Audit-Proofing Your Hospice

Practical Ways to Prevent Denials and Navigate Scrutiny

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Annette brings more than 30 years of home health and hospice experience, including a decade performing medical review and education for CMS at the hospice MAC.

Today, Annette marries the real world and regulatory world to empower agencies in commonsense approaches to quality and compliance through her organization, Provider Insights, Inc.

Agenda

1. Hospice climate today increasing audits
2. View from the medical reviewer's perspective
3. How day-to-day operations support compliance

Hospice Is in the News!

CBS NEWS

Arrests made in California fraud crackdown targeting LA hospice ring allegedly behind $267 million in bogus charges

The Hospice Hustle

Endgame: How the Visionary Hospice Movement Became a For-Profit Hustle

Former hospice patient Patricia Marble Melissa Lyttle for ProPublica

Who’s at Risk for Audit?

Everyone!

- A national review of hospice eligibility, focusing on those hospice beneficiaries who haven’t had an inpatient hospital stay or an emergency room visit in certain periods prior to their start of hospice care
- National review of patients at 90 days into stay
- MACs focusing on long length of stay
- SMRC focused on length of stay and GIP
- National audit on hospital billing for patients on hospice with the condition code “07,” stating these services were “not related” to terminal prognosis
- PPEO in six states, a whole new world of uncharted audit territory

Poll: Current Audits

Tell us about your audits! (NOTE: This is anonymous to the attendees.)

A. It's been more than two years since last audit
B. Completed an audit in last year
C. Currently under one type of audit
D. Currently working on responding to more than one audit

Who Is Medicare?

A. Payer?
B. Surveyor?
C. Quality Improvement?
D. All of the above

Medicare Roles and Rules

- Payer: The MAC pays your claims.
  - **Based on Chapter 9 of the Medicare Benefit Policy Manual**
  - **Based on Local Coverage Determinations**

- Surveyor: Medicare contracts your state agency and/or your accreditation organizations.
  - Based on the COPs/Interpretive Guidelines

- Quality Improvement: CMS creates quality measures to be able to measure our improvements and value.
  - QIO: Who the patient appeals a Discharge to
  - QIO: Available when patient has dispute about "Non-covered meds or services"
  - Uses the "CMS Innovation" for programs: latest VBID

- Police: CMS uses several contractors to police the accurateness of our payments looking for fraud or abuse. Based on Chapter 9 and LCDs.
  - **UPIC**
  - **SMRC**
  - **RAC**
  - **CERT**

View From Medical Review Perspective

Medical Review Hierarchy

1. Election Components (including addendum)
2. Certifications/Narrative/FTF for 3rd or later benefits (includes timing, six-month prognosis statement, narrative content, not copied/pasted, signature/date/credentials
3. POC updated every 15 days with four core disciplines confirmed
4. Terminal Prognosis, relying heavily on LCDs and decline s/s found in the “Decline” or “Adult Failure to Thrive” LCDs
5. Level of Care GIP/CHC/Respite (if applicable)
6. Physician/NP visits (if applicable)

#1 Denial: Terminal Prognosis Not Supported

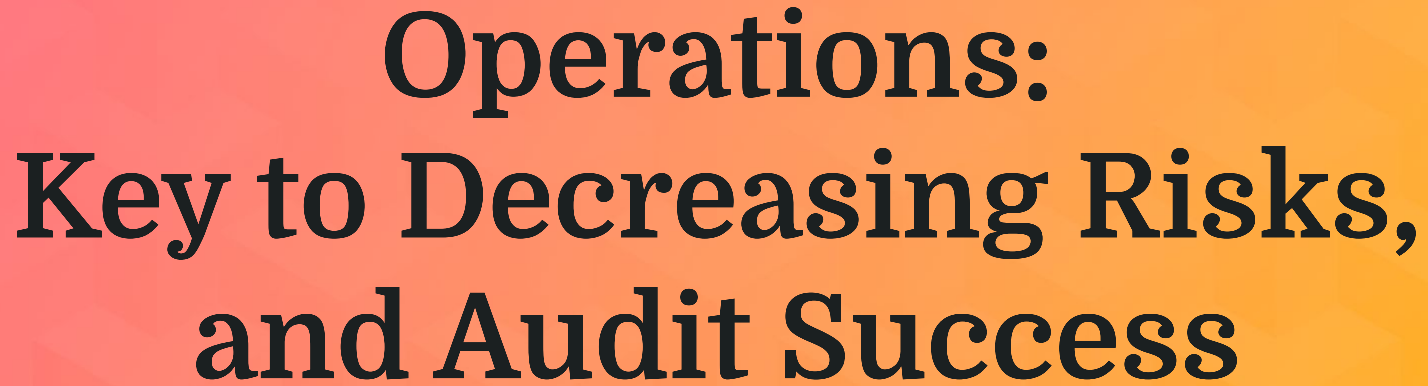
Up to 84% of the denials related to “not terminal”

