HALL RENDER

HEALTH LAW IS OUR BUSINESS. | HALL RENDER KILLIAN HEATH & LYMAN

Things I lost at the Physician's Office: F2F, CTI and other Physician Documentation Required in Homecare

Robert W. Markette, Jr. CHC

Presented By:

Robert W. Markette, Jr. CHC, HCS-C
Attorney, Hall Render
rmarkette@hallrender.com
(317) 977-1454

Robert W. Markette Jr., JD, CHC, HCS-C, is an attorney with Hall, Render, Killian, Heath & Lyman PC. For over 20 years, he has focused his practice on representing home health, hospice, private duty, and DME providers in all aspects of their operations. Markette works with his clients on issues related to Medicare/Medicaid compliance; payer issues; HIPAA compliance; Medicare and Medicaid fraud and abuse; purchasing and selling home health, hospice, and private duty agencies; and employment matters.

Disclaimer

- The following materials and presentation are for educational purposes only. Neither the contents of these materials nor the content of the presentation, including any answers provided by the speaker, are not intended to be and should not be considered to be legal advice.
- Any opinions offered by the speaker are the opinions of the speaker alone. They are not and should not be taken as the opinions of Hall Render or the Indiana Association for Home and Hospice Care

Agenda

Audit Trends

Home Health Face-to-Face. It's still #1

Certification of Terminal Illness—so many ways to fail.

Other common audit issues.

Home Health and Hospice Audit Trends

5

5

Audit Issues

- Being prepared for audits requires knowing what are current areas of auditor focus.
- Several sources of data. CGS and Palmetto both publish quarterly reports on top denial reasons.
- Palmetto did publish data from Review Choice Demonstration, but that has not been updated.

6

6

Audit Trends—Home Health

TOP FIVE HOME HEALTH DENIAL REASONS (CGS 09/22 – 08/23)		
Rank	**Code**	**Explanation**
1	5HN18	Skilled nursing services were not medically necessary.
2	5HC09	The initial certification was missing/incomplete/invalid; (20%)
3	5HC01	Face-to-face encounter was missing/incomplete/untimely. (18 %)
4	5HY01	Documentation did not show therapy services were reasonable a nd necessary and at a level of complexity requiring a thera pist. (15%)
5	56900	Medical records not received within the 45 day time limit; au ditor unable to determine Medical necessity of (4%)

7

Audit Trends—Home Health

TOP FIVE HOME HEALTH DENIAL REASONS (Palmetto 07/23-09/23)		
Rank	**Code**	**Explanation**
1	56900	Auto Denial — Requested Records Not Submitted (41.7%)
2	5FF2F	Face to Face Encounter Requirements Not Met (27.7%)
3	5F023	No Plan of Care or Certification (12.6%)
4	5F041	Information Provided Does Not Support the Medical Necessity for this service (2.3%)
5	5FNOA	Unable to Determine Medical Necessity of HIPPS Code Billed as App Oasis Not Submitted (No OASIS in state repository) (2.5%)
Addt'l	5F301/ 5A301	Information Does Not Support the Medical Necessity for Therapy Services (3.8% combined)
	5F072	No Physicians' Orders for Services (1.3%)

8

Audit Trends—Hospice

TOP FIVE HOSPICE DENIAL REASONS (CGS 09/22 – 08/23)		
Rank	**Code**	**Explanation**
1	5PM01	Information provided does not support a terminal prognosis of six months or less. (44%)
2	5PX06	Notice of Election did not meet statutory/regulatory requirements. (40%)
3	5PC08	Face-to-Face Encounter requirements not met. (5%)
4	56900	Medical records not received/not received timely. (3%)
5	5PX07	Notice of election not present. (2%)

