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Eli's Hospice Insider

Regulations: Expect Broader Coverage Expectations From Medicare, Proposed Rule Suggests

Your idea of what's included in the hospice per diem may differ significantly from CMS's.

The idea has been germinating at CMS for years, but hospices may see it burst into full and terrible bloom soon: paying for nearly all of your patients' services and items, including medications.

For quite some time, the **Centers for Medicare & Medicaid Services** has been implying that hospices haven't been shouldering as much of the cost burden for their patients as they should. Three years ago, CMS's **Lori Anderson** told **National Association for Home Care & Hospice** conference attendees that "a terminal diagnosis is not one ICD-9 code." At the end of life, "almost everything" is related to the terminal condition. "It's the exception and not the norm if it's not related," Anderson said (see Eli's Hospice Insider, Vol. 4, No. 5).

Anderson criticized cases where hospices were classifying anything not related to one ICD-9 code the patient's primary diagnosis as unrelated, and thus not subject to payment coverage by the hospice rate.

Now, in CMS's proposed rule for hospice payment in fiscal year 2015, the agency floats a number of provisions that aim to change what and how much hospices cover for their patients particularly drugs.

CMS already has taken the first steps down that path with its new requirement for prior authorization of drugs unrelated to the terminal illness, which started May 1 (see Eli's Hospice Insider, Vol. 7, No. 5). But it reinforces in the proposed rule that it will be considering nearly all drugs related to the terminal illness. "Several hospices have stated that pre-existing, chronic and/or controlled conditions are not related to the prognosis of the hospice beneficiary and should not be the responsibility of the hospice a concept which is contrary to the hospice philosophy of providing comprehensive coordinated care to patients at end of life," CMS insists in the rule.

For example: A patient admitted with a primary terminal diagnosis of COPD also has diabetes which pre-dates the COPD. The patient uses corticosteroids to manage the COPD and the diabetes is well managed with an oral hypoglycemic agent. The patient needs to continue the medication to manage the diabetes. "The hospice argues that since the diabetes is unrelated to the COPD, the oral hypoglycemic agent medication should not be covered by hospice," CMS says in the rule. "However, increased glucose levels are a common manifestation of corticosteroid use. While the hospice states that the admission to hospice is a result of COPD, treatment for the COPD has the potential to affect glucose levels, and hence the hypoglycemic agent would be covered by the hospice and not through Part D."

Hospices have slowly been shedding their drug coverage responsibilities, CMS intimates in the rule. Hospice cost report data analysis "revealed a declining trend in the drug costs per patient-day, with costs declining from a mean of $20 per patient-day in 2004 to $11 per patient-day in 2012," the agency points out.

"The ongoing concern is that hospices are not providing the broad range of medications required by hospice beneficiaries during a hospice election," CMS says.

"The most troubling aspect of the Part D discussion in the regulation are examples provided by CMS that send a clear signal of CMS' expectation ... for drug coverage under the hospice benefit," NAHC worries in analysis of the rule.

The proposed rule is full of many changes and logistical challenges. But "the bigger issues discussed in the reg what is part of the hospice bundle are the issues of greatest concern," NAHC's **Theresa Forster** tells **Eli**.

More provisions that point to CMS's intention to tighten up hospice bundling include:

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• **Definitions of "terminal illness" and "related conditions.**" Comments on the Part D memo about prior authorization highlighted that there is confusion about the terms "terminal illness" and "related conditions," CMS says in the rule. "It is our general view that ... hospices are required to provide virtually all of the care that is needed by terminally ill patients," CMS reiterates from previous rules. "Our expectation continues to be that hospices offer and provide comprehensive, virtually all-inclusive care."

Hospice regulatory "requirements ... do not delineate between pre-existing, chronic, nor controlled conditions" in hospice coverage, CMS insists in the rule. "All body systems are interrelated; all conditions, active or not, have the potential to affect the total individual."

"We want to ensure that the hospice services under the Medicare hospice benefit are preserved and not diluted, or unbundled in any way," CMS stresses.

CMS's proposal for a terminal illness definition is: "Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual's condition such that there is an unfavorable prognosis and no reasonable expectation of a cure; not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less."

CMS's proposal for a related condition definition is: "Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less."

• **Deadlines for filing NOEs and NOTRs.** "We propose to require hospices to file both the notice of election (NOE) and the notice of termination/revocation (NOTR) on behalf of beneficiaries within 3 calendar days of admission/discharge," CMS says in the rule. "If an NOE is not filed timely, the days from the effective date of election to the date of filing the NOE would be the financial responsibility of the hospice."