Based on documentation

Acuity or trajectory

Physician’s narrative for recertification

All IDT’s documentation support for terminal decline


Operations:
Key to Decreasing Risks,
and Audit Success

Operations and Systems Are a MUST

- Compliance can certainly be monitored by QA
- Some improvements can be made by QAPI
    - These are both still responsive to issues found
- The root of decreasing risk and increasing compliance is always operations/systems
    - Education, consistent approach, EMR or manual oversights in real time

Marketing/Facility or Referral Education

- What do you provide for tools/education for your referral sources about the basics of eligibility?
- Are your marketers/liaisons trained in the LCDs?
  - What language are the liaisons using regarding the hospice evaluation? Guaranteeing admission? Discussing an evaluation?
  - Careful with promises! Provide only education…

ALZHEIMER'S / DEMENTIA

1. Unable to ambulate, dress or bathe without assistance;
2. Urinary and fecal incontinence, intermittent or constant;
3. No consistently meaningful conversation. Vocabulary of six words or less
4. If Alzheimer's, FAST 7
5. **AND MUST HAVE** one of the following in last year: Aspiration pneumonia; upper urinary tract infection; Septicemia; Decubitus ulcers, multiple, stage 3-4; Fever, recurrent after antibiotics; OR Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl.

HOSPICE
REFERRAL
TRIGGERS

Intake Process

- Who is in this role? Training?
- What tools are used to ensure appropriate information is gathered?
- Always obtaining H&P/Progress notes, etc.? Needing the history to see changes that indicate “Why Hospice? Why Now?”
- Handing off to whom? Any communication at this point with Medical Director?
- Again, careful of the promises
- Recognizing speed to care is important, but to be careful not to cut the wrong corners!

SOC Comprehensive Assessment

- "The REAL picture" finally obtained
- Call to Medical Director to update and obtain Verbal Certification?
- Documentation toward the LCDs whenever possible
  - Does your EMR provide cues? Do you use a template?
- Involving team, caregivers—getting all of the angles

SOC Comprehensive Assessment

- Get the history from the family to further prove terminal decline
- Document extensively changes in mobility/ADLs
    - Necessity for most diagnoses, decline and for Palmetto the ICF
- Document increased complexity or difficulty with disease process(es)
- Document impact to the patient in a full 360 view (IDT)

Process of Verbal CTI Ensures Technical Compliance

- Must obtain the CTI within two days (verbal or written) of the benefit period
- When verbal, no narrative necessary at that time, simply the CTI six-month prognosis statement
- Who obtains the verbal CTI from the attending?
  - What if attending is NP or PA?
- What happens if no response from the attending?
  - How documented?
  - Medical Director always default, but must be clearly documented

Written CTI

- Only one narrative needed, even on initial CTI
  - Who completes at your agency?
- What must be included in narrative?
  - More than Dx! Physician must synthesize documentation, but your process may provide the facts in a tidy package.
  - Who reviews these narratives?
- Did you know: The Verbal does NOT need to be cosigned, may simply provide written—even if on a separate form

Poll: Operational Compliance

At what point is your *last compliant opportunity* to correct documentation issues before claim submission?

A. During IDT meeting
B. At recertification
C. During the Triple Check/billing audit process (just prior to billing)
D. After claim denial

FTF

- Timeliness: Who is directing?
  - EMR cues, spreadsheet, calendar, reports
- Some EMRs do not have a form to document the actual visit.
  - Does your EMR support the visit documentation? If not, where does the encounter get documented?
  - In addition, ensure the handoff if an NP to the doctor and the attestation of the doctor that the FTF was reviewed and used in the CTI.
  - Who monitors/tracks? EMR hard stops/cues?
  - FTF MUST be PRIOR to Certification (verbal and written). The FTF informs the physician in order to make decision on prognosis.