9

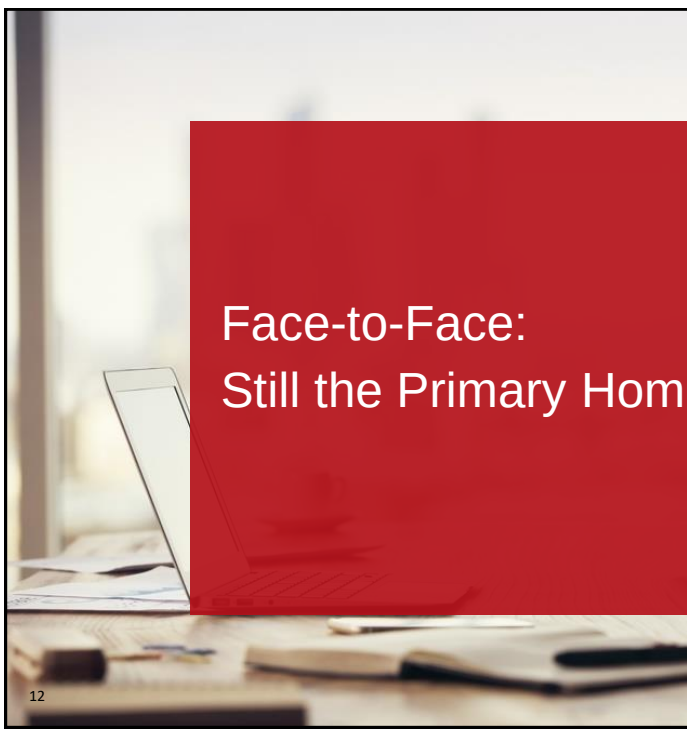
Audit Issues—Hospice

TOP FIVE HOSPICE DENIAL REASONS (Palmetto 07/23-09/23)		
Rank	**Code**	**Explanation**
1	5CF36/ 5FF36	Not Hospice Appropriate (38.8%) Not Hospice Appropriate (1.3%)
2	5CNER	Notice of election doesn't meet statutory/regulatory requirements. (22%)
3	56900	Records not submitted. (17.3%).
4		No Plan of Care. (2.8%)
5	5CFTF	Face to Face Encounter Requirements Not Met. (2.8%)
Addt'l	5CFH6	Initial Certification Not Timely. (1.8%)
	5CFH9	Physician Narrative not present/invalid. (1.5%)

10

Audit Trends—Overall

- Face to Face continues to be a significant issue in home health.
- Physician documentation plays a significant role in denials
  - Certifications
  - Narratives
  - Plans of care
- Missing/Incomplete physician documentation can be fatal to your claims.
- Missing/Incomplete physician documentation can also impact surveys.



Face-to-Face:
Still the Primary Home Health Audit Issue

Denial Reason—Reason for F2F Encounter Unrelated

- The F2F encounter between the patient and the physician/NPP must be "*related to the primary reason the patient requires home health services*."
- Auditors are denying claims on the grounds that the F2F encounter does not "relate to" the reason for the home health referral.
- This is an issue arising out of the home health plan of care and the physician encounter note.

Denial Reason—Reason for F2F Encounter Unrelated

- Related to means:
  - Referral to home health must have some connection to the encounter.
  - Reviewers are not "[to] take such a literal interpretation to look for a cause and effect relationship between a diagnosis on the physician's claim and the diagnosis on the home health claim." CMS comments to 2011 Final Rule.
  - Cause and effect relationship may not be required, but must be able to show some relationship between encounter and referral.

Denial Reason—Reason for F2F Encounter Unrelated

- Some reviewers expect to see a link in diagnosis codes between the physician/NPP's clinical encounter note and the diagnosis code(s) listed on the 485.
- There is nothing in the regulations or guidance that suggests such direct link is required.
- Reviewers may use a comparison of diagnosis codes as a "shortcut," but this is not supported by guidance.

Denial Reason—Reason for F2F Encounter Unrelated

- When auditors use the failure of diagnosis codes to match up as a reason for the denial, need to challenge auditors.
- This may require filing an appeal of the related recoupment demand.
- Be prepared to challenge these denials.

Denial Reason—Reason for F2F Encounter Unrelated

- The certifying physician's, the certifying NPP's and/or the acute/post-acute care facility's medical record for the encounter with the patient must contain information that justifies the referral for Medicare home health services. Does not have to have a direct link in diagnosis codes.
- CMS published a MedLearn Matters article on F2F. Not one of the examples relies upon a correlation of diagnosis codes to show relatedness. The clinical encounter note/documentation of the encounter in toto must support the referral.

Denial Reason—Reason for F2F Encounter Unrelated

- Example: Discharge Condition: Upon Discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new Coumadin medical regimen.
- CMS noted this documentation was related to the reason for home health.

Denial Reason—Reason for F2F Encounter Unrelated

- Patient may visit physician for reasons unrelated to ultimate referral, but if, during the encounter, an issue is identified and that issue leads to a home health referral, the encounter is now related.
- Example: patient visits his PCP for an annual wellness visit. During the visit physician discovers that the patient's glucose levels are fluctuating and out of control. The physician documents the facts and makes a referral for home health skilled teaching and monitoring of the patient's attention to measuring his glucose levels, appropriately administering insulin and adhering to nutritional teaching. Even though the precipitating reason for the encounter was not necessarily the patient's diabetes, the fact that an issue was discovered and forms the reason for a referral for home health and the primary condition being addressed by the Plan of Care makes the encounter valid. (Example courtesy of Face to Face Answers. 2021)

Denial Reason—Reason for F2F Encounter Unrelated

- If physician's/NPP's clinical encounter note contains no information that supports referral, this can lead to denial.
- For example, in the previous example, if the physician failed to document his findings regarding the patient's glucose levels, then the home health referral for diabetic care and management would not have been related to the physician encounter.
- Need to review the physician's clinical encounter note to verify that the physician/NPP's clinical note documents the medical issues for which you will be admitting the patient.

Denial Reason—Reason for F2F Encounter Unrelated

- If the encounter note does not mention the medical issues for which the patient was referred, need to ask why?
  - Physician/NPP noted, but failed to document?
  - Referral not related to most recent encounter?
- There are occasions where a home health referral is made later and is not based upon the last F2F encounter. This would require patient to see physician to ensure an appropriate F2F encounter occurred.

Denial Reason—Missing Clinical Note

- Another common denial is because the HHA does not have the clinical note from the F2F encounter. This has been a primary basis for claim denials since 2016.
- The HHA MUST HAVE THE CLINICAL NOTE FOR THE F2F ENCOUNTER WHEN AUDITED.
- **You must obtain the clinical note for the encounter in every case.**
- Agencies should never lose reimbursement because they failed to obtain the note.

