Advanced Revenue Cycle Management

GATEWAY
Home Health Coding & Consulting

PAISLEY & ELM, LLC
MEDICARE COST REPORT SPECIALIST

SUPERBOWL OF **HOSPICE KNOWLEDGE**

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ANNUAL PREGAME **CHECK UP**

Three billing and payment topics to review and revise for best practices
Two new additions for 2024

Review and strengthen payer eligibility reverification process

Review how often eligibility reverifications are completed on all patients for all payers.

Payer eligibility is always verified upon referral/admission

What is your frequency for reverifying coverage?

- Best practice is verifying payer eligibility at least monthly.
- Target patients who are nearing their 65th birthday, regardless of payer.
- Verify all Medicaid/Medicaid MCO patient eligibility monthly.
- Verify all commercial insurance coverage monthly.
- Verify all Medicare coverage monthly- Hospices are seeing many more patients receiving new MBIs and not notifying hospice.

- Search for MBI on your MAC's EServices MBI lookup tool using ss#

Review and strengthen payer eligibility reverification process

Review how often eligibility reverifications are completed on all patients for all payers.

- Payer change seen most often that hospices are not aware of are Medicaid/ Medicaid MCO patients who qualify for Medicare coverage before the age of 65.

- Medicare secondary payer patients who become Medicare primary due to termination of other primary insurance.

- Medicare patients who elect a new Medicare Advantage plan that is participating in the VBID pilot.

- Medicaid/MCO coverage changes from one plan to another or terminates coverage.
- Commercial plans terminate coverage at year end.
- Commercial plans starting 1/1 may not include hospice coverage or may need prior authorizations.

Review and strengthen payer eligibility reverification process

Review how often eligibility reverifications are completed on all patients for all payers.

- Autogenerated eligibility reports are not effective if not reviewed in detail.
- Who is responsible for reviewing reports and identifying changes? What frequency is your hospice management team confirming that changes are being identified timely and action is taken to avoid non covered days of care?

- Many EMRs and clearinghouses offer batch eligibility reports run at the agency's preferred frequency, but those reports still must be compared to the information on file for the patient.

- Many MSP or VBID patients do not get added to EMR generated Medicare batch eligibility verifications because their MBI is not in the primary payer field.

- These patients can usually be added to batch verification manually.

Review updated payer rates and compare to usual and customary charges

- Reimbursement rates increase annually for most payers, including Medicare, Medicaid, and VA. Some commercial payers are contracted to pay hospices a percentage of current Medicare rates, so those payments also increase annually.

- While Medicare states all payers must be charged the same amount for all services, you must be sure your usual and customary charges are not outdated and fall below your actual expected reimbursement.

- When some payers are under billed, they will pay the published reimbursement rate OR the stated charges, whichever is lower.

- To avoid being underpaid, you must analyze your usual and customary charges every year and make rate adjustments to avoid under billing.

Special Circumstances for Room and Board Rates

- Room and board rates are often updated retroactively.
- Claims submitted with usual and customary rates that exceed the NEW updated rates will often be recycled and paid correctly by the payer, without additional action by the hospice.
- Claims submitted with usual and customary rates (or actual charges) that do not exceed the new updated rates must be canceled and rebilled, or adjustment claims must be filed.
- For payers with short timely filing limits, adjustments are sometimes difficult or even impossible to get paid.

Review payer contract rates and seek opportunities to renegotiate

- Many commercial insurance contracts automatically renew and never expire.
- Rates are often a flat per diem rate for each level of care.
- Some contracts include small percentage increases annually, but their systems are not always updated each year to reflect new rates.
- Contracts more than four years old are likely based on old Medicare rates, reflecting low IPU and Respite reimbursement.
- Confirm your contracts include all levels of care at reasonable reimbursement rates.

For 2024 and Beyond

Learn about the Value Based Insurance Design
(VBID) hospice pilot that is testing carving hospice into coverage under Medicare Advantage.

- Three full years into the pilot, and rules are changing annually
- All hospices must participate and plans are based on geography

- If your hospice receives a referral for a patient with a participating plan, even if there are no active plans in your state or county, you must bill the Medicare Advantage plan and Medicare

- Hospices are required to follow all VBID billing rules, which include submitting NOEs to both Medicare and the plan, in order to get paid

For 2024 and Beyond

Analyze your hospice's transfer policy

Since Medicare changed the transfer rule requiring patients to transfer on the same calendar day from one hospice to another, there have been many billing challenges

- Well documented coordination of care with the sending hospice is one significant step to getting paid in the event of a billing dispute
- Confirm the patient only has one transfer, yours, in the current benefit period
- Confirm the prior hospice is not behind in billing for any reason- missing face to face, missing signed CTI, or claims in ADR
- Calculate the true benefit period in which the transfer is occurring if the prior hospice is behind on billing and the current benefit period is not reflected in the CWF
- If for any reason you are unable to see the patient on the date of transfer, the patient no longer meets transfer criteria
- Alert the sending hospice same day or next day and get written confirmation of receipt that they must bill the patient as a discharge and your hospice will proceed with a full admission and all required elements.