FTF for Admissions Into Third or Later Benefit

- If upon checking eligibility for a referral the patient has used two or more benefit periods, a FTF must be completed on the same day or prior to the new admission date
  - If patient is in a symptom crisis, the hospice may admit first and ensure an FTF is completed within two days of election

Old-School Process Management

Does your EMR ensure full compliance?

- Technology is great for technical components (dates, signatures, form complete)
- Expert eyes still need to ensure quality of content

		Yes	No	Initials/date
1	Patient Name: Admission Date:			
2	Diagnosis:			
3				
4	ADMISSION/INITIAL CERTIFICATION	Yes	No	Initials/date
5				
6	Admission Agreement: Assignment of benefits			
7	1. All blanks and box checked	____	____	____
8	2. Pt. Signature and date on consent forms	____	____	____
9	3. Effective Date of Benefit and signatures are present on NOE	____	____	____
10	4. If pt. unable to sign, the name and relationship	____	____	____
11	of responsible party. Specify ____________________________			
12	5. Reason pt. unable to sign	____	____	____
13	6. Signature and date of responsible party	____	____	____
14	Initial Orders and POC Complete			
15	1. Verbal Certification with RN & Medical Directors signatures	____	____	____
16	2. Related/nonrelated form completed and signed	____	____	____
17	3. Verbal Certification with Attending Physician signatures	____	____	____
18	3. Order present to admit to hospice with written signature and date	____	____	____
19		____	____	____
20	5. COTI Complete (LCD's, narrative meets the intent of regulation)	____	____	____

	Yes	No
Patient Name Admission Date:		
Diagnosis:		
LOC	Yes	No
1. LOC Change	____	____
2. If GIP daily SN note	____	____
3. CHC documentation shows over 50% of time is SN	____	____
4. Respite maximum of 5 continuous days validate with	____	____
EMR LOC report	____	____
5. Signed Order on chart for LOC change	____	____
Recertification Evaluation Form Complete		
Recertification COTI signed and dated within 14 days prior or 2 days	____	____
after recert date by Medical Director		
F2F visit within 30 days of recertification for the 3rd	____	____
and subsequent benefit periods		
Hospice Physician narrative present	____	____
Attestation is signed and dated	____	____
All visit notes complete and entered in computer	____	____
Clinical documentation and other supporting evidence is present	____	____
Nurse used LCD guidelines	____	____
Revocation/Discharge/Death:		

Poll: Face to Face

When must the Face-to-Face (FTF) encounter occur?

A. Within 30 days prior to recertification (for third cert or after)
B. In cases of emergency admission, related to uncontrolled symptoms (third cert or after), FTF must be completed within two days after admission
C. Prior to the physician certification
D. All of the above

IDT: Time to Put Our Heads Together

- On an ongoing basis, IDT should be the best tool to ensure ongoing eligibility
    - Team brings different perspectives, but all trained in eligibility/LCDs/ICF
- Ongoing basis, but even more scrutiny prior to recertifications
- Changes to IDG care plan can help support eligibility

IDT

- During the meeting, does your agency open up the chart and share the screen to view documentation?
- Do disciplines focus on s/s related to terminal prognosis?
  - CHF
  - Dementia
  - Avoiding the repetitive phrase of the day: “slow decline”

Coordination of Care

- Brings additional facts/perspective
    - Facility caregivers
    - Attending physician/provider
    - Family and caregivers

Discharge Planning

All about the logistics and language

- Avoid stating “patient no longer eligible” or “patient does not have six-month prognosis” until the time of discharge notice
- Reviewing plan of care: effectiveness
- Encourage the NOMNC appeal to QIO: takes weight of decision off the hospice
    - If QIO returns decision that patient should not be discharged, you may continue care, for now
    - Ensure biller knows so they can enter expedited determination code

Triple Check: Billing Audit

- Prior to billing is your agency's last chance at making many corrections
- As long as written CTI is corrected (if necessary) and signed/dated PRIOR to billing, you are compliant
- May do an attestation, or use a signature log if needed, to authenticate signature, credentials, or date

Poll: Your Hospice's Practice

How often does your hospice audit for any documentation compliance?