Denial Reason—Missing Clinical Note

- Technically you do not need to have the note in your possession at the time you submit a claim. Providers who are in the "pre-claim review" option in RCD must obtain encounter note to submit with pre-claim review request.
- Agency should Always request the note at time of admission. Train intake staff to request it. Have it in hand before auditors request it.
- When you receive the referral or when you receive the signed 485, verify a copy of the clinical note for the encounter has been included.

Denial Reason—Missing Clinical Note

- The physician/NPP is REQUIRED to provide it to you.

> Physician/NPP ***must supply*** the medical record documentation that supports the physician's certification that the patient is eligible for Medicare home health to the agency, review entities and/or CMS.
>
> 42 C.F.R. 424.22(c) (emphasis added).

Denial Reason—Missing Clinical Note

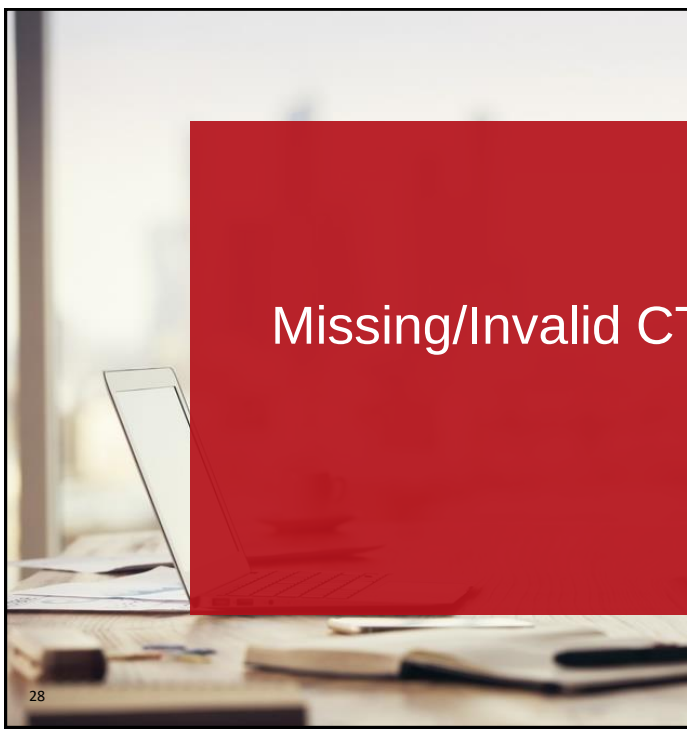
- Important Compliance Point: ALWAYS confirm that the physician/NPP has provided *the actual encounter note*. If you do not have the physician's clinical note from the patient encounter, your claim will be denied during an audit.
- It is recommended that you regularly audit a sample of charts to verify the presence of the clinical encounter note.
- Don't wait for an ADR to find out you need to get them.

Denial Reason—Untimely F2F Encounter

- The F2F encounter not only must be related to the reason for the home health referral, but also must have occurred within the required time frame.
- F2F Encounter must occur not more than:
  - Ninety (90) days before the start care; or,
  - Thirty (30) days after the start care.

Denial Reason—Untimely F2F Encounter

- This is another reason it is important to obtain the clinical encounter note at the time of referral/admission.
- When you review the note, verify the encounter is related to the reason you are providing home health and that the encounter occurred timely.
- If you are admitting a patient prior to the F2F encounter has occurred, then you need to ensure a F2F encounter happens within 30 days of the start of care.



Missing/Invalid CTI

Denial Reason—Missing or Invalid Initial Certification

- "As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician or allowed practitioner must certify the patient's eligibility for the home health benefit. . ." 42 C.F.R. 484.22(a)(1).
- ***If a physician or NPP has not certified the patient's eligibility, the <u>entire episode</u> will be recouped***.

Denial Reason—Missing or Invalid Initial Certification

- CARES Act amended Social Security Act to allow NPPs to order and certify home health.
- Indiana law allows NPP to order home health.
- Indiana law allows HHA to accept orders from out of state physician/NPP. "*A home health agency may accept written orders for home health services from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state*." 410 IAC 17-13-1(b)

Denial Reason—Missing or Invalid Initial Certification

- Impact of the initial certification on subsequent episodes.
- According to the Medicare Program Integrity Manual:
  - "if the requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered—even if the requirements for recertification are met."
- When the reviewers find the initial certification is invalid, they will recoup all subsequent episodes.

Denial Reason—Missing or Invalid Initial Certification

- This means getting their initial certification correct is extremely important.
- Requirements for the initial certification are set forth at 42 C.F.R. 424.22(a)(1).

Denial Reason—Missing or Invalid Initial Certification

- Physician/NPP must certify:
  - Need for intermittent nursing care, physical therapy or speech language pathology;
  - patient is confined to the home;
  - plan of care is established and periodically reviewed.
  - services are furnished while patient is under care of physician
  - F2F encounter

Denial Reason—Missing or Invalid Initial Certification

- CMS Form 855 includes a certification statement:

26. I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.

Denial Reason—Missing or Invalid Initial Certification

- This statement is taken straight out of the Medicare Benefit Policy Manual:

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with a physician or an allowed non-physician practitioner on 11/01/2020 and the encounter was related to the primary reason for home health care.

