Tools for Medicare Success

2019 Hospice Workshop Series

Presented by Palmetto GBA Provider Outreach and Education

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Disclaimer

The information provided in this handout was current as of January 31, 2019. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after January 31, 2019, posted at www.PalmettoGBA.com/hhh.

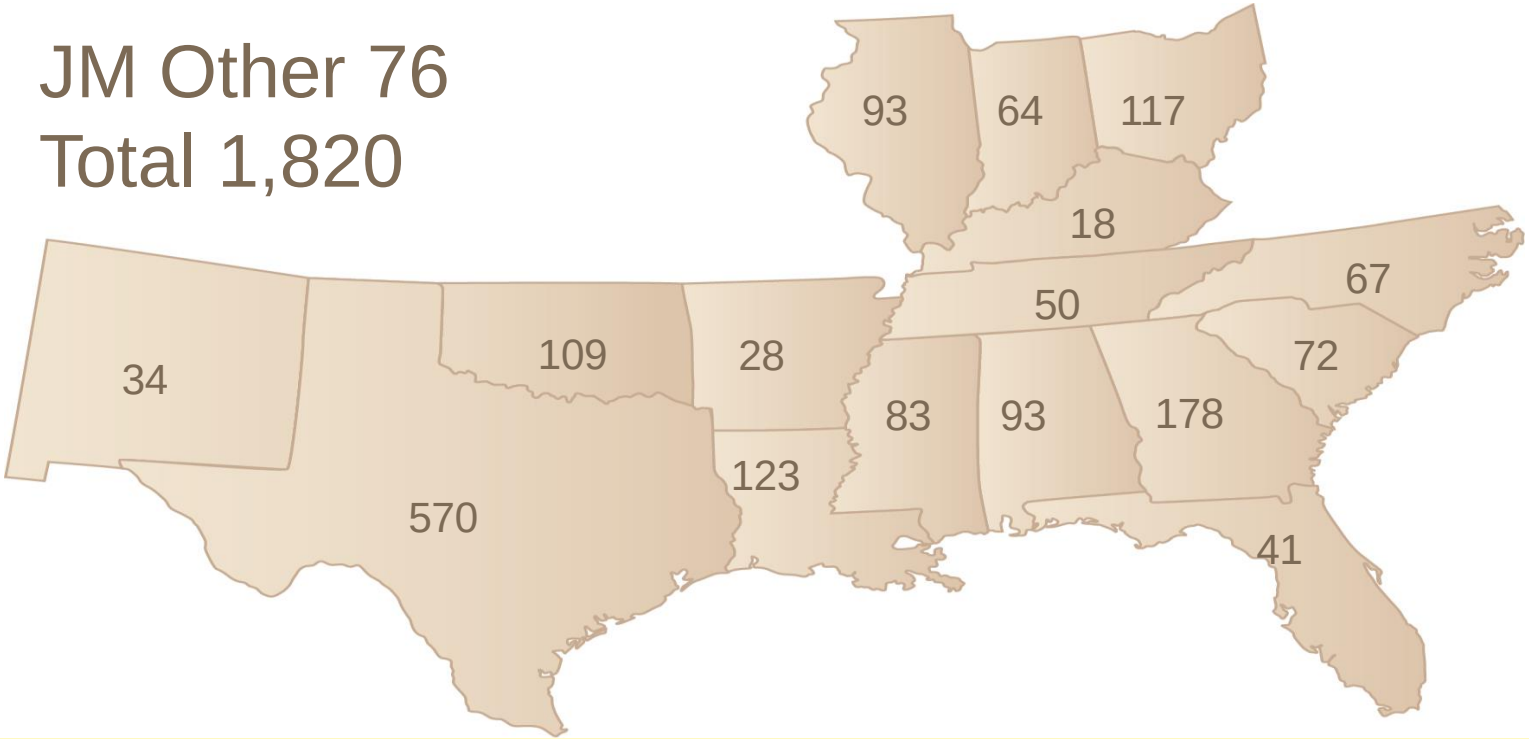
Part One Agenda

- Utilization
  - Length of Stay
  - Medicare Spending
- Improper Payments
- Continuous Home Care (CHC)
- Effective Documentation of Certification of Terminal Illness
- Documentation for the End Stage Renal Disease Patient

Hospice Utilization

Number of Hospice Providers (81X) — September 2018

JM Other 76
Total 1,820



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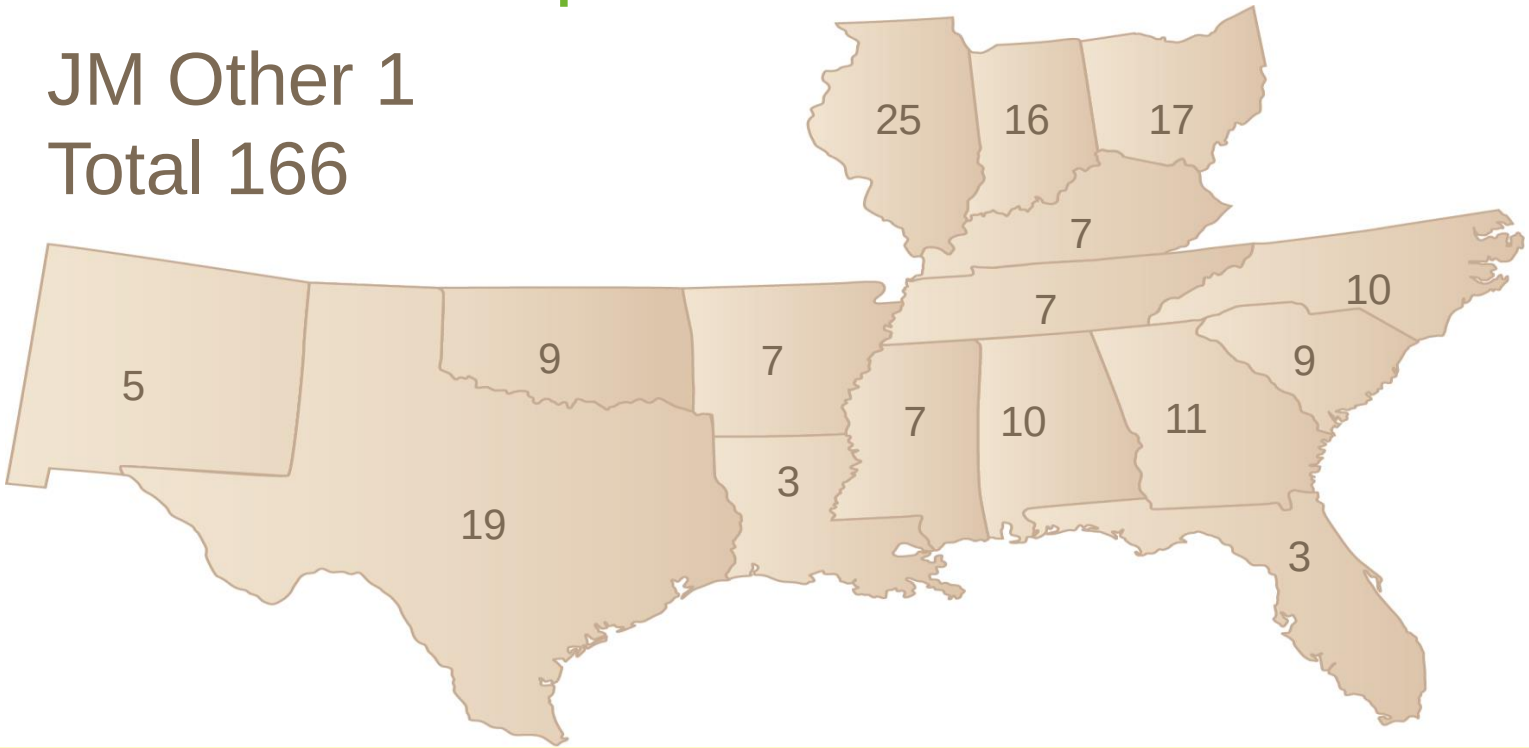
Number of Hospice Providers (82X) — September 2018

JM Other 1
Total 166



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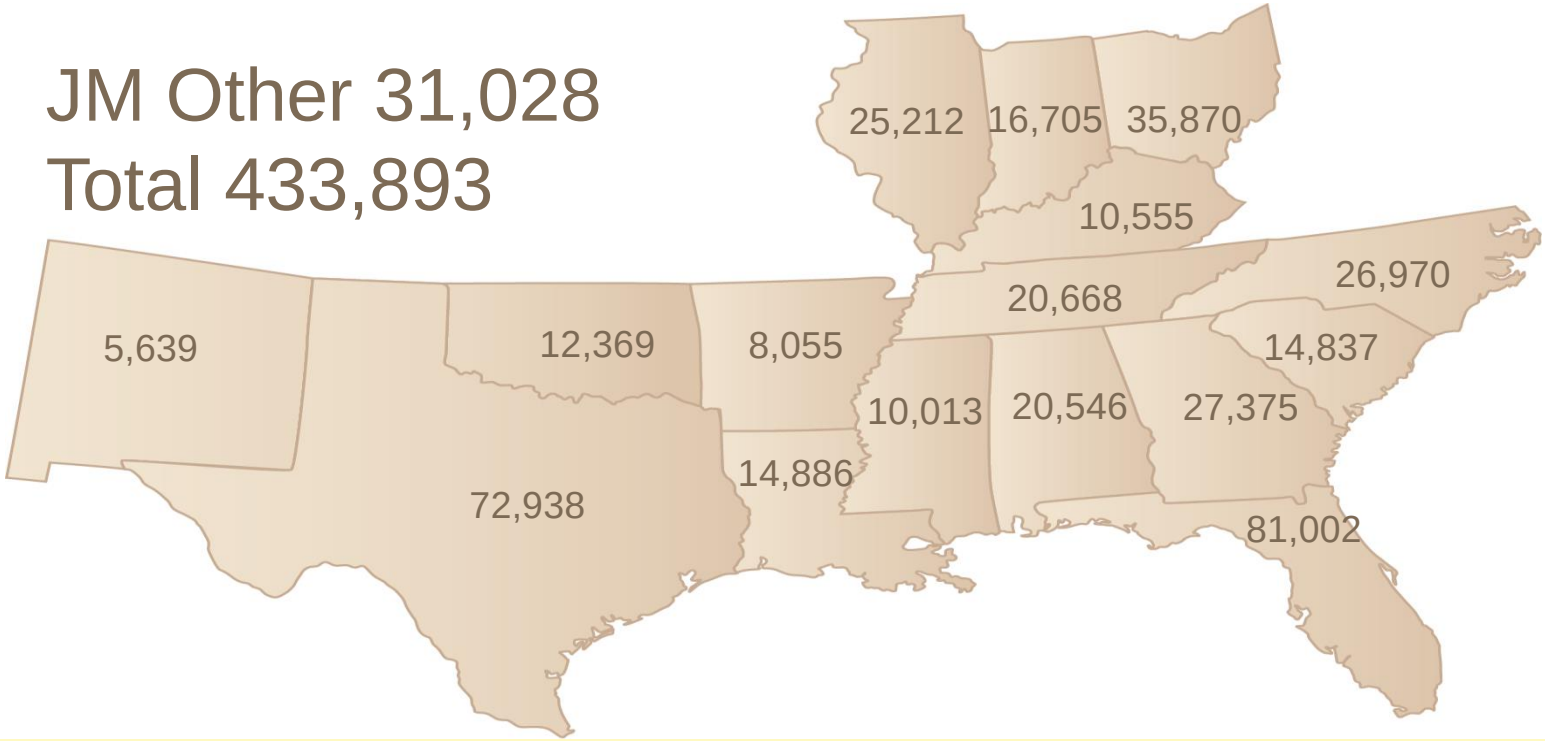
Number of Hospice Beneficiaries (81X) — September 2018

JM Other 31,028
Total 433,893



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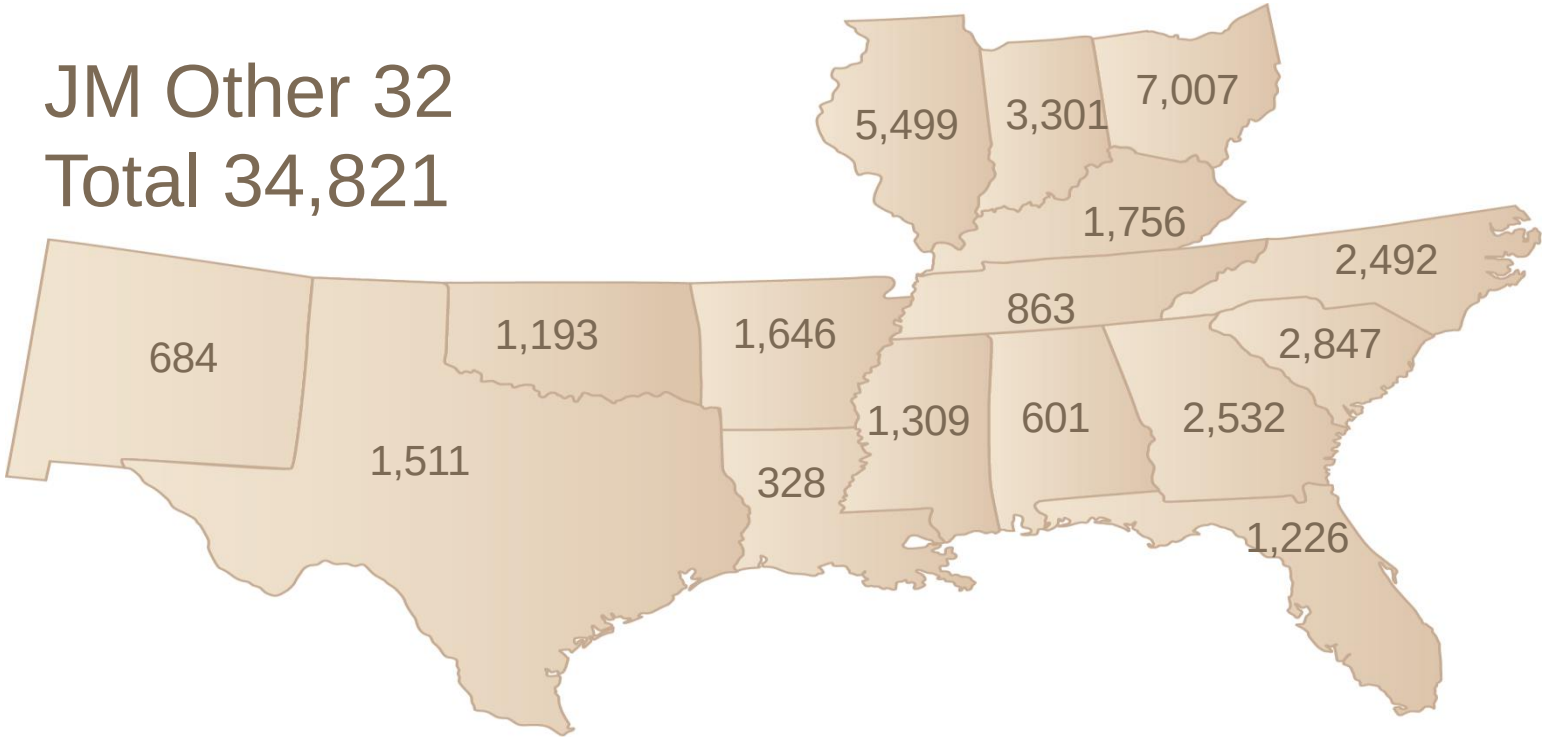
Number of Hospice Beneficiaries (82X) — September 2018



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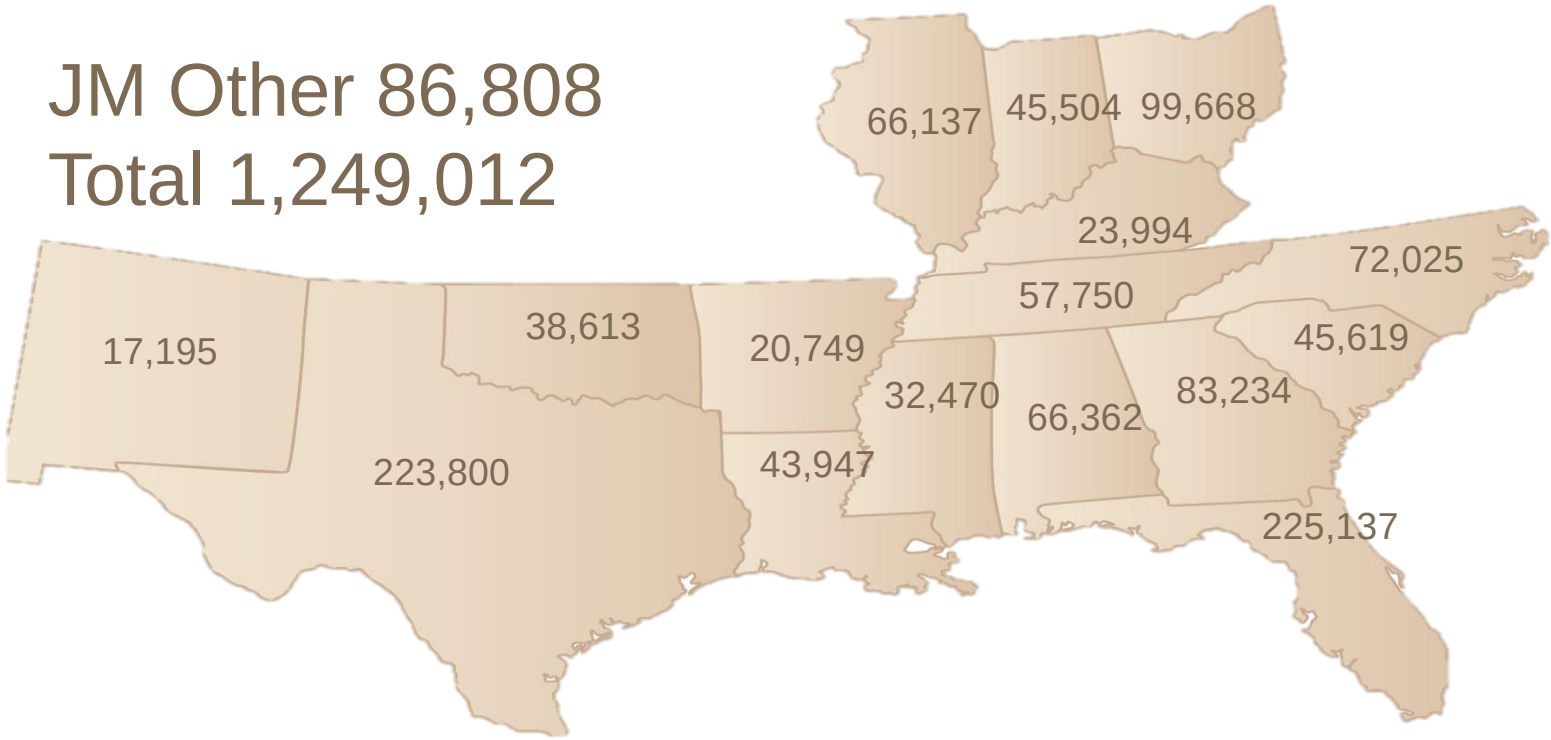
Number of Claims (81X) — September 2018



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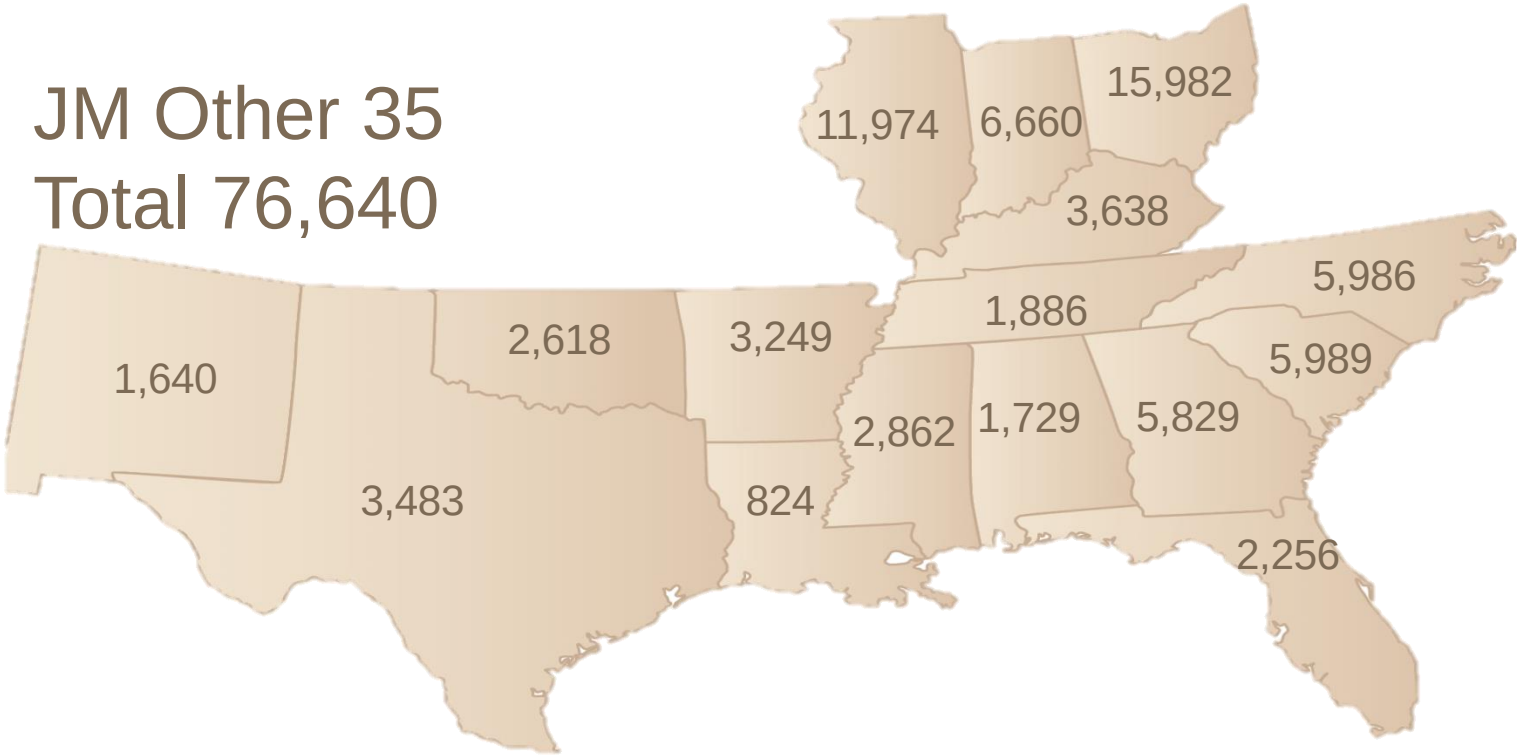
Number of Claims (82X) — September 2018



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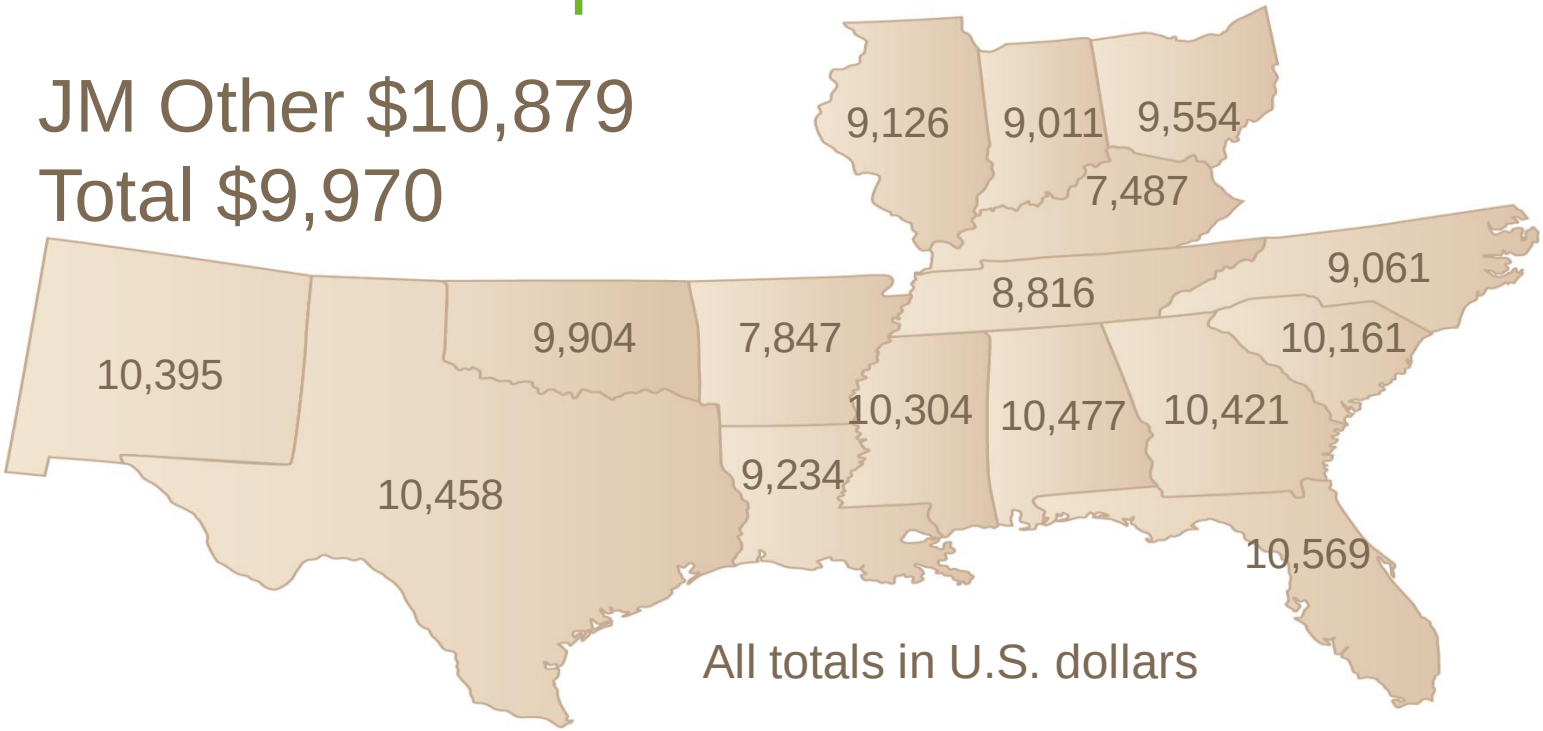
Disbursement Per Beneficiary (81X) — September 2018

JM Other $10,879
Total $9,970



All totals in U.S. dollars

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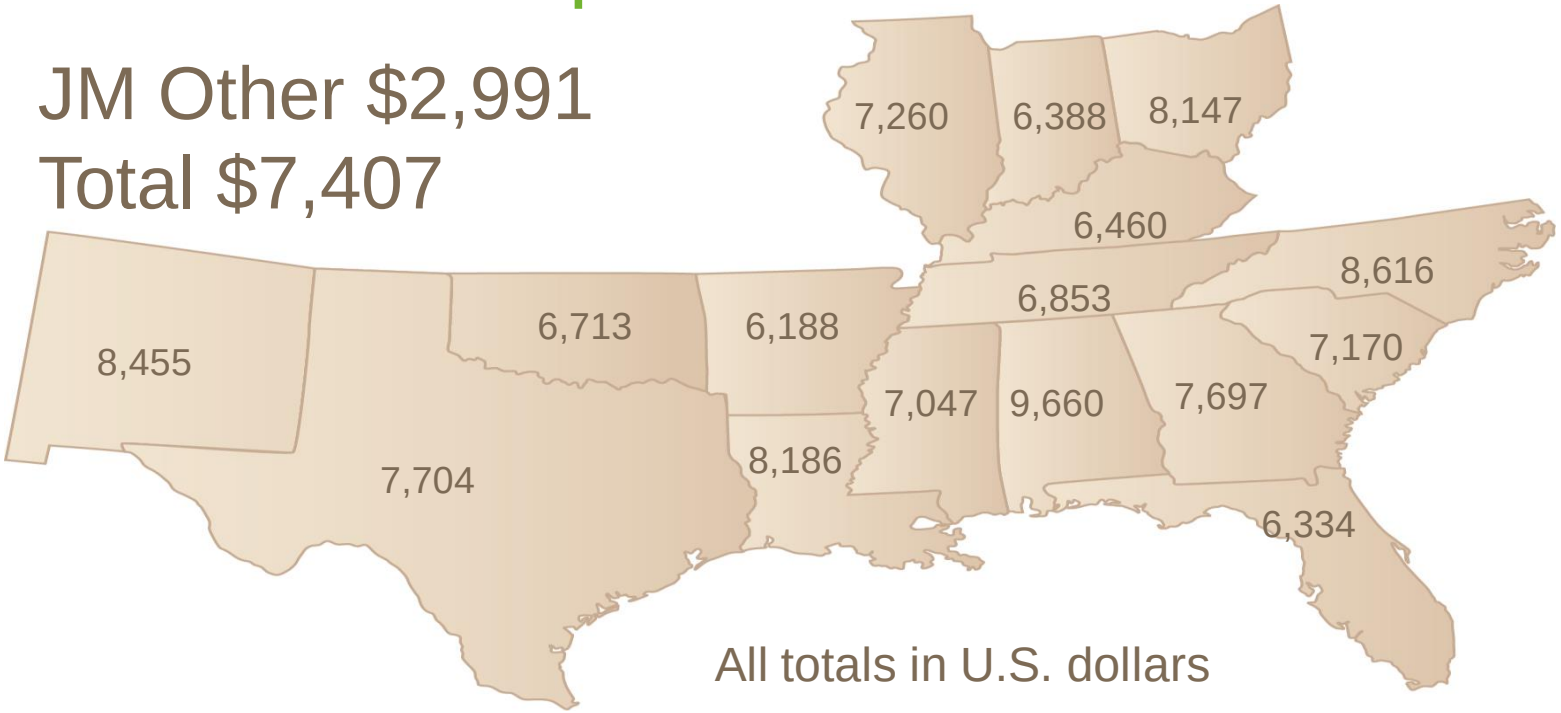
Disbursement Per Beneficiary (82X) — September 2018

JM Other $2,991
Total $7,407



All totals in U.S. dollars

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Medicare Hospice Use and Spending by State Aggregate

State	Providers	Hospice Beneficiaries	Total Days	Total Medicare Payment Amount	Percent Routine Home Care Days	Physician Services
AL	112	29,089	2,693,948	$376,557,946.59	99%	5,093
AR	50	15,541	928,611	$143,799,903.38	96%	21,612
FL	43	120,296	8,419,346	$1,540,827,150.80	94%	317,281
GA	197	44,402	3,703,167	$579,586,187.26	97%	31,772
IL	123	49,539	2,827,983	$480,316,529.54	97%	33,816
IN	88	30,910	2,015,689	$316,108,922.11	98%	5,891
KY	24	16,915	822,243	$132,927,160.36	96%	22,715
LA	136	22,262	1,784,459	$261,039,533.17	98%	15,284
MS	98	15,326	1,316,479	$189,131,046.05	98%	3,117
NC	78	45,614	3,048,701	$488,759,093.63	96%	79,259
NM	38	8,853	708,017	$111,644,577.23	99%	6,851
OH	140	67,154	4,693,627	$762,286,175.05	97%	66,934
OK	126	20,252	1,682,382	$237,440,544.73	99%	3,945
SC	94	27,620	2,434,304	$368,220,479.05	98%	16,487
TN	57	29,517	1,957,021	$288,114,397.56	98%	13,277
TX	493	106,405	9,054,276	$1,402,163,192.90	98%	60,118
Total	1,897	649,695	48,090,253	$7,678,922,839.41		703,452

