Progressive Corrective Action (PCA)

- Process designed by CMS, ensures a logical, fair methodology utilized for Medicare claim review
- CGS and other MACs are contracted to carry out PCA process
- Review process in detail in *Medicare Program Integrity Manual* (PIM), CMS Publication 100-08
PCA Process Components

- Data foundation for process
- When vulnerabilities are found, **probe edits** done
- Education essential part throughout process
- If significant findings, edit continues
- Can be widespread edit or if provider specific, can result in targeted review

Types of Edits

- Additional Development Requests (ADRs) are requesting the clinical record to support claim payment
- Multiple types of edits
  - Widespread issues
  - Provider specific
  - Beneficiary specific
**Widespread Edits**

- Claims selected by parameters set up in edit
- Widespread probe edits first completed
  - 100 claims
  - Providers notified of results via CGS Medicare Bulletin, listserv email and website

**PAST, Present, Future**

- Prior to 2012, the level of review for hospices was less than 1%
- In July of 2012, CGS announced a new widespread edit was initiated, after a probe found a high incidence of errors
- A much greater (unpublished) percentage of claims pulled for “5101T”
  - 6 months LOS with Dx of debility (799.3), Alzheimer’s (331) or COPD (496)
- Discontinued January 2013
HOSPICE WIDESPREAD EDITS

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5037T</td>
<td>This edit selects hospice claims with revenue code 0651 (Routine) and a length of stay of greater than 730 days.</td>
</tr>
<tr>
<td>5048T</td>
<td>This edit selects hospice claims based on a length of stay of 999 days.</td>
</tr>
<tr>
<td>5057T</td>
<td>This edit selects hospice claims with revenue code 0656 (General Inpatient Services [GIP]) with at least seven or more days in a billing period.</td>
</tr>
<tr>
<td>5091T</td>
<td>This edit selects hospice claims with HCPC codes Q5003 (Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)) and Q5004 (Hospice care provided in skilled nursing facility (SNF)), primary diagnosis of 799.3 (Debility, unspecified) and a length of stay greater than 180 days.</td>
</tr>
<tr>
<td>59BX9</td>
<td>This edit selects hospice claims due to previous denials for selected beneficiary.</td>
</tr>
</tbody>
</table>

Future of Medical Review

- Length of stay will continue to be reviewed
- Diagnoses related to debility or failure to thrive will be returned to provider for further details
  - Additional secondary diagnoses will provide more detail
- LCDs will need updated
Future… Other Audits

• Some insights from OIG reports
  – GIP
  – Relationships with Nursing Facilities
  – OIG pushes for increased oversight by State Agency (DIA)
    • 41% of Iowa Hospices have not had a survey in last six years
• RACs… 2014 new contractor just for us!? 

Provider Specific

• Referrals for provider specific edit primarily through data analysis
• Provider notified of probe edit - 20-40 claims
• Provider notified of results
  – Going off of review
  – Moving to targeted review
• Targeted review edits are reviewed quarterly
**Beneficiary Specific**

- Primarily as a result of a medical review denial
  - Reviewer sees vulnerability for next claim
  - Ongoing services
  - Removed when a claim is paid by Medical Review or the first level of appeal

**ADRs? How Do I Know?!**

- FISS will suspend claim selected in status/location “S B6001”
  - "Additional Development Request" (ADR) message generated in FISS
  - Providers should be monitoring for claims in S B6001 on a weekly basis

- **Resource**: CGS “Additional Development Request (ADR) Process” webpage
An ADR - What Now?

– Gather documentation to support services billed for timeframe requested
  • Use list of requested items found on claim page 08 as checklist
  • May include documentation from dates before and after those requested

– **Recommendation:** Clinician review, prior to sending
– Providers may include outline, or letter, but not considered actual documentation

Medical Review Standards

– CMS Medicare Benefit Policy Manual (CMS Publication 100-02)
  • Chapter 9 - Hospice

– CGS “Hospice Coverage Guidelines” webpage

– Hospice Local Coverage Determination: “Determining Terminal Status”
    – Click on “Hospice Determining Terminal Status”
Essentials for Payment

- Physician visits
- Non-Routine care supported?
- POC Updated every 15 days
- Disease Acuity or Trajectory supports terminal 6 month prognosis
- Technical Components: Certification/FTF if 3rd or later benefit period
- Valid Election Statement with Effective Date

On the Same Page?