MBPM, Chapter 7, Section 30.5.1

Denial Reason—Missing or Invalid Initial Certification

- If signed AND DATED by physician, that statement should be sufficient.
- Need to have signature, but by when?
- "The certification must be complete prior to when an HHA bills Medicare for reimbursement; **however, physicians and allowed practitioners should complete the certification when the plan of care is established, or as soon as possible thereafter.** This is longstanding CMS policy as referenced in Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 30.1. It is not acceptable for HHAs to wait until the end of a 60-day certification period to obtain a completed certification/recertification." MBPM, Chapter 7, Section 30.5.1.

Denial Reason—Missing or Invalid Initial Certification

- Agencies have little control over when the physician signs the 485. This can lead to, in some cases, significant delays in obtaining physician countersignatures.
- Many agencies rely upon having signature prior to billing.
- CMS has been pushing the "when plan of care established" and "not acceptable to wait" language. Basis for objecting to signatures after certification period.

Denial Reason—Missing or Invalid Initial Certification

- Recent false claims act case: Whistleblower alleged false claims due to certifications not being signed before the end of the cert period. Provider argued they had followed CMS guidance, because they did not bill before documents were signed.
  - Departmental appeals board has routinely upheld claims where physician signed after 60 days, but before claim submitted, as long as nurse had signed and dated the 485 as a verbal order.
- Court found that failure to obtain signed certifications before the end of the certification period could support a claim under the False Claims Act.
- Surveyors are also starting to challenge orders signed after cert period.

Denial Reason—Missing or Invalid Initial Certification

- Most agencies include the certification statement on the 485. Missing certification means missing signed physician order.
- IMPORTANT: RN signs, dates and notes the time she received the POC as a verbal order. CMS sample 485:

- The nurse signing, dating and noting the time in box 23 means you have a valid verbal order for care.
- Verbal orders are allowed by CoPs. 42 CFR 484.60(b).

Denial Reason—Missing or Invalid Initial Certification

- Agencies that have a large number of POCs that have not been signed and returned by the physician may have issues during a survey.
  - Agency can point to verbal orders for survey purposes, if nurse signed, dated and noted the time.
- Agencies who have a large number of POCs that have not been signed and returned by the physician and who discover the nurse has not properly signed the order (including date and time verbal order was received) have a significant problem:
  - They do not have physicians' orders this is
    - a survey issue – providing care without orders;
    - a payment issue. Visits provided without orders are not billable. LUPA?

Denial Reason—Missing or Invalid Initial Certification

- **AGENCIES CAN NO LONGER SIMPLY WAIT TO GET SIGNED ORDERS BACK FROM PHYSICIANS/NPPs.**
- **WAITING CAN RESULT IN SURVEY AND AUDIT ISSUES DUE TO "UNTIMELY" SIGNATURES.**
- **THIS PRESENTS A SIGNIFICANT CHALLENGE, BECAUSE WE CANNOT CONTROL WHAT THE PHYSICIANS/NPPs DO.**

Denial Reason—Missing or Invalid Initial Certification

- Need to be diligent in following up with physician to obtain dated signature before end of certification period.
- Document efforts. Record date 485 sent to physician/NPP; record *each follow-up* contact. Contacts should become more frequent as time passes. Consider sending staff to physician's office for an in-person request.

When you contact physician's/NPP's office, be sure to note the date, time and the person with whom you spoke.

Denial Reason—Missing or Invalid Initial Certification

- Making repeated contacts and documenting them will show your effort.
- Will allow you to argue later that you did not simply "wait until the end" of the certification period, but you obtained the completed certification "as soon as possible" after the POC was established.
- Be sure the physician/NPP dates their signature.
- If you discover missing dates later, address with an attestation statement.

Denial Reason—Missing or Invalid Initial Certification

- Need to be sure that the physician's record supports the certification.
- "Documentation in the certifying physician or allowed practitioner's medical record or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) or both must be used as the basis for certification of the patient's eligibility for home health…*Documentation from the HHA may also be used to support the basis for certification of home health eligibility*" 42 C.F.R. 424.22(c)(emphasis added).

Denial Reason—Missing or Invalid Initial Certification

- Agency reimbursement is dependent upon the physician's/NPP's documentation. If it does not support eligibility, HHA can lose payment.
- Problem: Physicians/NPPs documenting to support their billing/claims. May not document information that supports certification that patient is confined to home or that patient needs the services.
- This gap can lead to denials.

Denial Reason—Missing or Invalid Initial Certification

- Important to have intake obtain the clinical encounter note from the physician/NPP at the time of the referral.
- Need to review clinical encounter note early to verify contents and that the clinical encounter supports the referral for home health.
- You are entitled to a copy!
- Be proactive and get the copy early.
- You have to have the encounter note for an audit later. Failure to have the encounter note is a top reason for claims denials.

