Eli's Hospice Insider

Documentation: Physician Documentation Questions Worry Hospices

Hospice admission assessment can't be basis for eligibility, rule says.

Don't be surprised to see medical review of your patients' eligibility become more stringent, thanks to the 2018 payment final rule.

In the proposed rule released back in April, the **Centers for Medicare & Medicaid Services** didn't officially propose any changes to the physician documentation requirements. But it sent some alarming signals on the topic. With hospice spending and length of stay increasing significantly, CMS expressed concerns about patients being inappropriately certified as terminally ill (see Eli's Hospice Insider, Vol. 10, No. 6).

Then: "We are soliciting comments for possible future rulemaking, on amending the regulations at § 418.25 to specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility determinations," CMS said in the rule published in the May 3 Federal Register. "Clinical information from the referring physician and/or acute/post-acute care facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility" (emphasis added). CMS "also discussed the potential benefit of an initial face-to-face visit by the hospice medical director or physician designee, if needed, to support the clinical documentation required to accompany the certification of terminal illness," CMS notes in its final rule published in the Aug. 4 Federal Register.

Hospices were very concerned about this idea, even if it wasn't slated for imminent implementation and they told CMS so, in no uncertain terms, in numerous comment letters. "The majority of commenters expressed concerns that obtaining clinical documentation from outside physicians or facilities would delay hospice admission and services. In addition, commenters expressed concern that CMS was considering requiring hospice physicians to perform a face-to-face visit within the 2 day certification time frame in order to certify terminal illness," CMS summarizes in the final rule.

Now: In the final rule, CMS backtracks somewhat on the issue. The proposed rule discussion "was meant only to solicit comments on clarifying the source of the clinical information already required to be reviewed by the hospice medical director upon the initial certification," the agency insists. "Therefore, this clinical information can be obtained orally from the referring entity and documented in the patient's chart within the 2 day time-frame needed for certification... The referring entity's clinical documentation may arrive later for retention in the patient's medical record."

CMS further elaborates, "We believe that clinical information and documentation are critical to the certification decision and this information is needed for the hospice's interdisciplinary group (IDG) to develop the initial plan of care for the new patient and, therefore we would expect the information to accompany, in some fashion, the certification. Likewise, the requirement that the medical documentation that accompanies the initial written certification be obtained prior to submitting a claim remains unchanged and should not impede services."

CMS acknowledges that "the hospice admission assessment can also accompany the initial written certification; however, this information should further substantiate rather than provide the basis for certification."

F2F optional: On the matter of the F2F visit, "the hospice medical director or physician designee would not be required to perform a face-to-face visit before the third benefit period recertification," CMS clarifies. "Rather, the intent of the discussion and solicitation of comments in the ... proposed rule was to determine whether such optional visits could be useful to augment the referral source's clinical documentation to support a medical prognosis of 6 months or less."

Ultimately, CMS pledges to "carefully consider all comments for any future rulemaking proposals, if needed, regarding the sources of clinical information to support the certification of terminal illness."

Your Clinical Records Need These 3 Musts

In another part of the discussion, CMS allows "that hospices already obtain and analyze clinical information from a variety of sources, including referring providers," and current regulations already "require such information to accompany the certification of terminal illness." CMS doesn't seem so sure that's happening, though.

Watch out: "We plan to work with our Medicare Administrative Contractors (MACs) to confirm whether they are requesting such information when claims are selected for medical review and, if not, whether such information should be included in any additional documentation requests," CMS says in the final rule. "We continue to encourage providers to use the full range of clinical documentation when certifying terminal illness in order to ensure physician engagement and accountability."

The good news is that CMS proposed no CTI documentation changes this year, notes consultant **Lynn Stange** with **Weatherbee Resources Inc.** in Hyannis, Massachusetts.

But hospices should continue to be concerned, believes **Kim Skehan** with **Simione Healthcare Consultants** in Hamden, Connecticut. The final rule emphasizes that the hospice admission only substantiates and thus isn't the basis for the eligibility determination, Skehan points out. And MAC medical review may change accordingly.

"It will be interesting to see how this will impact medical review and potentially ADRs and denials," Skehan tells **Eli**.

Do this: "Hospices must ensure clear documentation to support eligibility for hospice services," Skehan urges.

"Hospices should ensure they are gathering the clinical information that medical directors are currently required to consider for the certification of terminal illness," advises **Katie Wehri** with **Healthcare Provider Solutions** in Nashville. Wehri recommends that providers make sure their documentation includes:

1. Diagnosis of the patient's terminal condition;
2. Other health conditions, whether related or unrelated to the terminal condition; and
3. Current clinically relevant information supporting all diagnoses.

Note: See the final rule at https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16294.pdf.