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THE HOSPICE **MEDICAL REVIEW** ENVIRONMENT:

Risks and Response

Why Hospice Providers Are Targeted for Audits

- Hospice spending by CMS continues to increase
- Overpayments, Fraud, and Abusive practices are real
- Government Initiatives
- Government reports demonstrate patterns of potential and actual abusive practices
- Government data analytics determine
    - Comparison to state, regional, MAC jurisdiction, national
    - Claims, quality, and beneficiary data

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CMS Hospice Review Contractors

- Medicare Administrator Contractors (MAC):
  - National Government Services (NGS), Jurisdiction 6 (J6)
  - National Government Services, Jurisdiction K (JK)
  - Palmetto GBA, Jurisdiction M (JM)
  - CGS Administrators, Jurisdiction 15 (J15)

- Unified Program Integrity Contractors (UPIC):
  - AdvanceMed
  - UPIC Southwest Jurisdiction (Qlarant)
  - Safeguard Services
  - CoventBridge

- RAC: Performant (Region 5)

- Supplemental Medical Review Contractor (SMRC)
  - Noridian Healthcare Solutions

- CERT: CERT Review Contractor – AdvanceMed

- NOTE: all CMS review contractors may be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map [accessed 12/5/23]

CMS Hospice Review Contractor Methods

- Medicare Administrator Contractors (MAC):
  - Use Targeted Probe and Educate (TPE
- Unified Program Integrity Contractors (UPIC):
  - Use audits based on credible evidence of waste, fraud, or abuse
  - Focused on billing, utilization, and higher levels of care service
- RAC: Performant (Region 5)
  - Pulls single claim reviews: rare for hospice reviews
- Supplemental Medical Review Contractor (SMRC)
  - Performs CMS directed specific audits that vary in size, trigger, and focus

Other Hospice Reviews

- Hospice Special Focus Program (SFP):
  - Will monitor hospices identified as poor performers based on selected quality indicators. Hospices selected for the SFP will be under additional oversight to enable continuous improvement. This required program includes the development and implementation of enforcement remedies for noncompliant hospice programs, as well as procedures for appealing determinations regarding these remedies. These enforcement actions can be imposed instead of, or in addition to, termination of the hospice program's participation from the Medicare program.

- Provisional Period of Enhanced Oversight (PPEO) :
  - New providers or suppliers are subject to prepayment medical reviews designed to address improper billing practices "right out of the gate." This program is for newly certified hospices as well as change of ownership.
    - New hospices in Arizona, Nevada, California, Texas
    - See MLN7867599
    - Started for new hospices/change of ownership 7/13/23

Risk From Reviews

- TPE
  - High for GIP
  - High for length of stay for routine level of care patients in facilities
  - Medium for diagnosis based-reviews of routine level of care
- UPIC
  - High for GIP
  - High for new provider
- SMRC
  - Very Low
- RAC
  - Very Low (GIP, CHC)
- PPEO
  - Very high for hospices meeting criteria

Areas of Focus by the Government

- Eligibility/Medical necessity to support 6-month prognosis
- Levels of Care
- Long Lengths of Stay (over 180 days)
- Patients in SNF and ALF
- Technical Requirements: Election statement, Waiver language, Patient choice of attending physician, CTI, Face-to-face, NOE addendum
- Inappropriate referrals
- Paying hospice medical director more than Fair Market Value
- Incentive programs
- Relationships with nursing facilities

JM Hospice Targeted Probe and Educate Active Medical Review List (Palmetto GBA)

- Bene Sharing
  - Description: Inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 656 and place of service codes Q5004–*Q5009 [Q5004 – Skilled nursing facility (receiving skilled care). Q5005 – Inpatient hospital. Q5006 – Inpatient hospice facility. Q5007 – Long term care hospital. Q5008 – Inpatient psychiatric facility. Q5009 – Place not otherwise specified]*

- New Hospice Providers Review of new hospice provider claims
- Hospice-Length of Stay (LOS) Greater than 365 Days

- Bene Sharing
  - Description: Review of Hospice Routine Home Care (on shared claims)

- Continuous Home Care [CHC]
- Non-Cancer Length of Stay (NCLOS)

Palmetto GBA Hospice Q&A 11/2/23

Question 2: There are now seven active Hospice Targeted Probe and Educate (TPE) Active Medical Reviews on the Palmetto GBA website. Please provide more details and information on all the new audits posted.

- a. Under “Code Type,” what is “Bene Sharing?”
  - Answer: The Bene Sharing audit is intended to target providers that serviced the same beneficiary during a specified time period.

- b. Regarding the new audits, what did the data demonstrate that prompted the inclusion of the new topics?
  - Answer: When looking at the Bene Sharing audit, we saw an average of 29 shared beneficiaries among hospices that were not unique business units. The maximum number of shared beneficiaries was 2,651 and a minimum of one. We also saw a high percentage of beneficiary sharing within Texas and Florida with higher reimbursement than the other JM states. This could be attributed to the large urban areas within those states such as Dallas, Houston, Miami and Orlando.

- c. How many hospices will be audited for each of these areas?
  - Answer: MACs do not identify a specified number of providers for any particular audit. Palmetto GBA targets the top percentile of providers for any given category. For the Hospice Bene Sharing audit, there are 2,187 providers that qualify for the audit. We will target the top ten percent of providers initially. If the audit shows Medicare savings, data is rerun, and we target another subset of providers.

- d. How many claims do you expect to pull per hospice, 40 claims as it has been recently, or will it vary by topic?
  - Answer: Hospices are subjected to the same methodology as other providers. Sample size is based on provider utilization. If a provider has a higher claim volume, they are subject to receive a higher number of claims pulled into their TPE sample. The sample sizes are selected to give providers the best opportunity to be removed from a TPE probe.

J15 Hospice Targeted Probe and Educate Active Medical Review List (CGS Administrators)

- Topic: LOS with Non-Oncologic Diagnosis
  - Description: Length of stay (LOS) >730 days and non-oncologic diagnosis code

- Topic: GIP Level of Care
  - Description: claims with GIP greater than or equal to 7 days

- Topic: New Providers
  - Relatively new providers who have submitted at least 50 claims

- Topic: Length of Stay (LOS) 313-515 days

List as of 9/20/22

JK/J6 Hospice Targeted Probe and Educate Medical Review Top Results (NGS)

- NGS does not post a listing of active medical topics.