Denial Reason—Missing or Invalid Initial Certification

- **Home health agency documentation can be used to support eligibility, if the documentation meets certain conditions.**
- Home Health documentation:
  - Must be corroborated by other medical record entries in the certifying physician or allowed practitioner's medical record…thereby creating a clinically consistent picture that the patient is eligible for Medicare home health services.
  - The certifying physician or allowed practitioner signs and dates the HHA documentation demonstrating that the documentation from the HHA was considered when certifying patient eligibility for Medicare home health services.

Denial Reason—Missing or Invalid Initial Certification

- Agency's ability to supplement physician's record is significant.
- If utilized properly, agency documentation can fill in gaps in physician's documentation.
- Agency should have a process to supplement physician's record.

Denial Reason—Missing or Invalid Initial Certification

- One approach: Utilize 485. Physician/NPP will sign and date, because the 485 is the physician/NPPs orders for care. Reduces agency burden to just ensuring corroborated by physician record.
- Agency needs to include details regarding components of assessment that support conclusion patient is confined to home and that supports the need for services.
- When physician/NPP signs and dates 485 the physician/NPP is adopting the information into the physician's/NPP's clinical record.

Denial Reason—Missing or Invalid Initial Certification

- Agency may consider other supplemental documentation outside of the 485.
  - A copy of some portion of the OASIS assessment; a separate written document where the agency details their conclusions—this could be a cover page to the fax or some other supplemental document. CMS MedLearn Matters Article MLN SE1436 gives an example where agency uses OASIS to supplement.
- Need to be sure that this supplemental documentation is signed and dated by the Physician/NPP.
- Must be corroborated by physician's/NPP's record

Denial Reason—Missing or Invalid Initial Certification

- When supplementing, remember Homebound requirements:

1. Patient must either:
   a. because of illness or injury, need the aid of supportive devices such as crutches, canes, etc.; special transportation; or, assistance of others to leave their residence; or,
   b. have a condition such that leaving home is medically contraindicated.

AND

2.a. There must exist a normal inability to the home; and,

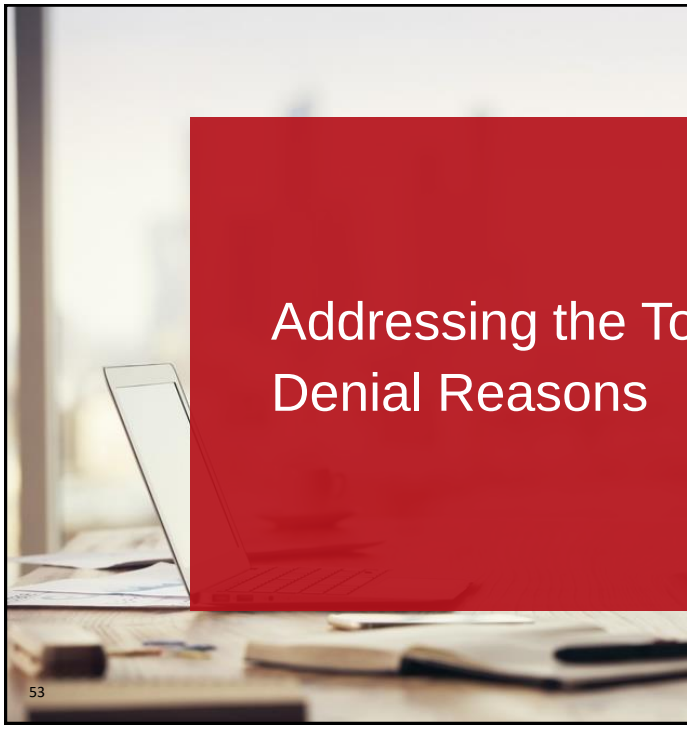
2.b. Leaving the home must require a considerable and taxing effort.

51

Denial Reason—Missing or Invalid Initial Certification

- Agencies must monitor presence of certifications.
  - Verify signatures
  - Verify dates
  - Have a process to push to get certifications within 60 days
  - Supplement the physician's record. Be sure supplemental information is corroborated by clinician's record and is signed and dated by physician.
- Certifications are a foundational component of reimbursement. A deficient initial certification can have significant impact on agency revenue.

52



Addressing the Top Hospice Denial Reasons

53

53

Audit Issues—Hospice Terminal Illness

- A significant issue for hospice is the record failing to support the conclusion the patient is terminally ill.
- "An individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C §1395x(dd)(3)(A).
- The physician certifies the patient's terminal illness based upon the physician's clinical judgment. 42 U.S.C. § 1395f(a)(7)(A)(i)-(ii)

54

54

Audit Issues—Hospice Terminal Illness

- The statute expressly states this is a clinical judgment of the professional. Benefit policy manual expressly recognizes that the physician makes this determination in his or her professional judgment. Medical Benefit Policy Manual, Chapter 9, Section 10.
- A patient may live longer than six months and still be terminally ill in the physician's medical judgment. (Should not be common.)

Audit Issues—Hospice Terminal Illness

- A very common misunderstanding in hospice is that the physician's certification, in the exercise of his or her professional judgment, ends the discussion about eligibility.
- The hospice may conclude they need to do nothing further.
- THIS IS INCORRECT. YOUR DOCUMENTATION MUST SUPPORT THE TERMINAL PROGNOSIS. (Six months or less.)

