Eli's Hospice Insider

Fraud & Abuse: Head Off Fraud & Abuse Concerns With These 5 Pointers

Know your own data before reviewers and whistleblowers do.

The feds have their eye on hospice fraud and abuse hot spots ranging from diagnosis coding to live discharges to visit frequency in the last days of life, according to Medicare's proposed rule for 2017 hospice payment.

The **Centers for Medicare & Medicaid Services** has gotten serious about tracking red flags for Medicare hospice payment, it says in its proposed rule issued April 21 (see Eli's Hospice Insider, Vol. 8, No. 6). And that means you'll likely be called on the carpet if your data identifies you for scrutiny.

Then: CMS's "long-time hospice regulatory compliance enforcement neglect did hospice no favor," maintains **Beth Noyce** with **Noyce Consulting** in Salt Lake City. "Instead, it reinforced complacency."

Now: "Hospice clinicians and leaders, still stunned by hospice regulatory whiplash over the past three years, are in for tighter scrutiny," Noyce warns.

Heed this expert advice to survive and thrive in the new regulatory enforcement landscape:

1. Know thyself. You need to know whether your own data is landing you on reviewers' radar. CMS is using "monitoring contractor Acumen ... to conduct comprehensive, real-time monitoring and analysis of hospice claims to help identify program vulnerabilities, as well as potential areas of fraud and abuse," the agency says in its proposed payment rule for fiscal year 2017.

CMS has promised to "continue digging into hospice claims with focus on claims showing long stays, live discharges, revocations, hospice care in non-household facilities, [and] claims with one diagnosis coded," Noyce tells **Eli**.

"We continue to communicate and collaborate across CMS to improve monitoring and oversight activities of hospice activities," the agency says in the rule. Sticking out on the high end of data trends can earn you medical review from various Medicare contractors.

In the wider view, industry data may spark more payment changes possibly unfavorable ones. "We expect to analyze more recent hospice claims and cost report data as they become available to determine whether additional regulatory proposals to reform and strengthen the Medicare hospice benefit are warranted," CMS says in the rule.

Tool: Use your PEPPER report to gauge your performance in relation to your peers. The latest version of the free report, issued in April, added benchmarks on Live Discharges Revocations; Live Discharges with LOS 61-179 Days; Claims with Single Diagnosis Coded; and No General Inpatient Care or Continuous Home Care (see Eli's Hospice Insider, Vol. 8, No. 5). They joined the existing benchmarks of Live Discharges No Longer Terminally Ill; Long Length of Stay; Continuous Home Care Provided in an Assisted Living Facility; Routine Home Care Provided in an Assisted Living Facility; Routine Home Care Provided in a Nursing Facility; and Routine Home Care Provided in a Skilled Nursing Facility.

In addition to its real-time monitoring for fraud-fighting purposes, Acumen will also track a number of data points to "monitor overall usage and payment trends in hospice," CMS notes. The contractor will track a wide variety of metrics

monthly and annually, according to the rule.

2. Run your own reports. Using government-supplied data is important, but not the only option for compliance and risk management. The **National Hospice & Palliative Care Organization** "encourage[s] individual providers to track their own data as well," says NHPCO's **Judi Lund Person**.

3. Boost your documentation. Your ability to defend against the ramp-up of medical review lies in your documentation, Noyce advises. Light scrutiny in past years led to substandard documentation in many cases.

For example: Hospices often tell Noyce, "We have CTIs that say the patient is terminal for every benefit period. That proves that our patients qualify for hospice, even if they're on service for years," she says. The hospice's own documentation is going to have to prove the patient's eligibility, especially for long-stay patients, she warns.

Do: And you can expect CMS and its contractors to get tough on the issue of related services. "If any patient condition needs treatment that is unrelated to the patient's terminal prognosis, the hospice physician must document why the treatment will be unrelated to the terminal prognosis," Noyce stresses.

Don't: "Some agencies still operate under the view that any treatment not for the terminal illness is unrelated to the terminal illness, unless it's an antidiarrheal, anti-emetic, laxative, opioid, or antianxiety drug (typical palliative medications)," Noyce notes. Your records must clearly show why the treatment is unrelated.

You'll need to bone up on hospice Local Coverage Determinations and make sure your patient records are covering all the bases to retain reimbursement for your patients, Noyce suggests.

4. Avoid fraud. You may get called on the carpet for subjective judgement calls on relatedness and eligibility under increased scrutiny. But some practices will fast-track you to accusations of fraud and whistleblower lawsuits.

For example: Noyce sometimes hears from providers that "we told the patient we will revoke their hospice benefit if they go to the emergency room," she relates.

"A hospice cannot 'revoke' a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request or demand that the beneficiary revoke his or her hospice election," CMS stresses in the rule. "Like the hospice election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services they wish to receive through Medicare."

Trying to get patients to revoke the benefit instead of discharging them may not help you anyway. The PEPPER report now tracks data on both actions.

5. Don't get lulled. You may have a sterling survey history, but that won't necessarily matter when CMS and its contractors start going through your data with a fine-tooth comb, Noyce notes.

Get proactive now to identify and resolve potential operational and billing problems before medical reviewers and/or surveyors do it for you.