This will be a big change for many hospices. HHH Medicare Administrative Contractors tell CMS that only 16.2 percent of NOEs are filed within 2 days of the effective date of election, 39.2 percent of NOEs are filed within 5 days, and 62.1 percent of NOEs are filed within 10 days, according to the rule.

"This will be tough," Forster predicts. "We are very concerned. We recognize the importance of it, but 3 days is pretty rigorous. Yes, hospices have people available 24/7, but not necessarily the folks who do this type of filing."

Medicare is paying for many Part A, Part B, and Part D claims during a beneficiary's stay due to late NOE filing, CMS emphasizes in the rule. "Prompt recording of the notice of election (NOE) prevents inappropriate payments, as claims filed by providers other than the hospice or the attending physician will be rejected by the system, unless those claims are for items or services unrelated to the hospice terminal illness."

New term: Late filing of a final claim or NOTR means patients may have trouble accessing needed medications, CMS says in the rule. "Providers are allowed 12 months to file a claim," the agency acknowledges. "So if a hospice is not prepared to file a final claim quickly, it should instead file a termination/revocation of election notice, so that the claims processing systems are updated to no longer show the beneficiary as being under a hospice election. Hereafter, we will refer to this as a Notice of Termination or Revocation, or NOTR."

"There have been ongoing concerns for years about delays in filings of the NOE and termination notices, related to other coverage under Medicare and to hospice care by other agencies," Forster points out. But "the Part D issues helped to bring these issues front and center."

There's no doubt the NOE and NOTR deadlines are connected to Part D, agrees **Judi Lund Person** with the **National Hospice and Palliative Care Organization.**

Hospices will be hoping to see this timeframe softened in the final rule. You can watch for the rule to come out in mid to late August, NHPCO says in its rule analysis.

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• **Identification of attending physician on the NOE and claim, and an attending physician change form.** CMS hasn't been happy to hear about hospices switching attendings when a patient enters inpatient care or in other circumstances. "We stress that in hospice, the attending physician, who may be a nurse practitioner, is chosen by the patient (or his or her representative), and not by the hospice," the rule says.

CMS wants hospices to identify the attending on the NOE and each claim, with enough detail in the NOE to make clear who they are. And "the language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient's (or representative's) choice," CMS instructs.

"Over a third of hospice patients had multiple providers submit Part B claims as the 'attending physician' using a modifier," CMS says in a release.

When a patient wants to change the attending, CMS proposes that the hospice "must follow a procedure similar to that which currently exists for changing the designated hospice." The patient must file a signed statement with the hospice identifying the new attending. "Additionally, we propose that the statement include the date the change is to be effective, the date that the statement is signed, and the patient's (or representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or representative's) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed." This change would help ensure "that any changes in the identity of the attending physician would be the result of the patient's free choice," CMS believes.

• **New coding edits for claims.** As announced in last year's payment rule, on Oct. 1 CMS plans to implement edits that will reject claims with "debility" and "adult failure to thrive" coded in the principal diagnosis field. But CMS will be implementing other edits on that date as well, the agency reveals in the proposed rule.

"To ensure additional compliance with ICD-9-CM Coding Guidelines we will implement certain edits from Medicare Code Editor (MCE), which detect and report errors in the coding of claims data ... for those claims submitted on or after October 1, 2014," CMS says. "Hospice claims containing inappropriate principal or secondary diagnosis codes, per ICD-9-CM coding conventions and guidelines, will be returned to the provider and will have to be corrected and resubmitted to be processed and paid."

Brush up on coding rules: "We will implement edits related to etiology/manifestation code pairs from the MCE," CMS says. "Therefore, it is important for hospice providers to follow the ICD-9-CM Coding Guidelines regarding codes that fall under this coding convention."

CMS repeatedly reminds hospices to code more than one diagnosis code on the claim. "Diagnosis reporting on hospice claims should include the appropriate selection of principal diagnoses as well as the other, additional and coexisting diagnoses related to the terminal illness and related conditions," the agency stresses in the rule.

A review of 2013 claims shows that 67 percent of hospice claims were still coming in with only one diagnosis listed. That's an improvement from the 72 percent figure from the year's first quarter. "Though this is a trend in the right direction, there still appears to be some confusion by the majority of hospice providers as to the requirements for diagnosis reporting on hospice claims," CMS notes.

Hospices fear a long list of codes on a hospice claim will lead to more financial burden for coverage of unrelated conditions.

Note: The final rule, published in the May 8 Federal Register, is at https://federalregister.gov/a/2014-10505.

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