Audit Issues—Hospice Terminal Illness

- Physician needs to document basis for decision.
- **Patient's clinical record needs to support this conclusion**.
- Clear, detailed documentation is extremely important.
- BURDEN ON PROVIDER TO PROVE.

Audit Issues—Hospice Terminal Illness

- Hospices should consider utilizing the relevant Local Coverage Determinations for terminal illness. Although MACs, etc. consider them to be binding, they are not. 42 U.S.C. § 1395ff(c)(3)(B)(ii)(II).
- Despite not being binding and not being formally promulgated, LCDs are relied upon by auditors and CMS in assessing eligibility.
- Because MACs rely upon them, they provide important guidance as to how to clearly support the medical necessity of the claim.

Audit Issues—Hospice Terminal Illness

- The MACs have all issued LCDs addressing terminal illness of hospice patients.
- Although the LCDs are not "binding" or determinative for coverage purposes, they should inform how you assess patients and document their conditions.
- The more of the detail outline in the LCD you have, the stronger your case for terminal illness will be.

Audit Issues—Hospice Terminal Illness

- Even though they are not "binding", it will be difficult for an auditor or investigator to disagree with the physician's certification if your documentation tracks what the MAC has specifically indicated are important factors for this determination in their published guidance (the LCD).
- Physicians and clinicians should be aware of the relevant LCD and document in light of it. They need to be clear and thorough. Auditors do not know your patients and DO NOT GIVE THE BENEFIT OF THE DOUBT.

Audit Issues—Hospice Terminal Illness and Decline

- Auditors and ALJs have been denying patients are terminally ill due to lack of documented "decline."
- Decline appears in one LCD as an alternative way to prove terminal illness, but does not appear in all LCDs.
- Example, LCD 34567, applies to Alzheimer's and Dementia. It requires the patient to have a FAST Score of 7 or worse and related co-morbidities.
- Decline does not appear anywhere in the record.

Audit Issues—Hospice Terminal Illness and Decline

- Decline is, arguably, contrary to Social Security Act.
- May be relied upon as a way to deny long length of stay patients. This is incorrect.
- Congress defined terminal illness as life expectancy of six months or less.
- Congress, simultaneously, stated an eligible individual can receive 2 90 day benefit periods and an "unlimited number" of 60 day periods.
- Congress recognized a patient may stay on hospice for much longer than 180 days.
- despite this, need to be aware of auditor focus on decline.

Audit Issues—Hospice Terminal Illness

- Because auditors do not know your patients:
  - CLINICIANS MUST WRITE EVERYTHING DOWN!!!
  - TELL THE STORY!!! DO NOT ASSUME ANYTHING IS OBVIOUS!!
  - IF YOU DON'T DOCUMENT!!!! IT DIDN'T HAPPEN!!!

63

Audit Issues—Hospice Terminal Illness

- Hospices must train their staff to document clearly, thoroughly and in light of relevant LCDs. Hospice personnel should understand as a matter of their professional license (nursing, therapy, etc.) clear documentation is important.
- This is not just a Medicare billing and compliance issue. **Nurses and other professionals can have their own license placed at risk.**

64

Audit Issues—Hospice Terminal Illness

- Also need to assess EMR implementation and results.
- EMRs try to be efficient. This efficiency can lead to overutilization of checkboxes and autocomplete text entries. This can result in every clinical note looking the same.
- Repetitive clinical notes will not paint a sufficient picture. May also lead to additional auditor suspicion/scrutiny.

Audit Issues—Hospice Terminal Illness

- IDG documentation should show consideration of patient's continued eligibility.
- For longer length of stay patients (more than 180 days), at each review, the IDG should consider whether the patient continues to be terminal and document why the IDG has concluded that the patient continues to remain appropriate for hospice.
- IDG should document this review and conclusion—explain.

Audit Issues—Hospice Terminal Illness

- If the IDG concludes the patient is no longer terminally ill, then the patient should be discharged. This can be a difficult decision, but if the patient has improved (which can happen) YOU CANNOT KEEP THEM ON HOSPICE!!!
- Discharge referral? Home health? Palliative care?
- Patient may later become eligible again.

Audit Issues—Hospice CTI

- In order for a patient to be eligible for hospice, a patient must be eligible for Medicare and be certified as terminally ill. 42 C.F.R. §418.20.
- Auditors like to deny CTIs because if the CTI is invalid, then the entire benefit period is invalid.
- CTI has a number of technical requirements.
  - Timing
  - Contents
  - Narrative
- Each can be the basis for a denial.

Hospice CTI and F2F Issues

- CTI Timing—42 C.F.R. 418.22(a)(1-3)
- Hospice must obtain CTI for each benefit period.
- Written CTI must be obtained within 2 calendar days of start of period. If not must obtain oral certification within 2 calendar days and **written certification before billing.**
  - Cannot complete certification more than 15 days before benefit period.
  - Recert may not be completed more than 15 days before subsequent period.
- Contents are defined in the regulation. **Technical compliance is important.**

Hospice CTI and F2F Issues

- **CTI Timing—42 C.F.R. 418.22(a)(1-3)**
- Timing of CTI is important.
- Need to document date and time verbal CTI is received. Must be within 2 days. Have a clear process in place designed to meet this timeframe.
- Once verbal CTI is obtained, need to have written CTI before billing. Be diligent in following up. Have a process for follow-up and to ensure claims are not submitted until written CTI is present.
- For recerts, obtain written CTI within the 15 day window prior to the start of the next period.