- Common denial reasons posted from ADRs:
  - 55H1B No certification present in the documentation submitted for the dates billed.
  - 55H1G The hospice election consent was not signed timely
  - 55H1L The information provided does not support a terminal prognosis of six months or less
  - 55H1R The notice of election is invalid because it doesn't meet statutory/regulatory requirements
  - 55H1Y The physician narrative statement was not present or was not valid

List as of 10/22/22

Hospice Denial Reasons

- Notice of Election is invalid/not present
- Certification not signed timely by physician
- No certification present in documentation submitted for the dates of service billed
- Physician narrative was not present or was not valid
- Missing face-to-face encounter

- Eligibility: information provided does not support a terminal prognosis of 6 months or less in accordance with the Medicare hospice requirements

- Level of care not supported by documentation (especially GIP and CHC)

Hospice IDG/IDT Changes for 2024

Question 2. Are hospices required to have a MFT [marriage and family therapist], MHC [mental health counselor], and social worker (SW) disciplines available to act as members of the interdisciplinary group (IDG)?

- Response: Hospices are required to have at least one of the three practitioners listed (SW, MFT, or MHC) as a member of the IDG. Note that a hospice must employ a SW as medical social services furnished by a qualified social worker are considered a core service under the Condition of Participation (see 42 C.F.R. § 418.64(c)).

- CMS Hospice Open Door Forum 11/29/23

The Role of MFT/MHC

Is the scope of service (the “work”) of the MFT/MHC is not part of social worker services?

Is the scope of service/interventions of the MFT/MHC different than that that of social work services and can they be considered a part of social services?

- Response: The work of the MFT and MHC are not part of social work services, or medical social services (see § 418.64(c)). MFTs, MHCs, and social workers each have their own scope of practice and licensure requirements. Please refer to § 410.53 “Marriage and family therapist services” and § 410.54 “Mental Health counselor services” for detailed information regarding the requirements for MFTs and MHCs. While all three professions can provide counseling services, social workers can also provide other services, such as case management, or refer patients to other services and resources. CMS considers the work of the MFT or MHC to fall under counseling services (88 FR 78818), which is defined at § 418.64(d) and must include, but are not limited to, bereavement, dietary, and spiritual counseling under the Condition of Participation.

- Source: CMS Open Door Forum 11/29/23

Denial Considerations

- Medical review follows billing:
  - Monthly (days of service) for routine level of care
  - Days billed at higher paying levels of care (CHC, GIP)

- Denial based on defective admission documents (NOE, CTI) risks denial of all hospice service.

- Denial based on terminal prognosis not supported risks denial of all hospice service from denied date continuing to current.

- Denial based on unsupported higher level of care (CHC, GIP) generally reverts to routine level of care payment.

- Denials for non-technical reasons will generally continue until patient is discharged or dies (when service prior to death may now be covered).

- ALL IMPOSE SIGNIFICANT FINANCIAL BURDEN ON THE HOSPICE PROVIDER

Charting Documentation and Timepoints

Admission

- Notice of Election (NOE)
- Certification of Terminal Illness (CTI)
- Face-to-face encounter (F2F)
- Admission assessment
- Plan of Care development

Ongoing

- Interdisciplinary meetings (IDT/IDG)
- Plan of Care updates
- Recertification of Terminal Illness (CTI)
- Face-to-face encounter (F2F)
- Visits
- Change in Level of Care (LOC)
- Death/Discharge/Transfer

Key Coverage/Payment Documents

- Notice of Election (NOE)
- Certification of Terminal Illness (at admission)
- Certification of Terminal Illness (each benefit period)

- Face-to-face encounter (all 60-day benefit periods)
  - Includes narrative related to LCD coverage content

- Interdisciplinary Team/Group (IDT/IDG) notes
- Plan of Care: initial and updated with changes
- GIP/CHC documentation of uncontrolled symptoms and relief actions taken
- ALL OF THESE MUST INTEGRATE APPROPRIATE HOSPICE LCD CONTENT

- NOTE: a PHYSICIAN must certify hospice terminal illness (NOT a non-physician practitioner)

Charting Compliance

1. At admission ensure all TECHNICAL items are complete
   - Notice of Election (NOE)
   - Certification of Terminal Illness (CTI)
   - Face-to-face encounter (F2F)
   - Hospice Election Statement (and addendum)

2. At admission a BASELINE hospice appropriate status is documented
3. During care (visits, IDT/IDG) palliative interventions are documented

4. At recertification ensure all TECHNICAL items are complete
   - Recertification of Terminal Illness (CTI)
   - Face-to-face encounter (F2F)

5. If no longer hospice appropriate: DISCHARGE

KEY: ALL THIS INCORPORATES the applicable MAC Hospice Local Coverage Determination (LCD) indicators of terminal illness

CTI: Clinical Findings

- Patient-specific clinical findings and other documentation supporting a life expectancy of six months or less.

