP Reduction

- https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BC6K632367

CERT

- https://www.cms.gov/files/document/2020-medicare-fee-service-supplemental-improper-payment-data.pdf

MLN Connects: CMS Resumes Targeted Probe & Educate Program

- https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2021-08-12-mlnc#_Toc79579748