Hospice CTI and F2F Issues

- **CTI Contents—42 C.F.R. 418.22(b)**
- "individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course."
- Supporting information and documentation "must accompany the certification," "filed in the medical record with the written certification."
- brief narrative explanation of the clinical findings that supports a life expectancy of 6 months.
- F2F Attestation
- "signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies."

Hospice CTI and F2F Issues

CTI Contents—42 C.F.R. 418.22(b)

- IMPORTANT: The CTI must be signed by a physician. **NPPs cannot certify terminal illness.**
- *Social Security Act expressly requires a physician and excludes NPPs.*
- The certification of terminal illness is "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." 42 C.F.R. 418.22(b)

Hospice CTI and F2F Issues

CTI Contents—42 C.F.R. 418.22(b)

- A CTI that is missing an element will not be considered valid.
- For example, if the CTI does not state that the "individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course," it will be deficient. Even though it is title "Certification of Terminal Illness."
  - This can happen if an EMR makes a mistake.
- Need to routinely review your CTI forms to ensure they contain all elements.

Hospice CTI and F2F Issues

CTI Contents—Narrative—42 C.F.R. 418.22(b)(3)

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.
- If the narrative is an addendum, the physician must sign the certification and **must also sign** immediately following the narrative in the addendum.

Hospice CTI and F2F Issues

CTI Contents—Narrative—42 C.F.R. 418.22(b)(3)

- The narrative shall include a statement **directly above the physician signature** attesting that by signing, the physician confirms that he/she composed the narrative based on **his/her review of the patient's medical record or, if applicable, his/her examination of the patient**.
- The narrative must reflect the patient's individual clinical circumstances; **no check boxes or standard language used for all patients**.
- If 3rd or later benefit period narrative must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

Audit Issues—Hospice—Narrative

- This is the certifying physician's narrative.
- The narrative should support/explain the physician's certification. This is important. Regulations do not state a specific requirement, but should be more than a few words.
- Physician should articulate the rationale for the certification. CONNECT THE DOTS!!!
- This is an opportunity to advocate for coverage. **Can be short; Must be clear.**

Hospice CTI and F2F Issues

Narrative Risk Areas:

- Placement of the signature: Signature not at the end, immediately after attestation.
- This would lead to a "technical denial."
- Review Narratives to ensure signature is in correct place. A misplaced signature can be fatal to a claim.

Hospice CTI and F2F Issues

Narrative Risk Areas:

- Someone else writes the narrative (copy and paste). Physician attests that the physician wrote the narrative. **Physician must write the narrative.**
- EMRs make it very easy to copy another clinician's narrative. Although the physician may consider the entire record, the physician cannot simply copy.
- Review narratives to check for copying.
- Educate physicians who copy. Explain risks.

Hospice CTI and F2F Issues

Narrative Risk Areas:

- Remind physicians of the narrative attestation requirement:
- The physician's "narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient." 42 CFR 418.22(b)(3)(iii)
- It puts the physician in an awkward position to sign affirming the physician composed the narrative when someone else did it.

Hospice CTI and F2F Issues

Narrative Risk Areas:

- Checkboxes, autocomplete and standard narratives.
- Narrative must be specific to the individual. Narrative must connect to the specific patient's record.
- If every CTI narrative looks the same, that is an issue. This may not be obvious until you look at multiple Narratives side by side.
- Regulation expressly prohibits using check boxes and autocompletes. Physicians may like them, because they are "simple." Will cause audit issues.

Hospice CTI and F2F Issues

Hospice Face to Face—42 C.F.R. § 418.22(a)(4)

- ". . . a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care."

Hospice CTI and F2F Issues

Hospice Face to Face

- "During a Public Health Emergency, as defined § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense." 42 C.F.R. § 418.22(a)(4)(ii)
- The PHE has ended, but this flexibility was extended through the end of 2024 by the Consolidated Appropriations Act. (Odds are it will be extended again.)

Hospice CTI and F2F Issues

- Hospice Face to Face—42 C.F.R. § 418.22(b)(4)
- The physician or nurse practitioner who performs the face-to-face encounter . . . **must attest**.
  - That the physician or NPP had a face-to-face encounter with the patient, including the date of that visit.
  - That the physician or NPP communicated the clinical findings of that visit to the certifying physician for use in determining continued eligibility for hospice care.
- Must have this attestation.
- NOTE: NPP can perform the F2F, but Physician still certifies.

Hospice CTI and F2F Issues

- Some auditors have been denying claims for lack of valid F2F when the NP or non-certifying physician signs the attestation after the physician certifies.
- Medicare Claims Processing Manual, Chapter 11, specifically states that the only timing requirement for the NP's F2F attestation is that the NP signs the attestation before the claim is submitted.
- This requirement goes back to an FAQ issued when the F2F requirement started.
- This is an improper effort to create a new payment requirement outside of the rulemaking process.