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/Downloads/HOSPICE16.pdf

Medicare Hospice Use and Spending by State Aggregate

State	Percent of Deaths in Hospice	Total Live Discharges	Hospice Beneficiaries with 7 or Fewer Hospice Care Days	Hospice Beneficiaries with More than 60 Hospice Care Days	Hospice Beneficiaries with More than 180 Hospice Care Days
AL	44%	5,101	5,591	12,595	5,438
AR	46%	1,432	5,017	4,287	1,666
FL	56%	11,302	36,742	38,497	16,399
GA	49%	6,464	10,861	17,279	7,376
IL	45%	3,677	16,063	13,215	4,949
IN	46%	2,799	9,273	9,569	3,680
KY	37%	1,153	5,363	4,057	1,199
LA	47%	2,563	5,181	8,123	3,503
MS	39%	2,587	3,370	6,138	2,678
NC	47%	3,986	12,248	14,415	5,579
NM	45%	1,009	2,203	3,290	1,401
OH	54%	5,439	19,275	21,750	9,016
OK	45%	2,603	4,642	7,873	3,293
SC	48%	5,198	6,165	11,992	4,768
TN	42%	2,296	7,984	9,087	3,544
TX	50%	12,831	26,931	40,965	18,655

Medicare Hospice Use and Spending by State Aggregate

State	Home Visit Hours per Day During Week Prior to Death	Skilled Nursing Visit Hours per Day During Week Prior to Death	Social Service Visit Hours per Day During Week Prior to Death
AL	0.36	0.99	0.07
AR	0.57	0.99	0.07
FL	0.92	3.76	0.13
GA	0.54	1.13	0.08
IL	0.43	1.1	0.11
IN	0.34	0.9	0.08
KY	0.48	0.98	0.1
LA	0.3	0.74	0.07
MS	0.41	0.76	0.07
NC	0.52	0.98	0.1
NM	0.31	0.75	0.09
OH	0.79	2.03	0.11
OK	0.35	1.01	0.08
SC	0.51	1.01	0.09
TN	0.35	0.86	0.08
TX	0.42	1.68	0.09

Medicare Hospice Use and Spending by State Aggregate

State	Hospice Beneficiaries with a Primary Diagnosis of Cancer	Hospice Beneficiaries with a Primary Diagnosis of Dementia	Hospice Beneficiaries with a Primary Diagnosis of Stroke
AL	7,189	5,708	2,948
AR	4,509	2,848	1,384
FL	33,317	18,279	16,686
GA	11,783	9,695	4,079
IL	14,922	8,682	5,403
IN	8,726	5,219	2,565
KY	6,102	2,523	1,168
LA	6,257	4,413	2,210
MS	4,212	3,053	1,304
NC	13,558	8,048	4,412
NM	2,437	1,323	895
OH	17,926	11,374	7,357
OK	5,397	3,703	1,613
SC	7,122	6,315	2,485
TN	9,070	5,309	2,419
TX	26,691	24,673	10,328
Total	182,902	123,634	68,409

Medicare Hospice Use and Spending by State Aggregate

State	Hospice Beneficiaries with a Primary Diagnosis of Circulatory/Heart Disease	Hospice Beneficiaries with a Primary Diagnosis of Respiratory Disease	Hospice Beneficiaries with Other Primary Diagnoses
AL	7,691	4,142	3,258
AR	2,565	2,210	2,417
FL	22,815	13,691	18,466
GA	8,869	6,351	6,425
IL	8,412	5,062	8,075
IN	6,271	3,977	5,050
KY	2,578	2,308	2,421
LA	4,440	2,534	3,413
MS	3,537	1,976	1,980
NC	7,676	5,638	7,207
NM	1,728	1,191	1,607
OH	12,658	8,091	11,407
OK	4,670	2,619	3,178
SC	5,587	3,890	4,346
TN	5,298	3,937	4,093
TX	21,461	12,487	16,007
Total	129,183	81,826	101,866

Medicare Hospice Use and Spending by State Aggregate

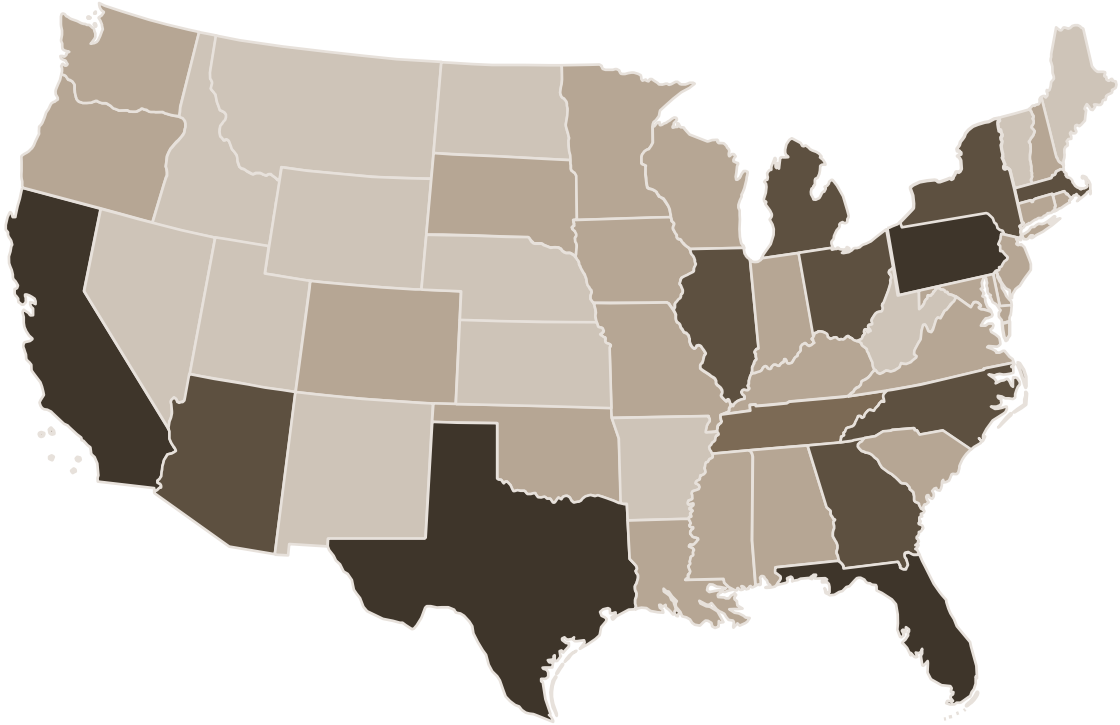
State	Site-of-Service — Home Hospice Beneficiaries	Site-of-Service — Assisted Living Facility Hospice Beneficiaries	Site-of-Service — Long Term Care or Non-Skilled Nursing Facility Hospice Beneficiaries
AL	22,672	617	3,398
AR	7,319	316	3,880
FL	56,062	15,366	14,608
GA	27,063	4,808	3,814
IL	22,265	3,555	12,028
IN	14,515	2,021	7,938
KY	9,833	334	2,891
LA	13,868	725	4,827
MS	9,910	953	1,878
NC	23,515	5,056	3,458
NM	5,758	1,127	575
OH	28,217	5,948	17,731
OK	10,774	1,627	6,519
SC	17,758	2,844	2,455
TN	17,303	1,869	5,962
TX	56,854	10,658	24,637
Total	349,612	59,458	121,470

Medicare Hospice Use and Spending by State Aggregate

State	Site-of-Service — Skilled Nursing Facility Hospice Beneficiaries	Site-of-Service — Inpatient Hospital Hospice Beneficiaries	Site-of-Service — Inpatient Hospice Beneficiaries	Site-of-Service — Other Facility Hospice Beneficiaries
AL	1,817	1,507	866	59
AR	106	1,187	2,869	255
FL	1,505	6,497	28,592	623
GA	2,526	2,297	6,233	460
IL	3,476	4,743	4,257	231
IN	2,228	2,929	2,046	131
KY	179	1,386	2,412	65
LA	877	1,152	1,738	80
MS	874	1,193	1,001	253
NC	3,968	1,725	8,093	724
NM	414	197	949	160
OH	3,428	3,582	9,345	560
OK	643	886	611	120
SC	1,996	1,357	3,130	205
TN	322	2,179	1,742	748
TX	4,473	6,155	7,983	883
Total	29,355	39,159	83,002	5,752

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/Downloads/HOSPICE16.pdf

Total Persons Served by Hospice Trend 2016



1,080-15,580

16,040-33,280

35,340-68,580

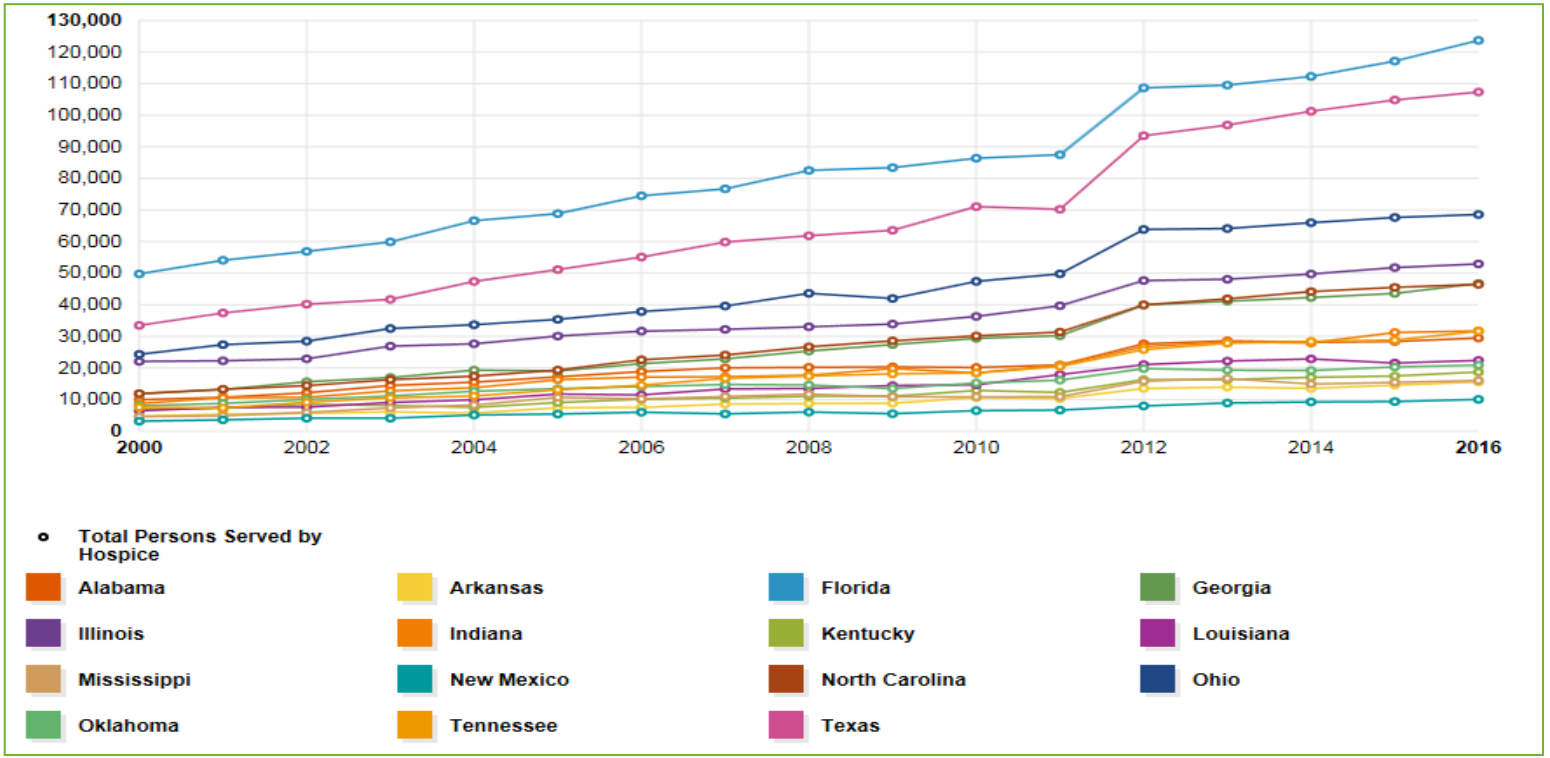
69,760-136,960

Kaiser Family Foundation analysis of a five percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2000-2016

Total Persons Served by Hospice

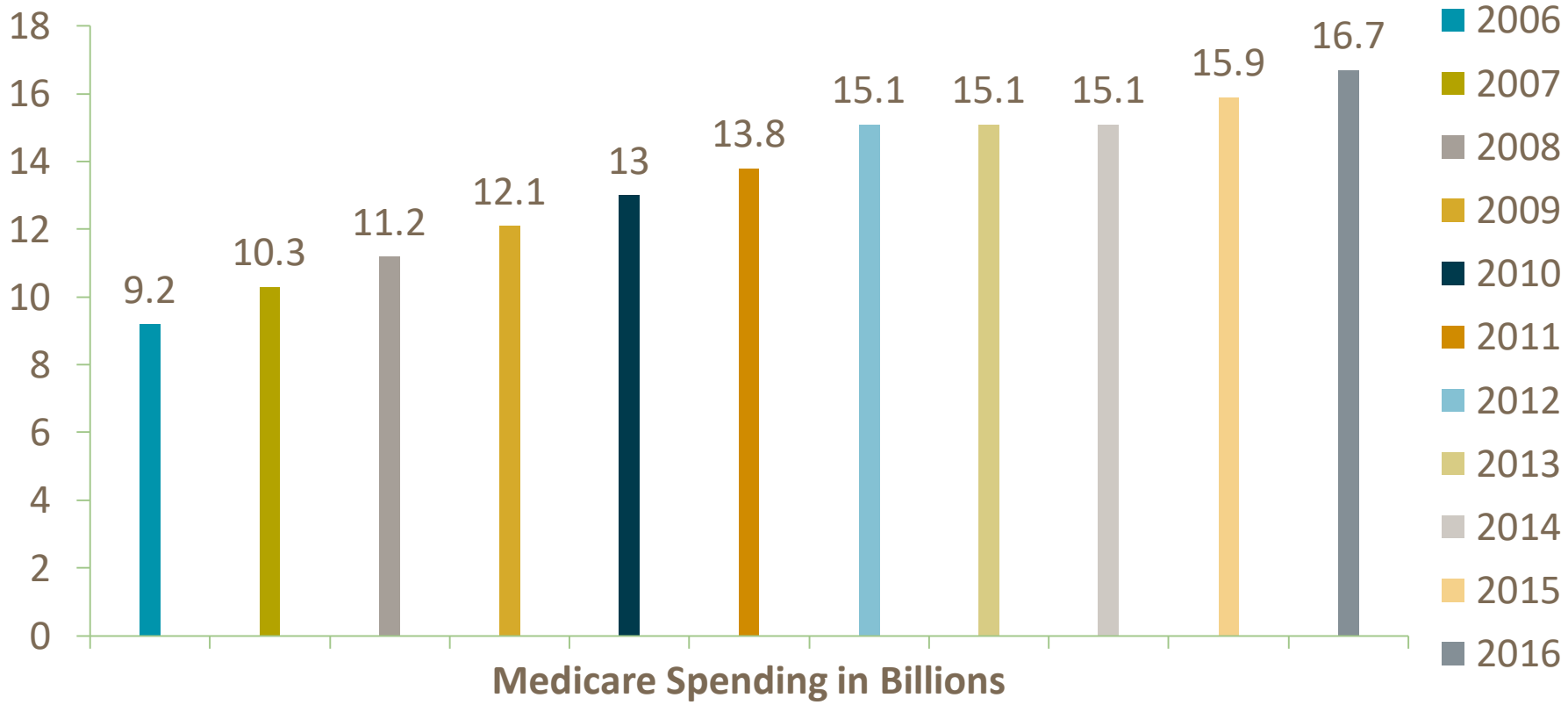
Location	Total Persons Served	Hospice Covered Days
Alabama	29,480	2,761,500
Arkansas	15,580	970,080
Florida	123,700	8,656,300
Georgia	46,760	3,843,640
Illinois	52,940	3,186,140
Indiana	31,740	2,197,780
Kentucky	18,720	839,280
Louisiana	22,400	2,023,160
Mississippi	16,040	1,380,320
New Mexico	10,060	828,160
North Carolina	46,460	3,333,100
Ohio	68,580	4,633,040
Oklahoma	20,920	1,654,940
Tennessee	31,640	2,083,460
Texas	107,360	9,238,500
Total	642,380	47,629,400

Total Persons Served by Hospice 2000-2016



Kaiser Family Foundation analysis of a five percent sample of Medicare claims from the CMS Chronic Condition Data Warehouse, 2000-2016

Hospice Payment Growth



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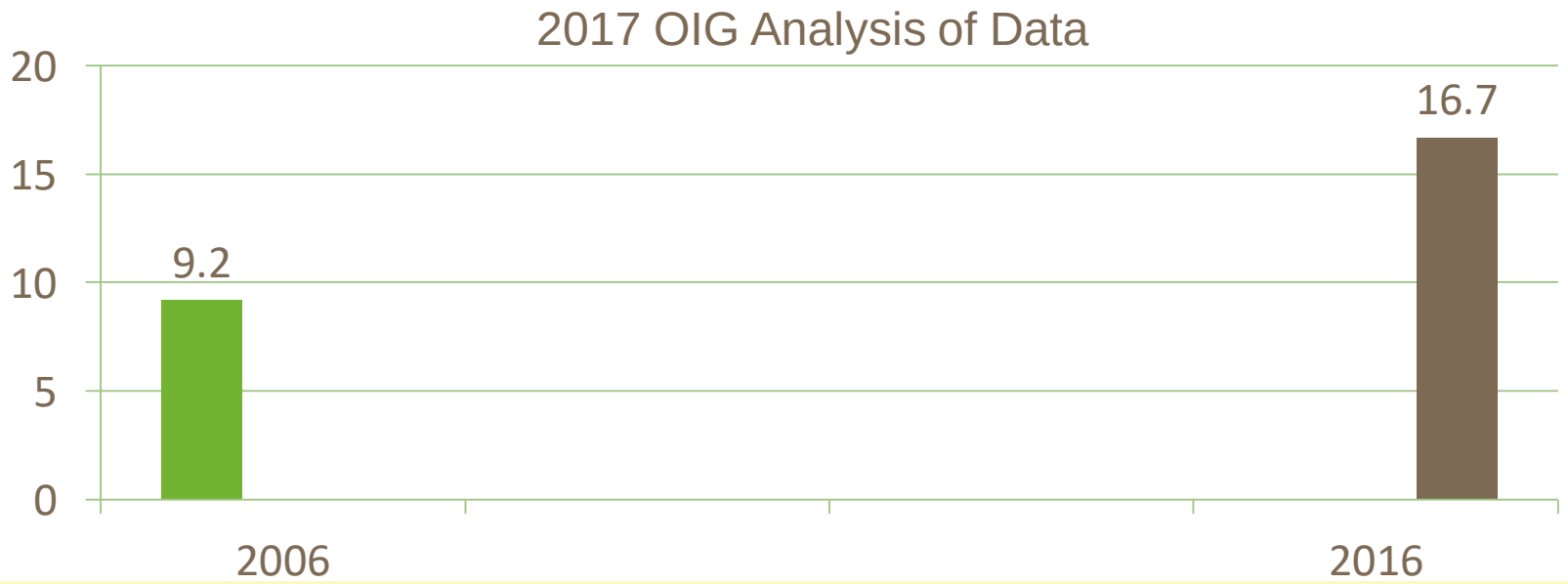
Increased Utilization

- Medicare paid $16.7 billion for hospice care in 2016, an increase of 81 percent since 2006
- About 1.4 million beneficiaries received hospice care in 2016, an increase of 53 percent since 2006
- Increases in hospice care were greater than increases in Medicare spending and enrollment in general
- From 2006 to 2016, total Medicare spending grew 66 percent, while the total number of Medicare beneficiaries grew 32 percent

Increase in Spending

Medicare spending for hospice care increased 81 percent since 2006
(in billions)



Number of Hospices Increased 43 Percent

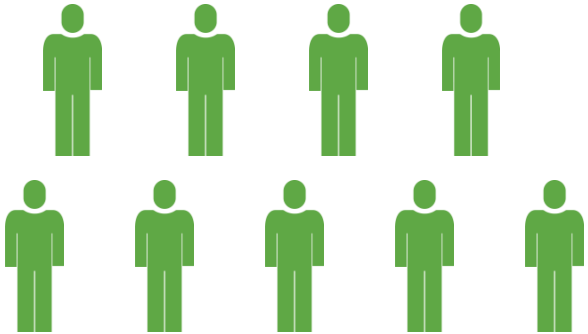
2006 — 3,062

2016 — 4,374

2017 OIG Analysis of Data

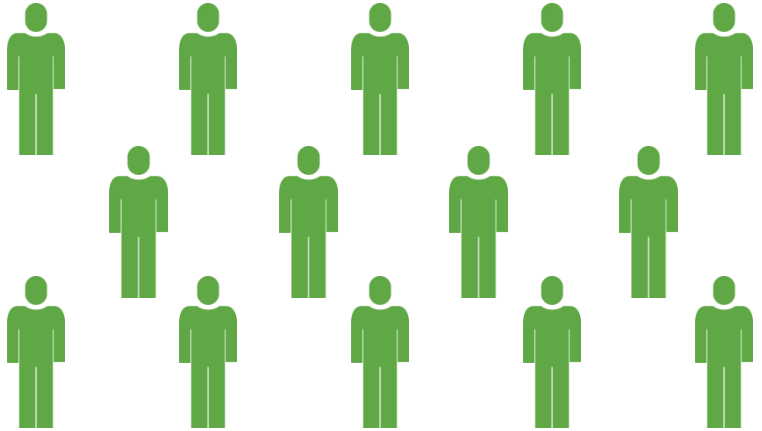
Number Beneficiaries Increased 53 Percent

2006 — 930,000



2017 OIG Analysis of Data

2016 — 1.4 million



Improper Payments

Report from the OIG totals over 10 years of hospice research into three categories

- Inadequate care
- Inappropriate billing
- Outright fraud

Types of Improper Payments

Fraud

Medicare **fraud** typically includes any of the following

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services

Abuse

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program

- Abuse includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards
- Examples of Medicare abuse include
  - Billing for unnecessary medical services
  - Charging excessively for services or supplies
  - Misusing codes on a claim, such as up-coding or unbundling codes
- Medicare abuse can also expose providers to criminal and civil liability

Inadequate Acute Care

- Hospices failed to provide adequate nursing, physician or medical social services in nine percent of general inpatient (GIP) care stays in 2012
- Examples
  - 101-year-old man with dementia who had uncontrolled pain for 16 days
  - 89-year-old man who had uncontrolled respiratory distress and anxiety for 14 days

Health Care Fraud and False Statements

- Knowingly and willfully submitting or causing to be submitted false and improper claims is healthcare fraud (18 U.S.C. § 1347)
- Knowingly and willfully putting false information in a patient file is a crime (18 U.S.C. § 1345)

Fraud Schemes Affecting Beneficiaries

- Owner of a Mississippi hospice used patient recruiters to solicit ineligible beneficiaries
- These patients were not even aware that they were enrolled in hospice care
- Owner submitted fraudulent charges and received more than $1 million from Medicare

DOJ, "Cleveland Woman Sentenced for Hospice Fraud," December 14, 2015. Accessed at https://www.justice.gov/usao-ndms/pr/cleveland-woman-sentenced-hospice-fraud

Fraud Schemes Affecting Beneficiaries

- Minnesota hospice chain agreed to pay $18 million to resolve allegations that it inappropriately billed Medicare for care provided to beneficiaries who were not eligible for hospice because they were not terminally ill
- The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries

DOJ, "Minnesota-Based Hospice Provider to Pay $18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill," July 13, 2016. Accessed at https://www.justice.gov/opa/pr/minnesota-based-hospice-provider-pay-18-million- alleged-false-claims-Medicare-patients-who

Fraud Schemes Affecting Beneficiaries

- Two certifying physicians from one California hospice were found guilty of health care fraud for falsely certifying beneficiaries as terminally ill
- Both physicians were excluded from the Medicare program
- The false certifications were part of a larger fraud scheme organized by the hospice owner
- The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, creating fraudulent diagnoses, certifying beneficiaries as terminally ill when they were not and altering medical records
- The owner pleaded guilty to health care fraud and was sentenced to 8 years in federal prison

DOJ, "Pasadena Doctor Sentenced to 4 Years in Prison for Falsely Certifying Patients Were Terminally Ill as Part of Healthcare Fraud Scheme," August 19, 2016. Accessed at https://www.justice.gov/usao-cdca/pr/pasadena-doctor-sentenced-4-years-prison-falsely-certifying-patients-were-terminally

Hospices Billing Inappropriately

Knowingly and willfully putting false information in a patient file is a crime (18 U.S.C. § 1345)

Hospices Billing Inappropriately

- Mississippi hospice inappropriately billed Medicare for a GIP care stay lasting over seven weeks for a beneficiary whose symptoms were under control
- She needed assistance only with personal care, eating, and the administration of medication, yet the hospice was paid almost $30,000 for GIP care

OIG, Hospices Inappropriately Billed Medicare Over $250 Million for GIP Care, OEI-02-10-00491, March 2016

Hospices Billing Inappropriately

- Florida hospice inappropriately billed for a beneficiary who entered GIP care for symptom management
- Her symptoms were managed within 2 days, yet she remained in GIP care for 15 additional days
- Medicare paid close to $12,000

OIG, Hospices Inappropriately Billed Medicare Over $250 Million for GIP Care, OEI-02-10-00491, March 2016

Hospices Billing Inappropriately

- New York hospice billed for one month of continuous home care for dates after the beneficiary's death
- Hospice improperly received at least $1,266,517 for services billed on behalf of this beneficiary and others that did not comply with Medicare requirements

OIG, Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services, A-02-13-01001, June 2015

Hospices Billing Inappropriately

- A Puerto Rico hospice billed for services after the beneficiary revoked the hospice election
- The hospice received at least $453,558 in improper payments for services billed on behalf of this beneficiary and others that did not comply with Medicare requirements

OIG, Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services, A-02-11-01017, August 2014

Fraud Schemes

A former hospice owner in Alabama pleaded guilty to defrauding Medicare of more than $3 million by billing for GIP care but providing a lower level of hospice care

DOJ, “Former Hospice Owner Sentenced for Health Care Fraud,” February 1, 2012. Accessed at https://www.justice.gov/archive/usao/aln/News/February%202012/February%201,%202012%20Hospice.html

Anti-Kickback Statute

Paying for patient referrals violates the Anti-Kickback Statute (42 U.S.C. § 1320a-7b) and may violate state laws

Fraud Schemes

- Illinois hospice billed Medicare for medically unnecessary hospice services
- Hospice paid bonuses to staff for placing patients in GIP care when it was not medically necessary and provided gifts and kickbacks to nursing homes for referring patients to the hospice

DOJ, "Director of Lisle-Based Hospice Company Convicted in Scheme to Fraudulently Bill Medicare for Medically Unnecessary Services," March 9, 2016. Accessed at https://www.justice.gov/usao-ndil/pr/director-lisle-based-hospice-company-convicted- scheme-fraudulently-bill-medicare-0

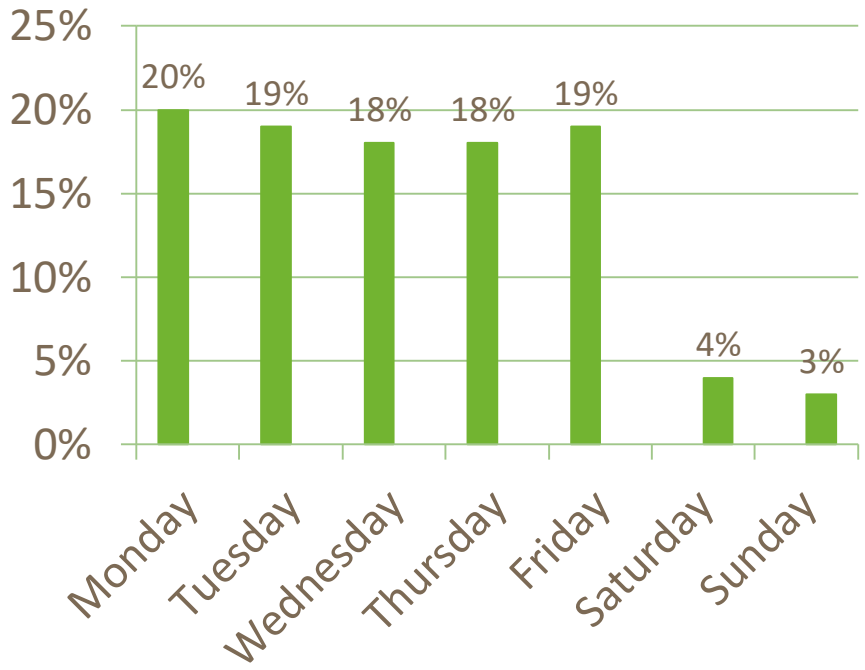
Fraud Schemes

- An owner of a Mississippi hospice was sentenced to almost six years in prison for submitting fraudulent charges to Medicare and receiving millions of dollars in Medicare funds based on alleged hospice services for patients who were not eligible for hospice care, services that were never provided and claims based on the forged signatures of physicians
- Another person involved in the scheme provided patient names and identifying information in return for kickback payments

https://www.justice.gov/usao-ndms/pr/greenwood-woman-sentenced-millions-hospice-fraud Greenwood Woman Sentenced for Millions in Hospice Fraud," December 19, 2014.

Weekend Visits

- Hospices rarely provided services on the weekends to patients in Assisted Living Facilities (ALF)
- Hospices were also more likely to provide GIP care on weekdays than on weekends



2013 OIG analysis of CMS data

Few or No Visits

- On average, hospices provided 4.8 hours of visits per week and were paid about $1,100 per week for each beneficiary receiving routine home care in an ALF in 2012
- Most of the visits were from aides. Of note, 25 hospices did not report making any visits to their beneficiaries receiving routine home care in ALFs in 2012.
- This involved 210 beneficiaries. Medicare paid these hospices a total of $2.3 million to care for these beneficiaries.

OIG, Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities, OEI-02-14-00070, January 2015.

ALFs

- Medicare paid $2.1 billion for hospice care provided in ALFs in 2012, an increase of 119 percent from 2007
- The median amount Medicare paid hospices for care for beneficiaries in ALFs was $16,195, twice as much as the median amount for beneficiaries at home
- The longer lengths of stay for beneficiaries in ALFs explain the higher payments
- Over one-third of beneficiaries in ALFs received hospice care for more than 180 days

OIG, Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities, OEI-02-14-00070, January 2015.