- Should give SPECIFIC clinical findings:
  - Signs
  - Symptoms
  - Lab tests
  - Weights
  - Anthropomorphic measurements
  - Oral intake
  - Local Coverage Determination (LCD) specific findings

CTI: Brief Narrative

- As of October 1, 2009
- Brief narrative explanation of the clinical findings that supports a life expectancy of six months or less
- May be an addendum to the certification/recertification forms
  - If part of the form—must be located DIRECTLY ABOVE the physician signature
  - If addendum, physician must sign BOTH the certification/recertification form and immediately following the narrative in the addendum.
- Must include:
  - Physician confirmation she/he composed the narrative
  - This was based on her/his review of the patient medical record and/or examination of the patient
  - May be dictated
  - Must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language that is used for all patients

Face-to-Face Encounter

- Needed starting with third benefit period and after (e.g. for 60-day benefit periods)
- Completed no more than 30 days prior to third benefit period recertification and each subsequent recertification
- May be completed on first day of benefit period
- Physician or nurse practitioner who performs attests in writing that the encounter occurred
  - Only the individual who performs the face-to-face encounter may attest to its completion
- If nurse practitioner or non-certifying hospice physician performed the face-to-face encounter
  - Must attest that the clinical findings were provided to the certifying physician
- Signed and dated by physician or nurse practitioner who performed the encounter

Common Hospice Certification Errors

- Medicare cannot make appropriate payment without correct dates, signatures and identifying roles of the physician(s). Common missing and inadequate information:
  - Predating physician(s) certification signatures
  - Not having both the hospice medical director and attending physician (if applicable) sign the initial certification as required
  - The physician narrative is missing
  - The physician's narrative does not include a statement attesting that it was composed by the physician
  - The attestation statement is missing
  - Not having verbal certifications by both the medical director and attending physician (if applicable)
  - No physician(s) signatures
  - Illegible physician signatures
  - Physician did not date his/her signature
  - Not clearly stating the dates the certification period encompasses
- AN INVALID CERTIFICATION MAKES ALL RELATED SERVICE NON-PAYABLE
- THERE IS NO VALID EXCUSE FOR HAVING AN INVALID CERTIFICATION OF TERMINAL ILLNESS!

IDT/IDG

- At least every 15 days
- Establishes the Plan of Care (with physician)
- Identifies treatment goals and coordination of services

- Documents changes in condition
  - Changes to the Plan of Care to address patient changes

- Incorporate when possible LCD requirements/indicators present in the patient
- Attendance documentation must be kept
- IDT/IDG is a KEY ITEM to show changes over time with the patient and a summary of changes of condition or decline

Local Coverage Determinations

- Found at
  - https://www.cms.gov/medicare-coverage-database/reports/local-coverage-final-lcds-contractor-report.aspx?contractorName=2&contractorNumber=373%7c1&lcdStatus=all [accessed 12/5/23]

- Palmetto GBA:
  - L34566 Hospice - HIV Disease
  - L34544 Hospice - Liver Disease
  - L34547 Hospice - Neurological Conditions
  - L34559 Hospice - Renal Care
  - L34567 Hospice - Alzheimer's Disease & Related Disorders
  - L34548 Hospice - Cardiopulmonary Conditions
  - L34558 Hospice - The Adult Failure To Thrive Syndrome

- National Government Services:
  - LCD L33393 Hospice – Determining Terminal Status

- CGS Administrators:
  - LCD L34538 Hospice - Determining Terminal Status

Using Local Coverage Determinations

- While Palmetto GBA has multiple LCDs, CGS Administrators and National Government Services each have one consolidated LCD for coverage guidance.

- If hospice has Palmetto GBA as MAC, follow their disease specific LCDs.
  - ALSO, review the content of either/both NGS LCD L33393 Hospice – Determining Terminal Status and CGS Administrators LCD L34538 Hospice - Determining Terminal Status
  - DOCUMENT relevant findings and content from the NGS/CGS LCDs in the F2F, narratives, IDT/IDG, notes, and CTI.

- If have NGS or CGS as hospice MAC use the respective LCD for charting guidance

DOING THIS PUTS THE HOSPICE IN A BETTER POSITION SHOWING PROGNOSTIC FINDINGS TO SUPPORT HOSPICE APPROPRIATENESS IN CASE OF MEDICAL REVIEW OR AUDIT.

LCD Coverage Abstract

Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. [Each] LCD describes guidelines to be used…in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits.…It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability…as well as…applicable to …specific diagnoses [are provided]… Patients who meet the guidelines…are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

General LCD Application

Coverage Indications, Limitations, and/or Medical Necessity

- Medicare coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of 6 months or less, if the terminal illness runs its normal course.

- Recognizing that determination of life expectancy during the course of a terminal illness is difficult…[the] Medicare Administrative Contractor (MAC) has established medical criteria for determining prognosis for non-cancer diagnoses.

- These criteria form a reasonable approach to the determination of life expectancy based on available research and may be revised as more research is available.

- Coverage of hospice care for patients not meeting the criteria in this policy may be denied. However, some patients may not meet the criteria, yet still be appropriate for hospice care because of other comorbidities or rapid decline. Coverage for these patients may be approved on an individual consideration basis.

KNOW THE CONTENT OF THE LCDS. TEACH THEM TO STAFF. USE THEM IN CHARTING!

Common Hospice Documentation Issues

- IDG/IDT notes contradict F2F narrative findings
- IDG/IDT notes do not address terminal illness prognostic findings
- IDG/IDT notes do not reflect LCD prognostic findings
- Level of Care qualification, orders, appropriateness
  - Continuous Care
  - General Inpatient
  - Respite
  - Facility records not obtained

- Clinician visit notes do not address terminal illness prognostic findings
- Visit notes do not reflect LCD prognostic findings
- Visit notes contradict certification/F2F narrative findings
- Visit notes do not identify terminal diagnosis relevant findings
- Visit notes are inconsistent between disciplines (nursing, social service, spiritual care)

Other Common Hospice Coverage Issues

- Principal diagnosis not coded correctly.
  - The principal diagnosis listed is the diagnosis most contributory to the terminal prognosis.

