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OIG Expands Focus on Hospice to Include Claims Paid By Medicaid

The federal government continues its war against hospice providers. In its 2012 work plan, the OIG announced that it will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. In fiscal year 2010, Medicaid payments for hospice services totaled more than $816 million.

The OIG's focus on Medicaid claims should not come as a surprise. For years now, CMS and its alphabet soup of contractors, including ZPIC, MAC, PSC, and RAC contractors, have scrutinized hospice claims for compliance with Federal regulations and coverage guidelines. Many states, including California, routinely partner with these contractors to review claims paid by state programs.

Having successfully appealed several of these contractor's findings, we have learned that hospice audits typically focus on compliance in three areas: (1) does the certification comply with federal regulations; (2) does the patient's condition comply with eligibility coverage guidelines; and (3) was the level of service billed appropriate for the patient. Additionally, it has been our experience that the medical professionals who review these claims typically interpret the Federal regulations and coverage guidelines very narrowly. In other words, they approve coverage for patients who died while on hospice, but routinely deny coverage for patients who are discharged, revoked, or who simply do not decline.

While the OIG and CMS may legally review these claims, we have concerns that auditing hospice claims on a post-payment basis is a practice that is ethically suspect at best, namely because the coverage guidelines have little predicative value to providers when admitting patients. In other words, the deck is stacked against the provider based on the criteria used to review claims.

Academics and medical professionals have criticized the CMS coverage guidelines for years. In a 2010 Journal of American Medical Association study titled *Prediction of 6-Month Survival of Nursing Home Residents With Advanced Dementia Using ADEPT vs Hospice Eligibility Guidelines*, researchers determined that the predictive value of the CMS coverage guidelines for terminal dementia was poor. Out of 606 patients who qualified for the study, only 65 patients strictly met the CMS criteria. However, 111 (18.3%) patients still died within six months despite not meeting the coverage guidelines. Similar studies have reached the same conclusion relating to other diagnoses.

This study demonstrates that a physician's judgment is better at predicting a terminal patient than the coverage guidelines. However, a problem for the provider arises when one of these non-compliant patients does not die while on hospice: the patient's claims become low hanging fruit for CMS to recover in a post-payment review because the patient does not comply with the guidelines. This problem begs the question of whether it is ethical for CMS to pursue these claims using a standard that would exclude coverage to many of the patients who actually died while on hospice.

As hospice providers know: predicting a patient's death is a delicate balance between art and science. However, a medical reviewer makes the same determination using only what is written in the patient's chart and applying it to the criteria in the guidelines. It bears repeating that any aspect of the patient's condition that is not written in the chart did not happen for purposes of a post-payment review.

The most important thing a hospice administrator can do to prepare for a post-payment review is to make sure that a patient chart "paints a picture" of why the patient is appropriate for hospice, especially if the patient does not strictly meet the coverage guidelines. The hospice should also make sure there is as much objective clinical information in the medical records as possible, especially patient weights and oxygen saturations. We have seen countless claims denied due to the fact these clinical indicators were missing.

Hospice is an area that is always scrutinized on review. The level of scrutiny will only continue to increase with the popularity of hospice. Post-payment reviews are no longer a question of "if," but are now a question of "when." Implementing preventative measures now, such as internal chart audits or compliance programs, will pay off

dividends down the road when auditors come knocking on your door.

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