ALF and NF (Nursing Facility) Typically Require Less Complex Care

Primary Setting of Hospice Care	Percentage of Beneficiaries with Diagnoses of Ill-Defined Conditions, Mental Disorder, or Alzheimer's Disease	Percentage of Beneficiaries with Diagnosis of Cancer
ALF	60%	10%
Nursing Facility	54%	13%
Skilled Nursing Facility	52%	15%
Home	27%	38%

2013 OIG analysis of CMS data

Missing Services

In nearly a third of Medicare claims filed for patients living in NFs, hospices provided fewer services than they promised in patients' plans of care

Providing Poor Quality Care

- A hospice billed Medicare for serving a 101-year-old beneficiary with dementia
- He had uncontrolled pain throughout his 16 days in GIP care
- The hospice did not change his pain medication until the last day and did not provide him the special mattress he needed for more than a week

Hospices Inappropriately Billed Medicare Over $250 Million for GIP Care, OEI-02-10-00491, March 2016

Providing Poor Quality Care

- A hospice billed for 17 days of GIP care for a 70-year-old beneficiary, but never visited him
- Instead, the hospice called his family to inquire how he was doing

Hospices Inappropriately Billed Medicare Over $250 Million for GIP Care, OEI-02-10-00491, March 2016

Providing Poor Quality Care

- An 89-year-old beneficiary's respiratory symptoms were uncontrolled for 14 days during a GIP care stay in which the hospice rarely changed his medication dosage
- The beneficiary continued to experience respiratory distress and anxiety

Hospices Inappropriately Billed Medicare Over $250 Million for GIP Care, OEI-02-10-00491, March 2016

Promote Physician Involvement and Accountability

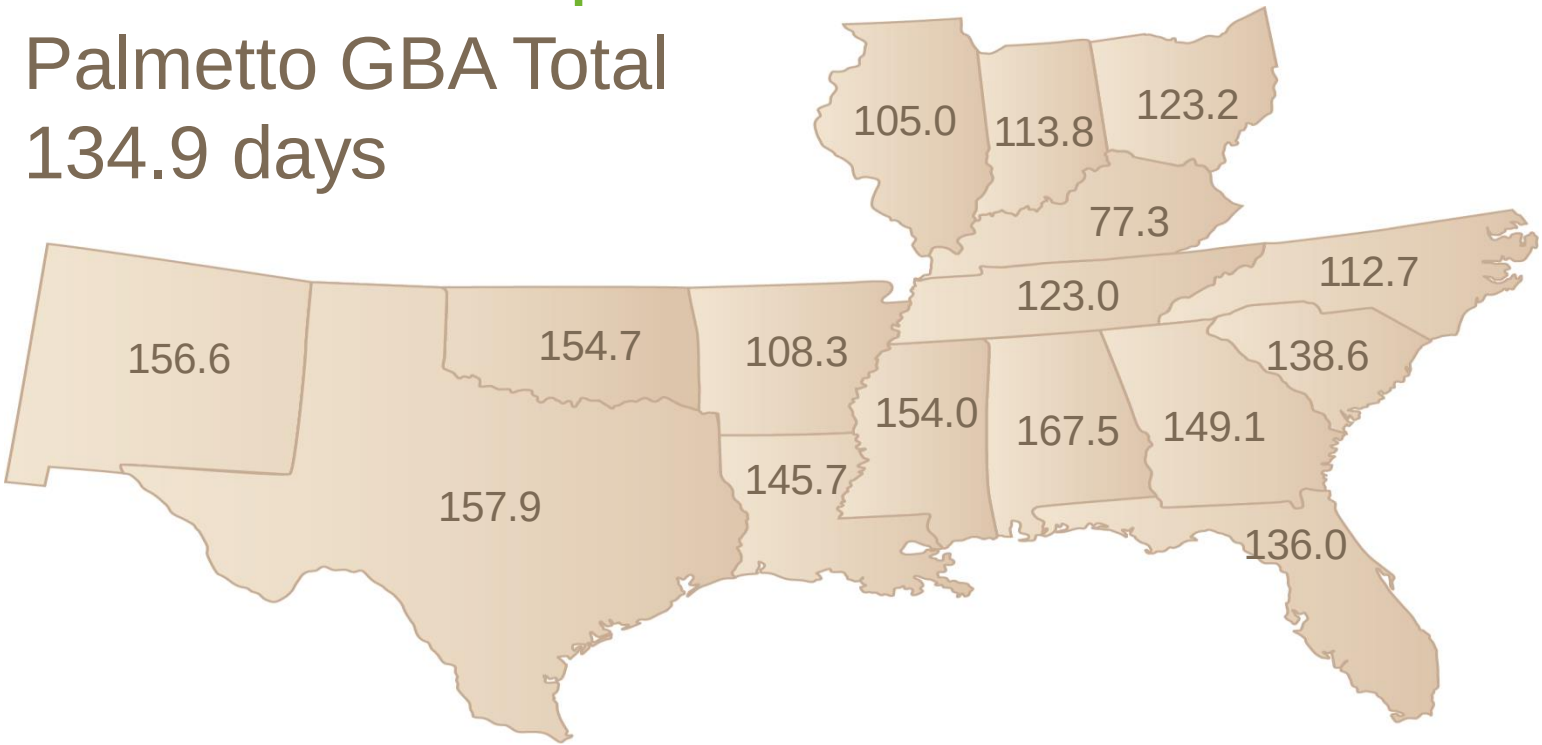
- Physicians serve a vital role in the appropriate provision of hospice services, but our work has shown that they are not always involved in decision making
- CMS has taken steps to remind hospices and physicians about the requirements for valid physician certifications and recertifications, but more needs to be done
- It was found that hospices did not always provide the care beneficiaries need to control pain and manage symptoms

Promote Physician Involvement and Accountability

- Ensure that a physician is involved in the decisions to start and continue GIP care
- Increased physician involvement could also help minimize the amount of time a beneficiary is in pain or has other uncontrolled symptoms
- The interdisciplinary group, which includes the physician, is required to review and revise the patient's plan of care as frequently as the patient's condition requires. However, the care-planning process, which Office of Inspector General (OIG) found lacking, does not offer sufficient safeguards against inappropriate use of GIP care.

Aggregated Length of Stay (ALOS) September 2018

Palmetto GBA Total
134.9 days



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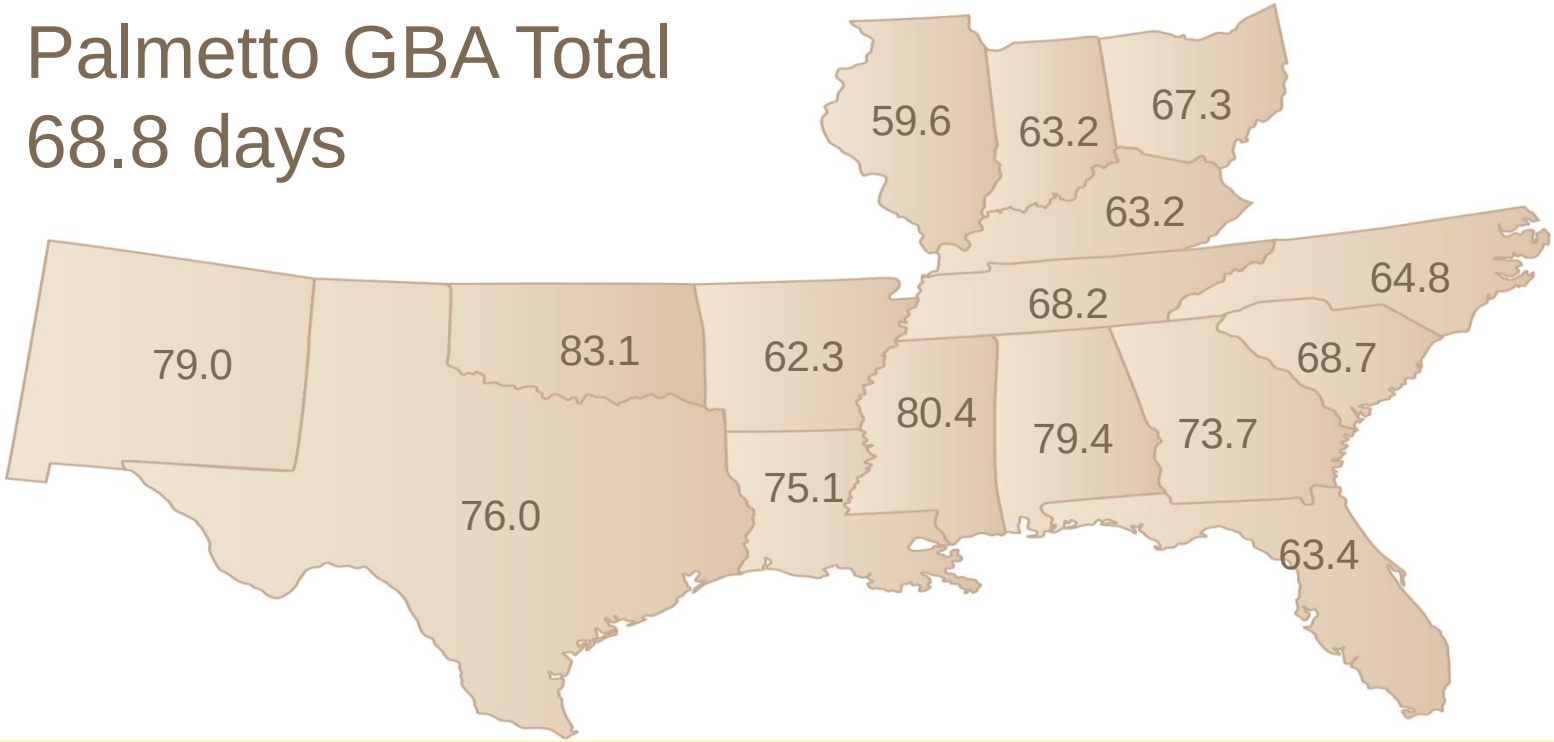
ALOS Calculation

- LOS = Ending Date - Admit Date - Any Discharge Days + One Day
- Ending Date is defined by Date of Service (DOS) of latest to date in time period
- Admit Date is defined by the DOS for earliest possible claim level from date
- Discharge days is defined as days the beneficiary was not on service with the hospice

Cancer ALOS September 2018

Palmetto GBA Total
68.8 days



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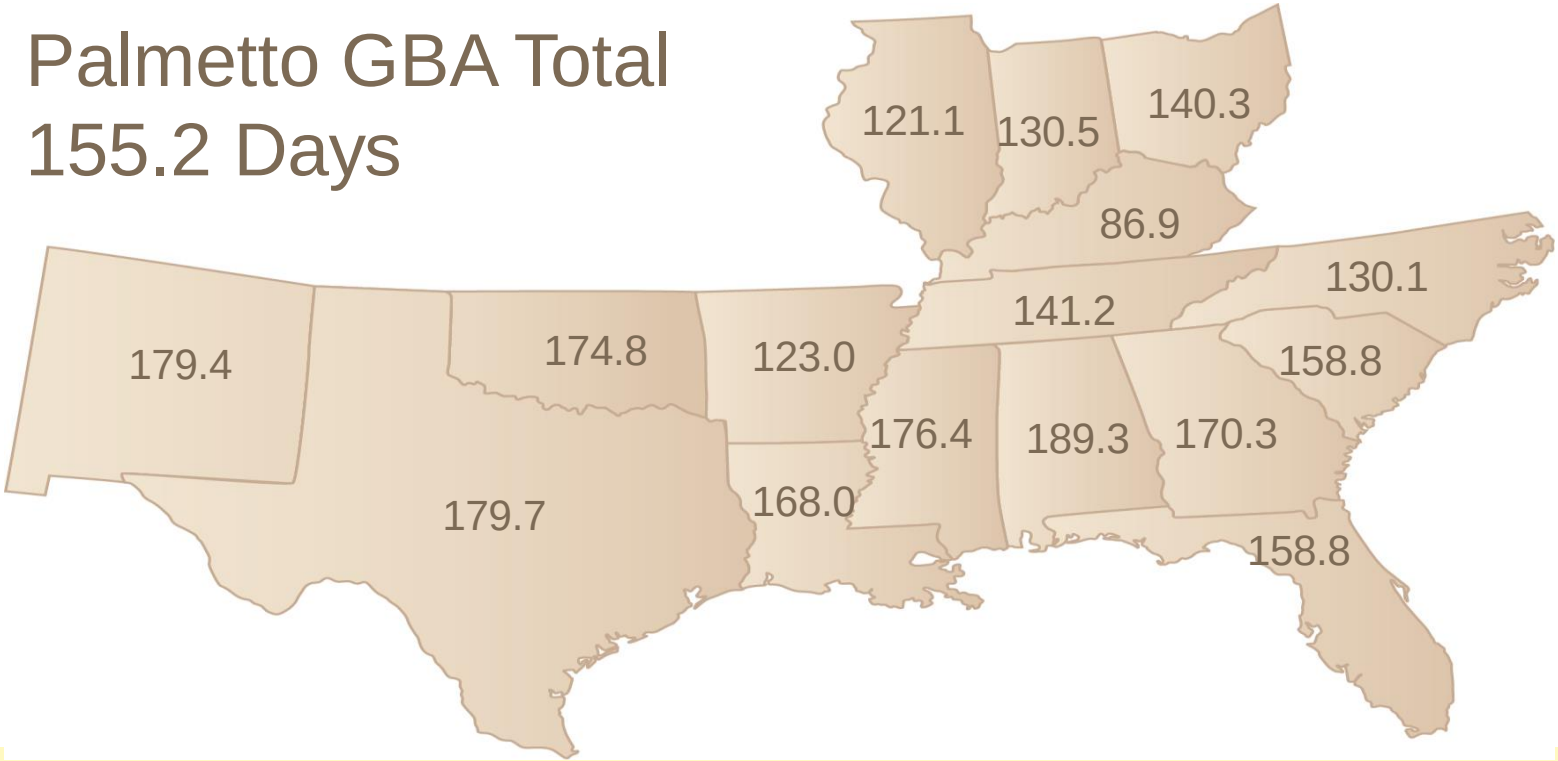
Non-Cancer ALOS September 2018

Palmetto GBA Total
155.2 Days



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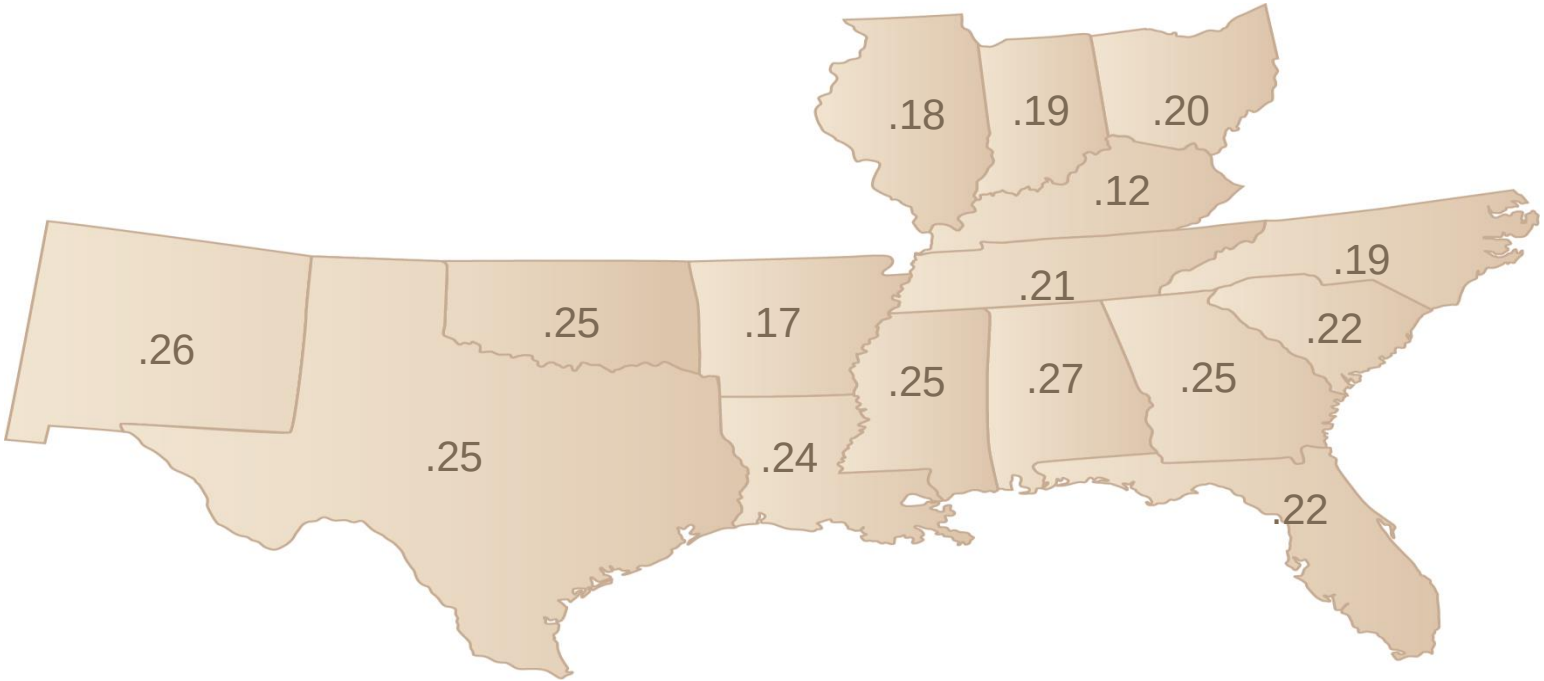
Non-Cancer Length of Stay (NCLOS) Rate Calculation

$$\frac{\text{Number of non-cancer beneficiaries with LOS>210}}{\text{Total number of non-cancer beneficiaries}}$$

- NCLOS Rate values can range from zero
  - No beneficiaries had stays > 210 days, to one
  - All had stays > 210 days
- The units are per 100 beneficiaries
  - A NCLOS Rate of 0.15 means that 15 beneficiaries out of 100 had stays > 210 days)

NCLOS Rate September 2018



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Continuous Home Care (CHC)

Need for CHC

- Difficulty managing symptoms with on regular visits
- Increase in evening and night hours calls
- Desires to go to the hospital or to call 911
- Caregiver can no longer provide skilled care

Reason for CHC

- Must clearly support the reason (or crisis) for increased level of care
- Document as frequently as necessary to support continued CHC
  - Symptom management
  - Skilled nursing care/interventions performed
  - Skilled monitoring
  - Care provided and patient's response to care
  - Frequency of medication administration
  - Patient's condition
  - Personnel providing care

Documentation Prior to the Start of CHC

- There must be a clinical need as evidenced by a medical crisis. What did the assessment show prior to starting CHC?
- Response to interventions attempted

CHC Utilization

- Only 42.7 percent of hospices (1,533 out of 3,592 hospices studied) provided CHC to at least one patient during the study period
- Within these 1,533 hospices, only 11.4 percent of patients used CHC

J Pain Symptom Manage. 2016 Dec; 52(6): 813–821.
Published online 2016 Sep 30. doi: 10.1016/j.jpainsymman.2016.05.031

CHC Utilization

- One study reported that patients using CHC were less likely to be transferred from home to another location before death

Barclay JS, Kuchibhatla M, Tulsky JA, Johnson KS. Association of hospice patients' income and care level with place of death. JAMA Intern Med. 2013;173(6):450–6

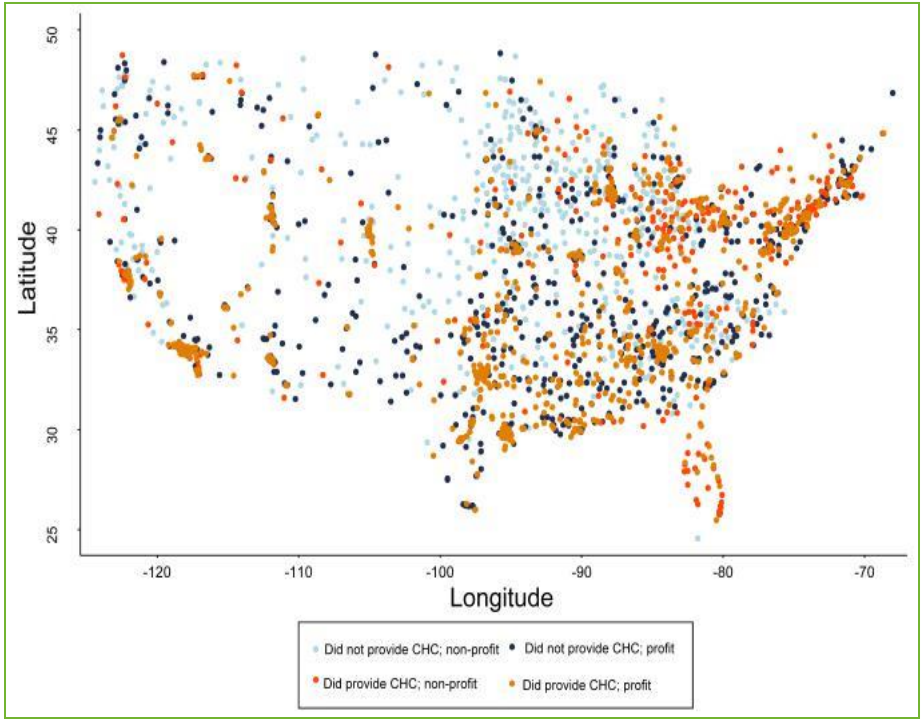
- Another study reported that patients using CHC were less likely to die in an inpatient hospice setting

Casarett D, Harrold J, Harris PS, et al. Does Continuous Hospice Care Help Patients Remain at Home? J Pain Symptom Manage. 2015;50(3):297–304

Results of a Study

Hospices which provided CHC

- 1,217 provided GIP care
- 316 did not provide GIP



Hospice Characteristics	Having CHC Claims 1533 (42.7%)	Not Having CHC Claims 2059 (57.3%)
Ownership		
For-profit	1118 (48.8%)	1175 (51.2%)
Nonprofit	403 (31.6%)	874 (68.4%)
Duration (year)	11.5	12.4
Volume (no. of patients in 2011)	371	177
Rurality		
Rural	266 (27.0%)	721 (73.0%)
Urban	1254 (48.6%)	1328 (51.4%)
GIP Care Provision		
Yes	1217 (47.0%)	1372 (53.0%)
No	316 (31.5%)	687 (68.5%)

Average CHC Stay

- For patients who used CHC, the mean duration of CHC was 4.5 days
- Among the 1,246 hospice agencies that had more than 20 enrollees during the study period, the mean percentage of decedents who received CHC was nine percent

CHC and GIP

- For patients who received CHC, only 12.4 percent received inpatient hospice care, whereas among patients who did not receive CHC, 30.5 percent received inpatient hospice care
- Among 2,642 decedents who received both CHC and inpatient hospice care, 784 (29.7 percent) received CHC first, while 1,858 (70.3 percent) received GIP hospice care first

Clinical Factors

Number of Comorbidities	Having CHC	Not Having CHC
0–2	2,227 (10.5%)	20,244 (12.2%)
3	2,737 (12.9%)	23,460 (14.1%)
4	4,009 (18.8%)	32,251 (19.5%)
5	4,493 (21.1%)	34,542 (20.8%)
6	3,865 (18.2%)	28,647 (17.3%)
7–8	3,943 (18.5%)	26,712 (16.1%)
Total	21,274 (11.4%)	165,856 (88.6%)

Clinical Factors

Primary Diagnosis for Hospice Enrollment	Having CHC	Not Having CHC
Neoplasms	6,857 (32.2%)	49,874 (30.1%)
Mental Disorders	2,242 (10.5%)	17,817 (10.7%)
Diseases of the Nervous System	2,516 (11.8%)	13,270 (8.0%)
Diseases of the Circulatory System	3,790 (17.8%)	31,228 (18.8%)
Diseases of the Respiratory System	1,638 (7.7%)	14,529 (8.8%)
Symptoms, Signs, and Ill-Defined Conditions	3,326 (15.6%)	28,610 (17.2%)
Other	905 (4.3%)	10,528 (6.3%)
Total	21,274 (11.4%)	165,856 (88.6%)

Clinical Factors

Receiving GIP Care	Having CHC	Not Having CHC
No	18,632 (87.6%)	115,274 (69.5%)
Yes	2,642 (12.4%)	50,582 (30.5%)
Average Days from Hospice Enrollment to Death	59.2	48.1
Total	21,274 (11.4%)	165,856 (88.6%)

Wang Shi-Yi, MD, PhD,. Aldridge Melissa D, PhD, Canavan Maureen , PhD, Cherlin Emily , PhD, and Bradley Elizabeth , PhD Continuous home care reduces hospice disenrollment and hospitalization after hospice enrollment J Pain Symptom Manage. 2016 Dec; 52(6): 813–821. Published online 2016 Sep 30. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5154927/

Certification of Terminal Illness

Certification of Terminal Illness

The hospice

- Must obtain written certification of terminal illness for each of the periods
- Must obtain the written certification before it submits a claim
  - Certifications may be completed no more than 15 calendar days prior to the effective date of election
  - Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period

42 CFR418.22 Certification of Terminal Illness

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Terminal Illness

An incurable disease that cannot be adequately treated and is reasonably expected to result in the death of the patient

Good Death

Patients, healthcare workers, and recently bereaved family members often describe a "good death" in terms of effective choices made in a few areas

- Pain and Symptom Management
- Clear Decision Making
- Preparation for Death
- Completion
- Contributing to Others
- Affirmation of the Whole Person

Steinhauser Karen E., PhD; Clipp Elizabeth C., PhD, MS, RN; McNeilly Maya, PhD; Christakis Nicholas A., MD, PhD, MPH; McIntyre Lauren M., PhD; Tulsky James A., MD In Search of a Good Death: Observations of Patients, Families, and Providers. Ann Intern Med. 2000;132(10):825-832

Probing Questions

- Would it be important not to have pain at the time of death?
- Who do you think you want to be with you when you die? Would you like to be with others or alone?
- How important would it be to have friends and family nearby?
- What kind of role would you like your friends and family to have in your death?
- How important would it be to have clergy/religious figures nearby?
- How important do you think it would be to say goodbye to people?

Steinhauser Karen E., PhD; Clipp Elizabeth C., PhD, MS, RN; McNeilly Maya, PhD; Christakis Nicholas A., MD, PhD, MPH; McIntyre Lauren M., PhD; Tulsky James A., MD In Search of a Good Death: Observations of Patients, Families, and Providers. Ann Intern Med. 2000;132(10):825-832

Probing Questions

- Where do you think it would be good to die? Would you prefer to die at home, at a hospital, at a hospice?
- How do you feel about being sedated?
- How important would it be to know in advance what is likely to happen when you die?
- How can health care providers affect the quality of death?
- What do you think are the roles of nurses, doctors, and social workers in affecting the quality of death?
- Imagine if you were to measure good compared with bad deaths. Can you give two things you would measure?
- How much control do you want over your death

Steinhauser Karen E., PhD; Clipp Elizabeth C., PhD, MS, RN; McNeilly Maya, PhD; Christakis Nicholas A., MD, PhD, MPH; McIntyre Lauren M., PhD; Tulsky James A., MD In Search of a Good Death: Observations of Patients, Families, and Providers. Ann Intern Med. 2000;132(10):825-832

Probing Questions

- Do you think about how much money will be spent related to your death?
- What do you consider to be proper financial preparations related to your death? This might mean making wills and planning for a funeral.
- What are your feelings about the uncertainty that surrounds death?
- What are your feelings about the communication between the dying person, the person's family, and the person's caregivers around the time of death?
- What kinds of emotions do you think are normal around the time of dying?

Steinhauser Karen E., PhD; Clipp Elizabeth C., PhD, MS, RN; McNeilly Maya, PhD; Christakis Nicholas A., MD, PhD, MPH; McIntyre Lauren M., PhD; Tulsky James A., MD In Search of a Good Death: Observations of Patients, Families, and Providers. Ann Intern Med. 2000;132(10):825-832

Face-to-Face Encounter

- As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay is anticipated to reach the third benefit period
- The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care

Certification

Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements

- The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course
- Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification

Eligibility Requirements

In order to be eligible to elect hospice care under Medicare, an individual must be

- Entitled to Part A of Medicare; and
- Certified as being terminally ill

Admission to Hospice Care

- The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician
- In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information
  - Diagnosis of the terminal condition of the patient
  - Other health conditions, whether related or unrelated to the terminal condition
  - Current clinically relevant information supporting all diagnoses

Content of Written Certifications

- The statement that the individual's medical prognosis is that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course
- Patient-specific clinical findings and other documentation supporting a life expectancy of six months or less
- The certification should give specific clinical findings, for example, signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake, etc.

Content of Written Certifications

The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers

- Physician signature and date signed
  - The physician must sign and make an appropriate date entry for his/her signature, for example, John Smith M.D. MM/DD/YY
- If the physician signature is not legible, you may type or print the name below the signature. Another alternative to ensure a legible signature is to submit a signature log with the physician's printed name and signature.
- Certification/ Recertification benefit period — Make an entry on the certification that gives the specific “from” and “through” dates, for example, benefit period date MM/DD/YY to MM/DD/YY
- Simply stating benefit period three is not acceptable documentation. The “from” and “through” dates must appear on the certification.

Narrative

- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient. The physician may dictate the narrative.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients
- The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative
- It would not be acceptable to have any other language such as the certification "from" and "through" dates, the attestation of a face-to-face, or any other documentation located between the narrative and the physician's signature

Physician Signature

Guidance

- According to the “Medicare Benefit Policy Manual,” Chapter 9, Section 20.1, Timing and Content of Certification, the regulations state if the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician signature
- As part of the narrative, the narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his/her examination of the patient

Face-to-Face Encounter and Attestation

- For recertification, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice beneficiary prior to the beginning the beneficiary's third benefit period, and prior to each subsequent benefit period
- The face-to-face encounter (when applicable) is a part of the recertification

Documentation Tips

- Structural impairments
- Functional impairments
- Activity limitations
- Comorbid conditions
- Secondary conditions

Example #1 of Physician Certification

- I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates 1/1/20XX to 3/30/20XX.
- Brief narrative statement (review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78-year-old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy, but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over past 2 weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath.

