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Complete Healthcare Compliance Manual
Post-Acute Care: Hospices

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What Is Hospice Care?

Hospice is a philosophy of care that supports patients who have a life-limiting illness (usually six months or fewer), patients' families, and patients' caregivers. Initially all volunteer, hospice became a covered Medicare Part A benefit in 1983 in Tax Equity and Fiscal Responsibility Act of 1982.[3] Since that time, most Medicaid and other commercial insurances have added a hospice benefit. Hospice focuses on palliative rather than curative care. The goal is quality compassionate care and services provided in the patient's residence, even if the patient resides in a facility.

When a patient elects the Hospice Medicare Benefit (HMB), traditional Medicare coverage ends for all things related to the terminal prognosis. Medicare pays the hospice a daily rate and from that the hospice covers all care and services related to the terminal prognosis, including medications, durable medical equipment, nursing care, physician services, medical supplies, bereavement services, and other services needed for the palliation of pain and symptoms.

Between 2000 and 2019, Medicare spending for hospice care increased from $2.9 billion[4] to $20.9 billion[5]. With the substantial increase in payments came an increase in scrutiny and multiple enforcement actions. In addition to payment scrutiny, quality of care issues have been identified.[6] In 2019, the Office of Inspector General (OIG) published a report titled "Hospice Deficiencies Pose Risks to Medicare Beneficiaries."[7] This report highlighted quality concerns and survey deficiencies that ultimately affect beneficiaries of these services. Higher payments combined with quality concerns is certainly enough to increase scrutiny.

Enforcement and Settlement Activities

Key focus areas for enforcement and settlement activity related to hospice care include patient eligibility; long lengths of stay, providing a higher level of care than appropriate; untimely documentation; inappropriate payments to non-hospice providers, and financial relationships with referral sources, including medical director reimbursement.

Patient Eligibility

To qualify for the HMB, a patient must have a prognosis of six months or fewer if the disease runs its normal course. While prognostication is not an exact science and relies on the determination of physicians, guidelines are provided for determining the patient's prognosis based on the primary terminal diagnosis. Red flags include long lengths of stay, high number of live discharges, high percentage of nursing facility and assisted living facility patients, and exceeding the Medicare aggregate cap.

In addition to this, the OIG has been focused on patients who have not had a hospitalization or emergency department visit prior to the hospice admission.[8] This type of review can be done remotely and without the

hospice's knowledge that an audit is taking place.

Long Lengths of Stay

An OIG Report[9] was clear that Medicare should modify payments to prevent hospices from targeting long length of stay patients. Medicare listened and has modified payments and recommended audits of patients with long lengths of stay. As a result, hospices have seen increased audits of these patients.

Level of Care

Hospice provides four levels of care:

1. Routine home care,
2. General inpatient care,
3. Respite care, and
4. Continuous care.

The majority of care is provided at the routine level, and inpatient care is limited to 20% of the total number of Medicare patient days provided to all patients served by that provider. Medicare has provided criteria for when each level of care may be provided.[10]Failure to meet these requirements may result in billing for a higher level of care than was necessary.

Untimely Documentation

Untimely documentation includes, among others, the written certifications, physician face-to-face visits, and records of interdisciplinary team meetings.

- **Written certifications**. The certification periods for the HMB include two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. These benefit periods are based on the beneficiary, not the hospice, so if a beneficiary has received hospice services in the past, that patient may be admitted into the second or later benefit period. This is important when determining the number of days the physician is certifying and whether a face-to-face visit is required.
- **Physician face-to-face visits**. Any patient entering a third or subsequent benefit period must have a face-to-face visit with a qualified provider (physician or nurse practitioner). The results of that visit must be used when determining a terminal prognosis. The logical conclusion is that the face-to-face visit must occur prior to the written certification and both must fall within the timelines provided by the hospice regulations.
- **Records of interdisciplinary team meetings**. The plan of care must be reviewed by the interdisciplinary team, at a minimum, every 15 days.[11] It is expected that this review is documented in the clinical record. Failure to document this review results in services that are not billable. For example, if plan-of care-reviews are conducted on March 1 and April 1, the days between March 15 (15 days from the last interdisciplinary team review) and April 1 would not be billable.

Inappropriate Payments to Non-hospice Providers

In the 1983 final rule, CMS stated: "It is our general view that the [Social Security Act §1812(d)(2)(A) 'exceptional

and unusual circumstances'] waiver required by the law is a broad one and that hospices are required to provide virtually all the care that is needed by terminally ill patients"[12] While this is not a new requirement, according to the OIG, Medicare paid $6.6 billion to nonhospice providers for items, services, durable medical equipment, and medications that should have been covered by the hospice per diem.[13]Medicare has clearly stated that they view virtually all care provided to the patient to be related to the terminal condition. Any variance from this requires the physician to indicate why that would not be a covered hospice benefit. Patients should also be informed when something is not covered by the hospice, and they have a right to request that information in writing.

Financial Relationships with Referral Sources

These include arrangements with another healthcare provider who the hospice knows is submitting claims for services already covered by the hospice benefit. The Medicare expectation is that hospices should be providing "virtually all care needed by the individual who has elected hospice."[14] Additionally, medical directorships may be examined closely to ensure remuneration is based on a fair market value and not based on number of referrals or an expectation of referrals. Physicians should be reimbursed based on time spent providing the hospice with services. Monthly stipends that are not based on the time spent providing hospice services are at risk.

The Anti-Kickback Statute prohibits incentives to actual or potential referral sources.[15] Closely scrutinized in this area are relationships with nursing facilities who have the potential to make patient referrals. An example of this may be a promise to provide a full-time aide for every X number of patients admitted to the hospice, or referrals to the nursing facility in exchange for referrals to the hospice.