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What Every Hospice Needs to Know About the New OIG Report

Amidst the flurry of information about the Conditions of Participation (CoPs), reform legislation and other legal developments, the recent report from the Office of the Inspector General (OIG) is truly required reading for all hospices.[1] Although the OIG reviewed claims of hospice patients who resided in nursing homes, its findings have application to all hospice claims. As the report explains, the OIG reviewed a sample of hospice claims and found that 82% did not meet the Medicare coverage requirements for hospice services. The OIG report signals a potential shift in the reasons that hospice claims may be denied, and hospices should respond proactively to ensure that their claims are not at risk.

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The OIG's Focus on Specific Medicare Coverage Requirements

The focus of the OIG's report was unexpected. Historically, when the appropriateness of hospice claims has been questioned, the focus has been on whether the beneficiary was clinically eligible for hospice (i.e., whether the documentation in the medical record supports a six-month prognosis). However, the OIG report did not examine the clinical eligibility for hospice services. Instead, they examined whether the claims met specific Medicare "coverage requirements." The coverage requirements, which are summarized in 42 C.F.R. § 418.200, require hospice services to meet the following criteria to be covered by Medicare:

- The services must be reasonable and necessary for the palliation or management of the terminal illness, as well as related conditions
- The individual must elect hospice care in accordance with § 418.24
- A plan of care must be established as set forth in § 418.56 before services are provided
- The services must be consistent with the plan of care
- A certification that the individual is terminally ill must be completed as set forth in § 418.22

The OIG focused on issues related to plans of care, notices of election and certifications of terminal illness. For each of these requirements, the OIG went beyond merely looking to see if the record contained a plan of care, notice of election and certifications of terminal illness. Rather, the OIG considered whether these documents met some of the detailed requirements set forth in the regulations (§ 418.56 for plans of care, § 418.24 for notices of election and § 418.22 for certifications of terminal illness). The OIG also examined the medical records to determine whether the services provided were consistent with those called for in the plans of care.

Using these principles, the OIG reviewed a sample of hospice claims that were paid in 2006. All of these claims were for hospice patients who also resided in nursing homes. However, the problems the OIG identified are unlikely to be unique to the nursing home setting.

The OIG's Findings

The OIG found that 82% of the 450 claims it examined did not meet at least one of the coverage requirements. More specifically, 63% of claims did not meet the plan of care requirements, 33% did not meet notice of election requirements, 31% did not provide services consistently with the plan of care and 4% did not meet requirements for certifications of terminal illness. The OIG also found that nonprofit hospices were less likely to meet these requirements than for-profit hospices, with 89% of claims from nonprofit hospices failing to meet the coverage requirements, compared with 74% of for-profit hospice claims.

The most common reasons the claims did not meet the coverage requirements include:

- Plans of care were not established by all members of the IDG (34% of claims). Pastoral counselors and social workers were the most common members of the IDG that did not participate in establishing the plans of care.
- Fewer services were provided than were called for in the plan of care (31% of claims). Most commonly, the hospices did not provide home health aide services as often as the plan of care specified.
- Plans of care did not identify the scope of at least one service (29% of claims). Most often, the plans of care called for nursing or home health aide services, but did not describe the scope of such care, such as the tasks to be performed by the aide or the issues the nurses would assess and monitor.

- Notices of election did not include required language or were not signed (29% of claims). Most commonly, the notices of election did not explain that hospices provide palliative rather than curative care or that the beneficiaries waive Medicare coverage of most other services related to the terminal illness.

Possible Consequences of the OIG's Report

The OIG recommended that CMS use targeted medical reviews and other oversight mechanisms to improve compliance with the coverage requirements, especially with respect to establishing plans of care and providing services that are consistent with the plans of care. Although hospices have previously seen occasional claim denials based on faulty notices of election (sometimes referred to as "technical denials"), these types of denials generally have not been very widespread. The OIG report could lead to greater scrutiny and increased claim denials based on notice of election forms. Further, the OIG report raises the possibility that claims could be denied because the plan of care does not meet all of the requirements in 42 C.F.R. § 418.56, or because the hospice failed to provide all services called for in the plan of care. To our knowledge, hospice claims have never previously been denied for these reasons.

In response to the OIG report, CMS said it will instruct Medicare contractors to consider the issues in the report when prioritizing medical review strategies. CMS also stated that it will share the OIG's report with the Recovery Audit Contractors (RACs). While it is too early to tell whether, and how thoroughly, the contractors will examine the issues identified by the OIG, the RACs have every incentive to identify any possible noncovered claim, since they are paid a percentage of each overpayment they identify. Hospices should not wait for a contractor to start denying claims over these issues before taking actions to ensure that the claims they are submitting meet all Medicare coverage requirements.

How Hospices Can Respond to the OIG Report

- Read the OIG report, paying particular attention to the problem areas that the OIG identified. Note that the OIG did not review all of the coverage requirements, and that the new CoPs created additional requirements for plans of care.
- Become familiar with all of the coverage requirements by rereading the regulations related to the plan of care (42 C.F.R. § 418.56), notice of election (42

C.F.R. § 418.24) and certifications of terminal illness (42 C.F.R. § 418.22).[2] CMS recently revised the certification requirements so that, effective October 1, 2009, physicians must provide a narrative explanation of the clinical findings supporting a six-month prognosis on the certification and recertification forms or as an addendum to the forms.

- Examine your procedures for meeting the coverage requirements. Consider developing checklists or other tools to help ensure that the coverage requirements are met for every claim. The OIG recommended that CMS develop a checklist of items that must be included in the plan of care, but CMS has not responded to this specific recommendation.
- Evaluate how to improve your care planning and documentation practices so that reviewers will plainly see that the claims meet all coverage requirements. For example, the OIG highlighted the problem of hospices providing fewer services than called for in the plan of care. This discrepancy could be the result of poor documentation of instances in which patients refused visits or the lack of an individualized plan of care. Hospices should ensure refusals are clearly documented and that care plans are reviewed and revised to reflect the assessed needs of the patient.
- Consider conducting prepayment audits of claims to determine whether they meet coverage requirements. Prior to submitting select claims, review the documentation in the medical record to ensure that all coverage requirements are met.
- Review notice of election forms. The OIG recommended that CMS provide model text for hospice election forms, but it remains unclear whether CMS will do so. Hospices should closely review their election forms to ensure they clearly contain all of the required elements.

Hospices should not be tempted to dismiss the issues identified by the OIG as "just paperwork." Poor documentation or failure to comply with a technical requirement, no matter how slight, could potentially lead to significant amounts of claim denials.

[1] The OIG report is available online at http://www.oig.hhs.gov/oei/reports/oei-02-06-00221.pdf.

[2] The CMS manuals also contain interpretations of these requirements. See Section 20 in Chapter 9 of the Medicare Benefit Policy Manual, Section 2080A in Chapter 2 of the State Operations Manual and the plan of care requirements in

Appendix M of the State Operations Manual.