Example #1 of Physician Certification

- Attestation
  - I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one)
- Physician (printed name) — Dr. Marcus Welby
- Physician (signature) — *Dr. Marcus Welby*
- Date — 1/1/2016

Example #2 of Physician Certification

- I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates — 1/1/2016 to 3/30/2016
- Physician (printed name) — Dr. Marcus Welby
- Physician (signature) — *Dr. Marcus Welby*
- Date — 1/1/2016
- Please note — Physician Narrative Addendum below. (Physician Narrative Addendum must accompany the Initial Certification of Terminal Illness when the narrative is not included on the certification)

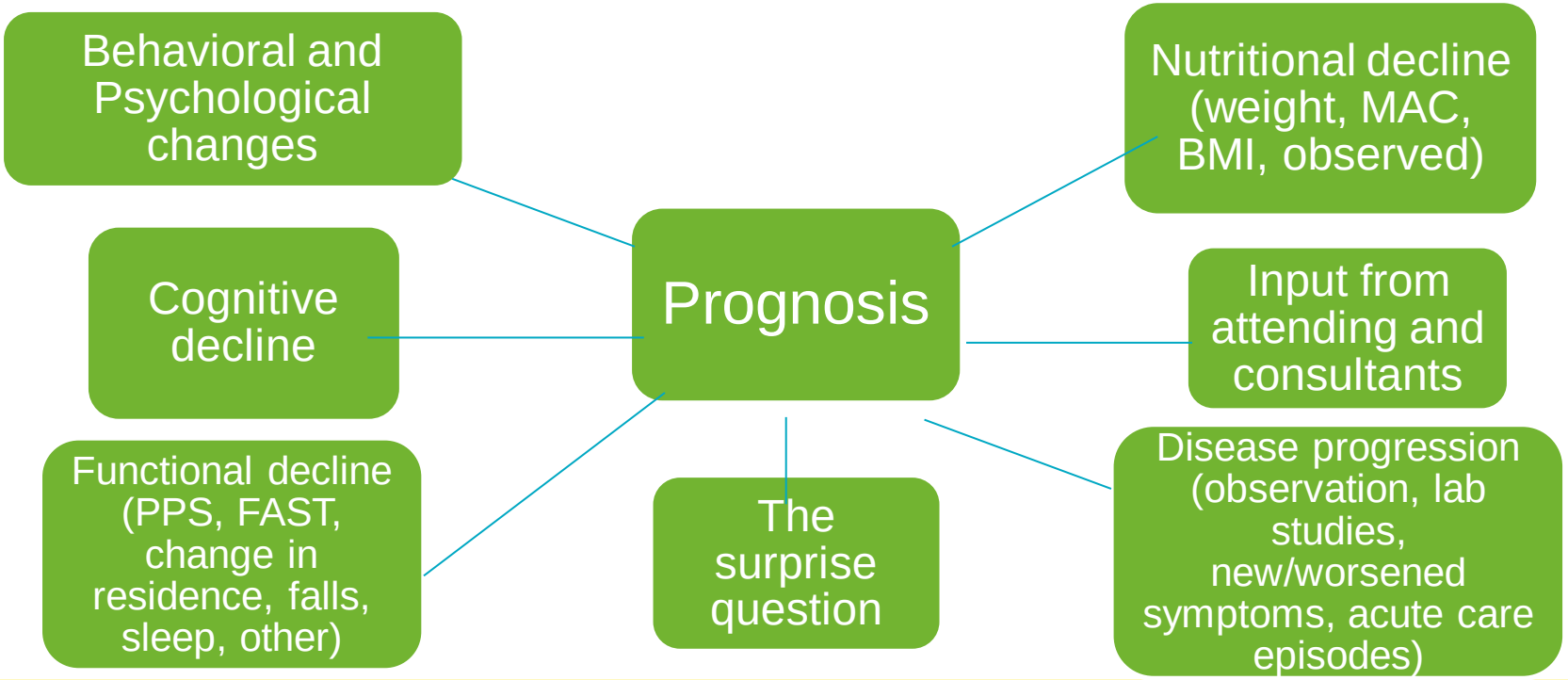
Example #2 of Physician Certification

- Certification period dates — 1/1/2016 to 3/30/2016
- Brief narrative statement — (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78-year-old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over the past two weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath.
- Attestation — I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one)
- Physician (printed name) — Dr. Marcus Welby
- Physician (signature) — *Dr. Marcus Welby*
- Date — 1/1/2016

References

- 42 CFR 418.22 — Certification of Terminal Illness
- 42 CFR 418.20 — Eligibility Requirements
- 42 CFR 418.25 — Admission to Hospice Care
- MLN Matters® Number: SE1628 — Documentation Requirements for the Hospice Physician Certification/Recertification

Types of Data Used for Recertification

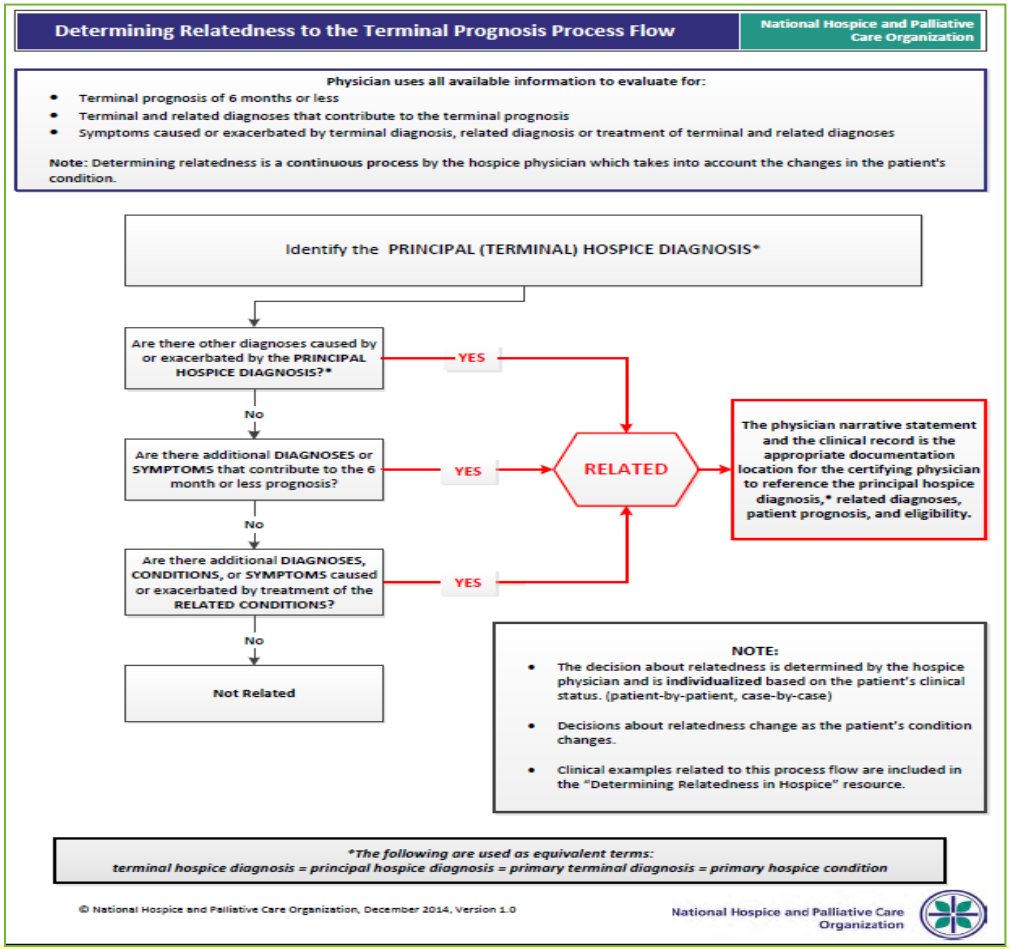


Related or Unrelated

It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients. Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal prognosis. It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal prognosis.

CMS-1629-F

National Hospice and Palliative Care Organization 2014 Determining Relatedness to the Terminal Prognosis Flow



The Determination Process

Is the condition being considered a diagnosis or a symptom (or both)?

- Diagnoses will need a determination of whether they are related or unrelated
- Symptoms are almost automatically related
  (Coding guidelines state these do not need to be listed **if** they are a normal part of the diagnosis)
- What if they are both diagnosis and symptom?
  (Example — Depression)

Examples of Unrelatedness

Two examples are repeatedly offered for unrelatedness (neither has been validated by CMS)

1. “Glaucoma is pathophysiologically unrelated to the patient’s lung cancer, and does not contribute to the terminal prognosis”
2. “Hypothyroidism is physiologically unrelated to the patient’s COPD, and since it is well-managed, it does not contribute to a worsened prognosis”

The Value of Candor

- Patients use information about the expected course of their illness, including how long they are likely to survive, in a variety of ways
- It can help them decide whether to take a long-awaited trip, which therapies are worth pursuing, what kind of support system they may need as their condition worsens, and how much time they will have to put their affairs in order

Brody Jane E. Tough Question to Answer, Tough Answer to Hear March 7, 2007 NY Times

The Value of Candor

- Patients often have things they want to accomplish before they die, and knowing that their time is short may prompt them to attend to such matters
- Receiving a terminal prognosis may also open up conversations about death and dying that may be painful at first but can bring considerable relief to patients and family members alike

Brody Jane E. Tough Question to Answer, Tough Answer to Hear March 7, 2007 NY Times

Hope

- A common fear among doctors is that providing a terminal prognosis will strip patients of hope
- Indeed, it will dash hopes of long-term survival. But the doctor can convey other sources of hope.
- For example, patients may be relieved to learn that they will remain well enough to attend an important family event, or that palliative care is available for distressing symptoms like pain, nausea and shortness of breath

Brody Jane E. Tough Question to Answer, Tough Answer to Hear March 7, 2007 NY Times

Medical Director Medical Knowledge

- Assess and differentiate types of pain including total pain
- Assess and manage
  - Acute and chronic pain
  - Medications for pain
  - Non-opioid medications for pain
  - Non-pain symptoms
  - Non-pharmacologic measures for pain and non-pain symptoms (complementary and alternative therapies)
  - Disorders (e.g., delirium, dementia, depression, and anxiety)

Medical Director Medical Knowledge

Demonstrate knowledge of

- Physical, emotional, spiritual, and psychosocial dimensions of care settings where hospice and palliative care are provided
- Patient assessment and management across hospice care settings
- Addiction, pseudo-addiction, opioid toxicity, and dependence and tolerance
- Brain death, persistent vegetative state, and minimally conscious state
- Normal and complex grief
- Signs and symptoms of impending death
- Various routes of medication delivery
- Palliative sedation

Medical Director Medical Knowledge

- Manage medical conditions commonly encountered in hospice care
- Assess and manage of risk associated with drug abuse, addiction and diversion
- Identify indications for interventional symptom management, including radiation therapy
- Formulate and certify prognosis for hospice patients by
  - Reviewing available clinical data (e.g., comorbid and secondary conditions, medical findings, disease progression, medications and treatment orders)
  - Understanding the patient's and family's expectations and goals for care

The Hospice Medical Director: What Should They Be Doing? Tommie W. Farrell, MD HMDCB FAAHPM Pathways at Hendrick Hospital Palliative and Supportive and Hospice Care Abilene Texas

Renal Failure

“Classic” Renal Hospice Criteria

The patient has 1, 2 and 3

1. The patient is not seeking dialysis or renal transplant
2. Creatinine clearance is < 10 cc/min (<15 for diabetics)
3. Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)

“Classic” Renal Hospice Criteria

Supporting documentation for chronic renal failure includes

- Uremia, Oliguria (urine output < 400 cc in 24 hours)
- Intractable hyperkalemia (> 7.0)
- Uremic pericarditis
- Hepatorenal syndrome
- Intractable fluid overload

Supporting documentation for acute renal failure includes

- Mechanical ventilation
- Malignancy (other organ system)
- Chronic lung disease
- Advanced cardiac disease
- Advanced liver disease

Rationale for Revision of Policy

- A study of 115,239 subjects identified that among a cohort of patients who received dialysis and died during a two-year study period, 15,565 patients (13.5 percent) also received hospice services
- Among the 25,075 study subjects who withdrew from dialysis prior to death, less than half received hospice services
- This despite evidence supporting that after withdrawal approximately 96 percent of individuals die within 30 days

Clinical Journal of the American Society of Nephrology 1: 1248 – 1255, 2006.

Rationale for Revision of Policy

For beneficiaries with end stage renal disease (ESRD), the identification of relevant comorbid and secondary conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors would help establish hospice eligibility and maintain a beneficiary-centered plan of care.

Kidney Failure

- Kidney failure (or ESRD) is the last stage of chronic kidney disease
- When kidneys fail, it means they have stopped working well enough for survival without dialysis or a kidney transplant

http://www.kidneyfund.org/kidney-disease/kidney-failure/

ESRD

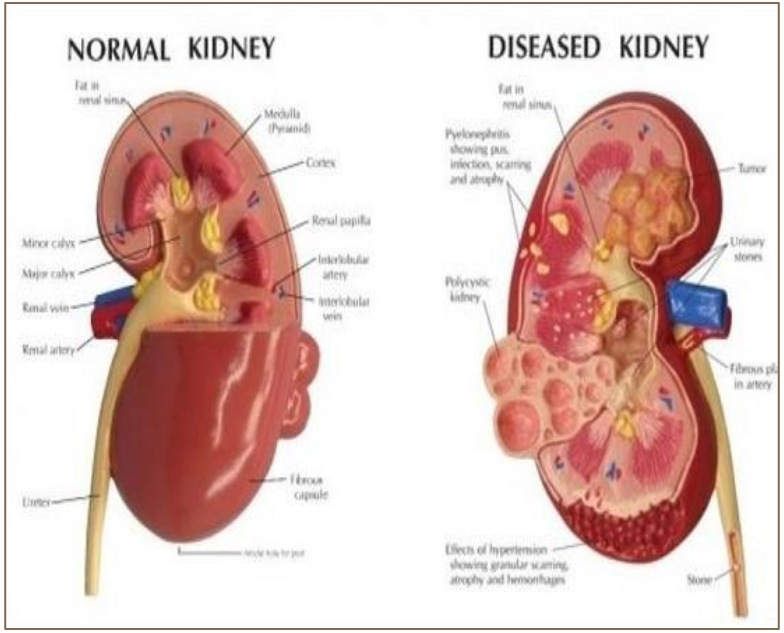
- ESRD is a complete or near complete failure of the kidneys to function to excrete wastes, concentrate urine and regulate electrolytes
- It usually occurs as chronic renal failure worsens to the point where kidney function is less than 10 percent of normal

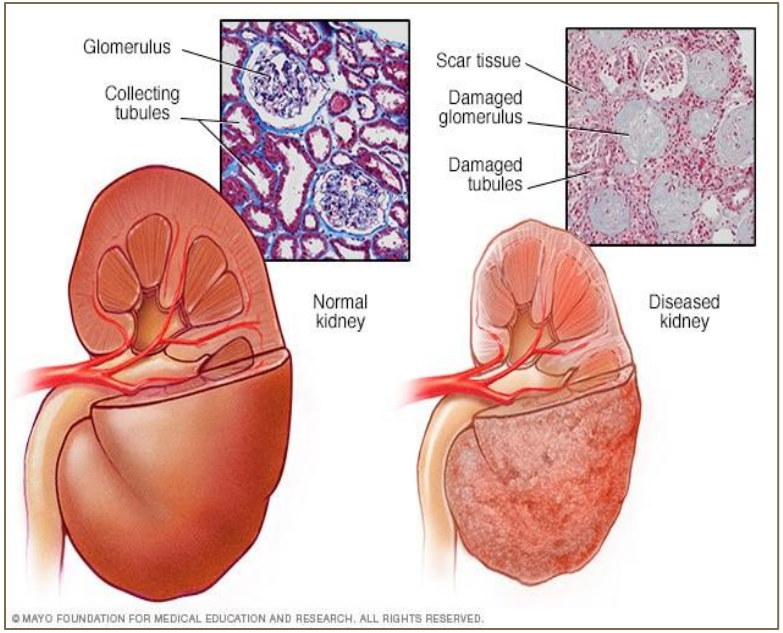
Kidney Failure

- The kidneys filter wastes and excess fluids from your blood, which are then excreted in urine
- When the kidneys lose their filtering capabilities, dangerous levels of fluid, electrolytes and wastes can build up in the body

https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-20354532

Normal Kidney vs. Diseased Kidney

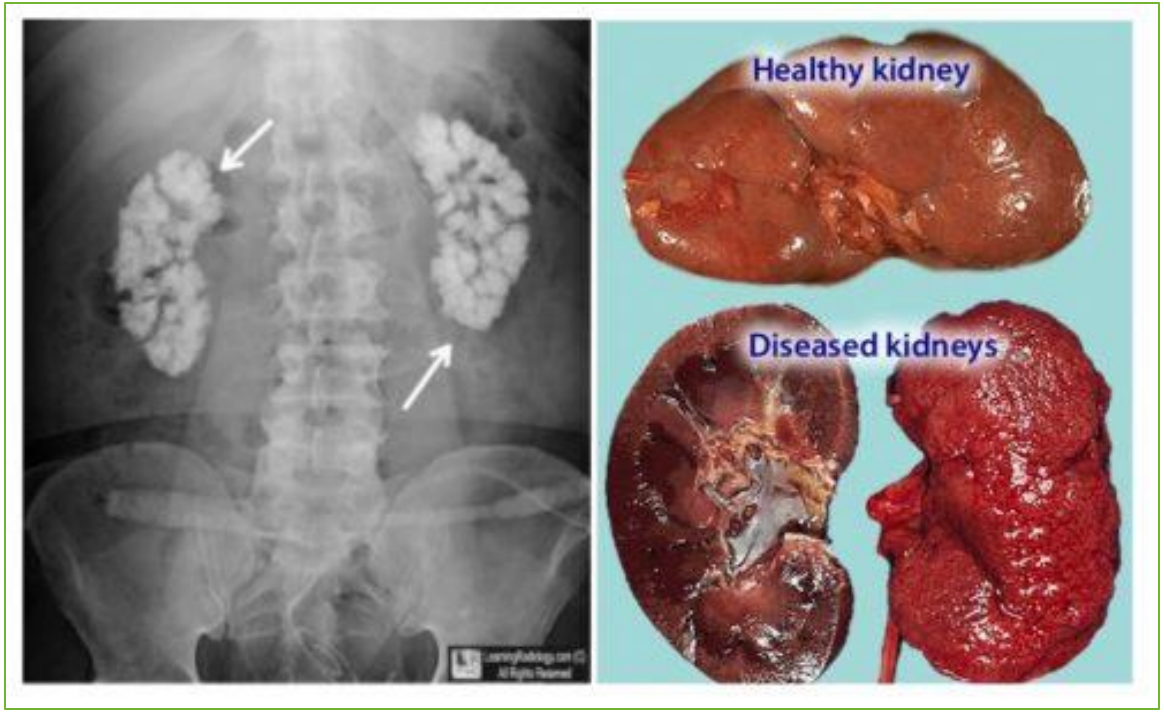




https://www.quora.com/What-are-the-common-causes-of-kidney-disease

https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-20354532

Normal Kidney vs. Diseased Kidney



https://positivemed.com/2016/08/25/kidney-failure/

Going Beyond Diagnosis

- Structural Impairments
- Functional Impairments
- Activity Limitations

Renal Structure

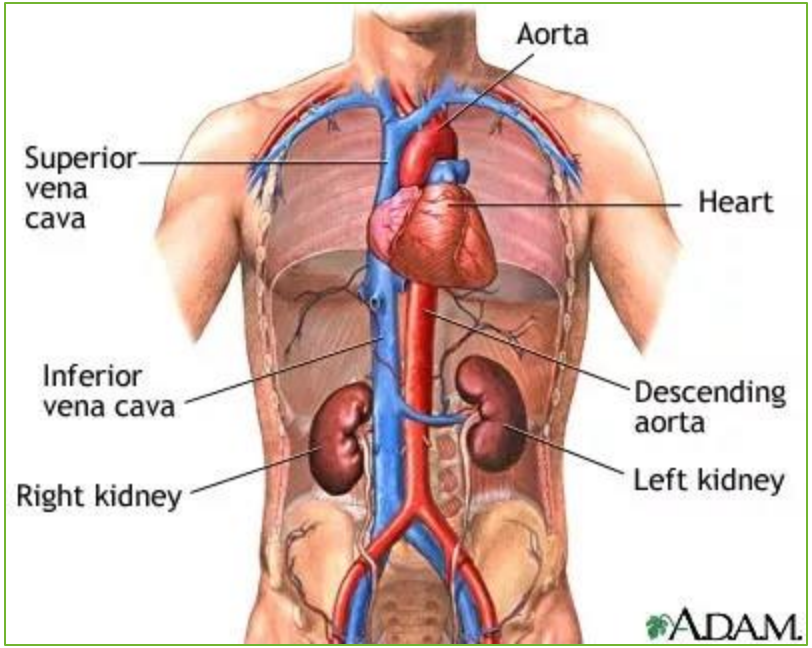
In humans, the kidneys are located high in the abdominal cavity, one on each side of the spine, and lie in a retroperitoneal position at a slightly oblique angle

https://health.howstuffworks.com/human-body/systems/kidney-urinary/kidney.htm

https://blackdoctor.org/460288/4-steps-to-clean-your-kidneys/

Renal Structure

The asymmetry within the abdominal cavity, caused by the position of the liver, typically results in the right kidney being slightly lower and smaller than the left, and being placed slightly more to the middle than the left kidney



https://www.quora.com/What-are-the-3-main-functions-of-the-kidneys

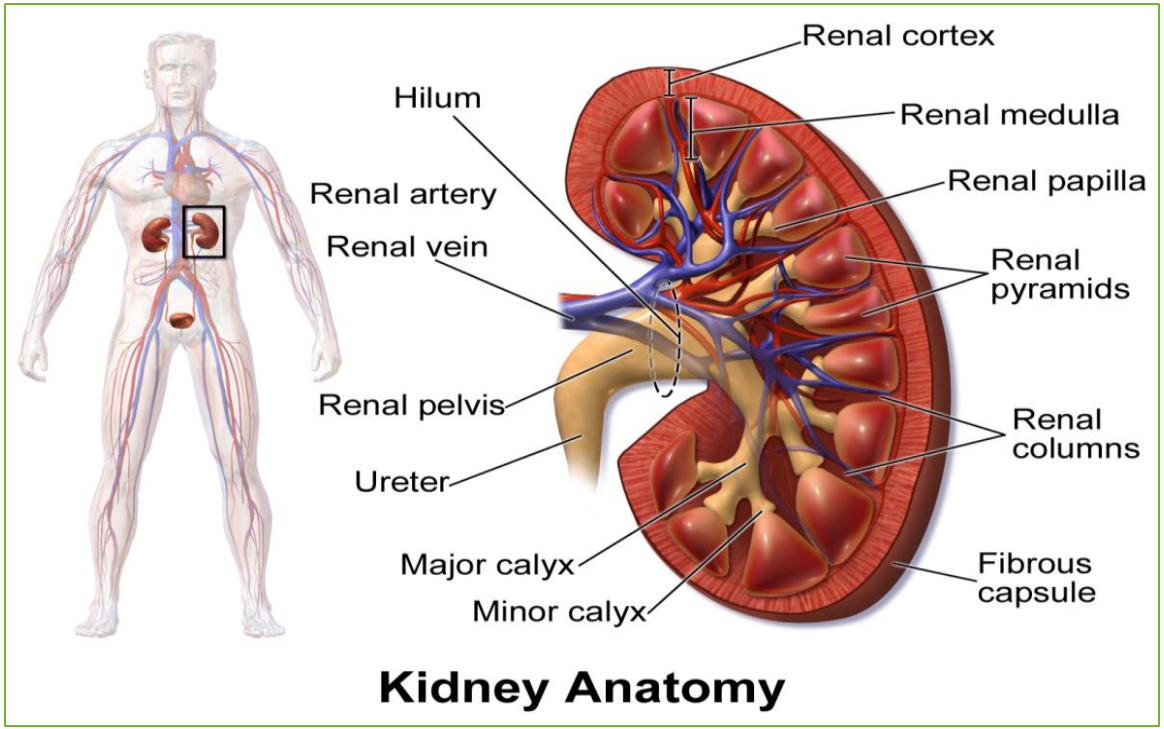
Glodny B, Unterholzner V, Taferner B, et al. (2009). "Normal kidney size and its influencing factors – a 64-slice MDCT study of 1.040 asymptomatic patients". BMC Urology. 9 (1): 19. doi:10.1186/1471-2490

Renal Structure

- The left kidney is approximately at the vertebral level T12 to L3, and the right is slightly lower
- The right kidney sits just below the diaphragm and posterior to the liver
- The left sits below the diaphragm and posterior to the spleen
- On top of each kidney is an adrenal gland
- The upper parts of the kidneys are partially protected by the 11th and 12th ribs
- Each kidney, with its adrenal gland is surrounded by two layers of fat: the perirenal fat present between renal fascia and renal capsule and para-renal fat superior to the renal fascia

Bålens ytanatomy (Superficial anatomy of the trunk). Anca Dragomir, Mats Hjortberg and Godfried M. Romans. Section for human anatomy at the Department of Medical Biology, Uppsala University, Sweden.

Renal Structure



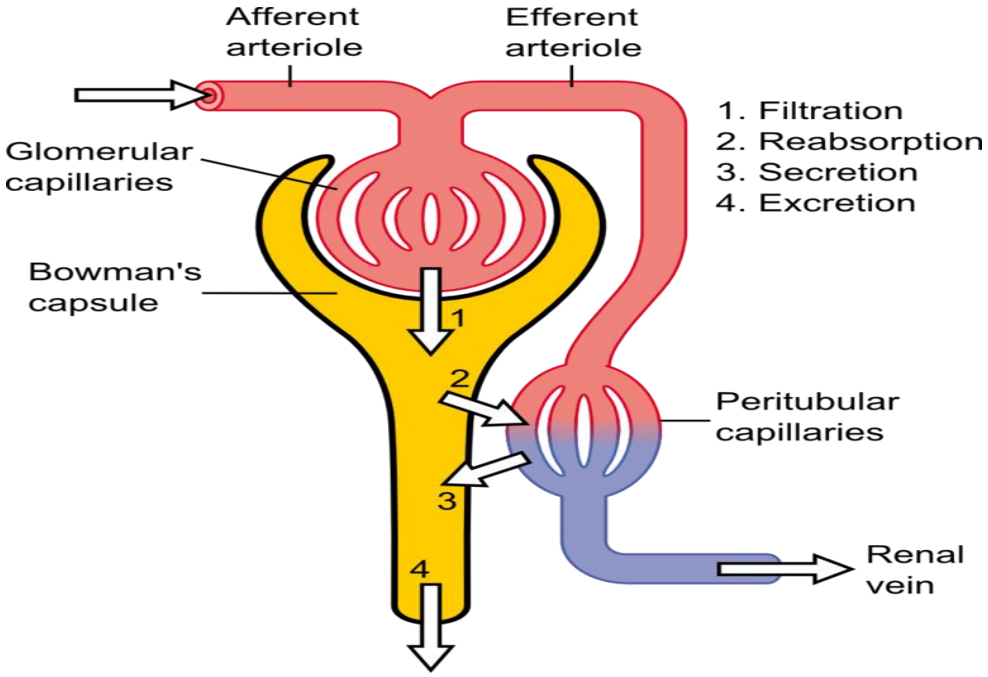
Blausen.com staff (2014). "Medical gallery of Blausen Medical 2014". WikiJournal of Medicine 1 (2). OI:10.15347/wjm/2014.010. ISSN 2002-4436. - Own work, CC BY 3.0, https://commons.wikimedia.org/w/index.php?curid=31118599

Blood Supply

- The renal circulation supplies the blood to the kidneys via the renal arteries, left and right, which branch directly from the abdominal aorta
- Despite their relatively small size, the kidneys receive approximately 20 percent of the cardiac output

Walter F. Boron (2004). Medical Physiology: A Cellular And Molecular Approach. Elsevier/Saunders. ISBN 1-4160-2328-3.

Renal Function



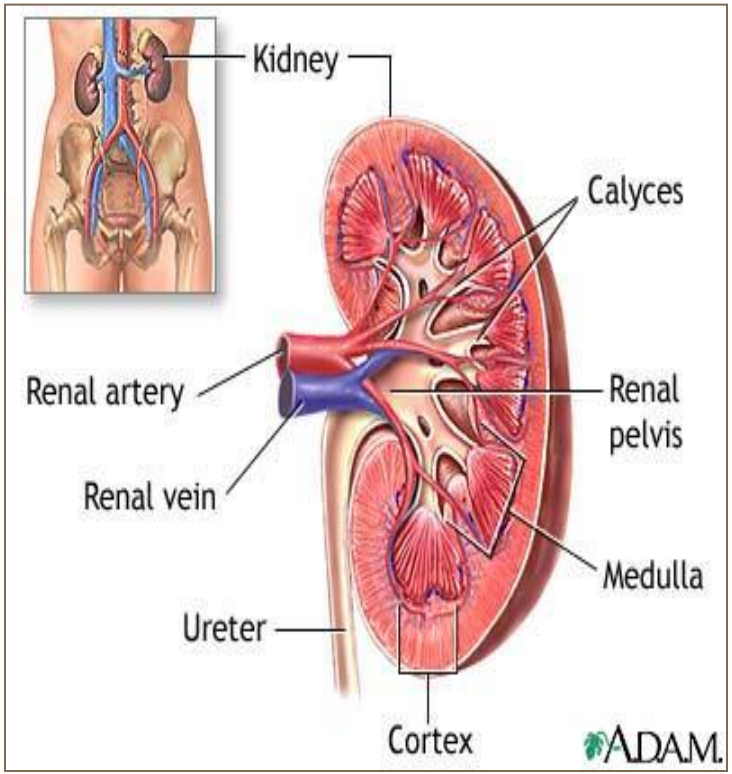
Excretion = Filtration – Reabsorption + Secretion

http://learnlearn.net/naturen/Fordyelse.htm

Kidney Function

The kidneys are responsible for removing wastes from the body, regulating electrolyte balance and blood pressure, and stimulating red blood cell production

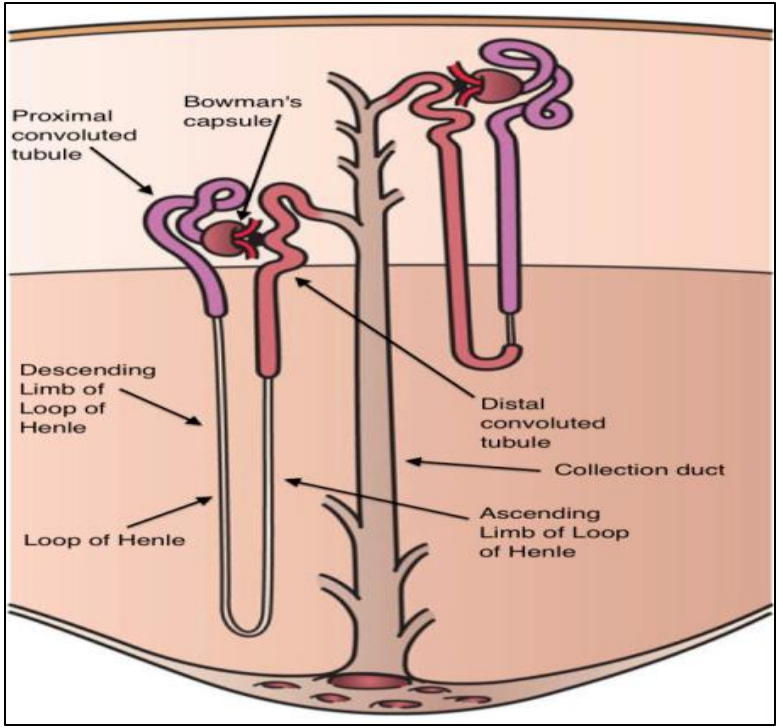
www.nlm.nih.gov/medlineplus/ency/imagepages/1101.htm



Renal Function

The nephron is the structural and functional unit of the kidney. Each adult kidney contains around one million nephrons. The nephron utilizes four processes to alter the blood plasma which flows to it.

- Filtration
- Reabsorption
- Secretion
- Excretion



https://upload.wikimedia.org/wikipedia/commons/9/98/Kidney_Nephron.png

Filtration

- Filtration is the mass movement of water and solutes from plasma to the renal tubule that occurs in the renal corpuscle
- About 20 percent of the plasma volume passing through the glomerulus at any given time is filtered
- This means that about 180 liters of fluid are filtered by the kidneys every day
- Thus, the entire plasma volume (about 3 liters) is filtered 60 times a day
- Note that the kidneys filter much more fluid than the amount of urine that is actually excreted (about 1.5 liters per day). This is essential for the kidneys to rapidly remove waste and toxins from the plasma efficiently.

https://mcb.berkeley.edu/courses/mcb135e/kidneyprocess.html

Reabsorption

- Reabsorption is the movement of water and solutes from the tubule back into the plasma
- Examples of substances reabsorbed are
  - Solute-free water
  - Sodium
  - Bicarbonate
  - Glucose
  - Amino acids

https://mcb.berkeley.edu/courses/mcb135e/kidneyprocess.html

Secretion

- Even after filtration has occurred, the tubules continue to secrete additional substances into the tubular fluid
- This enhances the kidneys' ability to eliminate certain wastes and toxins
- It is also essential to regulation of plasma potassium concentrations and pH
- Examples of substances secreted are
  - Hydrogen
  - Ammonium
  - Potassium
  - Uric acid

https://mcb.berkeley.edu/courses/mcb135e/kidneyprocess.html

Excretion

Excretion is what goes into the urine, the end result of the previous three processes

Acid-Base Balance

- Two organ systems, the kidneys and lungs, maintain acid-base homeostasis, which is the maintenance of pH around a relatively stable value
- The lungs contribute to acid-base homeostasis by regulating carbon dioxide (CO_2) concentration
- The kidneys have two very important roles in maintaining the acid-base balance — to reabsorb and regenerate bicarbonate from urine, and to excrete hydrogen ions and fixed acids (anions of acids) into urine

Regulation of Osmolality

- Maintaining water and salt level of the body
- Any significant rise in plasma osmolality is detected by the hypothalamus, which communicates directly with the posterior pituitary gland
- The two factors work together to return the plasma osmolality to its normal levels

Hormone Secretion

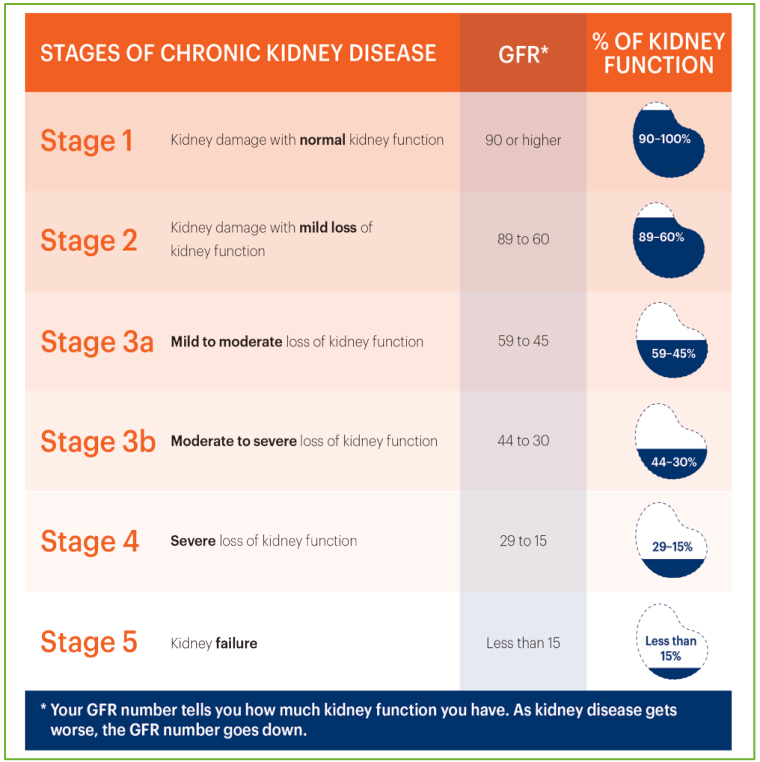
- The kidneys secrete a variety of hormones, including erythropoietin, calcitriol, and renin
- Erythropoietin is released in response to hypoxia in the renal circulation
- It stimulates erythropoiesis in the bone marrow
- Calcitriol, the activated form of vitamin D, promotes intestinal absorption of calcium and the renal reabsorption of phosphate
- Renin is an enzyme which regulates angiotensin and aldosterone levels

Blood Pressure Regulation

- Although the kidney cannot directly sense blood, long-term regulation of blood pressure predominantly depends upon the kidney
- This primarily occurs through maintenance of the extracellular fluid compartment, the size of which depends on the plasma sodium concentration

Stages

- Kidney disease is a chronic, progressive disease. As a result, there are specific symptoms associated with its progression. Many nephrologists (kidney specialists) use a standard classification system to describe these common symptoms and stages.
- Many symptoms are associated with what is known as the Glomerular Filtration Rate (GFR). According to the Foundation for IgA Nephropathy, the GFR is the rate at which the kidneys filter waste and relates to a patient's "kidney function."



https://www.kidney.org/atoz/content/gfr

Glomerular Filtration Rate (GFR)

- GFR is a test used to check how well the kidneys are working
- Specifically, it estimates how much blood passes through the glomeruli each minute
- Glomeruli are the tiny filters in the kidneys that filter waste from the blood

https://medlineplus.gov/ency/article/007305.htm

Albuminuria vs. Albumin

- **Albuminuria** is a pathological condition wherein the protein albumin is abnormally present in the urine. It is a type of proteinuria.
- **Albumin** is a major plasma protein (normally circulating in the blood). In healthy people, only trace amounts of it are present in urine, whereas larger amounts occur in the urine of patients with kidney disease.

