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Eli's Hospice Insider

Medical Review: Intermediary Targets Heart Claims for Review

Are your hospice election and certification forms are up to snuff?

You'd better make sure your inpatient hospice claims and claims for long-stay hospice patients with cardiomyopathy can stand up to scrutiny, or you'll risk forfeiting your Medicare payments for those patients.

After two probe reviews -- one of claims with revenue code 0656 (general inpatient services), the other of claims with a primary diagnosis of 425.4 (Primary Cardiomyopathy NEC) and a length of stay greater than 181 days -- regional home health intermediary Cahaba GBA is initiating widespread reviews of both sets of claims.

You can identify the review by code 5055T for the cardiomyopathy edit and 5057T for the inpatient edit. Here are the reasons reviewers shot down the claims center on documentation.

Reason #1: In the probe, Cahaba frequently denied inpatient claims for reduction of care level, the intermediary says in its November provider newsletter. "General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings," Cahaba allows. But "the documentation submitted must support the need for the general inpatient care billed."

Reason #2: Reviewers often denied claims because the medical record didn't support the six-month terminal prognosis, Cahaba points out in the Newsline. Don't just rely on a diagnosis code to support the life expectancy, the RHHI tells providers.

"The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six month certification," Cahaba instructs. "Documentation is essential in 'painting the picture,' especially for patients that have remained on the hospice benefit for an extended length of time, and/or have chronic illnesses with a more general decline."

And don't assume that once you've documented the life expectancy you can ignore the matter. "The patient's appropriateness for the hospice benefit must be clearly supported in the medical record from admission and throughout the hospice care provided," Cahaba stresses.

Reason #3: Reviewers also denied many claims because of missing, incomplete or untimely election statements, Cahaba says.

Don't let paperwork torpedo your claims. "An election statement that is signed by the beneficiary or their representative with an effective date prior to the provision of covered hospice care is required," Cahaba reminds hospices.

Hospices can generate their own election statement forms. But they must include these key items: hospice ID information, the patient's (or representative's) acknowledgment that the individual has been given a full understanding of hospice care, the patient's (or rep's) acknowledgment that the individual understands that certain Medicare services are waived by the election, the effective date of the election, and the patient's (or rep's) signature.

Reason #4: A valid physician's certification is also necessary for coverage, Cahaba adds. Reviewers denied claims because of missing, incomplete, or untimely certifications.

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Pitfall: The cert form must include specific dates for the benefit period, Cahaba instructs. "Simply having the statement 'third benefit period' is not enough to be able to tell which certification period the physician is signing," Cahaba warns. "The certification period must list the first date of the benefit period and the duration (60 days or 90 days), or provide the exact certification dates."

Furthermore, "if the date span for which the physician is certifying cannot be identified, your claim may be denied," Cahaba cautions. "Please take the time to review your agency's certification and recertification forms and make sure there is a place on the form to document the exact certification period dates."

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