- Comorbid and secondary conditions not documented.

- Level of care changes do not record the date, time and reason why the level of care (LOC) changed.
  - Inpatient Respite: Must show when LOC was changed and the reason
  - GIP: Upon transfer should include both:

A precipitating event (onset of uncontrolled symptoms or pain)
The interventions tried in the home that have been unsuccessful at controlling the symptoms

- Ongoing GIP should include frequent evaluation by a doctor or nurse, medication adjustment, Intravenous (IV) medications that cannot be administered at home, aggressive pain management, complicated technical delivery of medication

- Continuous Home Care (CHC) supportive documentation does not:
  - Show the patient's condition needed the hospice higher LOC interventions
  - Describe the patient's response to care

INCORPORATE THESE INTO HOSPICE INTERNAL RECORD REVIEWS

Stabilization

- If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit.

- Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less.

- On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care yet have a reasonable expectation of continued decline for a life expectancy of less than six months remain eligible for hospice care.

- NOTE: Long length of stay significantly increases risk of medical review.

GIP/CHC Summary

- Only use GIP or CHC level of care when the NEED for it is established
- Use MAC guidelines and checklists to ensure that charting captures the specifics to support current and continued GIP/CHC level of care
- When the GIP/CHC level of care instability is no longer present, transition the patient to most appropriate level of care
- Communication with facility and among staff is vital to managing GIP/CHC level of care service
- Collaborate with facility staff to ensure their charting is correctly identifying patient needs and is consistent with GIP level of need
- Ensure level of care status is communicated with the facility (GIP) to maintain accurate billing of service
- Hospice GIP and CHC level of care is an ACTIVE condition: monitoring patient status without a clear need, no changes to the plan of care for any uncontrolled symptoms, and keeping patients on GIP or CHC service without changes in condition DO NOT QUALIFY for this level of care.

Tips for Responding to an ADR

- **Assign an ADR lead**. Choose an administrative team member or nurse to lead this task, which should include watching for new ADRs, monitoring the status of existing ADRs, and ensuring documentation is submitted in a timely manner.

- **Check for ADRs.** Work with the ADR lead to create an internal process to check on ADRs at least once a week.

- **Note the due date.** Mark down the due date listed in the ADR to ensure response on time. ADRs are due within 45 calendar days of the request.

- **Double-check the documentation.** Ensure that documentation is correct for the patient and claim by attaching a copy of the ADR letter (or FISS Page 07) as the first page.

- **Organize documents if you are submitting more than one ADR.** For multiple medical review ADR requests, clearly separate the documentation for each claim.

What You Need to Respond to an ADR

To respond to an ADR, you'll need to share things like physician's office and hospital records, admission records, plans of care, and other medical records.

- ADR letter (or FISS Page 07 screen print) and Contact Form
- Signed election statement
- Addendum(s) (as applicable)
- Plan of care with physician certification/recertifications
- Physician Face-to-Face documentation (for third and later benefit periods)
- Physician orders

- IDT/IDG reviews/POC updates
  - Note: include reviews for each 15-day period to cover the billing period. This may include reviews/updates that occurred prior to the billing period.
- Initial assessment for billing period
- Visit notes (nursing, social worker, chaplain, etc.)
- Physician visit notes
- Other relevant documentation
- Admission assessment

Responding to a GIP or CHC ADR

- Facility records pertinent to the GIP level of care can be included with the response.
  - These may include narrative notes, orders, assessment sheets, communications, care plans, or physician notes during the time the beneficiary was on GIP.
  - Gathering these at time of GIP service ensures they are available in case of later Medical Review.

- For CHC ADRs include tracking logs showing nursing and non-nursing service provided on each date.

- Include documentation of level of care changes: dates, time, level of care changed to/from.

Documentation Focus Areas

- Valid and timely Election of Benefits with valid addendums if required.
- Certification of Terminal Illness (CTI) –verbal and written certifications.
- Content of the physician narrative and defense of terminal prognosis.
- Face-to-Face (F2F) encounters
- Plan of Care (PoC) and IDT/IDG documentation of patient changes and care plan adjustments

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Checklist for 2024

- ✓ Review National Coverage Determination (NCD) (CFR, MBPM) coverage requirements
- ✓ Review applicable LCD content
- ✓ Review other available prognostic guidance
- ✓ Inservice staff on specific content of the LCD and GIP/CHC documentation needs

- ✓ Check that all NCD technical requirements are met
  - ✓ At admission
  - ✓ With each recertification

- ✓ Train, integrate, and implement the LCD guidance throughout all hospice charting

- ✓ Review agency EMR for how it prompts staff to generate compliant charting using prognostic guidance

- ✓ Review GIP/CHC requirements and inservice staff on additional documentation needs
- ✓ When ADRs are received respond timely and thoroughly

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TOP ITEMS FOR **HOSPICE AGENCIES**

FY 2024

Three Core Items for Every year for Hospice

1. Budget
2. Management Reports – Key Indicators
3. CAP Report

Two Additional Items for FY 2024

1. CAP Monitoring – Monthly
2. Accounts Receivable Analysis

Budget FY 2024

Annual Budget Preparation for Hospice

1. Revenue Budget – based upon Patient Census/type of care
2. Direct Care Budget– Variable Cost
3. Administration/Indirect Budget – Relatively Fixed Costs