KDIGO (Kidney Disease Improving Global Outcomes (2013). "KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease" (PDF). Kidney International Supplement. **3** (1): 1–150. Retrieved 5 February 2016.

ESRD Affects Every System in the Body

Cardiac Alterations

Cardiovascular disease is the leading cause of death for ESRD patients

- Hypertension
- Congestive Heart Failure
- Uremic Pericarditis

Uremic Pericarditis

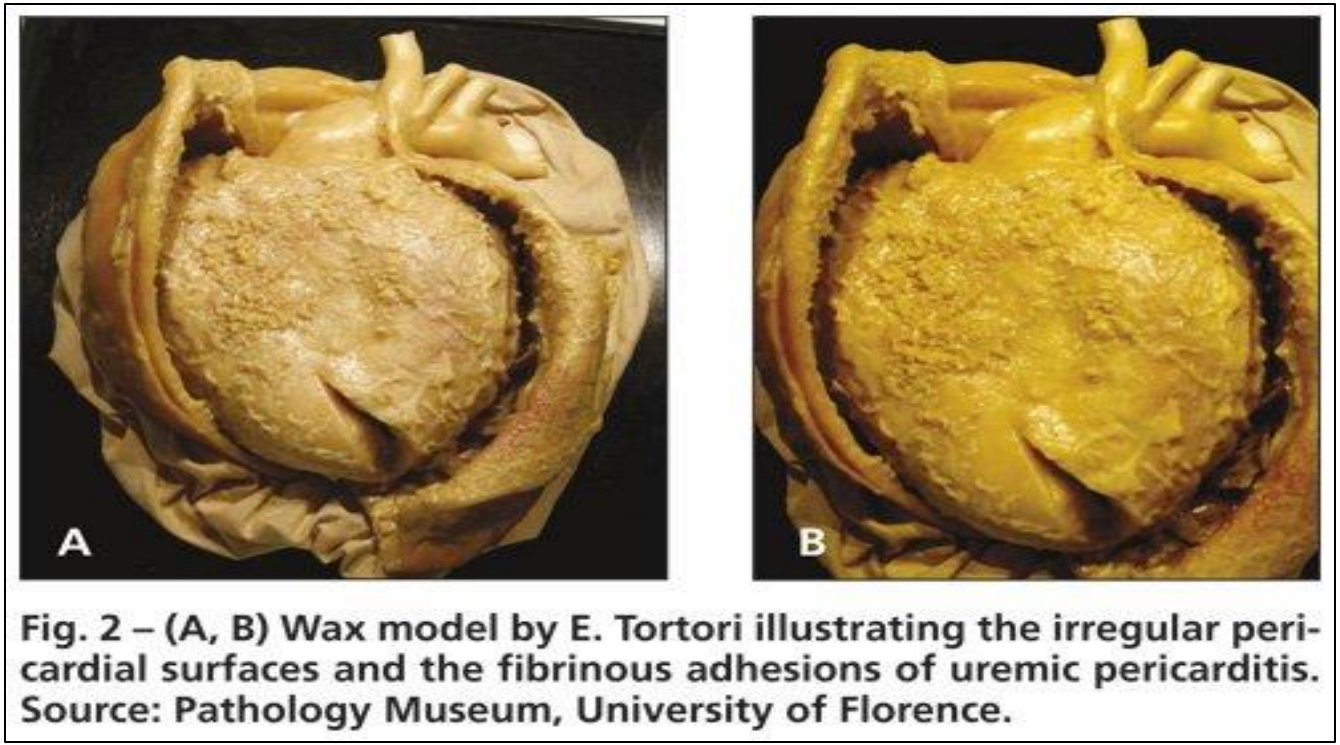


Fig. 2 – (A, B) Wax model by E. Tortori illustrating the irregular pericardial surfaces and the fibrinous adhesions of uremic pericarditis. Source: Pathology Museum, University of Florence.

http://www.e-coretvasa.cz/text/view?id=9551

Hematologic Alterations

- Anemia
- Decreased Erythropoietin
- Decreased Red Blood Cell Survival
- Iron and Folic Acid Deficiency
- Bleeding

Gastrointestinal Alterations

- Mouth Inflammation (ulcers)
- Anorexia
- Nausea
- Vomiting
- Hiccups
- Uremic Colitis
- Diarrhea or Constipation

Neurologic Alterations

- Lethargy and Daytime Drowsiness
- Decreased Attention Span
- Insomnia
- Weakness in Extremities
- Parentheses
- Seizures and Coma

Pulmonary Alterations

- Respiratory Effort Changes (Kussmaul's Breathing)
- Breath Smells Like Urine (Uremic Halitosis)
- Deep Sighing
- Yawning
- Shortness of Breath

Integumentary Manifestations

- Skin Oils and Turgor Decreased
- Pruritus (itching)
- Ecchymoses (bruises)
- Purpura (purple patches)
- Uremic Frost

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

Uremic Frost

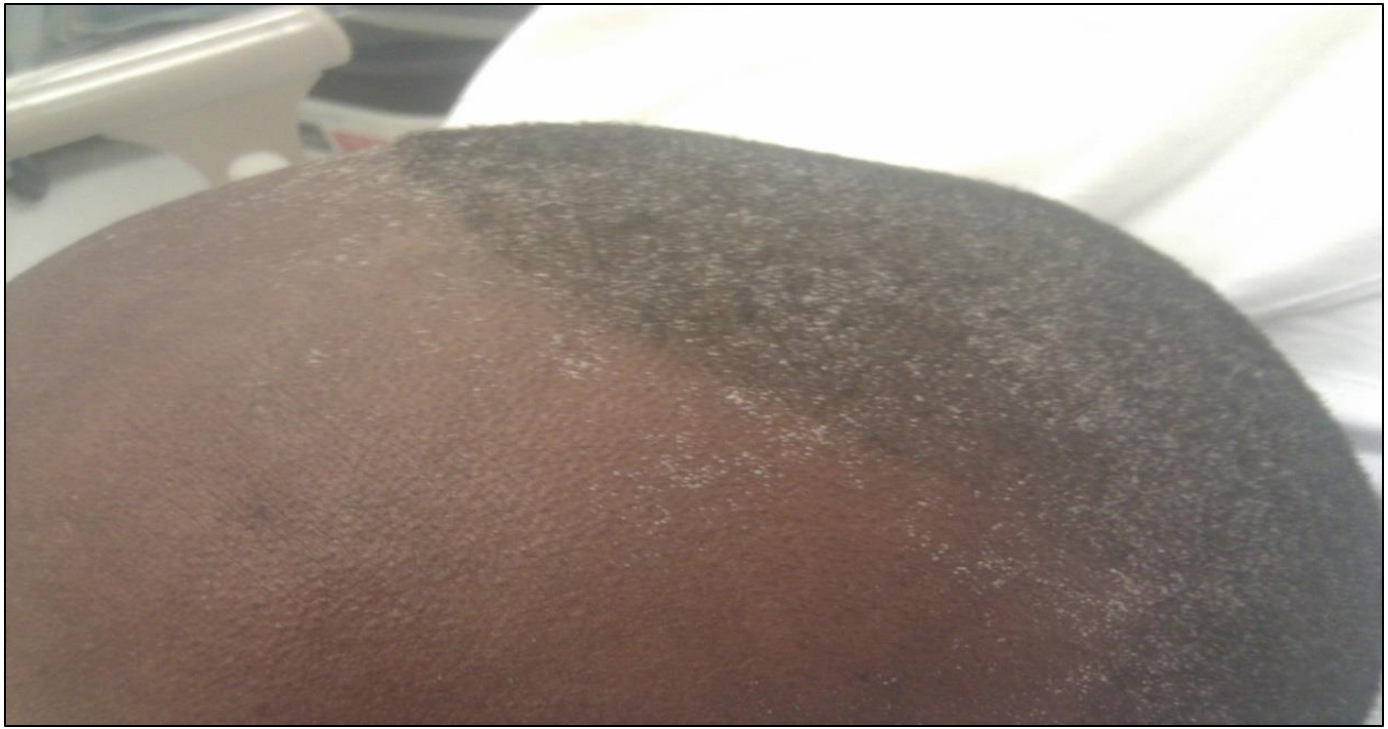
- Uremic frost is a colloquial description for crystallized urea deposits that can be found on the skin of those affected by chronic kidney disease. In states of prolonged kidney failure and subsequent uremia, the high level of urea in the bloodstream leads to high levels of urea secreted by eccrine sweat glands as a component of sweat. As water evaporates off of the skin, it results in crystallization of the remaining urea.

Dennis, Mark; Bowen, William Talbot; Cho, Lucy (2012). "Uremic frost". Mechanisms of Clinical Signs. Elsevier. p. 556. ISBN 978-0729540759; pbk

- This condition is more common in severe, untreated uremia and is associated with serum BUN levels >200. It is becoming rare in people with chronic kidney disease managed on long-term hemodialysis, with estimated prevalence between 0.8 and 3 percent.

Lynde, Carrie; Kraft, John. "Skin manifestations of kidney disease". Parkhurst Exchange. Retrieved 2 October 2014.

Uremic Frost



https://commons.wikimedia.org/w/index.php?curid=47569752 Fythrion at English Wikipedia, CC BY-SA 3.0,

Metabolic Alterations

- Urea and Creatinine
- Sodium
- Potassium
- Acid-Base Balance
- Calcium and Phosphate

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

Sodium

Hyponatremia
Fluid Excess
Sodium Deficit

Hypernatremia
Fluid Deficit
Sodium Excess

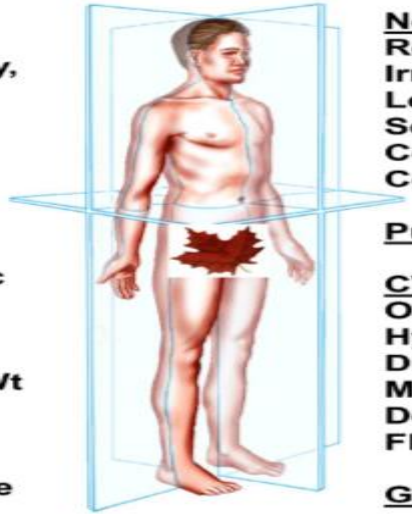
Neuro: Headache, Fatigue, Apathy, Seizures, Confusion → Coma

Pulm: Resp Distress

CV: Orthostatic Hypotension, Drop CVP

GI: Anorexia, Wt Loss, N/V, Abd Cramps

Mus/Sk: Muscle Weakness



Neuro: Restlessness, Irritability, Lethargy, Seizures, Confusion→ Coma

Pulm: Dyspnea,

CV: Tachycardia, Orthostatic Hypotension, Dry Mucous Membranes, Dehydration, Flushed Skin

GU: Low Urine

Mus/Sk: Muscle Weakness

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

Potassium

Hypokalemia
Decrease Intake
Increased Loss
Shift of K into Cells

Hyperkalemia
Excess Intake
Decreased Loss
Shift K out of Cells

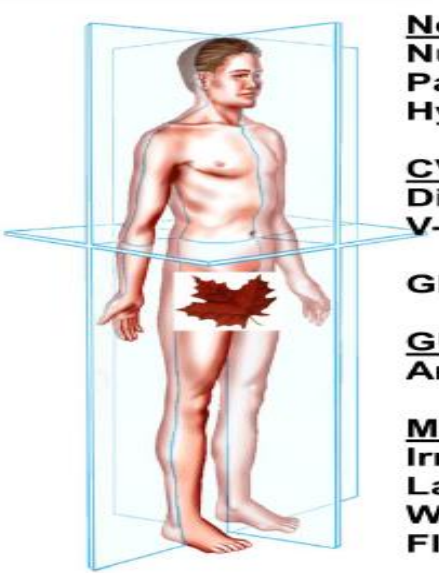
Neuro: Lethargy, Decreased Reflexes, Confusion, Depression

CV: Drop BP, Dysrhythmias, Cardiac Arrest

GI: Anorexia, N/V, Distension Ileus

GU: Dilute, Urine, Water Loss, Thirst

Mus/Sk: Weak, Flaccid, Resp Arrest



Neuro: Numbness, Paresthesias, Hyporeflexia

CV: Conduction Disturbances, V-Fib, Asystole

GI: N/V/D

GU: Oliguria, Anuria

Mus/Sk: Early → Irritabliity
Late → Weakness
Flaccid Paralysis

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

Magnesium

Hypomagnesemia
Excess Loss
Decreased Intake
Impaired Absorption
Alkalosis

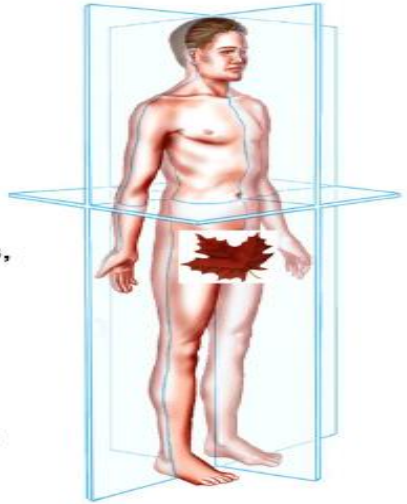
Hypermagnesemia
Excess Intake
Renal Insufficiency/Failure
Acidosis

<u>Neuro:</u> Agitation, Depression, Confusion, Convulsions, Paresthesias, Ataxia, Hyperreflexia, Vertigo, Seizures

<u>CV:</u> Dysrhythmias, Tachycardia, Hypertension, Vasoconstriction

<u>GI:</u> N/V

<u>Mus/Sk:</u> Cramps, Spasticity, Tetany



<u>Neuro:</u> Hyporeflexia, Lethargy → Coma

<u>Pulm:</u> Resp Depression, Apnea

<u>CV:</u> Dysrhythmias, Hypotension, Flushed/Warm Skin, Vasodilation

<u>Mus/Sk:</u> Muscle Fatigue, Hypotonia, Bone Pain, Osteoporosis, Fractures

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

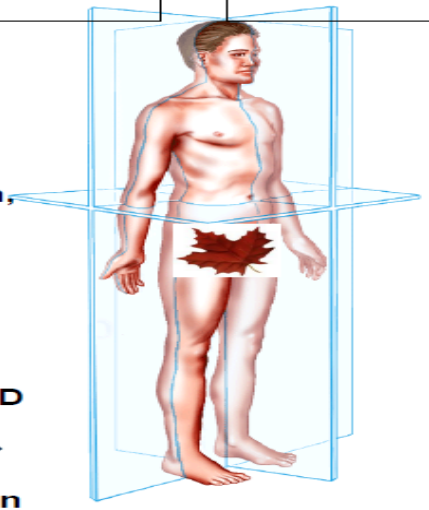
Calcium

Hypocalcemia

Excess Loss
Inadequate Intake
Decreased Ionized
GI/Bone Absorption
↓Alkalosis

Hypercalcemia

Excess Intake
Loss from Bones
Mobilization from Bones
↑Acidosis



Neuro: Tingling → Convulsions, Hyperreflexia
Pulm: Larynogospasm, Bronchospasm
CV: Dysrhythmias, Cardiac Arrest, Bruising, Bleeding
GI: Inc Peristalsis, N/V/D
Mus/Sk: Osteoporosis → Fractures, Abn Deposits of Ca in Body Tissues, Muscle Spasm, Tetany

Neuro: Dec Reflexes, Lethargy → Coma, Seizures
CV: Depressed Activity, Dysrhythmias, Cardiac Arrest
GI: Dec GI Tract Motility, N/V, Constipation
GU: Kidney Stones, Flank Pain
Mus/Sk: Muscle Fatigue, Hypotonia, Bone Pain, Osteoporosis, Fractures

ECG Changes
Hypo: > ST segment, > QT, torsades de pointes, < HR
Hyper: Short ST/QT, Heart Blocks

http://www.hagerstowncc.edu/sites/default/files/documents/15-coned-ccrn-renal.pdf

Mineral and Bone Disorder

- Mineral and bone disorder related to kidney disease happens when there is an imbalance in your blood levels of calcium and phosphorus
- This mineral imbalance can affect your bones, heart and blood vessels

https://www.kidney.org/atoz/content/MineralBoneDisorder

Kidney Failure Leads to Bone and Heart Disease

- Kidneys can no longer filter out extra phosphorus and remove it from the body in the urine
- Over time, phosphorus from the foods you eat can build up to high levels in your blood
- Healthy kidneys also change vitamin D from sunlight and the foods you eat into active vitamin D that your body can use. When kidneys fail there is a short supply of active vitamin D. This causes calcium and phosphorus to get out of balance.
- When the blood phosphorus level goes up and blood vitamin D level goes down, your body makes too much parathyroid hormone (PTH). High PTH levels cause calcium to move from your bones into your blood. As calcium leaves your bones they become weaker, more brittle, and are more likely to break. Some calcium may also end up in the heart and blood vessels. This may cause or worsen heart disease.

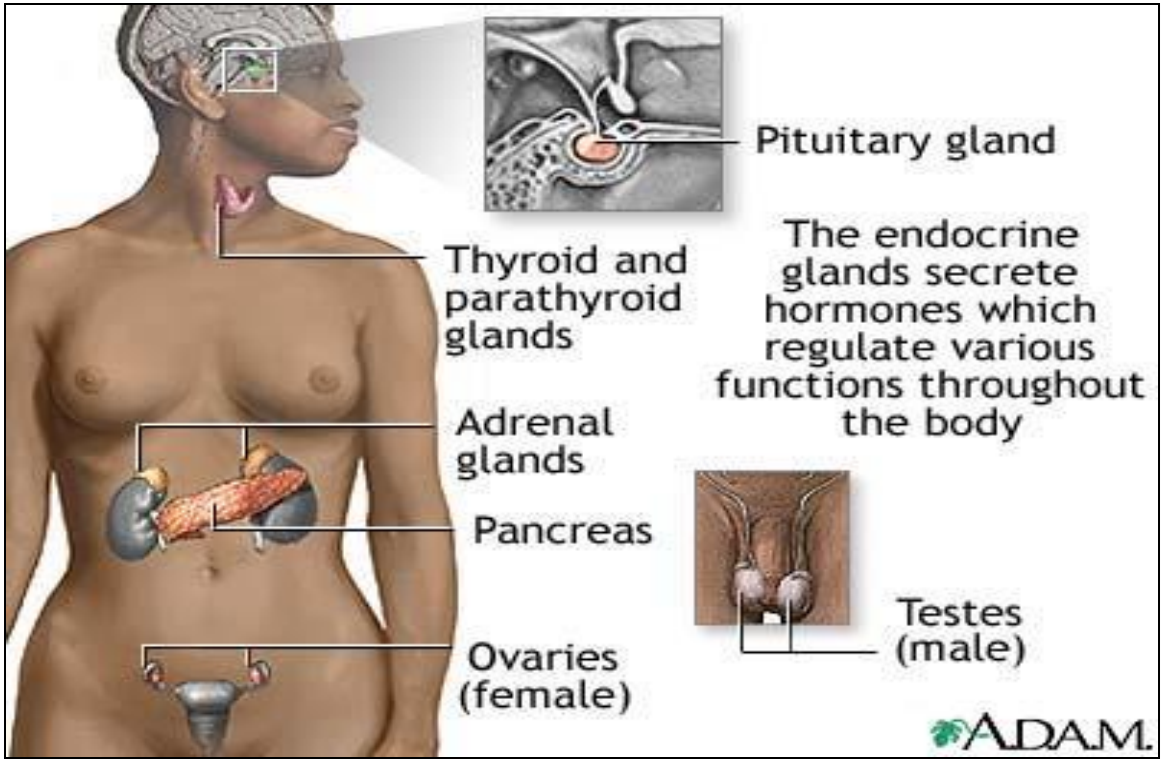
https://www.kidney.org/atoz/content/MineralBoneDisorder

Signs and Symptoms of Mineral and Bone Disorder

- Itchy skin
- Bone pain
- Weak bones that break easily
- Blocked blood vessels
- Heart problems
- Anemia
- Nerve problems
- Difficulty fighting off germs

https://www.kidney.org/atoz/content/MineralBoneDisorder

Endocrine Gland Functions



http://www.nlm.nih.gov/medlineplus/ency/imagepages/1093.htm

Secondary Hyperparathyroidism

Parathyroid hormone helps maintain blood calcium by regulating bone turnover, absorption of calcium from the gut, and release of calcium in the urine.

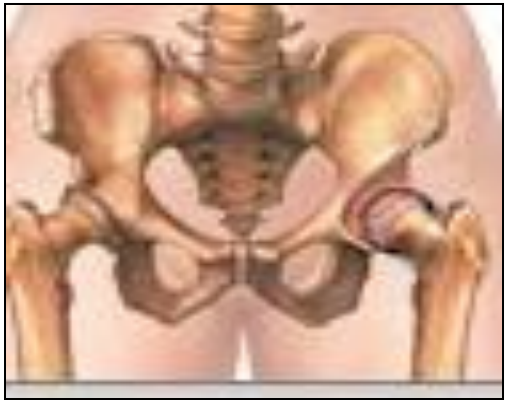
Secondary Hyperparathyroidism

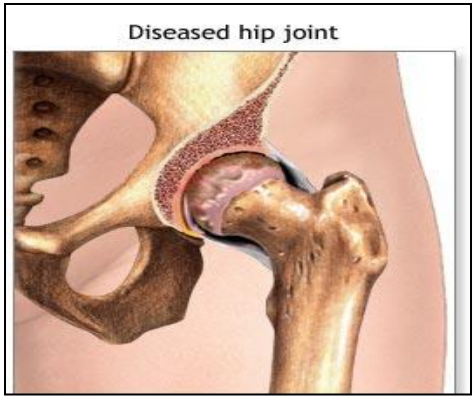
- Not enough phosphate is cleared from the body
- Phosphate is released from bone
- Vitamin D is not produced
- Absorption of calcium in the gut is low
- Blood levels of calcium are lowered
- Bone is broken down in an attempt to regulate abnormal levels of the above chemicals, and the high levels of phosphates in the blood rise higher

Secondary Hyperparathyroidism

Symptoms include

- Osteomalacia
- Osteoporosis
- Bone pain
- Fractures





Reduced Urination

- Fully functioning kidneys clean the blood of wastes and excess fluid
- These items are eliminated through urine
- Because kidneys with ESRD do a very poor job of removing these items, waste and fluid build up to unhealthy levels in the body and can make a person feel sick
- This is a condition called uremia
- When fluid is not removed from the body, tissues will swell and lead to a condition called edema
- Excess fluid in the bloodstream can also increase blood pressure

Complications

Kidney damage, once it occurs, can't be reversed. Potential complications can affect almost any part of the body and can include

- Fluid retention, which could lead to swelling in the arms and legs, high blood pressure, or fluid in the lungs (pulmonary edema)
- A sudden rise in potassium levels in the blood (hyperkalemia), which could impair the heart's ability to function and may be life-threatening
- Heart and blood vessel (cardiovascular) disease
- Weak bones and an increased risk of bone fractures
- Anemia

https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-2035453

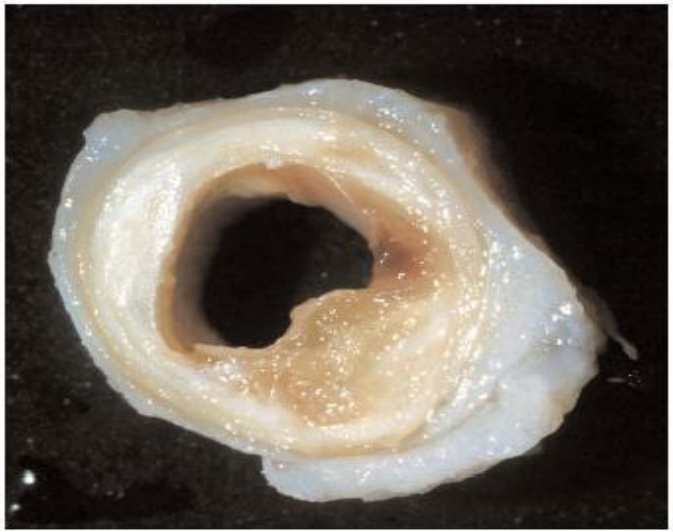
Complications

- Decreased sex drive, erectile dysfunction or reduced fertility
- Damage to your central nervous system, which can cause difficulty concentrating, personality changes or seizures
- Decreased immune response, which makes a person more vulnerable to infection
- Pericarditis, an inflammation of the saclike membrane that envelops the heart (pericardium)
- Pregnancy complications that carry risks for the mother and the developing fetus
- Irreversible damage to the kidneys (end-stage kidney disease), eventually requiring either dialysis or a kidney transplant for survival

https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/symptoms-causes/syc-2035453

Comorbid Conditions
Coronary Heart Disease

Failure of coronary circulation to supply adequate circulation to cardiac muscle and surrounding tissue

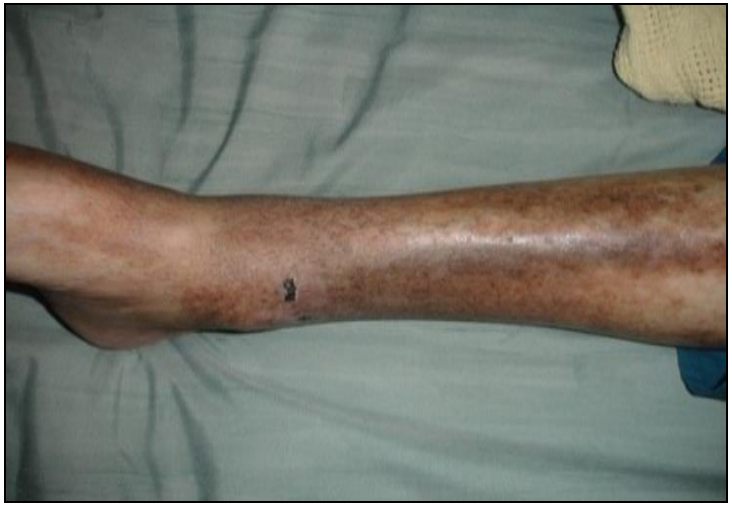


http://en.wikipedia.org/wiki/Coronary_heart_disease

http://www.faqs.org/nutrition/Ca-De/Cardiovascular-Disease.html

Comorbid Conditions
Peripheral Vascular Disease

- Disease caused by the obstruction of large peripheral arteries leading to stenosis, an embolism or thrombus formation
- It causes either acute or chronic ischemia



http://en.wikipedia.org/wiki/Peripheral_vascular_disease

http://www.oxfordjournals.org/our_journals/bjaint/eletter/brjanael3152fig1.jpg

Vascular Dementia

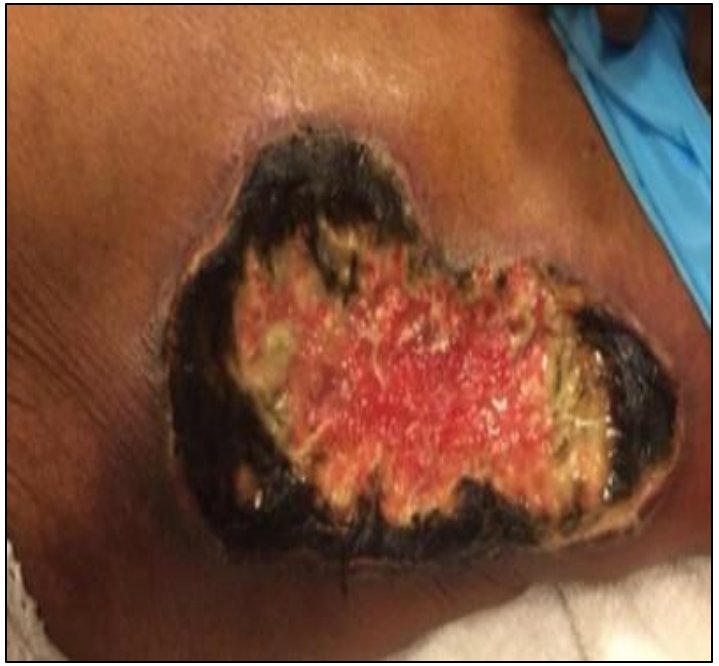
Decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of vital oxygen and nutrients. Vascular dementia signs and symptoms include

- Confusion
- Trouble paying attention and concentrating
- Reduced ability to organize thoughts or actions
- Decline in ability to analyze a situation, develop an effective plan and communicate that plan to others
- Difficulty deciding what to do next
- Problems with memory
- Restlessness and agitation
- Unsteady gait
- Sudden or frequent urge to urinate or inability to control passing urine
- Depression or apathy

https://www.mayoclinic.org/diseases-conditions/vascular-dementia/symptoms-causes/syc-20378793

Calciphylaxis

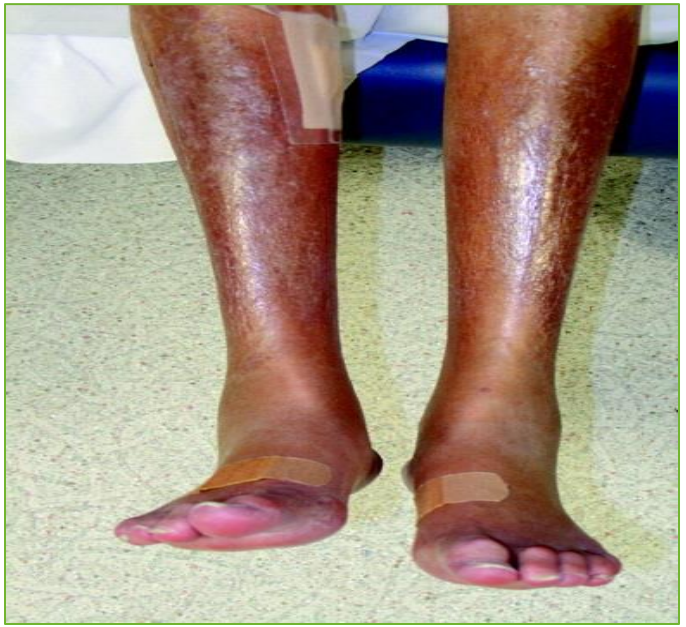
- Syndrome of vascular calcification and skin necrosis
- Results in chronic non-healing wounds



https://www.dovepress.com/cr_data/article_submission_image/s115000/115701/24_aug_2016_figure_190.jpg

