Eli's Hospice Insider

Medical Review: Beware Claims Denials For OBS Patients

Other claims getting caught up in edits include those for nursing home patients, vascular lymphoma, and cardiomyopathy.

If your patient has a primary diagnosis of organic brain syndrome (294.8) and a length of stay exceeding 240 days, you'll be waving a big red flag to medical reviewers.

Home Health & Hospice Medicare Administrative Contractor **CGS** recently released results of a widespread edit of such claims during the July 1 to Sept. 30 period. The edit racked up a 64 percent denial rate, the MAC reports in its December newsletter for providers.

The top denial reason for the edit was 5PTER, "Six-month terminal prognosis not supported," CGS reveals. "Patients with OBS ... may be appropriate for hospice,

but it is the hospice agency's responsibility to ensure the documentation supports the six month prognosis," the MAC exhorts.

The 5PTER denial "is related to the common obstacle of documenting a six-month terminal prognosis," CGS continues. "Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy is six months or less."

Often hospice claims get denied because the documentation excludes adequate decline specifics and focuses primarily on custodial care, noted RNs **Beth Noyce** and **Dana Walling** of Ogden, Utah-based **Applegate HomeCare and Hospice of Utah** in a presentation at this fall's **National Association for Home Care & Hospice** annual meeting in Las Vegas.

"Documentation is essential for patients that have remained on the hospice benefit for an extended length of time, or for patients that have chronic illnesses or general decline," CGS stresses.

Remember: "The documentation must present a visual picture of the patient, their conditions and symptoms to support terminal prognosis," CGS says in a tool, "Suggestions for Improved Documentation to Support Medicare Hospice Services." (For ideas in improving documentation, see related story, p. 4).

Nursing Home Focus Shows Up in Medical Review

OBS claims aren't the only ones seeing problems in this area. CGS also racked up a 64 percent denial rate in a widespread edit of claims for nursing home patients with a LOS greater than 180 days, it says. The edit topic coincides with interest from the **HHS Office of Inspector General** and other authorities in hospice services furnished to patients residing in nursing homes.

In Noyce and Walling's Oct. 4 session, "Hospice Widespread Edits," they identified these additional targets of hospice widespread edits:

- 290.40 (Vascular dementia) diagnosis and LOS exceeding 240 days;
- long LOS (one year, two year);
- 202.xx and 203.xx (Lymphoma) primary diagnosis and LOS exceeding 180 days;
- 425.4 (Cardiomyopathy NEC) primary diagnosis and LOS exceeding 180 days;
- claims for patients who are discharged and readmitted; and

- providers exceeding their hospice cap who haven't undergone review in the past year.

Note: CGS's article is at www.cgsmedicare.com/hhh/pubs/mb_hhh/2011/12_2011/index.html#024.