Revenue Budget
Patient Days Utilization Budget

						13.00	138.00	
						512.56	1,098.63	**Projected Number of Patient Days**
	Patients	**Days**	**Rate**	**Monthly Revenue**	**Regular**	**IP**	**GIP**	**Total**
January	52	30	187.27	292,141.20				
February	52	30	187.27	292,141.20				
March	52	30	187.27	292,141.20	876,423.60	1,665.82	37,902.74	915,992.16
April May	52	30	187.27	292,141.20				
June July	52	30	187.27	292,141.20	876,423.60	1,665.82	37,902.74	915,992.16
August	52	30	187.27	292,141.20				
September	52	30	187.27	292,141.20				
October	52	30	187.27	292,141.20	876,423.60	1,665.82	37,902.74	915,992.16
November	52	30	187.27	292,141.20				
December	52	30	187.27	292,141.20	876,423.60	1,665.82	37,902.74	915,992.16
Total				3,505,694.40	3,505,694.40	6,663.28	151,610.96	3,663,968.64
								0.00

Annual Hospice Budget – Revenue and Direct Care

2024 Annual

Revenues	Budget	Percentage
Hospice Care	3,663,968.64	
Total	**3,663,968.64**	**100.00%**
Cost of Sales		
Skilled/LPN Nursing	549,595.00	15.00%
Spiritual Counseling	128,239.00	3.50%
Home Health Aides	192,358.00	5.25%
Medical Social Workers	91,599.00	2.50%
Nurse Practitioner	164,879.00	4.50%
Medical Director	75,000.00	
Medical Supplies	91,599.00	2.50%
Pharmacy	174,039.00	4.75%
Outpatient Diagnostic Testing	18,320.00	0.50%
Other Therapy	12,824.00	0.35%
Mileage	18,320.00	0.50%
Total Cost of Sales	**1,516,772.00**	**41.00%**
Gross Profit	**2,147,196.64**	**59.00%**

Indirect Expenses

Admin Salaries	640,000.00
Marketing Salaries	75,000.00
Bereavement Salaries	45,000.00
Volunteer Services Salaries	32,500.00
Retirement Plan Expense	125,000.00
Employer Taxes	170,929.00
Insurance General	17,500.00
Insurance Health	25,500.00
Insurance Workers Comp	18,500.00
Training	9,500.00
Telecommunications	11,750.00
Office Expense	42,500.00
Office Equipment	4,950.00
Printing	8,500.00
Medical Equipment Rental	128,239.00
Billing & Software Fees	71,447.00
Professional Fees	85,000.00
Licenses & Permits	8,500.00
Legal Fees	3,850.00
Memberships & Publications	4,500.00
Postage & Delivery	3,500.00
Rent	130,000.00
Utilities	8,500.00
Repairs & Maintenance	5,500.00
Meals & Entertainment	8,500.00
Room & Board Fees	0.00
Payroll Fees	7,500.00
Depreciation & Amortization	20,400.00
Promotions/Marketing	45,500.00
Supplies	
Bereavement	6,850.00
Quality Assurance	5,500.00
Bank Charges	125.00
Total Indirect Costs	**1,770,540.00**
Total Expenses	**3,287,312.00**
Net Income	**376,656.64**

ARM PAISLEY & ELM, LLC MEDICARE COST REPORT SPECIALIST GATEWAY

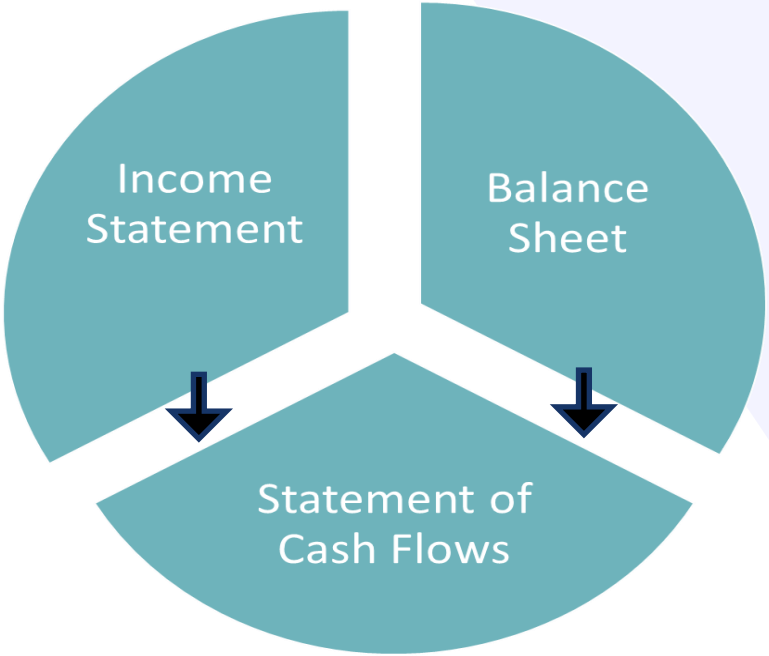
Hospice Management Reports-Financial Statements

- Financial Statement Data
  - Income Statement
  - Balance Sheet
  - Statement of Cash Flows

- The Statement of Cash Flows reconciles net income to the net change in cash by three categories:
  - Cash flow form Operating Activities
  - Cash flow from Investing Activities
  - Cash Flow from Finance Activities

Your financial reporting system needs to be accurate and complete to be able to produce a good analysis of your Hospice Agency.