Nephrogenic Systemic Fibrosis

- Involves fibrosis of skin, joints, eyes and internal organs
- Patients develop large areas of hardened skin
- Flexion contractures with an accompanying limitation of range of motion can also occur



Preethi Yerram et al American Society of Nephrology 2007;2:258-263

Nephrogenic Systemic Fibrosis

- Patients with Nephrogenic Systemic Fibrosis may develop large areas or patches of hardened skin or thickened skin with fibrotic nodules and plaques
- These areas of thick skin and flexion contractures can severely limit a patient's range of motion

Activity Limitations

- Fatigue
- Exercise intolerance
- Mobility

2019 Hospice Workshop Series

Part 2

Part Two Agenda

- What You Need to Know for 2019
  - 2019 Final Rule
  - Targeted Probe and Educate (TPE)
  - Medicare Beneficiary Identifier (MBI)
  - Improvements in Hospice Billing and Claims Processing
- Data Driven Topics
- Comparative Billing Report (CBR)
- eServices Online Provider Portal
- Reminders
  - CERT
  - Provider Enrollment Revalidation
- Provider Resources/Self Service Tools
  - Forms/Tools
  - CMS Resources
  - Top Links
  - Social Media
  - Education/Events

What You Need to Know for 2019

2019 Hospice Final Rule

Change Request (CR) 10573

MLN Matters® SE18007: Recent and Upcoming Improvements in Hospice Billing and Claims Processing

Targeted Probe and Educate (TPE)

The Medicare Beneficiary Identifier (MBI)

2019 Hospice Final Rule

Changes in regulations text to recognize physician assistants (PAs) as designated attending physician

- Effective January 1, 2019
- Result of Section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123), which amended section 1861 (dd)(3)(B) of the Social Security Act
- Defined as a professional who graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform

Final Rule (CMS-1692-F)

2019 Hospice Final Rule

- Payment may be made for PA services when selected by the patient as the attending physician
  - Payment is made at 85 percent of the fee schedule amount
- May not act as medical directors or physicians of the hospice or certify beneficiary's terminal illness
- Hospices may not contract with a PA for attending physician services
- Not allowed to perform the face-to-face encounter

Final Rule (CMS-1692-F)

Change Request (CR) 10573

- Issued: April 27, 2018
- Effective: October 1, 2018
- Implementation: October 1, 2018
- Subject: Enhancements to Processing of Hospice Routine Home Care Payments
- Purpose: Creates new fields on the hospice pricer output to display the number of days paid at the high, and at the low rates, adds a separate field on the claim record that will store the days from a prior period and provides instructions to discontinue submission of detailed drug data on the hospice claim
- Applies to: Dates of service on or after October 1, 2018

Change Request 10573

CR 10573

- Adds Value Codes 62 to indicate the total number of RHC days paid at the high rate and Value Code 63 to indicate the number of days paid at the low rate
  - Value codes are added by the Medicare Administrative Contractor (MAC) when the claim is processed
- Hospices have to option to begin reporting a monthly charge total for all drugs using revenue code 0250 and DME infusion using revenue code 029x and DME infusion drugs using revenue code 0294
  - Reporting of revenue code 0636 is no longer required
  - Reporting of NDCs for drugs is no longer required

Change Request 10573

Improvements in Hospice Billing and Claims Processing

MLN Matters® SE18007

- Issued: June 7, 2018
- Subject: Recent and Upcoming Improvements in Hospice Billing and Claims Processing

MLN Matters® SE18007

Improvements in Hospice Billing and Claims Processing

Redesign of CWF hospice information that has the following benefits

- Reduce NOE timely filing exception requests for providers, by ensuring benefit periods can be cancelled without removing the NOE receipt date
- Allow NOTRs to be submitted at any time, rather than only when a benefit period covering the revocation date has been created by claims
- Reduce workload for providers when reprocessing periods by automatically removing benefit periods when all claims in the period are cancelled
- Enable easier implementation of future policy changes by ensuring data in Medicare systems reflect hospice coverage requirements more clearly

Improvements in Hospice Billing and Claims Processing

- Changes also include new election period file and screen
  - Hospices will view the Hospice Election Period screen to determine the existence of a hospice election
  - Hospices will view a separate screen for benefit period information
- NOEs will no longer set up the benefit periods
  - Benefit periods will be set up when the first claim is submitted

MLN Matters® SE18007

Hospice Benefit Period — Screen One

```
     HIQACOP                    CWF  PART A  INQUIRY REPLY                PAGE 02 OF 20

IP-REC  CN                    NM           IT      DB              SX


IMMUNO/TRANSPLANT DATA  COV. IND.:         TRANS. IND.:      DISCH. DATE: 000000
                                                                          000000
                                                                          000000
HOSPICE DATE    PERIOD 003 OWNER CHANGE 003 PERIOD 002 OWNER CHANGE 002
START DATE1     031218      000000          122417      000000
TERM DATE1      051018                      031018
PROV1

INTER 1         11004                       11004
DOEBA DATE      031218                      122417
DOLBA DATE      043018                      031018
DAYS USED       030                         077
START DATE2     000000      000000          000000      000000
PROV2

INTER2
REVOCATION IND 0                            0

 PF1=INQ SCREEN   PF3/CLEAR=END    PF7=PREV    PF8=NEXT
```

Hospice Benefit Period — Screen Two

```
     HIQACOP                    CWF  PART A  INQUIRY REPLY                PAGE 03 OF 20

IP-REC  CN                    NM           IT      DB              SX


IMMUNO/TRANSPLANT DATA  COV. IND.:         TRANS. IND.:      DISCH. DATE: 000000
                                                                          000000
                                                                          000000
HOSPICE DATE    PERIOD 001 OWNER CHANGE 001 PERIOD 000 OWNER CHANGE 000
START DATE1     092517     000000           000000      000000
TERM DATE1      122317                      000000
PROV1

INTER 1         11004
DOEBA DATE      092517                      000000
DOLBA DATE      122317                      000000
DAYS USED       090                         000
START DATE2     000000     000000           000000      000000
PROV2

INTER2
REVOCATION IND 0

 PF1=INQ SCREEN    PF3/CLEAR=END     PF7=PREV     PF8=NEXT
```

Hospice Election Period Screen

```
HIQACOP                    CWF  PART A  INQUIRY REPLY                PAGE 18 OF 20
                             HOSPICE ELECTION PERIOD

IP-REC  CN                    NM          IT      DB              SX        INT 11004



HOSPICE
ELECTION        PERIOD  2       PERIOD  1       PERIOD          PERIOD

ELECT DATE      03122018        09252017
RECIPT DATE     04202018        09272017
REVOC DATE                      03102018
REVOC IND       0               1
PROVIDER
NPI

 PF1=INQ SCREEN    PF3/CLEAR=END     PF7=PREV     PF8=NEXT
```

Improvements in Hospice Billing and Claims Processing

- NOEs for a subsequent election will not post if the current election period is not terminated
- Providers must submit an NOTR or final claim to terminate an existing election in order for a subsequent NOE to process and post

MLN Matters® SE18007

Improvements in Hospice Billing and Claims Processing

NOTR (8XB) submission changes require the following

- If no change in the provider number has been made, the "from" date submitted on the NOTR will match the effective election date
  - Date submitted on the NOE (8XA)
- If the revocation/discharge date follows a transfer, the "from" date on the NOTR must match the Start DATE2 on the benefit period that initiated the transfer
  - The "from" date on the 8XC that the receiving hospice submitted
- Admission date on the NOTR must match the "from" date

MLN Matters® SE18007

Improvements in Hospice Billing and Claims Processing

With the implementation of the July, 2018 Quarterly Systems Release, an NOTR can be submitted even if the discharge / revocation date is outside of the current benefit period posted to the Common Working File (CWF)

MLN Matters® SE18007

Removing a Notice of Termination/Revocation (NOTR)

- To remove an NOTR that was filed in error, providers will need to follow the steps outlined below
  1. Cancel the final claim — if the final claim has not yet been submitted, you will need to submit it with the “through” date as the date that was submitted on the NOTR. Once the final claim has processed, initiate a cancelation claim.
     - Check the Hospice Election Period (HOEP) screen to see if the revocation date and indicator were removed. If the revocation date and indicator have been removed, proceed with resubmitting the final claim. If the revocation date and indicator are not removed, proceed to step two.

Notice of Termination/Revocation of Election (TOB 8XB) Job Aid

Removing an NOTR

2. Cancel all claims in the benefit period in which the NOTR ended the hospice election

- After all claims in the benefit period have been canceled, check the HOEP screen again. If the revocation date and indicator have been removed, proceed with resubmitting the claims in sequential order. If the revocation date and indicator are not removed, proceed to step three.

Notice of Termination/Revocation of Election (TOB 8XB) Job Aid

Removing an NOTR

3. Cancel the NOE
   - This will remove the entire election period and will need to be resubmitted
   - Once the NOE has been canceled, you will need to resubmit it within two business days after the cancelation was completed
   - Upon resubmitting the claims in sequential order, you will need to request an exception to the late NOE based upon the system limitations that would not allow you to remove the NOTR that was submitted in error

Notice of Termination/Revocation of Election (TOB 8XB) Job Aid

Targeted Probe and Educate (TPE)

Background

- TPE began as a pilot program in June of 2016
- Developed from the Inpatient as well as HH Probe and Educate models
  - Prior models included participation of all providers with smaller review samples
- Previous success was demonstrated
  - Decreased appeals
  - Increased acceptance of provider education

Change Request 10249

What is TPE?

- MAC conducts data analysis to identify areas with the greatest risk of inappropriate program payment
- CMS may also identify areas of risk and direct MAC to review
- Providers are selected for review based on data analysis
  - Provider-specific only
  - Eliminates service-specific reviews

How the TPE Process Works

- Conduct data analysis of billing data indicating aberrancies that may suggest questionable billing practices
  - May include providers previously reviewed on a targeted or service-specific review with high error rate
- Notification letters are mailed to providers selected for review
- Up to three rounds of review
  - Limited to 20 to 40 claims per round
  - Rounds two and three (if applicable) for HHH will begin with submission dates 45–56 days after the individual provider education is provided
  - Discontinuation of review may occur if appropriate improvement and compliance is achieved during the review process

How the TPE Process Works

- Prior to conclusion of each round, medical reviewer will call the provider to discuss summary of the review
- At conclusion of each round, letter with review results will be mailed to the provider
- If high denial rate continues after three rounds, provider will be referred to CMS

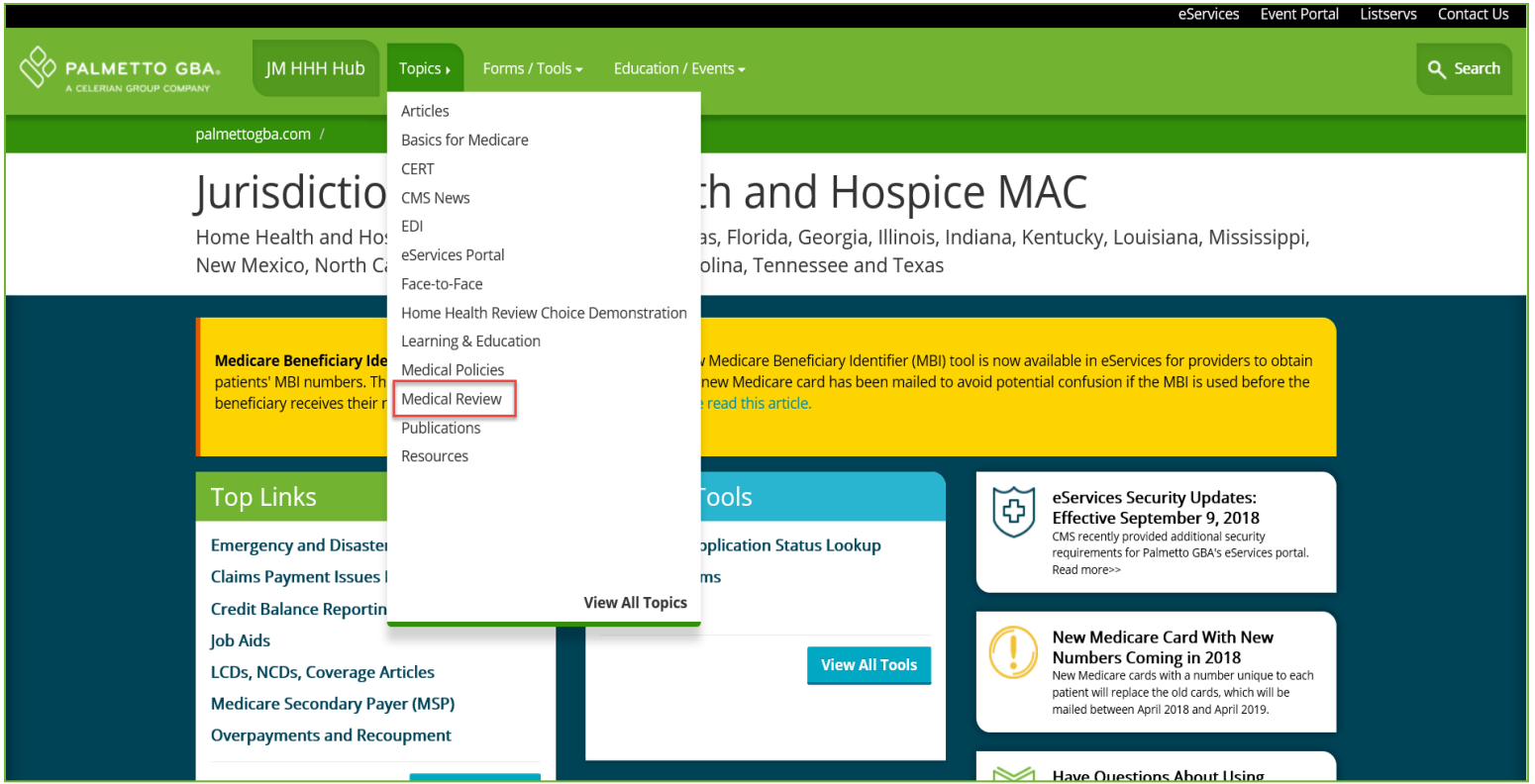
S B6000 vs. S B6001

- When a claim is selected for possible TPE review, it will go into an S B6000 location in Direct Data Entry (DDE)
  - Narrative will indicate the claim was selected and documentation is requested
- Do not respond with medical documentation unless the claim moves to S B6001 location
- Claims in location S B6000 may not advance to S B6001 for review and could be released for processing without review

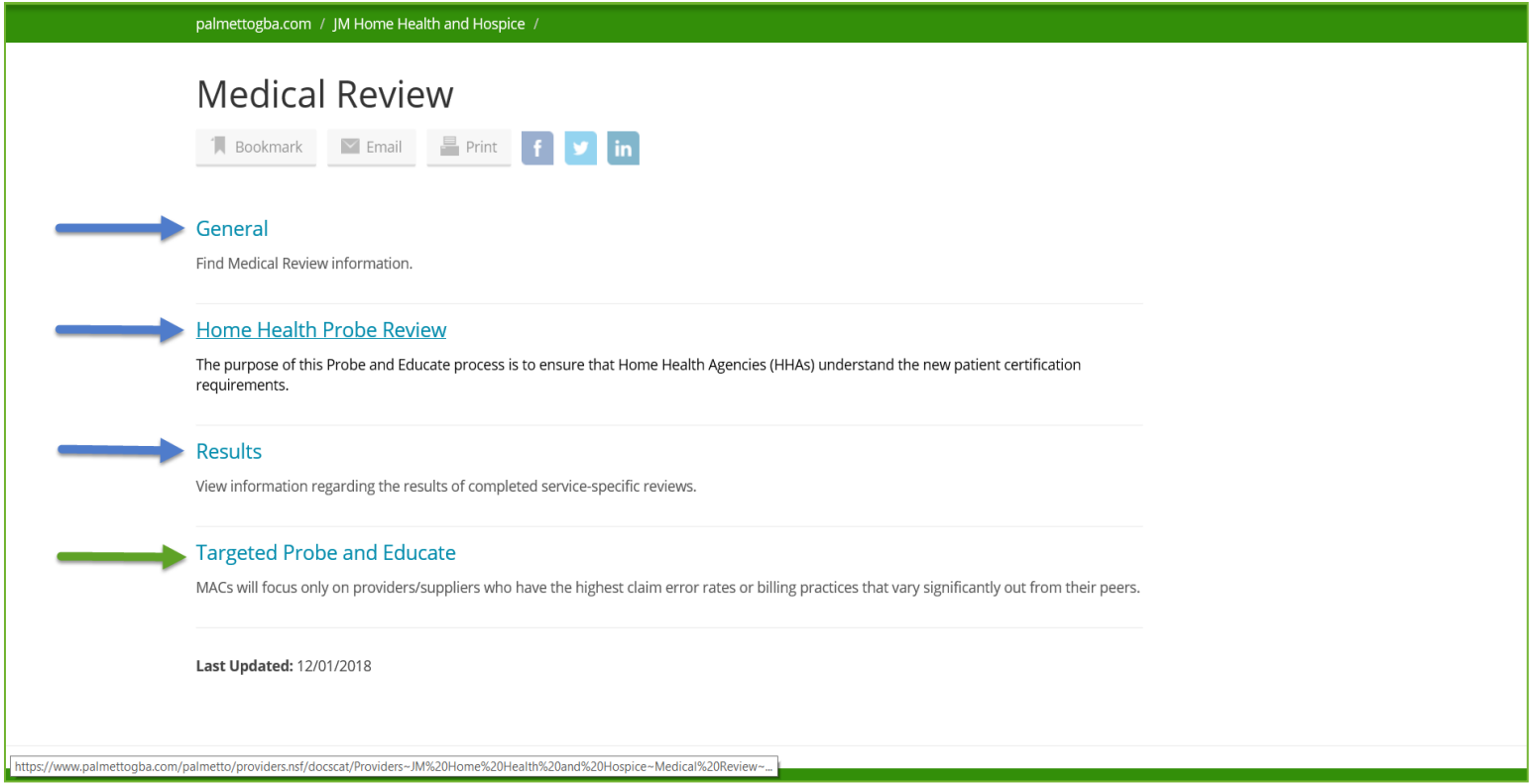
Provider Contact

- It is imperative when responding to the ADR that you include the name and number of your designated contact person
- Our medical reviewer will contact your designated person to discuss a pattern discovered during the review and/or prior to the conclusion of each TPE round to discuss the review summary

TPE Resources



TPE Resources



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TPE Resources

2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE) Teleconference Schedule

- These calls are open to all providers. Please mark your calendars to join our Medical Review Subject Matter Experts as they discuss and answer your questions concerning current TPE process.
  - March 4, 2019
  - June 3, 2019
  - September 3, 2019
  - December 2, 2019

Palmetto GBA Event Registration Portal

Common TPE Questions and Answers

Is there a documented threshold to determine if the provider should move to the next round?

- TPE claim denial or charge denial rate of 20 percent or above may result in progression to the next round

Who conducts the TPE reviews at Palmetto GBA?

- Registered Nurses
- Certified Coders
- Physical Therapists

Common TPE Questions and Answers

Who should participate in the 1:1 education?

- There are no requirements for who should participate
- Anyone the organization chooses to participate in the call is welcome
- Recommend including participant(s) that can benefit from the education and can facilitate implementation of any necessary changes

Common TPE Questions and Answers

What is the process to appeal a TPE denial?

- The appeals process has not changed due to TPE
- If you have a review determination during TPE that results in a claim denial, we encourage you to review the medical records you submitted, and if you disagree with that determination — you should follow the established appeal's process

Can we designate where the notification or results letters are mailed to?

- Letters are mailed to the correspondence address as listed on the Provider 855A or 855B

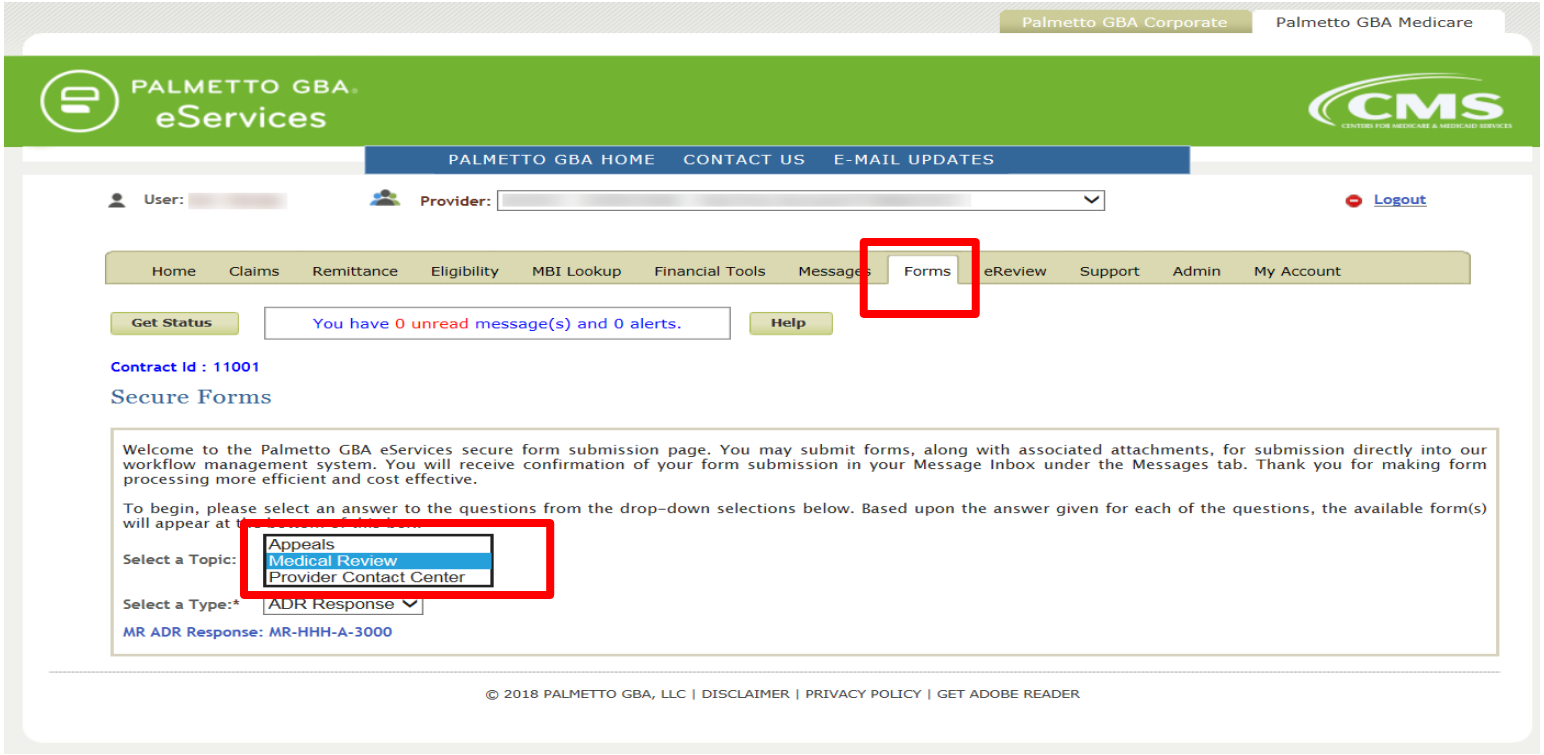
Responding to a TPE Additional Documentation Request (ADR)

Responding to an ADR

eServices

- Must be PDF document
- Unlimited number of attachments
  - Each attachment up to 40 MB
  - A total of 150 MB for all attachments combined

Responding Through eServices



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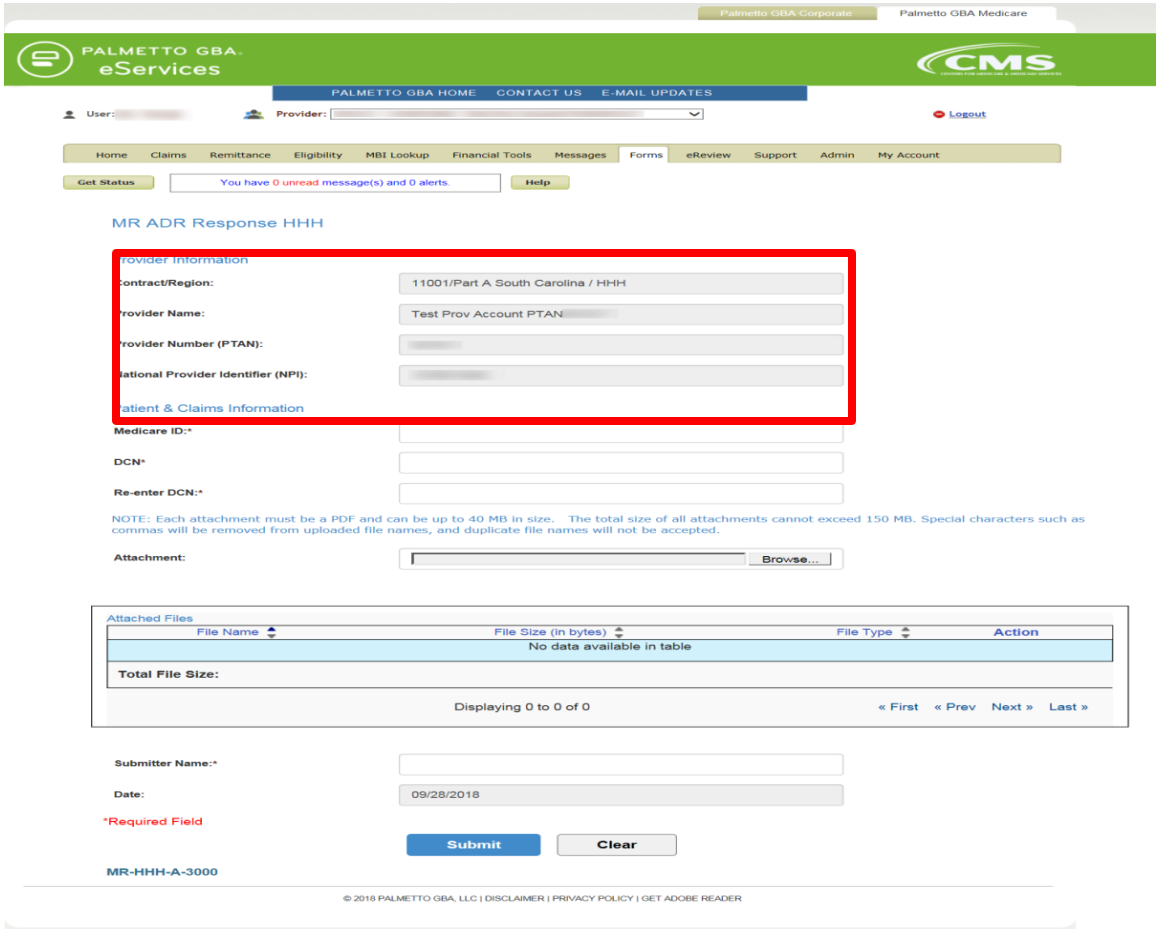
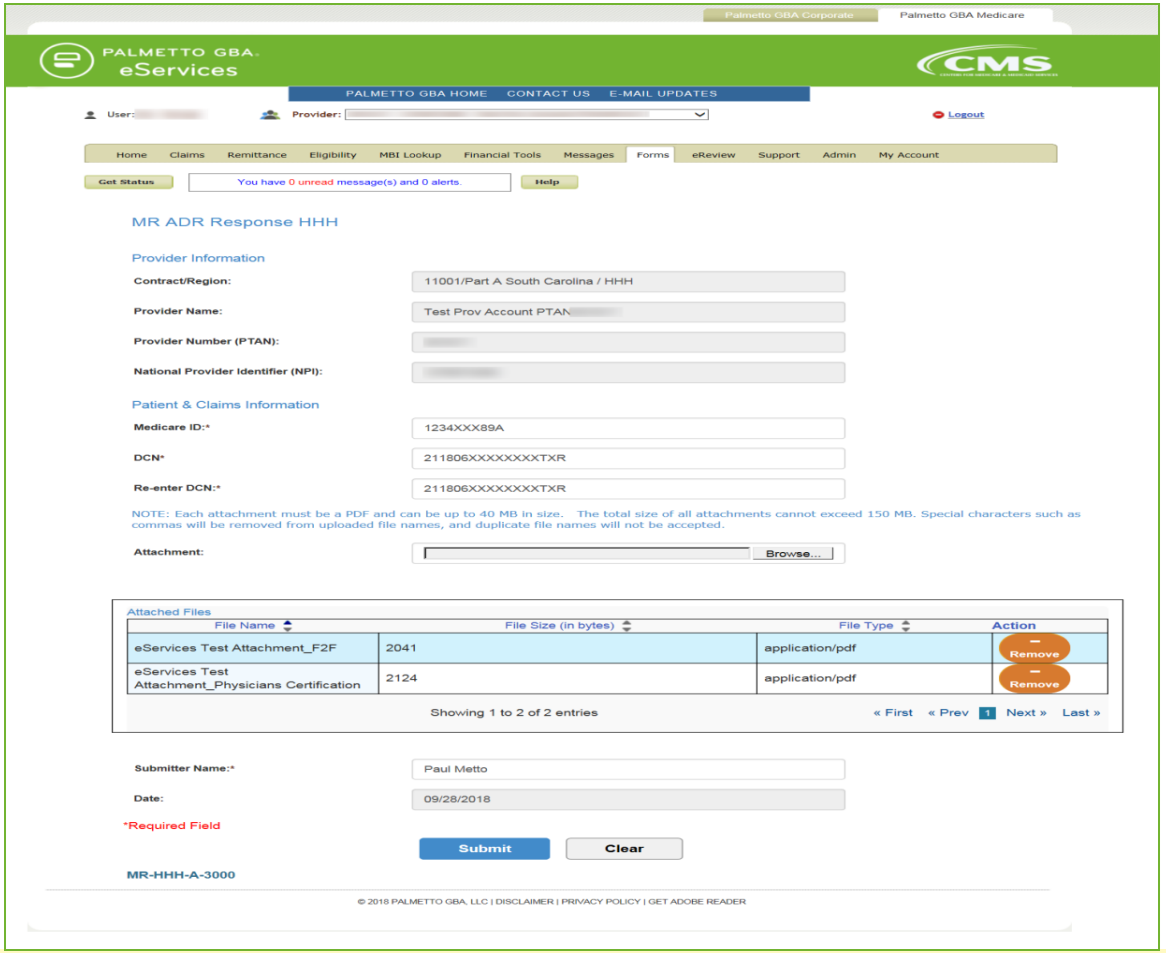
eServices ADR Response Form



eServices Sample ADR Response Form



Responding to an ADR

Fax

- Back of page
- Margins
- Clean copy
- Colored pages

CD

- Each record as an individual image
- Password

Responding to an ADR

Mail

- Attach a copy of the ADR request to each individual claim
- If responding to multiple ADRs, separate each response and attach a copy of the ADR to each individual set of medical records
- Ensure each set of medical records is bound securely so the submitted documentation is not detached or lost
- Do not mail packages C.O.D.
- Return the medical records to the address on the ADR
- Be sure to include the appropriate mail code

