Codify
BY AAPC

Eli's Hospice Insider

REPORTS: OIG Finds Fault with Hospice Claims in Nursing Facilities

Review your form documents to make sure they include these required elements.

The Office of the Inspector General (OIG) has asked the Centers for Medicare & Medicaid Services (CMS) to take a closer look at hospice claims for beneficiaries in nursing facilities. Is your reimbursement at risk?

If you learn a few lessons from a recent OIG report, you could save your agency the time and headaches of medical review.

OIG Finds Coverage Requirements Lacking

A recent OIG report found that Medicare paid approximately $1.8 billion in 2006 in hospice claims for beneficiaries in nursing facilities that didn't meet at least one Medicare coverage requirement.

The same report found that 33 percent of nursing facilities' hospice claims didn't meet election requirements, and a whopping 63 percent didn't meet plan of care requirements.

Another 4 percent didn't meet certification of terminal illness requirements.

Good news: The OIG's report is based on 2006 data gathered before the hospice conditions of participation were finalized in 2008, points out attorney **Marie Berliner** with Lambeth & Berliner in Austin, Texas.

Most of the issues the OIG found should no longer be a problem, so long as providers are complying with the Conditions of Participation (CoPs). Both CMS and the intermediaries have provided training to help ensure agencies are up-to-date.

Money maker: In a companion piece, the OIG examined the hospice services provided to the beneficiaries in nursing facilities. That study found that Medicare paid $2.59 billion at an average of $960 per week per beneficiary.

Hospices provided nursing services on 96 percent of claims, home health aide services for 73 percent of claims, and medical social services for 68 percent of claims, the report discovered. 96 percent of claims included the provision of drugs.

Be Prepared for Medical Review?

The government doesn't gather and analyze data for no reason, Berliner says. The fact that they are tracking the types of service hospice provides likely means they are trying to discover whether they are overpaying for certain services. But agencies likely won't feel the repercussions of these findings for some time, because it would takes time to propose and enact any new regulations.

Recommendations: Based on the high percentage of noncompliance and spending, the OIG suggested that CMS take the following steps:

• Educate hospices about coverage requirements and how to ensure quality of care

• Provide tools and guidance to help hospices meet the coverage requirements

• Strengthen the use of targeted medical reviews and other oversight methods to eliminate waste and noncompliance. CMS has already put most of those measures in place over the past few years, but it does plan to share the OIG's findings with its contractors so that they better prioritize medical review strategies and other interventions.

CPT® 2023 American Medical Association. All rights reserved.

The OIG hopes its companion report will help CMS "determine whether the types and frequencies of hospice services provided to beneficiaries in nursing facilities meet the goals of the hospice benefit and whether current payment rates are aligned with the hospice services being provided."

These studies were based on data from a medical record review of random samples of 450 hospice claims. Of the sample, 43 percent were from nonprofits, 53 percent were from forprofits, and 4 percent were from government hospices.

Watch Claims for Documentation Vulnerabilities

While most providers have already taken measures to address the issues brought to light by the OIG's recent report, their claims aren't necessarily in the clear. The need for more detailed documentation is a growing concern, Berliner says. Hospice providers should make certain they are complying with the recent change to terminal illness certification that requires an accompanying physician narrative, Berliner says.

And of even greater concern is the potential for a lack of documentation that demonstrates you rendered services in line with the plan of care.

Bottom line: The plan of care specifies a level or frequency of services, but if your documentation isn't detailed, surveyors will be left wondering whether the services weren't documented or weren't provided, Berliner cautions.

Take action: Review your form documents to make sure they are upto- date and include all the required elements that are set out in the CoP, including the new requirement for a physician narrative, Berliner advises.

If your agency has the resources for an internal review of claims before they are submitted for payment, check to make sure that the plan of care and the services documented as being rendered are in sync.

Resource: Read the report at www.oig.hhs.gov/oei/reports/oei-02-06-00221.pdf and the companion piece at www.oig.hhs.gov/oei/reports/oei-02-06-00223.pdf.

CPT® 2023 American Medical Association. All rights reserved.