A. Only if under audit or preparing for survey
B. Monthly prior to billing
C. As often as daily, looking at new admissions, recertifications, long length of stay, etc.
D. Never—we just don't have time

QAPI Process

- May consider outside audit for eligibility for objectivity
- Develop Performance Improvement Process when necessary
  - If related to the documentation of prognosis, drill down problem areas. Specific Dx? Specific facility? Specific RN?
  - Where does your EMR support? Lack?
  - May consider a “side by side” tool to highlight changes if EMR doesn’t have it
    - Compare monthly the primary diagnosis s/s supporting continued care
    - Compare monthly the overall decline factors, cited routinely by MACs
      - Weight loss
      - Recurrent infections

How Can Our Hospice Use LCDs?

- Provides guidelines
    - Admissions
    - Recertifications / ongoing care
- Provides consistency
- Educational for identifying hospice-eligible patients = referral sources
- IDT format

Creating a Culture of Eligibility in Your IDT Meeting

- Be sure every clinician in your organization has a current copy of the LCD guidelines
- Keep a copy in IDT, and review one at the beginning of every meeting: LCD of the Week
- Use LCD-specific worksheets for admissions and recertifications.
- Review the LCD guidelines for every admission and recertification before it is presented

Self-Check

HOSPICE Documentation Checklist Tool

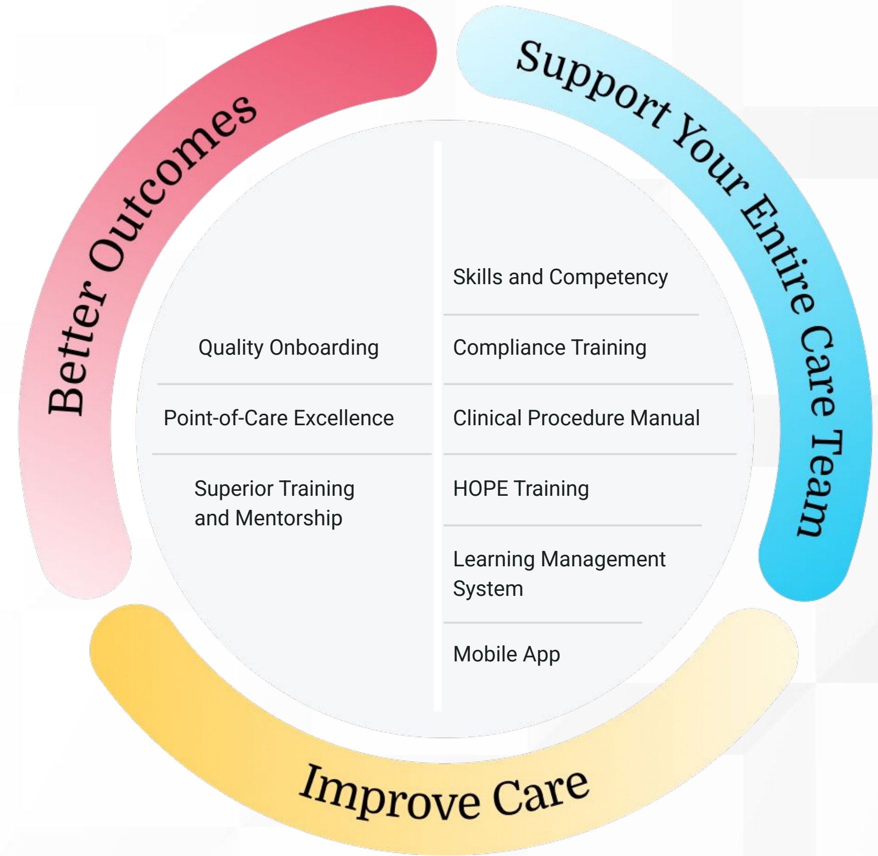
Election Statement	
Does the Election Statement include the following information: • Identification of the hospice that will provide care • Acknowledgement the beneficiary has been given a full understanding of the nature of hospice care, **palliative versus curative** • Acknowledgement certain Medicare services are waived by the election of hospice • Effective date of the election - May be the first day of hospice care or a later date, but cannot designate a retroactive effective date • Designated attending physician information (if any) including, but not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician • Beneficiary's acknowledgement the designated attending physician was their choice	
Effective October 1, 2020: • Indication that services unrelated to the terminal illness and related conditions are exceptional and unusual and hospice should be providing virtually all care needed	

Medbridge Hospice Ecosystem

The Complete Hospice Solution

A single platform that supports your complete care team from day one and helps excellent care and family support.

