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Eli's Hospice Insider

PAYMENT COMPLIANCE: Shore Up Documentation to Support Hospice Eligibility

Take these steps to prevent claim denials, payment recoupment, or worse.

The first rule of thumb in payment compliance: Don't let auditors do the troubleshooting for you. And if your hospice hasn't taken a good look at how it determines -- and documents -- patients' eligibility for the Medicare hospice benefit, the organization is fair game for everything from payment recoupments to fraud and abuse investigations.

Overcome this problem: Hospice teams tend to do "snapshot documentation" about the hospice visit where the interdisciplinary group members describe what they saw and did for the patient, says **Joy Barry, RN, MEd, CLNC,** principal of Weatherbee Resource Inc. in Hyannis, Mass. But that approach doesn't provide "a good picture -- painted in words -- of the patient's trajectory of illness over time ..."

Instead: The narrative documentation should include "clinically measurable" data points that show the patient's decline is consistent with a six month or less prognosis. In addition to vital signs, examples include the following, according to Barry:

• Body mass index

• Mid-arm or mid-thigh circumferences

• Palliative performance scale scores

• Functional assessment staging scores

• Infection history

• Physician office or emergency room visits

• Increasing levels of caregiver support with ADLs

• Increasing frequency of hospice visits, changing medical equipment, or medication-related needs.

One Trajectory Doesn't Fit All

Hospices also have to anticipate and address a terminal illness' expected trajectory of decline. For example, "dementia typically has a long, slow, dwindling decline," says Barry. By contrast, organ-system diseases, such as cardiac or pulmonary disease, tend to produce a "saw-tooth pattern" of exacerbations followed by slight improvements with periods of relative stability in between. But over time, the patient fails to recover his baseline and shows decline, she notes.

Pivotal point: By knowing the expected trajectory, the hospice providers can document accordingly. "Documenting decline in dementia, for example, could be as simple as noting the person needs increasing caregiver support with all ADLs," says Barry.

You also have to know the local coverage decisions. For example, the LCD might have criteria for dementia spelling out how many ADLs the person can perform and a "whole list of elements" that would determine a prognosis of six months or less, says attorney **Mary Michal,** with Reinhart Boerner Van Deuren in Madison, Wis.

Terminal cancer usually has a rapid, downhill trajectory, Barry says. So if the hospice is seeing a saw-tooth pattern in a

patient with cancer, the team should take a closer look, she advises. "Some cancers -- pancreatic cancer or glioblastoma, for example --can be very aggressive" and cause the person to die in fewer than six months. By contrast, stomach cancer and certain lung cancers may not have such a "rapid downward trajectory."

Ask these key questions:

"Hospice staff may not be able to discern one cancer from another --relative to eligibility requirements -- without asking about the type of cancer, how widespread the cancer is, what the treatment plan has been to date, the patient's response to treatment, etc.," says Barry.

Home in on Outliers

If the patient lives longer than expected, the hospice has to determine whether it is a situation involving what's called failure to die -- or one where the patient should be discharged from hospice due to an extended prognosis, says Barry.

"Failure to die" is a real issue, however, she adds. A patient can be very appropriate for hospice services and simply not die --and no one can explain why," although the patient is declining. In such cases, the hospice documentation must speak to the "failure to die" issue -- and the patient's eligibility for continuing hospice care, Barry emphasizes. "The hospice should be proactive in getting physicians to make home visits to help document the patient's eligibility."

Also keep in mind that hospice patients fall on a bell curve, which includes outliers on both ends. "If you pay close attention to the latter part of the definition of terminally ill, it allows for outliers," says attorney **Connie Raffa** with Arent Fox in New York, N.Y. She points to a study by a Harvard researcher published in the New England Journal of Medicine which concluded that if a hospice has 5 percent or less of its population living beyond a year from the date of admission --those are the outliers." And the outliers are permitted by the second part of the definition of "terminally ill" in 42 C.F.R. 418.3 "if the illness runs its normal course," says Raffa. "That isn't fraud."

Editor's note: See the related article on p. 23 of this issue.