- Provide staff with the rules - Information is Power!!
- Guide decisions and empower clinicians with coverage criteria
- Education on coverage and documentation standards
- Oversight of documentation
- Ensure the technical pieces are covered
# Top CGS Hospice Denials

<table>
<thead>
<tr>
<th>Denial Codes</th>
<th>Description</th>
<th># denials 2nd Quarter 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 5PTER</td>
<td>Six-month terminal prognosis not supported</td>
<td>1106</td>
</tr>
<tr>
<td>2 5PCER</td>
<td>Missing, incomplete, untimely certification/recertification</td>
<td>240</td>
</tr>
<tr>
<td>3 5PPOC</td>
<td>Plan of care requirements not met</td>
<td>180</td>
</tr>
<tr>
<td>4 5PNOE</td>
<td>Election statement incomplete/untimely</td>
<td>130</td>
</tr>
<tr>
<td>5 5PRLM</td>
<td>Reduced level of care (medical necessity)</td>
<td>124</td>
</tr>
</tbody>
</table>

#1: 5PTER - Prognosis

- Reliant upon documentation
  - If error - research - is it the patient or the documentation?
- Full denial
- Use the Local Coverage Determination (LCD) to assist with coverage decisions and documentation
  - [http://www.cgsmedicare.com/hhh/coverage/](http://www.cgsmedicare.com/hhh/coverage/)
Documentation to Support

• http://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/5C.html

Documentation To Support

– Obtain history and physical information
– Use functional scale
  • Karnofsky Performance Scale
  • Palliative Performance Scale
– Use the POC & IDG reviews of the POC
– Obtain physician written documentation of the patient’s course of illness
– Include physician contacts with patient/hospice staff
– Show the severity, or the trajectory of the disease
– Remember quality versus quantity
Local Coverage Decision

- The Local Coverage Decision (LCD) is meant to provide guidelines to both the medical community and CMS contractors [SSA section 1862 (a)(1)(A)]
  - Know & use on a routine basis
- Hospice – Determining Terminal Status

Hospice LCD: Determining Terminal Status

- Consists of 3 parts plus an appendix
  - **Part I**: Decline
  - **Part II**: General Guidelines (to be used as gateway to diseases in appendix)
  - **Part III**: Co-morbidities
  - **Appendix**: Specific disease processes, including cardiac, Alzheimers, Pulmonary disease, etc.
- Allows client’s clinical decline to be a *component* of terminal prognosis
#2: 5PCER - Certification

- Ensure signed and DATED by physician
  - Both attending and medical director on initial benefit (if attending designated)
- Ensure narrative tells story, with symptoms, progression to support prognosis
  - Narrative must be completed/dated/signed prior to billing
- Certification obtained within two days
  - Can be verbal, must be dated
  - All must be signed/dated prior to billing

#3: 5PPOC – POC Updates

- Condition of Participation and payment
- Documentation must include POC
  - Roadmap to care
- Documentation must show updates by IDG at minimum every 15 days
  - Signatures of core IDG on update OR
  - Minutes of IDG when updates made and core IDG members noted (or signed in) as present
  - Any documentation to show core involvement
#4: Election Statement

- Must contain:
  - Name of hospice with whom electing
  - Palliative vs Curative model understanding
  - Waiving of traditional Medicare for terminal conditions
  - Effective date
  - Signature
#5: 5PLRM - GIP Not Supported

- Partial denial - as the terminal prognosis is supported, just not the level of care
  - All or some of the days billed at higher level of care have been reduced to “Routine”
- “Short term,” for management of s/s that can not be controlled in another setting
  - Can be helpful to show what has been tried prior

<table>
<thead>
<tr>
<th>Appeal Level</th>
<th>Name of Appeal Level</th>
<th>Decision Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Redetermination</td>
<td>120 days to file, Decision in 60 days</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Reconsideration</td>
<td>180 days to file, Decision in 60 days</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>ALJ Hearing</td>
<td>60 days to file, Decision in 90 days</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Appeals Council Review</td>
<td>60 days to file, Decision in 90 days</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Final Judicial Review</td>
<td>60 days to file</td>
</tr>
</tbody>
</table>
• First level of appeal for any CMS audit is sent to your MAC

