Eli's Hospice Insider

Reimbursement: Learn Occurrence Code 42 Lessons From PEPPER Reports

More hospice target areas may emerge.

If you were unclear on how to use a certain discharge code in 2009 through 2011, it could be landing you on reviewers' radar screens now.

A number of hospices that received their PEPPER comparative billing reports this past fall found themselves on the high side for the "Live Discharges" target area. To calculate that figure, PEPPER report contractor **TMF Health Quality Institute** divided the numerator (count of beneficiaries discharged alive with occurrence code 42 [date of termination of hospice benefit] and with a length of stay less than 25 days) by the denominator (count of all beneficiaries discharged [by death or alive] with a LOS <25 days excluding discharge patient status code 30 [still a patient]), TMF explains in its report definition.

Problem: Some hospices were mistakenly using occurrence code 42 for all discharges, they discovered. That caused them to show up in the above-80th-percentile category when compared to their peers at the national, jurisdiction, and/or state level.

For example, "we have discovered upon review of your report that we have used occurrence code 42 for all discharges," one hospice told TMF. "What corrective action do we need to take to correct the occurrence code for those beneficiaries who were discharged due to death?" the hospice asked the contractor in a recent question-and-answer set.

Solution: "If you identify any billing errors, you should take the necessary steps to submit corrected claims," TMF instructs in the Q&As. "According to the Medicare Claims Processing Manual, Chapter 11 Hospice section 30.2, hospices should utilize patient discharge status codes 40, 41 or 42 as appropriate if the beneficiary has died during the billing period."

Hospices should coordinate with their HHH Medicare Administrative Contractors for questions on how to submit corrected claims, TMF adds.

Weigh Benefits Of Wholesale Corrections

But correcting all claims for three cap years may be unnecessary. "It's hard to justify a witch hunt to identify and correct claims incorrectly coded with occurrence code 42 for patients that have expired," says billing expert **M. Aaron Little** with **BKD** in Springfield, Mo. "The error isn't going to impact the beneficiary or other providers in any way because the patient is no longer living. And, it doesn't impact the Medicare payment, though, obviously it does have an impact on PEPPER and other billing stats."

Consider: "Our suggestion would typically be to correct the claim coding error going forward," Little tells **Eli**. "It's difficult to imagine a scenario where we might suggest going back and correcting previously billed and paid claims."

But **Judy Adams** with **Adams Home Care Consulting** in Chapel Hill, N.C. takes a different view. "Having an 80 percent or more rate in either of the two risk groups impacts the agency's data profile and potentially places the hospice at higher risk for Additional Documentation Requests for claim reviews/potential denials by intermediaries, Recovery Audit Contractors (RACs) and/or Zone Program Integrity Contractors (ZPICs)," Adams cautions. "It would be truly advisable for hospices that were using Code 42 inappropriately for all patients ... to revise their data to reduce their risk of being targeted for improper use of the hospice benefit."

Bottom line: "Ensuring that your hospice agency's data is accurate could limit unnecessary time and expense involved in extensive pre- and postpayment record review," Adams believes.

At the least, agencies should take immediate action to ensure that current and future claims use the correct condition codes "to be sure future reports are an accurate reflection of reasons for discharges from the hospice program and minimize inappropriate targeting as a potential inappropriate provider of the hospice benefit," Adams advises.

Reminder: Starting back in July, the **Centers for Medicare & Medicaid Services** instructed hospices to use occurrence code 42 only for beneficiary revocations of the hospice benefit, not when hospices discharged the patient for no longer being terminally ill, for moving, or for cause (see Eli's Hospice Insider, Vol. 5, No. 3).

TMF plans to "filter out revocations for future reports" for the Live Discharge measure, it says in a separate Q&A. For the current reports that cover 2009 to 2011, "we would prefer to exclude revocations, but the claims submission guidelines in effect for the claims contained in this release of PEPPER do not allow for this distinction."

Medicare Also Eyes Long LOS

The current report that about 2,700 hospices received (see related story, p. 1) covers two target areas: Live Discharges and Long Length of Stay. But those may not always be the only areas included.

"The target areas are approved by CMS and they may change over time," TMF says in the Q&As. "Suggestions for new target areas or revisions to existing target areas are welcome at any time; these may be submitted through the 'feedback' link at www.PEPPERresources.org.

Medicare plans to distribute hospice PEPPER reports annually, but CMS has not set the next distribution schedule yet, TMF adds.

TMF repeatedly says in the Q&As that it does not know how CMS and its other contractors will use the PEPPER report comparisons. But it does warn hospices that "percentile values at or above the 80th percentile indicate that the hospice is at risk for improper Medicare payments."

Do this: Hospices should prioritize their comparison by 1) nation, 2) jurisdiction, and 3) state, TMF advises. "The higher the percentile, the greater the risk of improper payments."

Medical reviewers, law enforcement, and others surely will use these stats to target their efforts, industry experts predict.

Note: More information about the reports is at www.pepperresources.org/TrainingResources/Hospice.aspx.