Interrelationship of the Financial Statements



Hospice Management Reports-Financial Statements

Reports from Financial Statement Data

Financial ratios are key tools used to evaluate the financial health of a company. They can be categorized into several types:

1. Liquidity Ratios: These ratios measure the ability of a company to meet its short-term obligations.
   - Current Ratio: Current Assets / Current Liabilities
   - Quick Ratio (Acid-Test Ratio): (Current Assets - Inventories) / Current Liabilities

2. Profitability Ratios: These ratios assess a company's ability to generate earnings relative to its revenue, operating costs, and equity.
   - Net Profit Margin: Net Income / Revenue
   - Return on Assets (ROA): Net Income / Total Assets
   - Return on Equity (ROE): Net Income / Shareholder's Equity

3. Leverage (Debt) Ratios: These ratios evaluate the degree of a company's financing with debt relative to its equity.
   - Debt to Equity Ratio: Total Debt / Total Equity
   - Interest Coverage Ratio: Earnings Before Interest and Taxes (EBIT) / Interest Expenses

Hospice CAP Report

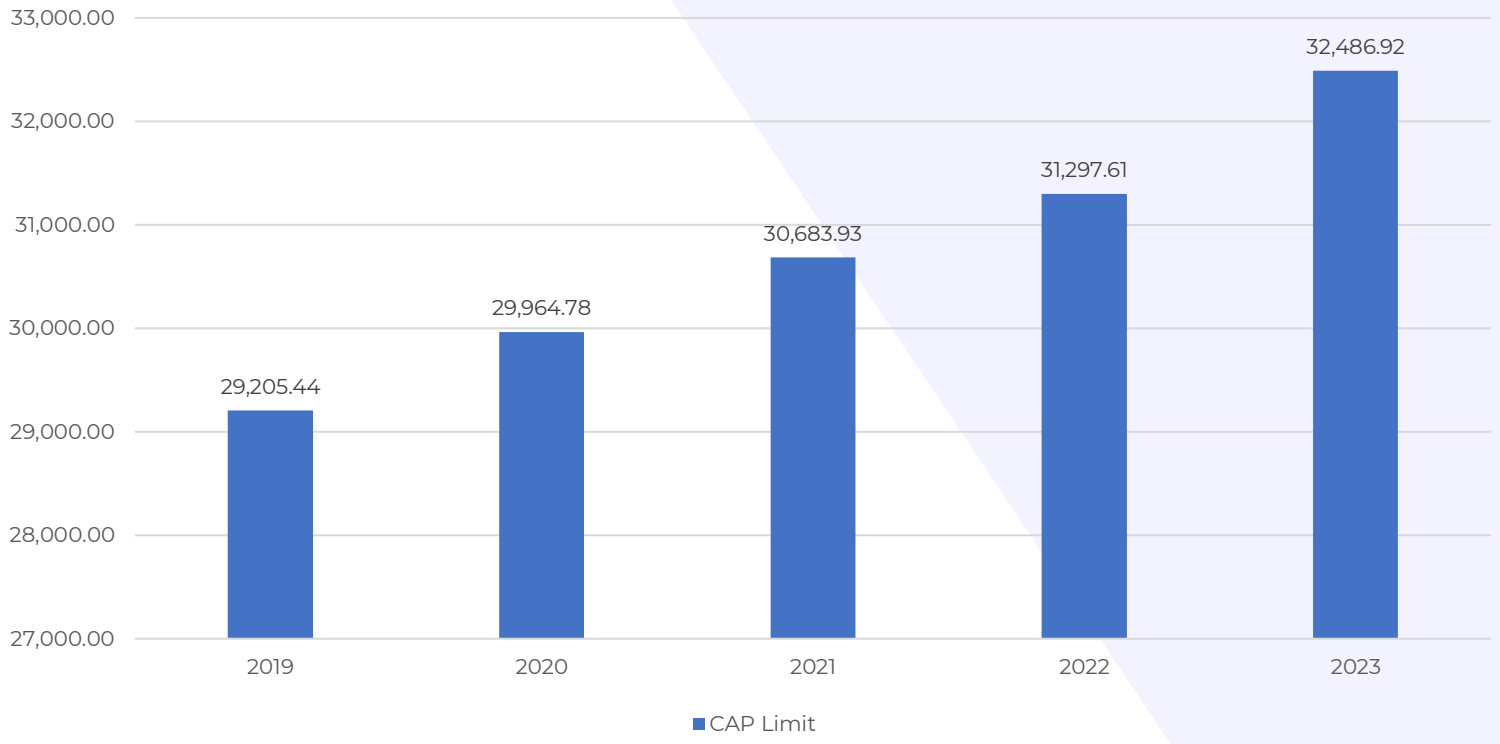
- Due Date
  - The 2023 provider self-determined aggregate cap limitation report is due on February 28, 2024

- CAP Period
  - The cap period is 10/01 through 9/30 for the cap year (i.e., for 2023 cap period, this is 10/01/2022 through 9/30/2023)

- Hospice Beneficiary Count Report –
  - Beneficiary Identification Period for the 2023 cap year the period is 10/01/2022 through 9/30/2023)

- Payments
  - Paid date - use the date of the report run (Current Date).
  - Must be on or after 01/1/2024 to make a valid 2023 report.