• 120 days from original denial for Medical Review
  – Form found at:
Qualified Independent Contractor

Reconsideration = Second level of appeal

180 days to appeal after redetermination denial


- Two regions - both “Maximus”
  - [www.maximus.com](http://www.maximus.com)
ALJ Hearing

- Administrative Law Judge
- Third level of appeal, after the appeal to the contractor (redetermination) and the QIC (reconsideration)
- Request must be within 60 days of reconsideration’s decision
- No additional documentation at this level
Tools to Avoid Audits…

Benchmarking: A Tool to Avoid Audit

- What is your average LOS? Median LOS?
- What is your average GIP utilization?
- Do you have any outstanding diagnoses?
- What percentage of the patients you serve reside in a NF or SNF?

- Use benchmarking vendors and your Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER)

- Reports
- [www.PEPPERresources.org](http://www.PEPPERresources.org)
**Internal Audits and Education**

- See ADR Audit tool- ensure all components are there prior to an ADR
- If ADRs are received- use this tool to ensure medical record is complete prior to sending
- Use the LCD!

**How Can You Use LCD?**

- Provides guidelines for decisions on coverage
  - Admissions
  - Re-certifications/ongoing care
- Provides consistency in documentation
  - Updated Prognosis Worksheets
- Educational for identifying hospice-eligible patients = Referral sources
- IDG Format
Debility and Failure to Thrive

- “Clarification” was published re: the use of Debility, Adult Failure to Thrive
- CMS instructed not to use these as a primary diagnosis
- CMS will be “RTP”ing (return to provider) claims with these diagnoses as primary conditions 10/1/2014
- CMS clarified again the expectation to consider and include all diagnoses that are contributing to the terminal prognosis (and responsibility)

Debility and Failure to Thrive

- Agencies should not be using Debility or Adult FTT on new admits, and have a plan to be ensure all patients have a more specific diagnosis as a primary dx
- Do not use these upon new admissions
- Use IDG for recertification (or sooner) to identify an appropriate primary diagnosis
**Dementias**

- Avoid using 290.x-294.x, or any of the dementias that state “Code the underlying diagnosis” as a primary
  - May use as a secondary/related
- Use instead those dementias from the Neuro chapter

**Hospice Supportive V Codes**

- V66.7 Encounter for palliative care
  -- End-of-life care
  -- Hospice care
  -- Terminal care
- V49.86 Do Not Resuscitate status
- V49.84 Bed Confinement status
- V45.87 Transplanted organ removal status
- V49.83 Awaiting Transplant
- V46.3 Wheelchair dependence
- BUT NOT AS PRIMARY!
Questions?
Thank you!!
ADR Checklist for Hospice Agency Review

____ Written summary/highlights of eligibility/hospice care (optional, best practice)

____ Election statement
   (Includes name of agency, knowledge of the hospice benefit- palliative
   versus curative model, understanding of waiving traditional Medicare for
   terminal disease and related conditions, and patient’s signature/date)

____ Certifications covering all dates of service requested (NOTE: May be outside
   these DOS!)
   Must be obtained no later than 2 days after benefit period-may be verbal
   Must have narrative and attestation. Signed/dated by physician before final bill
   Check for stamped signatures (not acceptable) and if legible per CR6698
   (Initial certification includes attending physician and medical director)

____ Face to Face for all 60-day certifications

____ Plan of Care proof of updates every 15 days by IDG

____ IDG notes

____ Visit notes for all IDG members and additional supportive services
   (Must have visit notes for each visit on bill, and legible signatures)

____ Notes from contracted services, such as GIP contracted facility

____ Physician visit notes
   (Must be present if billing physician visit on hospice bill, but otherwise
   can also be helpful in supporting eligibility for hospice care)

____ Other supportive documentation, such as:
   H&P, hospital or facility discharge notes, information from the patient
   history- during or prior to hospice, and most recent documentation that
   may be after the dates of service selected for ADR

____ Clinician reviewed ADR information

Does the documentation answer the questions:
- Why hospice/why hospice now? Does it appear this patient has a less than six-
  month prognosis? (Generally basing on LCD)
- Why GIP or CHC? Does the documentation support the need for this intensity of
  service?