Part B Insider (Multispecialty) Coding Alert

HOSPICE: OIG Finds Startling 82 Percent Error Rate in Hospice Billing, Accounting for $1.8 Billion

Plus: Get ready for new requirements in your hospice certification statements.

The OIG thoroughly examined hospice care payments -- and didn't like what it found.

A new OIG study focused on hospice claims for beneficiaries in nursing facilities in 2006, for which the OIG reviewed medical records and random samplings of hospice claims. The result was the Sept. 8 report, "Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements."

Outcome: The OIG found that "82 percent of hospice claims for nursing facility beneficiaries did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services or certifications of terminal illness," the report indicated.

In addition, the OIG found that 63 percent of the claims did not meet plan of care requirements. Although meeting these requirements may seem like a no-brainer to many hospice administrators, others struggle to keep up. The key to ensuring you meet Medicare's requirements, however, is to designate one or more departments to double-check plan of care requirements before you submit your bill to Medicare.

"We work with many hospices throughout the country; all of them have an interdisciplinary group (IDG) or interdisciplinary team (IDT) that meets routinely to discuss each hospice patient," says **Jean Acevedo,LHRM, CPC, CHC** of Acevedo Consulting, Inc., in Delray Beach, Fla. "This would be the ideal setting for a patient's plan of care to be reviewed, as, should any deficiencies be identified, this is the group of nurses, social workers, physicians, etc. who have the ability to effectuate a change in the type and level of care the patient receives."

If the hospice has a sophisticated medical record department with trained and credentialed health information management staff, "this department could also serve as a quality check to see if everything that should be documented in a patient's chart is documented before submitting the claim to Medicare," Acevedo suggests. "Since hospice billing to Part A is done on a monthly basis, it would seem that this type of quality assurance is essential to help ensure that the hospice does not find itself being asked to repay a month's worth of care."

Comply With New Regs

Meanwhile, in addition to contending with the OIG report, Medicare will soon require an additional statement on hospice patients'certification statements.

As first proposed in April, CMS adopted the Medicare Payment Advisory Commission's recommendation that physicians include "a brief narrative explanation of the clinical findings that support a life expectancy of [six] months or less" when they certify (or recertify) hospice patients as being terminally ill.

Published in the Aug. 6 Federal Register, the final rule notes that CMS will accept the narrative either as a typed addendum to the certification form or as information entered onto the form. If the narrative is part of the form, it must come directly above the physician's signature. The addendum must also be signed by the physician following the narrative.

Required: No matter how physicians supply it, the physician narrative must be composed by the physician performing the certification or recertification and not by hospice personnel. In addition, it must include a statement confirming that the physician composed the narrative based on his review of the patient's medical record or patient exam.

The statement also has to reflect the patient's individual clinical circumstances and not include any checked boxes or standard language used for all patients.

CMS is placing increased emphasis on "assuring that the right care is being provided to the right person at the right time" -- and this narrative is another way of making that happen, points out **HeatherWilson,** a consultant with Weatherbee Resources in Hyannis, Mass.

Hospices will now have "another piece of documentation to use as evidence of a patient's initial and continued eligibility," Wilson says.

To read the OIG report, visit www.oig.hhs.gov/oei/reports/oei-02-06-00221.pdf.