- **Reduce onboarding time** with high-quality, setting-specific content
- **Improve competence and confidence** with tablet-optimized Clinical Procedures
- **Elevate clinical performance and care quality** with our digital Skills solution
- **Support your entire team** with setting- and role-specific content for better experiences



2026 Medbridge Products

Expert-led dynamic education that ensures compliance, boosts new hire productivity, and uplevels the practice of every provider.

Clinical Development
Provide resources for staff to expand their knowledge and grow their careers.

- CEUs
- Guided programs
- Live webinars
- Podcasts

Learning Management
Manage onboarding, annual training, quality care initiatives, and more across your org.

- LMS
- Compliance
- Clinician app
- Historical completion reporting

Competency Management
Support student/mentor workflows and ensure high-quality care delivery.

- Digital skills
- Procedure manuals

Prebuilt and custom digital care integrated into workflows to expand access to care, improve engagement, and deliver better outcomes.

Traditional Programs
Build and assign custom exercise and educational programs for patients.

- Fully customizable exercise builder
- Patient and care team messaging
- Patient app

Guided Pathways
Prebuilt clinical programs that improve access and help standardize care.

- Programs supporting MSK, pelvic health, fall prevention, and surgical
- Autoprogressing and updating programs
- Patient reminders and reengagement
- Motion capture assessments

Remote Monitoring and Outcomes
Support hybrid care models and collect outcomes on patients, all in one workflow.

- RTM assignment for HEP and smart programs
- RTM reporting
- Automated time tracking for 98980, 98981
- Patient-reported outcomes collection

Content - Integrations - Analytics - AI

Education Built for the Whole Hospice Agency

For Hospice Nurses

- Hospice-Specific RN Onboarding
- Hospice Case Management
- Clinical Procedures
- HOPE Series

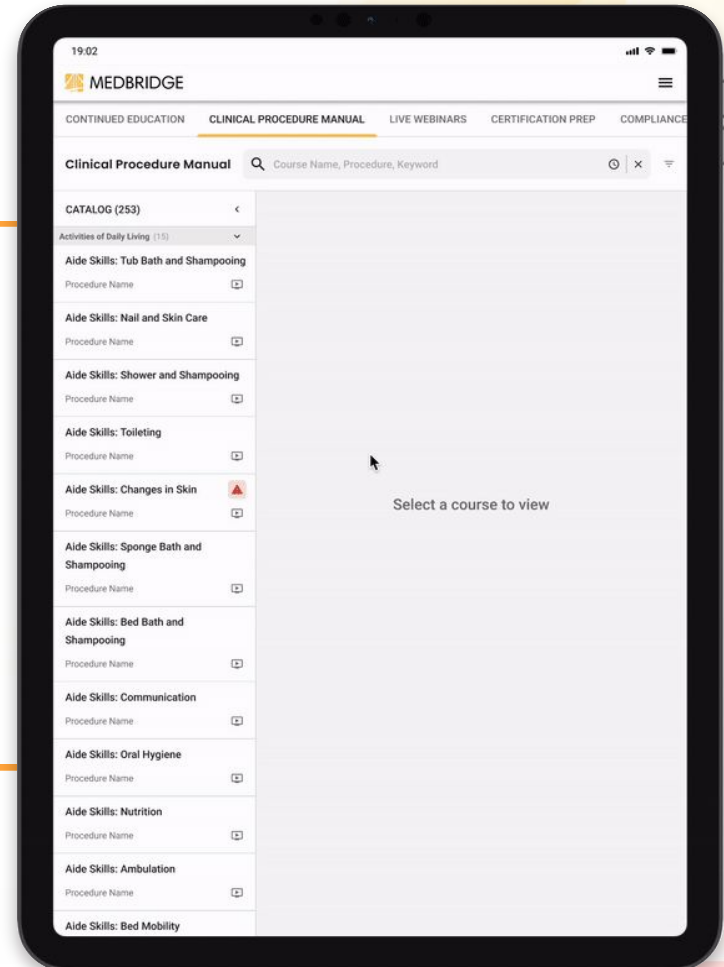
For Hospice Leadership

- Hospice Regulatory Requirements
- Medicare Reimbursement
- Leadership Development
- People Skills

For Team Members

- Patient- and Family-Centered Care
- Admission and Eligibility
- Documentation for Success
- ACHC- and CHAP-verified annual compliance training

The Ultimate Digital Companion for Nurses



Polling slide

1. Would you like to learn more about our ________ solution?

    a. Yes, I would like to hear from a Medbridge expert
    b. No, thank you

Questions?

Thank You