Medicare Beneficiary Identifier (MBI) Updates

MBI Transition Period

- Transition period: **April, 2018, through December 31, 2019**
- Systems began to accept and return the MBI on April 1, 2018
- Provides may submit **either** the MBI or HIC number during the transition period
  - CMS will actively monitor the transition and adjustment to the new MBIs to ensure adoption so Medicare operations aren't interrupted and that everyone is ready to use only MBIs by January 2020

SE18006 - New Medicare Beneficiary Identifier (MBI) Get It, Use It

MBI Transition Period

Use of HIC number and MBI for the same patient on the same batch of claims

- During the transition period, we'll process all claims with either the HIC number or MBI, even when both are in the same batch

MBI Exceptions After Transition

Once the transition period is over, you'll still be able to use the HIC number in these situations

1. **Appeals**
   - Appeal requests and related forms will be accepted with either a HIC number or MBI
2. **Adjustments**
   - HIC number can be used indefinitely for certain systems (i.e., Drug Data Processing System, Risk Adjustment Processing system and Encounter data system) for all records, not limited to adjustments

Three Ways to Obtain the MBI

- Ask your Medicare patients
  - If they haven't received a new card, give them the "Still Waiting for Your New Card?" handout (in English or Spanish) or refer them to 800-Medicare (1-800-633-4227)
- Use the MAC's secure MBI Lookup Tool
  - Sign-up for eServices
- Check the remittance advice

eServices MBI Lookup

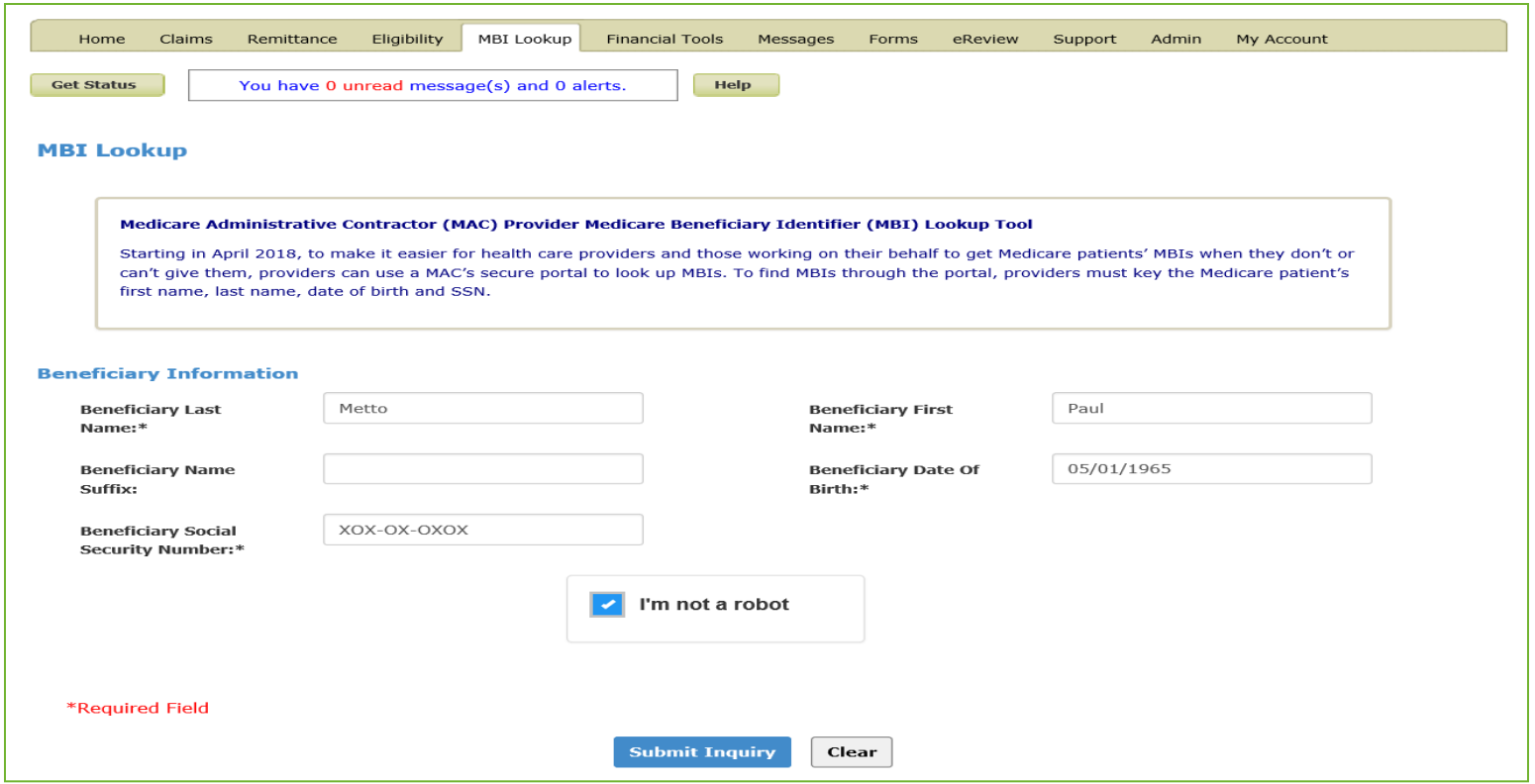
Required Fields

- Beneficiary Last Name
- Beneficiary First Name
- Beneficiary Date of Birth
- Beneficiary Social Security Number

Optional Field

- Beneficiary Name Suffix — may be entered in this field if the beneficiary has it printed on their Medicare health insurance card

MBI Lookup Tab



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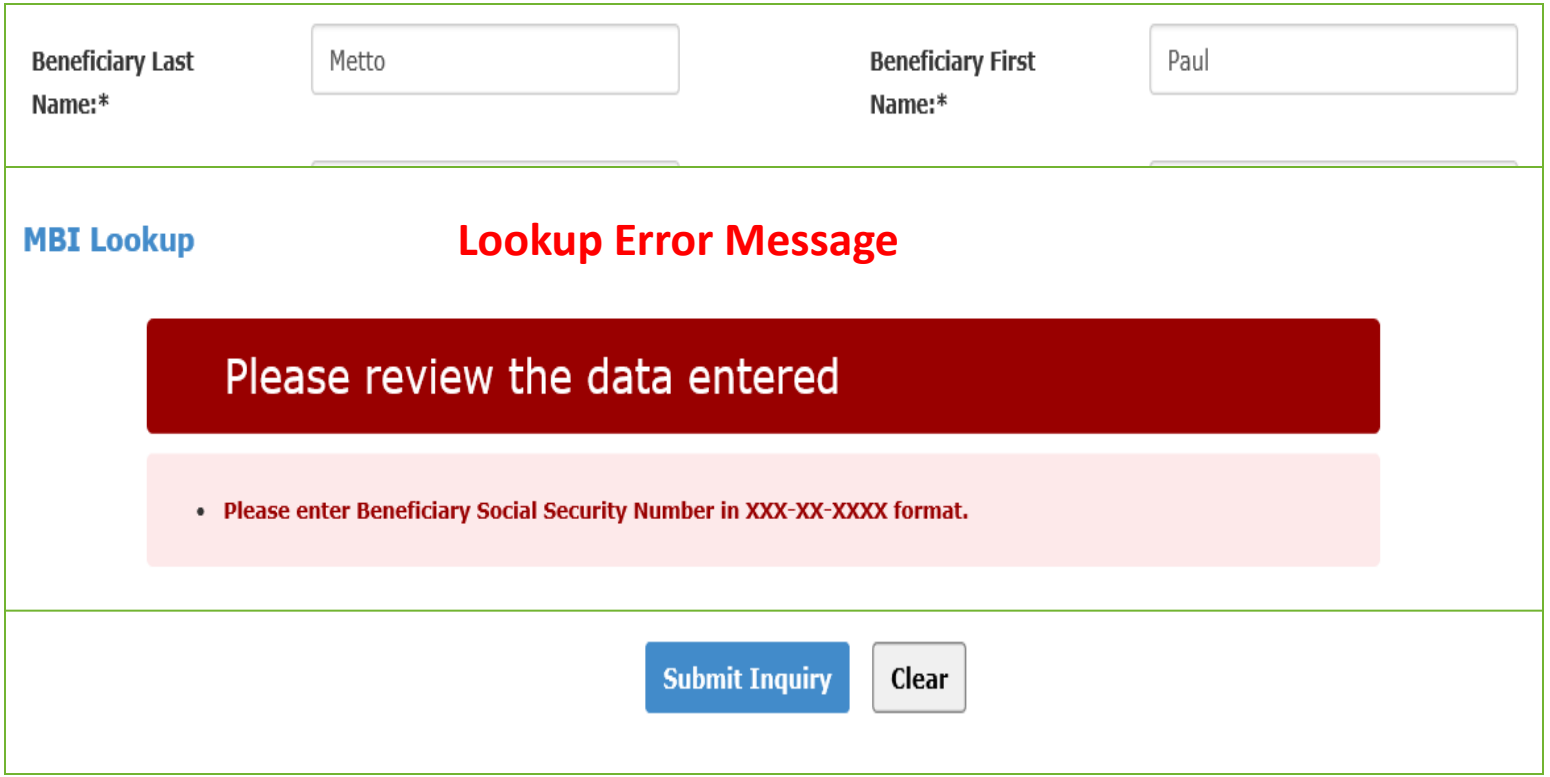
MBI Lookup Tab



FISS Paper Remittance Advice

Beginning October 1, 2018, through the transition period

- The MID field (line 32) will show the Medicare ID submitted on the claim
- The MBI field (line 66) will show the MBI when a provider submits a valid and active HICN

FISS Paper Remittance Advice

1 MEDICARE PART A 2 STREET ADDRESS 3 CITY 4 ST 5 999999999 6 VER# 5010

7 CONTACT NAME 8 PHONE: 000-000-0000 9 EXT: 10 FAX: 11 EXT: 12 EMAIL:

13 NPI# 14 PROVIDER NAME 15 PROVIDER ADDRESS 16 CITY 17 ST 18 999999999 19 PART A

20 PAID DATE: MM/DD/YYYY 21 REMIT#10 22 PAGE

23 PATIENT NAME 24 PATIENT CNTRL NUMBER 25 RC 26 REM27DRG# 28 DRG OUT AMT 29 COINSURANCE 30 PAT REFUND 31 CONTRACT ADJ

32 MID 33 ICN NUMBER 34 RC 35 REM 36 OUTCD 37 NEW TECH/ECT 38 COVD CHGS 39 ESRD NET ADJ 40 PATIENT RESP

41 FROM DT 42 THRU DT 43 HICHG 44TOB 45 RC 46 REM 47 PROF COMP 48 MSP PAYMT 49 NCOVD CHGS 50 INTEREST 51 PROC CD AMT

52 CLM STATUS 53 COST 54 COVDY 55 NCOVDY 56 RC 57 REM 58 DRG AMT 59 DEDUCTIBLES 60 DENIED CHGS 61 PRE PAY ADJ 62 NET REIMB

66 MBI 63 SEQUESTRATION

64 PBP REDUCT

65 ISLET ADD ON

SMITH	J	XXXXXXXXXXXXXXXXXX	29	N211	057		.00	.00	.00	15743.55
000000000A		XXXXXXXXXXXXXXXX	16	MA18			.00	.00	.00	.00
10/01/2018 10/31/2018		111				.00	.00	.00	.00	.00
4		1				7857.47	.00	15743.55	.00	.00
1EG4TE5MK72							.00			
							.00			
							.00			

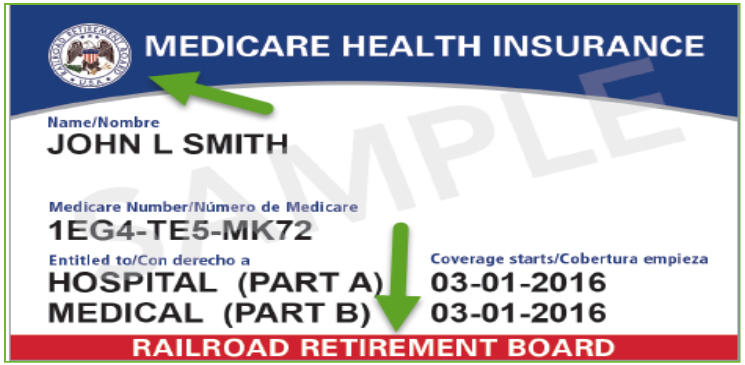
Old vs. New Medicare Card

OLD

- Remove SSN with indicator code
- Remove Date of Birth
- Remove Signature line

NEW

- Retains patient's name
- Adds new Medicare number
- Retains entitlement information
- Railroad Retirement Board (RRB)



Data Driven Topics

Election Statement Requirements

Transfers

Election Statement Requirements

- Each hospice designs and prints its election statement
- As you develop your own Hospice election statements and certifications of terminal illness, please review the MLN Matters Special Edition Article SE1631 (https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1631.pdf) for
  - Specific requirements you must include for valid documentation
  - Example text
- Information can be all on one document or multiple documents
  - If more than one document, ensure that all documents are submitted with the medical record

Disclaimer — Election Statement

- The examples on the following slides and in the MLN Matters® article SE1631 are for illustrative purposes only, and they do not imply this is the only acceptable format
- Hospice providers may use these examples as they design their own forms or format to ensure their election statements are valid and meet all requirements

Election Statement — Requirement 1

Must include information of the particular hospice that will provide care and the beneficiary's name

I, _____choose to elect the Medicare hospice
(Beneficiary Name)
benefit and receive Hospice services from _____.
(Hospice Agency)

Note: *The beneficiary/representative is not required to hand write this information on the form. The hospice can preprint the name of their agency on the form.*

Election Statement — Requirement 2

Full understanding of hospice care

- Information must be clear to the patient that the care to be provided is palliative and not curative
- Language should be in simple terms that the beneficiary/representative can understand
  - Includes alternate languages (e.g., Spanish)
- Does not have to be on the same page, but must be clear that the beneficiary/representative understands what hospice care is

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

Election Statement — Requirement 3

Effects of a Medicare election

- Beneficiary/representative must waive rights to Medicare payments under the traditional fee-for-service program for services related to the terminal illness
  - Payment for related services will only be made to the hospice and attending physician (if there is one)

I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (giving up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare.

Election Statement — Requirement 4

Designated attending physician (if any)

- Beneficiary has the right to choose an attending physician
- Is not required to choose an attending physician
- Election statement must clearly state that patient was given a choice

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician

Election Statement — Requirement 4

Designated attending physician (if any)

- If attending physician is selected, the election statement must include the full name of the physician or nurse practitioner selected
- The election may also include other information such as
  - NPI of Physician or NP
  - Address of Physician or NP

I acknowledge that my choice for an attending physician is:

Physician Full name: _____ NPI (if known) _____

Office Address: _____

Election Statement — Requirement 5

The effective date of the election

- May be the first day of hospice care or a later date
- May be no earlier than the date of the election statement is signed
  - Beneficiary may not designate an effective date that is retroactive

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by _____
(Hospice Agency)

to begin on _____
(Effective Date of Election)

Election Statement — Requirement 6

Beneficiary's or representative's signature and date

- If representative is signing, may include relationship to beneficiary
- If beneficiary unable to sign, may include reason why
  - Witness signature and date may be included

Signature of Beneficiary/Representative _____(Date)_____

☐ Beneficiary is unable to sign

Reason: _____

Signature of Witness _____(Date)_____

Transfers — Definition

- A patient may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care
- The change of the designated hospice is not considered a revocation of the election, but is a transfer
- Where one hospice discharges a patient and another hospice admits the same patient on the same day, each hospice is permitted to bill, and each will be reimbursed at the appropriate level of care (LOC) for its respective day of discharge or admission

CMS IOM, Publication 100-02, Chapter 9, Section 20.2.1

Transfer Requirements

- When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, an election date cannot be the same as the revocation or discharge date
- A change of ownership (8XE) of a hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part

Transfer Requirements

- To change, the patient/representative must file a transfer statement with both hospices
- Palmetto GBA's expectation is that the receiving and/or the transferring hospice will assist the patient/representative with completing the transfer agreement
- Both hospices must agree on date of transfer
  - Valid transfer occurs on the same day or the day after
  - No gaps in dates of service

CMS IOM, Publication 100-02, Chapter 9, Section 20.2.1

Receiving Agency Requirements

The hospice agency receiving the patient must perform a complete admission, which includes

- Physician Certification
- Transfer Agreement
- Plan of Care
- A new face-to-face is not required for transfers that occur in the third or later benefit period if the receiving hospice can verify that the originating hospice had the encounter

CMS IOM, Publication 100-02, Chapter 9, Section 20.2.1

Transferring Hospice — Final Claim

- Submit the final claim (TOB 8X4)
- Ensure the following are included
  - “Through” date is the last day the patient was on service with the agency
  - Patient Discharge Status code must be 50 or 51
    - 50 – Discharged/transferred to hospice (home)
    - 51 – Discharged/transferred to hospice (medical facility)
  - All other data as normal

Receiving Agency — Notice of Change

- The Notice of Change (8XC) notifies the contractor and CWF that the admission is a continuation of the current hospice election period
- Receiving hospice must submit an 81C/82C to indicate the patient is transferring agencies
- Ensure previous (transferring) hospice has submitted their final claim (8X4)

Receiving Agency — Notice of Change

- Submit 8XC prior to submitting the first claim
- Ensure that the following are include
  - "From" date is the date of the transfer
  - Admit date is the date of the transfer (must match the "From" date)
  - Occurrence Code 27 and date
    - This is the certification date
    - The date must match the certification date of the transferring hospice
      - If the transfer date is the same as the certification date, the 8XC is not required
    - **Do not enter a Patient Discharge Status code**

Handling a Dispute in Transfer Situations

- If hospice agencies follow the transfer requirements, there should not be an overlap in the dates of service
- Palmetto GBA's expectations are that the two agencies attempt to resolve the matter between them

Handling a Dispute in Transfer Situations

- If the hospice agencies are unable to resolve the matter, Palmetto GBA can intervene
- Either the receiving or the transferring hospice agency may request assistance by submitting a Billing Dispute Resolution Request Form

Submitting A Billing Dispute Resolution Request

When a resolution cannot be reached, submit the **Billing Dispute Resolution Request Form**

- Access the form at www.PalmettoGBA.com/HHH; select “Medicare Forms” in the Forms/Tools box on the home page; select Billing Dispute Resolution Request under the Provider Contact Center heading

Note: The form is not required, but all requests must include the elements contained in the form

Billing Dispute Request — Receiving Agency

The request must include

- Copy of the HIQA page 1 (recommended)
- Copy of the transfer agreement
- Copy of the communication(s) between the hospices (telephone call log, emails, etc.)
  - Palmetto GBA's expectation is that the receiving agency has communicated with the initial hospice to facilitate an agreement on the transfer date
    - Unanswered communications regarding the patient's desired transfer date are not acceptable

Billing Dispute Request — Transferring Agency

The request must include

- Copy of the transfer agreement
- Copy of the communication(s) between the hospices (telephone call log, emails, etc.)
  - Transfer situation does not end the patient's enrollment in the Medicare Hospice Benefit
  - The patient should not be signing a revocation notice

Billing Dispute — Timely Filing Billing Requirements

Do not wait until the last minute to request assistance from Palmetto GBA

- Allow the other hospice agency a reasonable amount of time to complete their billing or make the necessary corrections
- Providers that fail to comply with the request from Palmetto GBA will not be granted an exception to the late filing of an NOE or an extension to timely filing requirements on claims if the timely filing should lapse before the matter is resolved

Palmetto GBA's Process

- Palmetto GBA makes every attempt to resolve billing disputes as quickly as possible
- Billing dispute requests are considered to be written correspondence, and Palmetto GBA has up to 45 business days to process written correspondence
- Research is done to ensure that the request contains all the required information and supporting documentation (when applicable)

Palmetto GBA's Process

The request will not be processed if

- The information and supporting documentation is not received
  - The provider must submit a new request with the required information and supporting documentation
- Claim(s) that is/are past the timely filing requirements
  - This includes a resubmitted request if the original request was not processed
- The provider will be notified in writing of the decision for either situation

PALMETTO GBA®

eServices

eServices Goal

- Palmetto GBA's goal is to give the provider secure and fast access to Medicare information seamlessly via our website through the eServices application
- Palmetto GBA's eServices is a **free** Internet-based, provider self-service secure application

eServices Functions

- **Eligibility**
- **MBI Lookup**
- **Claims Status**
- **Remittances**
- **Financial Information** — payment floor and last three checks paid
- **Financial Forms** — eOffset requests, eCheck payments and CMS-838 Credit Balance Form (Part A and HHH only)

eServices Functions

- **Secure Forms** — Appeals, Medical Review ADR Response Form and General Inquiry Form
- **eReview** — Electronic Review
  - **eCBR** — Electronic Comparative Billing Report (eCBR)
  - **eAudit** — Electronic Audit
    - CERT audit data by error code category
    - Medical review data
- **eDelivery**
  - Receive Palmetto GBA mailings electronically

eServices Key Points

- No cost for registering and using eServices
- You can participate in eServices if you have a signed EDI Enrollment Agreement on file with Palmetto GBA
- The person who registers is the provider administrator
  - Grants access for additional users to access
  - Views and prints information from eServices related to registered provider

eServices Administrator

The provider administrator's responsibilities include

- Creating and maintaining user profiles
- Assigning application permissions to the provider user
- Creating additional provider administrators
  - Ensure you have at least 1 back-up administrator

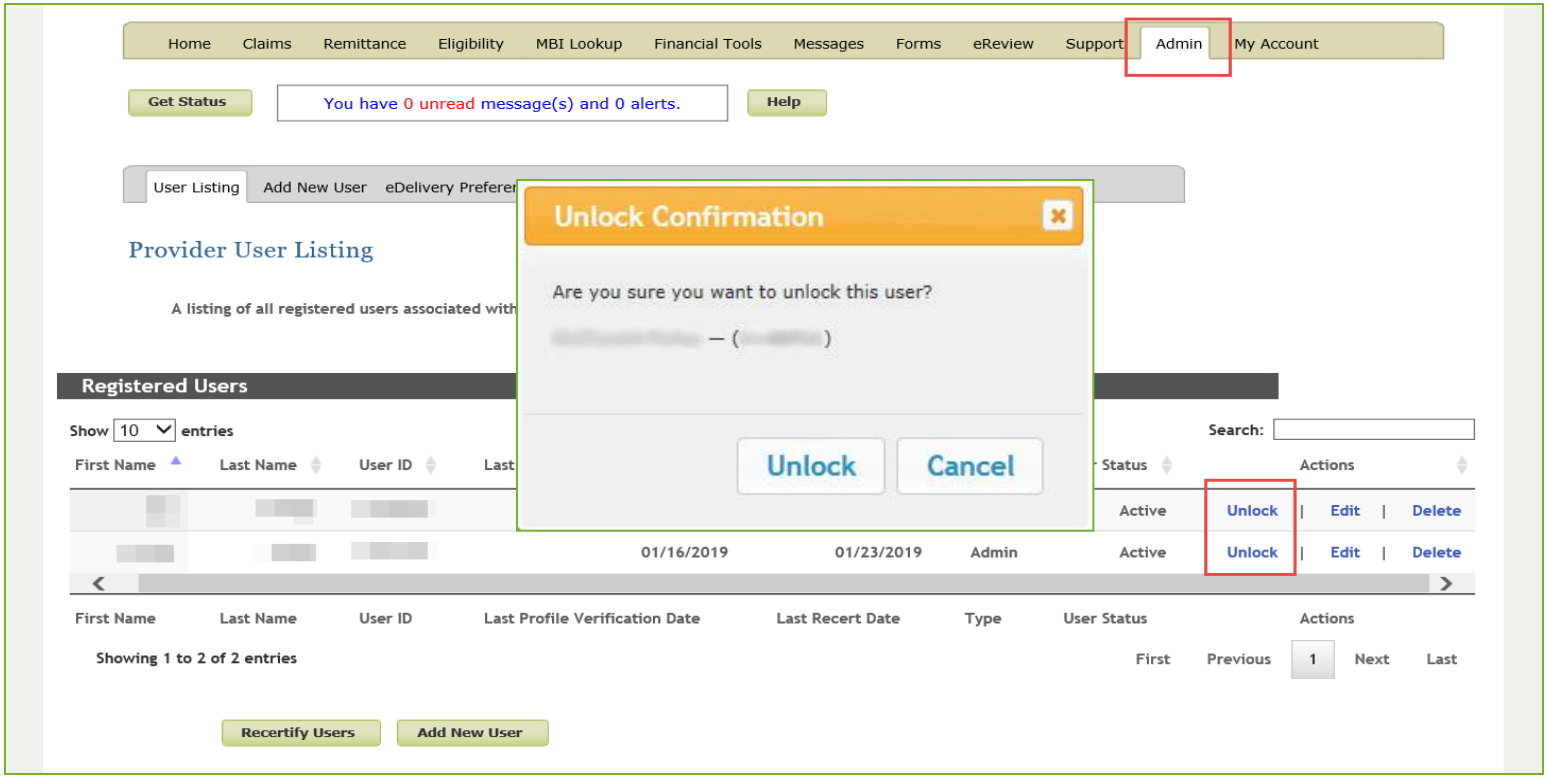
eServices Administrator

- If the initial administrator leaves your agency without assigning another administrator, contact the EDI Department to change administrators on file
- Terminating users or administrators
  - A user will continue to have access until they are terminated or fail to login once every 60 days
  - New provider administrator can login and delete the old provider administrator

eServices Administrator Unlock

- eServices now has a feature that allows eService administrator to unlock accounts
  - No longer have to contact our Provider Contact Center to unlock your account
- Your eService administrator will be able to unlock users and additional provider administrators from the administrator screen

eServices Administrator Unlock



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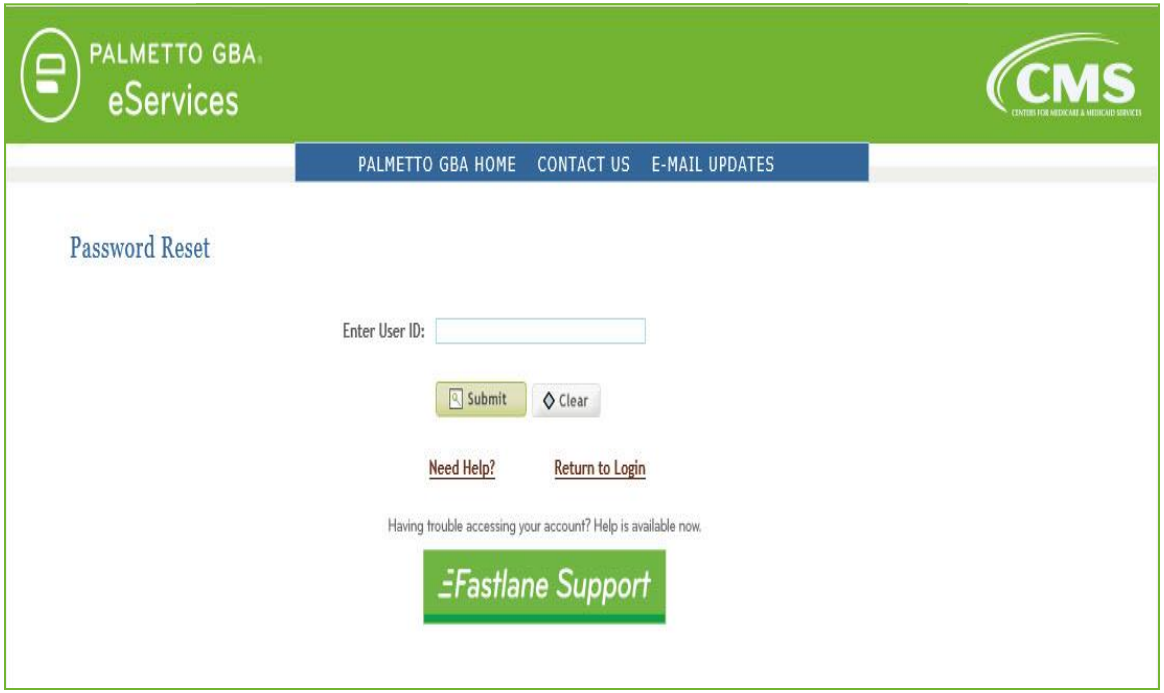
eServices Fastlane Support

If no other eService provider administrator is available, or you need to reset a password, you can also use the new Fastlane Support button

- After selecting the button — **available only during Web chat hours** — you are instantly connected with an online operator who can assist you in unlocking your account

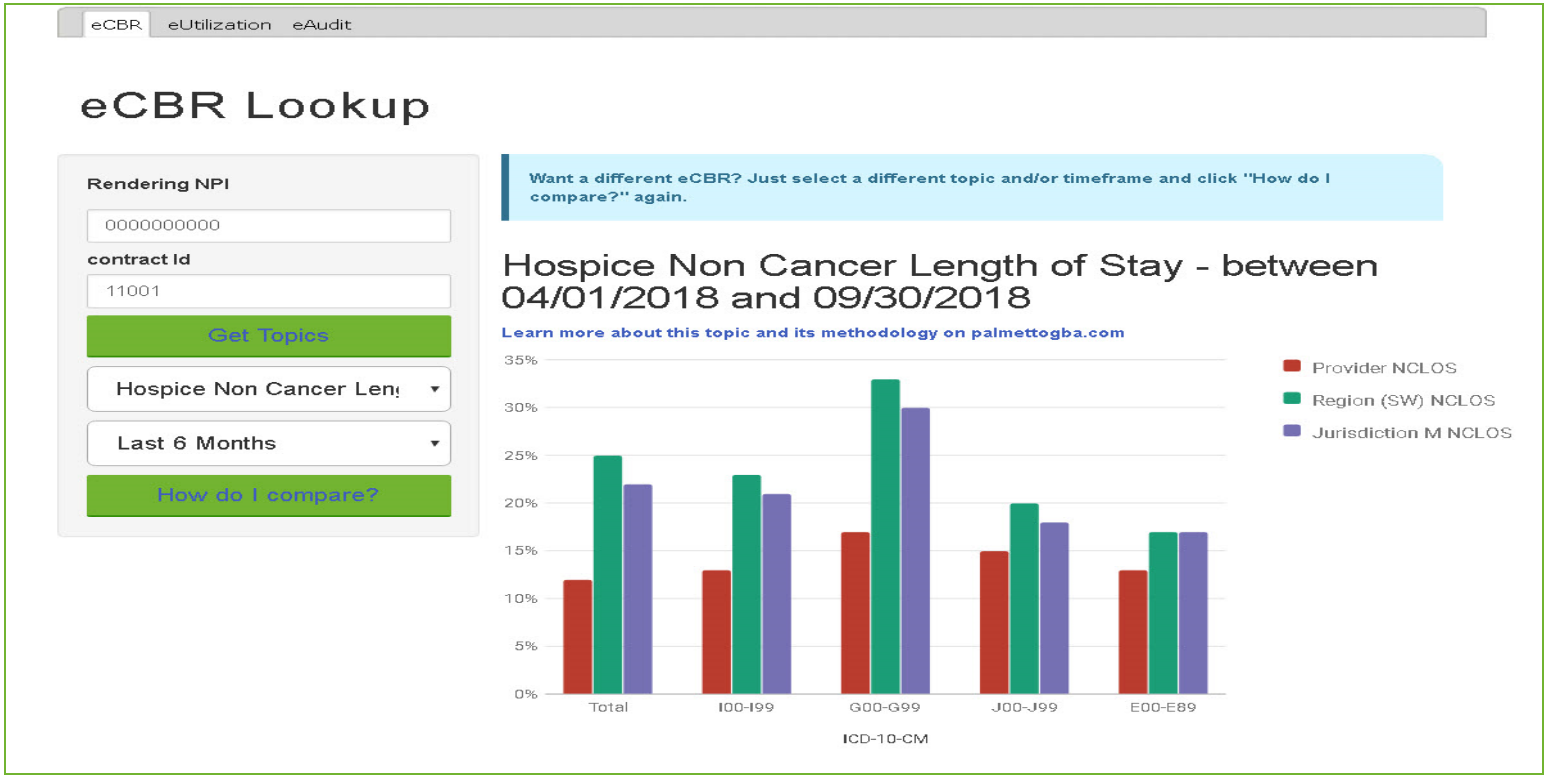
eServices Fastlane Support



eCBR

- eCBR information is located under the eReview tab
- One of the many tools used to assist individual providers to become proactive in addressing potential billing issues and performing internal audits to ensure compliance with Medicare guidelines