Audit Issues—Hospice CTI

- One advantage hospices have over home health agencies is that the hospice often has more control over the physician.
- CTIs and other documents may be coming from physicians who have a contractual relationship with the hospice.
- For medical directors and other contracted physicians – require timely submission of documentation as a condition of getting paid.
- When the physician is not a hospice physician. Need to follow-up. Document follow-up.

Audit Issues—Hospice Notice of Election

- Electing Hospice Care is required by the Social Security Act.
- **Hospice care; election; waiver of rights; revocation; change of election**
  - (1) **Payment under this part may be made for hospice care** . . . if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this subchapter. 42 U.S.C. § 1395d(d)(1)
- See, also, 42 C.F.R. § 418.24(a)(1).
- Note the lack of details regarding what must be in an election.
- Related: OIG concerned patients not fully informed what it means to elect hospice.

Audit Issues—Hospice Notice of Election

- The NOE must be filed within five (5) calendar days of the effective date of the Notice. 42 C.F.R. § 418.24(a)(2)
- "When a hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, **Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election. These days are a provider liability, and the provider *may not bill the beneficiary* for them**." 42 C.F.R. § 418.24(a)(3)
- If the NOE is not timely filed, then Medicare will not pay for days from the effective date until the NOE is filed.

Audit Issues—Hospice Notice of Election

- CMS has provided some exceptions to the 5 day rule. Regulation states that CMS *may* waive the consequences of late filling if, the late filing is due to:
  - Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the hospice's ability to operate.
  - A CMS or Medicare contractor systems issue that is beyond the control of the hospice.
  - A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.
  - Other situations determined by CMS to be beyond the control of the hospice.
- Rare for CMS to find an exception applies.

Audit Issues—Hospice Notice of Election

- Need to obtain NOE and get NOE filed quickly. This is a very clear coverage/payment issue.
- Late filing=lost dollars.
- Have a clear process. Verify it is being followed. A breakdown in the process can lead to significant losses as 5+ days per patient can add up very quickly.

Audit Issues—Hospice Notice of Election

- Federal regulations provide detailed content requirements for NOE.
  - identify hospice and attending physician. Beneficiary must acknowledge that the attending physician was their choice.
  - beneficiary's (or representative's) acknowledgement that they understand the palliative, rather than curative, nature of the care.
  - information regarding what is covered by hospice and what services are waived by the election. Should note that unrelated services are unusual and hospice should be providing all of the care. (CMS reminding you how broadly they view related to.)

Audit Issues—Hospice Notice of Election

- Federal regulations provide detailed content requirements for NOE.
  - The effective date of the election. This can be the first day of hospice care or a later date. May not be earlier than the date of the election statement.
  - Information on individual cost sharing.
  - Notice of right to receive an election statement addendum.
  - Information on the BFCC-QIO.
  - Signature of the individual or representative.

Audit Issues—Hospice Notice of Election

- The NOE Addendum has additional specific requirements.
  - **Must be titled** "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."
  - State name of hospice.
  - State patient's name and medical record identifier.
  - Identify the individual's terminal illness and related conditions.
  - List "the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.

Audit Issues—Hospice Notice of Election

- The NOE Addendum has additional specific requirements:
  - Include "[a] written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions."

Audit Issues—Hospice Notice of Election

- The NOE Addendum has additional specific requirements:
  - References to any relevant hospice clinical practice, policy, or coverage guidelines.
  - Information regarding:
    - Purpose of Addendum.
    - Right to Immediate Advocacy. State "that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice's determination."

Audit Issues—Hospice Notice of Election

- The NOE Addendum has additional specific requirements:
  - Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not the individual's (or representative's) agreement with the hospice's determinations. If the beneficiary (or representative) refuses to sign the addendum, the hospice must document on the addendum the reason the addendum was not signed and the addendum would become part of the patient's medical record. If a non-hospice provider or Medicare contractor requests the addendum, the non-hospice provider or Medicare contractor are not required to sign the addendum.
  - Date the hospice furnished the addendum.

95

Audit Issues—Hospice Notice of Election

- Auditors will review NOEs to see if all of the elements are present.
- Auditors may deny if any elements are missing.
- Have you updated your NOE since the requirements changed as part of the FY2022 Final Rule?
- Not clear that all of the NOE requirements are necessary under the statute and/or are material to Medicare's decision to pay.

96

Audit Issues—Hospice Notice of Election

- CMS states in regards to the NOE requirement that the individual acknowledge the hospice's coverage responsibility, "For Hospice elections beginning on or after October 1, 2020, this would include providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and *hospice should be providing virtually all care needed by the individual who has elected hospice*. 42 C.F.R. § 418.24(b)(3).
- CMS takes a very broad view of what services are "related to" a hospice patient's terminal illness.

97

Audit Issues—Hospice Notice of Election

- OIG has focused on election statements as well. OIG's primary focus is on whether or not beneficiaries are informed regarding palliative v. curative.
- OIG also considers this in marketing materials.
- OIG report noted cases where beneficiaries were admitted, but did not realize they had foregone curative care.
  - in one case an individual was told they could remain on the transplant list even after electing hospice.
- OIG sees this as a potential fraud issue.

98

Thank you. Questions?

Rmarkette@hallrender.com

99