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Eli's Hospice Insider

Medical Review: Beware These Medical Review Red Flags

Expect the number of whistleblower suits aimed at hospices to rise.

Recent action by the feds should remind you that your hospice documentation needs to be strong enough to stand up to scrutiny -- because it's likely to get it.

In January, the **Department of Justice** joined in a whistleblower lawsuit against for-profit chain **AseraCare Hospice** (see Eli's Hospice Insider, Vol. 5, No. 2). And the **HHS Office of Inspector General** has entered a $25 million settlement with **Odyssey Hospice**, now owned by **Gentiva Health Services Inc.** (see story, this page).

You can expect these suits and settlements to be the first of many in the hospice industry, experts predict. "We are seeing a change in how the OIG perceives hospice," judges attorney **Robert Markette Jr.** with **Benesch Friedlander Coplan & Aronoff** in Indianapolis. That seems particularly true for for-profit hospices.

"That honeymoon period that hospices enjoyed for such a long time is really over," agrees attorney **Marie Berliner** with **Joy & Young** in Austin, Texas.

As whistleblower lawsuits in the hospice industry get more attention -- particularly the monetary rewards for relators -- you'll see more attorneys soliciting them and more disgruntled employees filing them, expects financial consultant **Tom Boyd** with Rohnert Park, Calif.-based **Boyd & Nicholas**.

Watch Out For These Hot Spots

Recent lawsuits, settlements, audits, and reports by the OIG, **Medicare Payment Advisory Commission** and others point to these issues as red flags that are likely to draw attention:

Diagnosis. Scrutiny and enforcement action in the hospice industry boil down to proving whether the patient was eligible for hospice services. One simple way to attack a patient's eligibility is to look at his diagnosis.

Non-specific diagnoses like debility NOS and failure to thrive, or neuro conditions like dementia or Alzheimer's are easy targets, Markette warns. "Medicare is having a hard time coming to grips with hospices serving non-cancer patients," he observes.

"Those are the easy target cases," Berliner cautions. "It's the easiest place to find fault."

Watch for diagnosis to become a potential target for Recovery Audit Contractors, which recently announced home care topics for review. Under an automated audit based simply on using non-terminal diagnoses, hospices would see lots of claims denied, says consultant **Joy Barry** with **Weatherbee Resources** in Hyannis, Mass. Examples include diabetes, multiple sclerosis and peripheral vascular disease, Barry says.

Length of stay. Another way to attack eligibility is to focus on the patient's terminal status and length of stay.

The average length of stay for Medicare hospice users has grown from 54 days in 2000 to 86 days in 2010, MedPAC said in its Jan. 12 meeting. During the same time period, median LOS grew only modestly from 17 days to 18 days. That means more very lengthy stays are pushing up the average.

"It's not illegal for the patient to live more than six months," Berliner points out. But having a lot of long-stay patients on your census is sure to attract attention from reviewers and others.

Even if you're doing everything right, if you have a lot of long-stay or "vague diagnosis" patients on your rolls, you're going to get looked at, Markette warns. You need to take steps to make sure your documentation will support your claims (see related story, this page).

It's ironic that long stay is a hot topic, because it's the high number of extremely short stay episodes that is proving such a logistical challenge for many hospices. "Short length of stay is killing them," Barry says.

Related vs. unrelated. Even if the patient's hospice eligibility isn't in question, hospices can get slammed for failing to pay for services that it deems unrelated, but that Medicare sees as related to the terminal diagnosis.

It's true that you aren't responsible for covering unrelated comorbidities, Barry says. But a lot more things may be related than you think. "We hear a lot of gasping in the audience" when they present seminars on this issue, she tells **Eli**.

For example: You may be serving a patient with end-stage cardiac disease and kidney disease and not covering kidney dialysis, Barry offers. But if the kidney disease occurred as a late effect of the cardiac disease, it's related. That can put you on the hook for dialysis and ambulance services. Look for whether the cardiac or kidney disease occurred first to help determine its status, she suggests.

"There's a lot more nuance to these issues" Barry cautions. Remember that if a condition is due to the negative outcomes resulting from the terminal diagnosis (weight loss, skin breakdown, falls, fractures, etc.), then it's related too.»

- Level of care. Authorities are taking notice of hospices that bill more than the usual amount of general inpatient (GIP) days. For example, an Alabama hospice owner recently was sentenced to more than two years in jail for billing Medicare for GIP days when the hospice provided routine home care (see Eli's Hospice Insider, Vol. 5, No. 3).
- Readmissions. Multiple readmissions after live discharges are a huge red flag to auditors and investigators, Barry notes. This could indicate a patient who doesn't really have a terminal prognosis, or a patient who doesn't really want to forego curative treatment.

It's a patient's right to revoke the hospice benefit if she chooses, Barry notes. But auditors may think the hospice and patient are colluding to relieve the hospice of expenses.

- Location. Hospice services delivered in nursing homes are drawing major scrutiny from the OIG, MedPAC and others. Expect this scrutiny to translate into lawsuits, investigations, and other enforcement actions, experts predict.
- For-profit status. It may not be fair, but it's clear from public reports, releases, etc. that the OIG, DOJ, and MedPAC are casting a harsher spotlight on for-profit hospices, Markette points out.