Hospice CAP Limits



CAP Monthly Monitoring FY 2024

CAP Monthly Monitoring

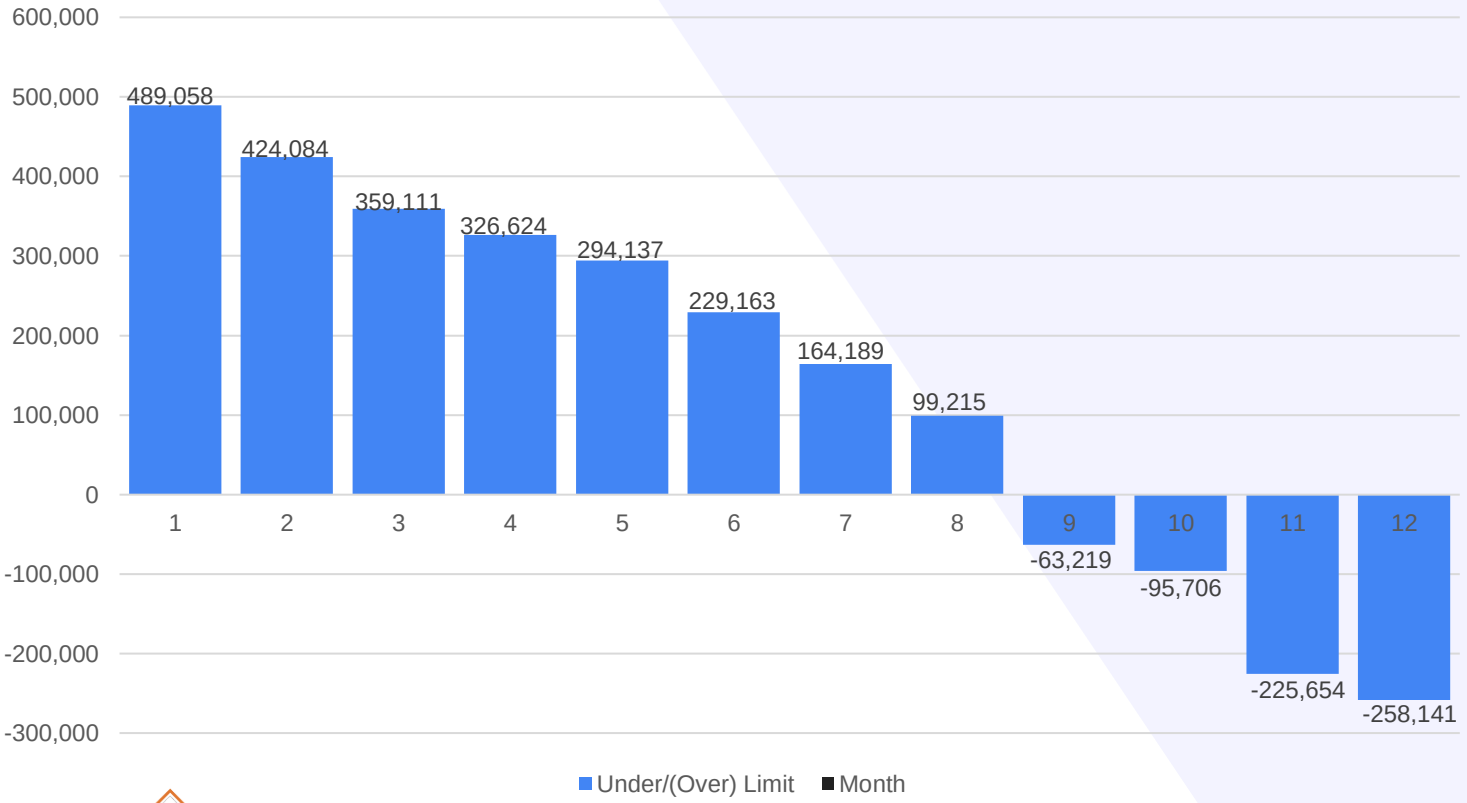
1. CAP Calculation Current Year – Monthly
2. CAP Calculation Prior 3 Look back Years – Monthly
3. Graph of each year - Monthly

ARM Paisley & Elm, LLC Medicare Cost Report Specialist Gateway

CAP Monitoring - Monthly

CAP Monthly Monitoring Report													
FY 2024													
CAP Year	CAP Limit	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2024	33,494												
	Aggregate CAP Amount	1,172,290	1,507,230	1,741,689									
	Beneficiaries	35	45	52									
	Payments	189,000	365,000	595,000									
	Under/(Over) Limit	983,290	1,142,230	1,146,689									
2023	32,487												
	Aggregate CAP Amount	2,339,058	2,274,084	2,209,111	2,176,624	2,144,137	2,079,163	2,014,189	1,949,215	1,786,781	1,754,294	1,624,346	1,591,859
	Beneficiaries	72	70	68	67	66	64	62	60	55	54	50	49
	Payments	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000	1,850,000
	Under/(Over) Limit	489,058	424,084	359,111	326,624	294,137	229,163	164,189	99,215	-63,219	-95,706	-225,654	-258,141

CAP Monthly Monitoring CAP Year 2023



Accounts Receivable FY 2024

Accounts Receivable Analysis

1. Review Accounts Receivable Aging Report – Monthly
2. Calculate the Accounts Receivable Turnover ratio
3. Periodically test a patient through intake/billing/payment
4. Run your Unbilled Report Monthly

Accounts Receivable Aging Report

FY 2024					
Insurance	**0-30 Days**	**31-60 Days**	**61-90 Days**	**Over 90 Days**	**Total Due**
Medicare	68,500	2,500	150	185,300	**256,450**
Medicaid	38,500	93,500	7,500	62,500	**202,000**
Private	42,500	75,200	52,000	63,400	**233,100**
Total	**149,500**	**171,200**	**59,650**	**311,200**	**691,550**
	21.6200%	24.7600%	8.6300%	**45.0000%**	

Accounts Receivable Turnover Ratio

The formula for calculating the Accounts Receivable Turnover Ratio is:

$$\text{Accounts Receivable Turnover Ratio} = \frac{\text{Net Credit Sales}}{\text{Average Accounts Receivable}}$$

An Accounts Receivable Turnover Ratio of 12 would indicate that the receivables are collected in 30 days.

Sales/Average AR = **1,000,000/83,333 = 12 times**

Number of days = **360/12 = 30 days** on average for collections


THANK YOU
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