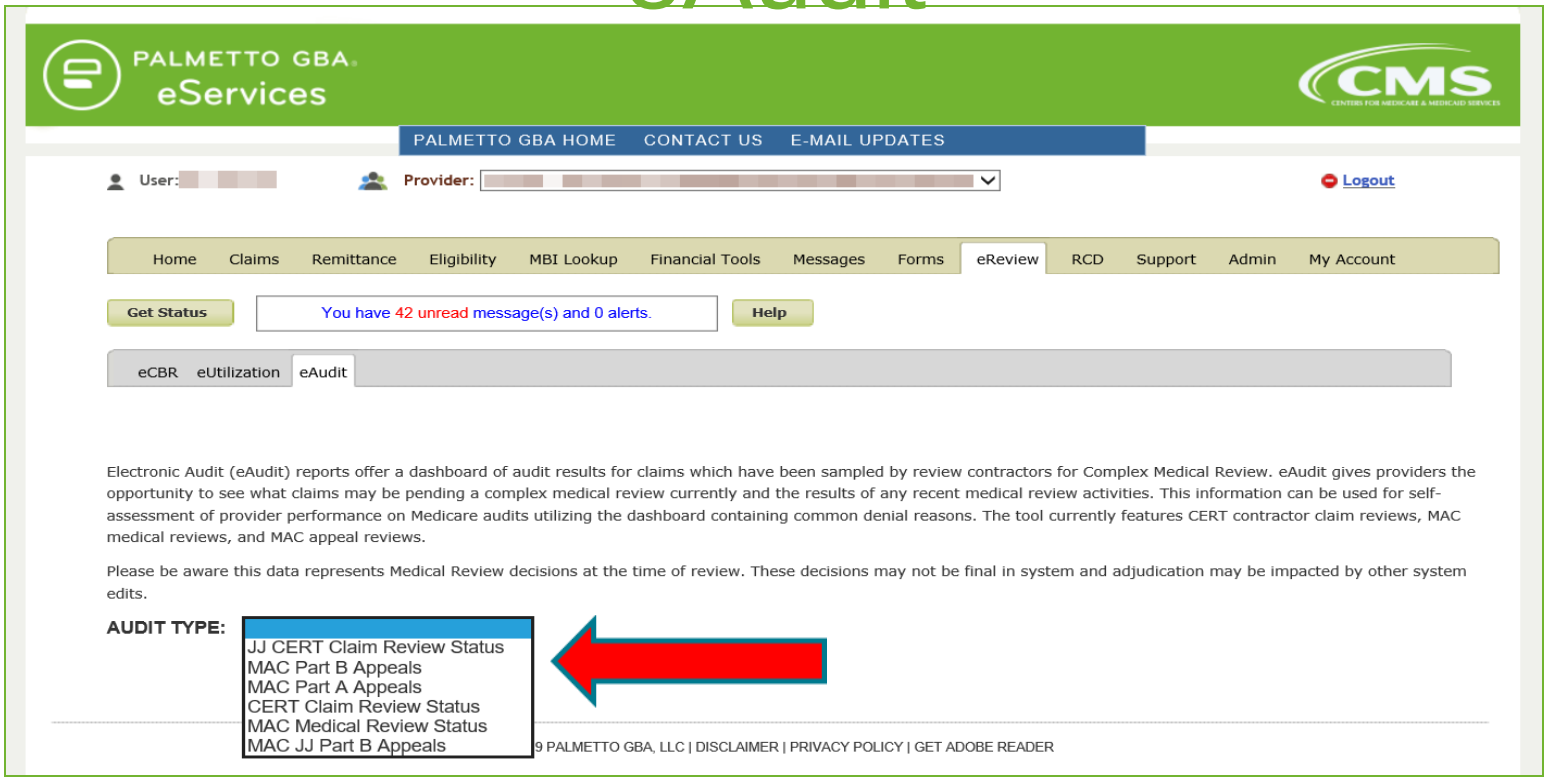
eCBR – NCLOS Reports



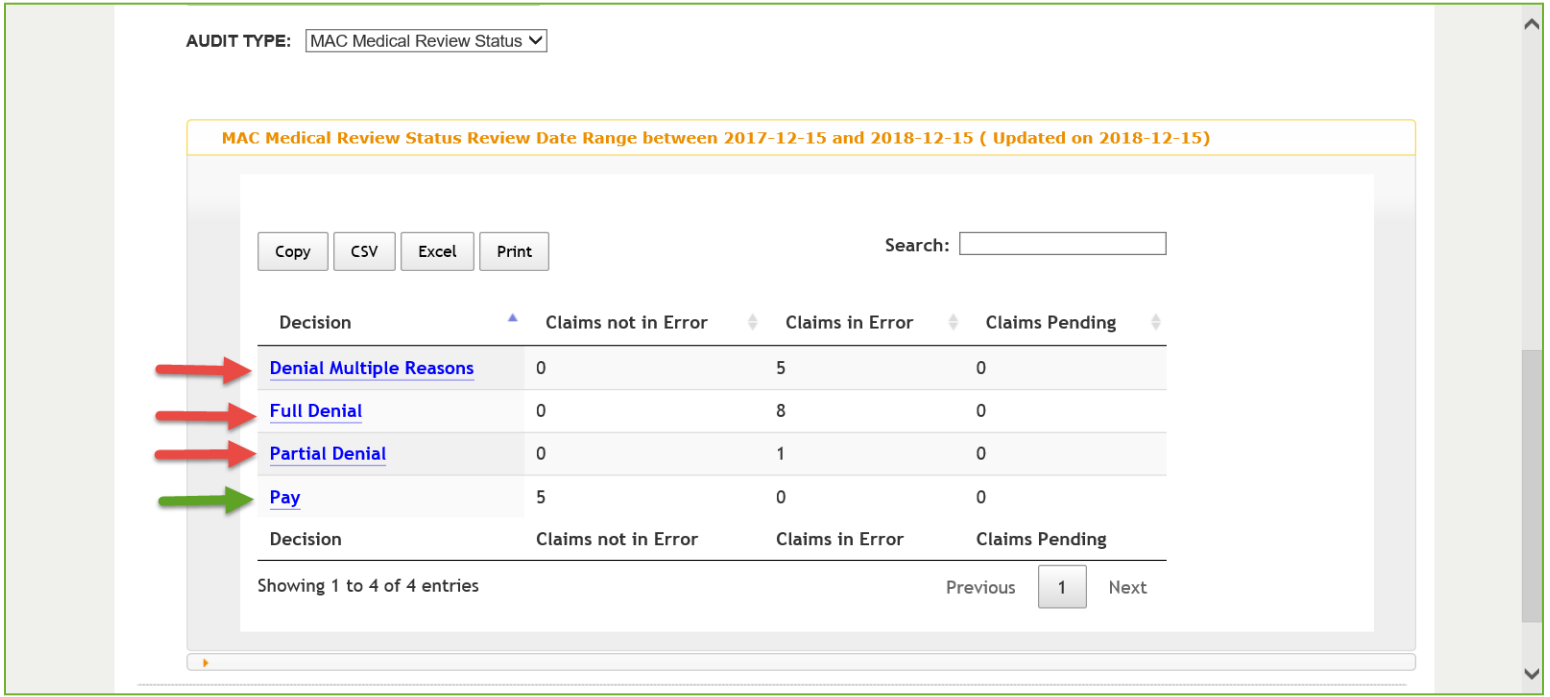
eAudit

- eAudit is located under the eReview tab
- Allows providers the ability to access personal reports of audit results for claims which have been chosen for Complex Medical Review by various Medicare review contractors
- Gives providers the opportunity to see what claims may be pending Complex Medical Review currently and the results of any recent review decisions
- Information can be used for self-assessment of provider performance on Medicare audits utilizing a dashboard which contains the most common denial reasons
- Currently features CERT data by error code category

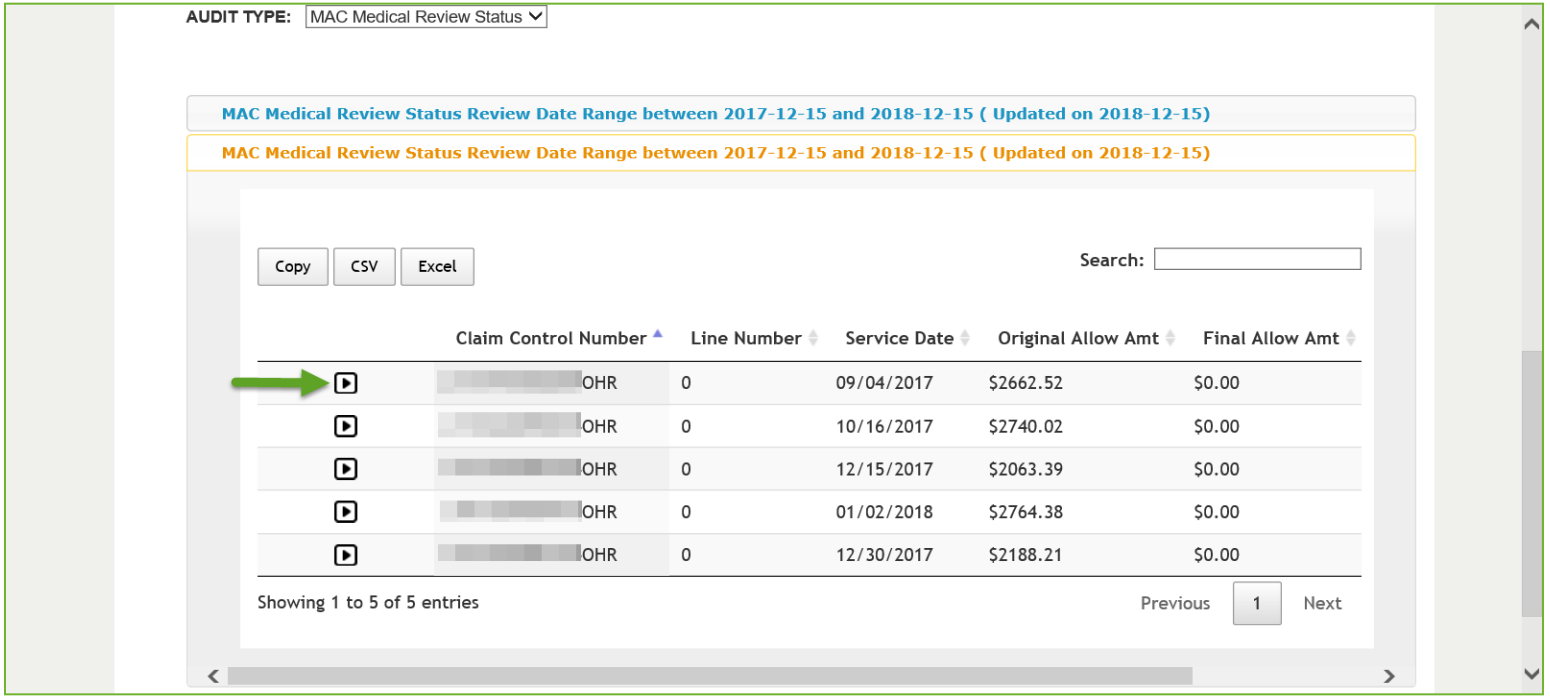
eAudit


PALMETTO GBA
eServices
CMS
PALMETTO GBA HOME
CONTACT US
E-MAIL UPDATES
User:
Provider:
Logout
Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
RCD
Support
Admin
My Account
Get Status
You have 42 unread message(s) and 0 alerts.
Help
eCBR
eUtilization
eAudit
Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons. The tool currently features CERT contractor claim reviews, MAC medical reviews, and MAC appeal reviews.
Please be aware this data represents Medical Review decisions at the time of review. These decisions may not be final in system and adjudication may be impacted by other system edits.
AUDIT TYPE:
JJ CERT Claim Review Status
MAC Part B Appeals
MAC Part A Appeals
CERT Claim Review Status
MAC Medical Review Status
MAC JJ Part B Appeals
9 PALMETTO GBA, LLC | DISCLAIMER | PRIVACY POLICY | GET ADOBE READER

eAudit – MAC Medical Review



eAudit – MAC Medical Review



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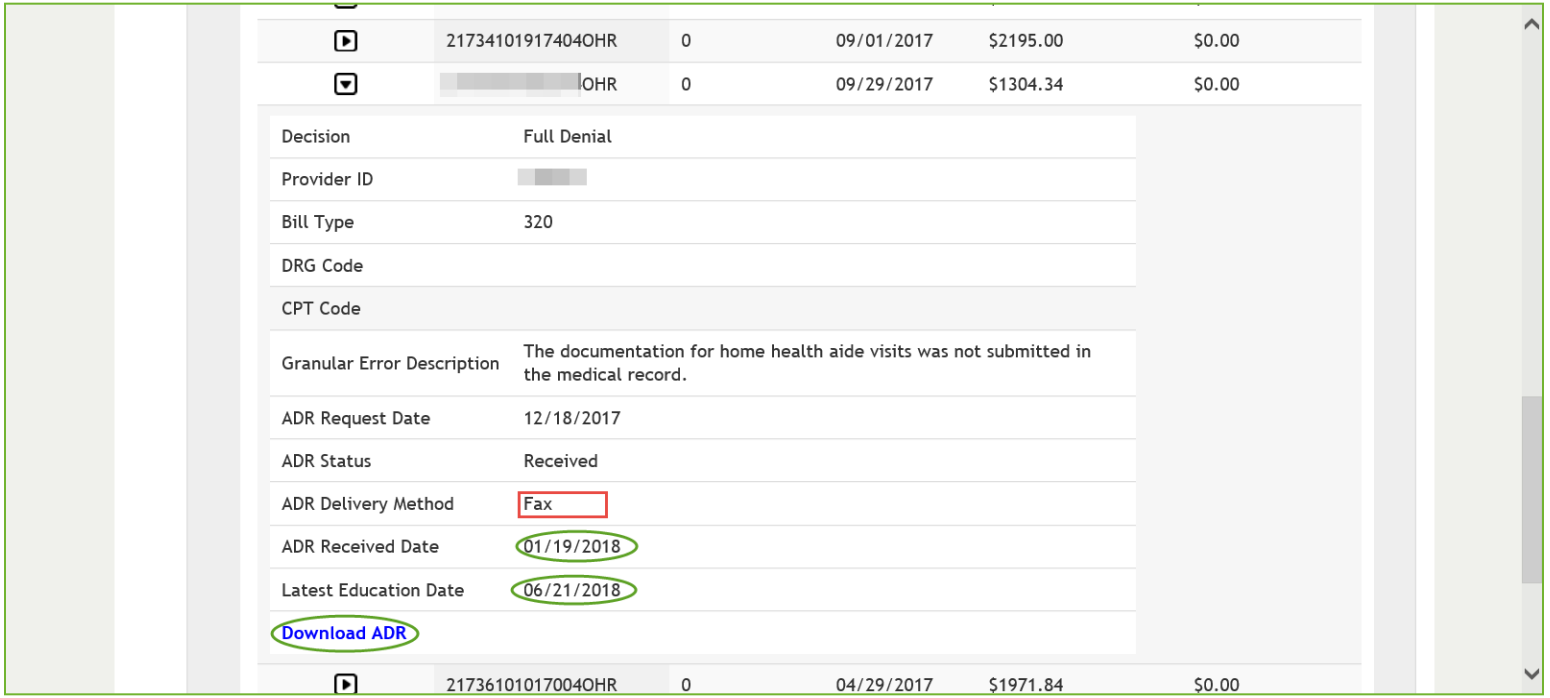
eAudit – MAC Medical Review

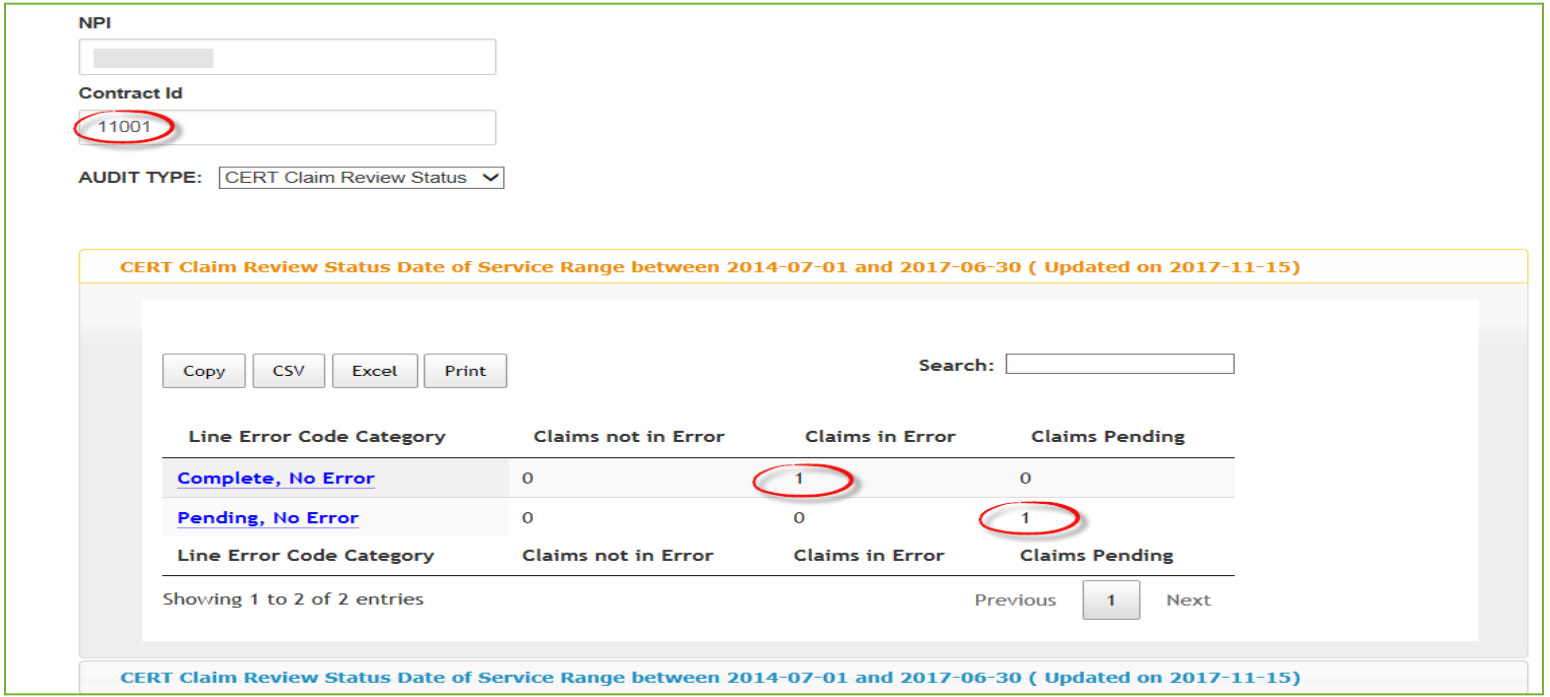


	21734101917404OHR	0	09/01/2017	$2195.00	$0.00
	[redacted]OHR	0	09/29/2017	$1304.34	$0.00

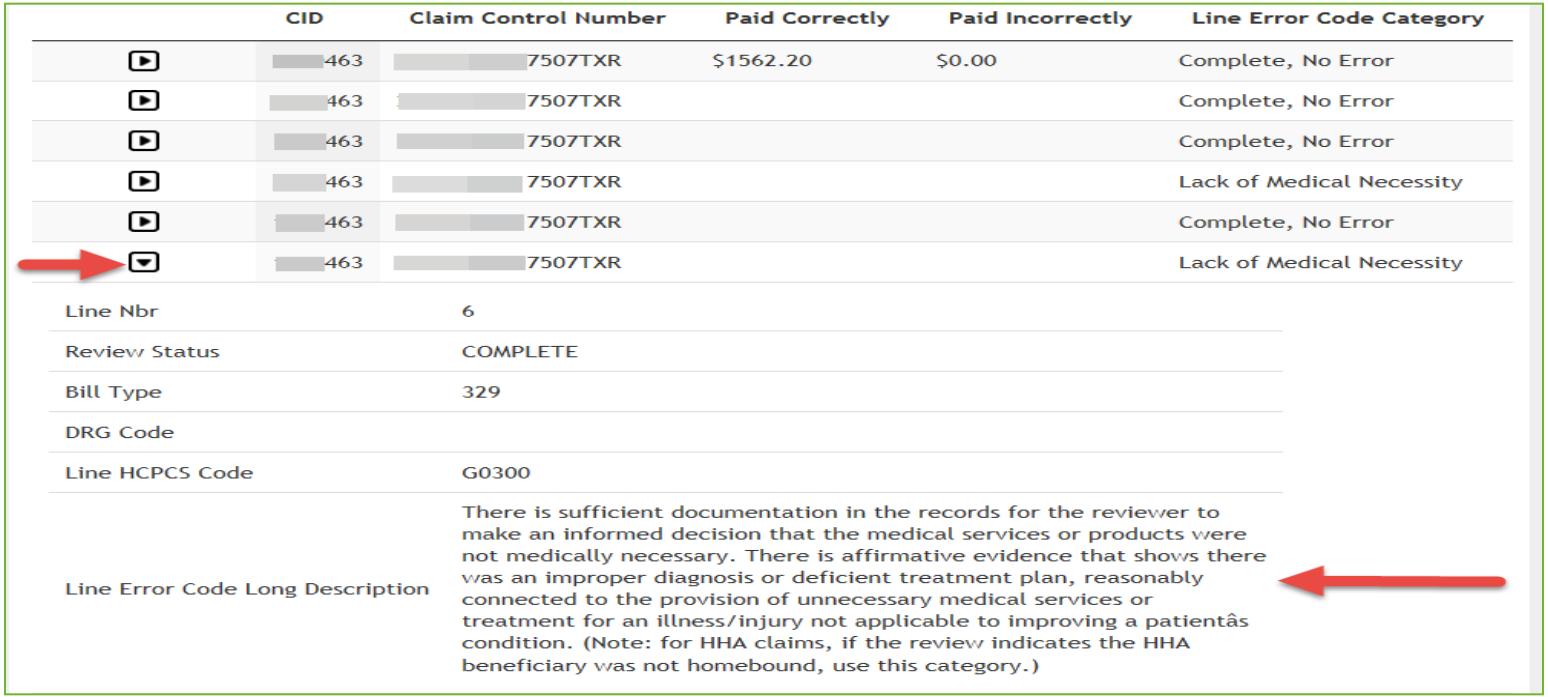
Decision	Full Denial
Provider ID	[redacted]
Bill Type	320
DRG Code	
CPT Code	
Granular Error Description	The documentation for home health aide visits was not submitted in the medical record.
ADR Request Date	12/18/2017
ADR Status	Received
ADR Delivery Method	Fax
ADR Received Date	01/19/2018
Latest Education Date	06/21/2018
Download ADR	

	21736101017004OHR	0	04/29/2017	$1971.84	$0.00

eAudit – CERT Review



eAudit – CERT Review



	CID	Claim Control Number	Paid Correctly	Paid Incorrectly	Line Error Code Category
▶	[redacted]463	[redacted]7507TXR	$1562.20	$0.00	Complete, No Error
▶	[redacted]463	[redacted]7507TXR			Complete, No Error
▶	[redacted]463	[redacted]7507TXR			Complete, No Error
▶	[redacted]463	[redacted]7507TXR			Lack of Medical Necessity
▶	[redacted]463	[redacted]7507TXR			Complete, No Error
▼	[redacted]463	[redacted]7507TXR			Lack of Medical Necessity

Line Nbr	6
Review Status	COMPLETE
Bill Type	329
DRG Code	
Line HCPCS Code	G0300
Line Error Code Long Description	There is sufficient documentation in the records for the reviewer to make an informed decision that the medical services or products were not medically necessary. There is affirmative evidence that shows there was an improper diagnosis or deficient treatment plan, reasonably connected to the provision of unnecessary medical services or treatment for an illness/injury not applicable to improving a patientâs condition. (Note: for HHA claims, if the review indicates the HHA beneficiary was not homebound, use this category.)

eAudit – Appeal

MAC Part A Appeals Appeal Close Date Range between 2018-12-15 and 2018-06-18 (Updated on 2018-12-15)

Copy CSV Excel Print

Search:

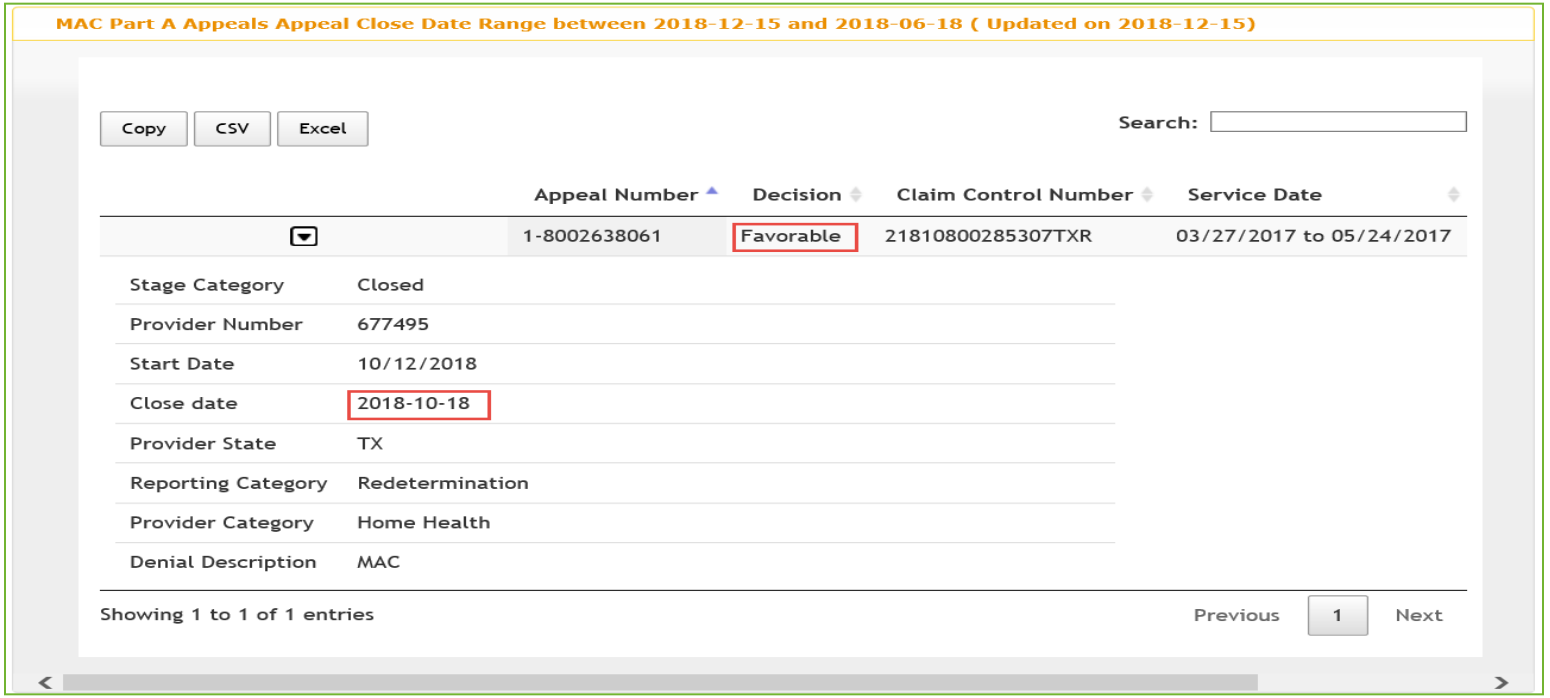
Decision	Claim Not in Error	Claim in Error	Pending or Dismissed
Favorable	1	0	0
Unfavorable	0	1	0
Decision	Claim Not in Error	Claim in Error	Pending or Dismissed

Showing 1 to 2 of 2 entries

Previous 1 Next

MAC Part A Appeals Appeal Close Date Range between 2018-12-15 and 2018-06-18 (Updated on 2018-12-15)

eAudit – Appeal



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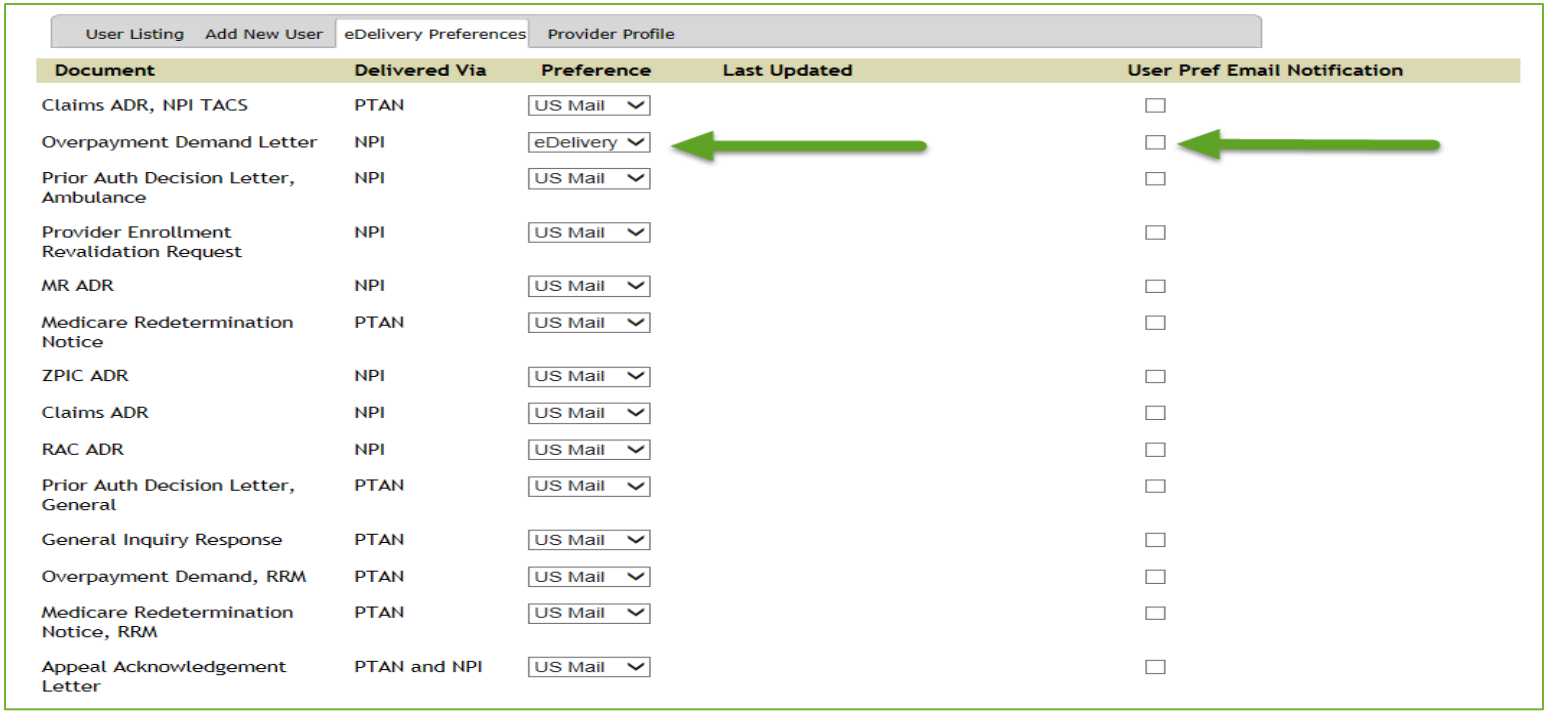
eDelivery

- Provider Administrators may select to receive letters electronically
- Providers can opt to receive their letters by US Mail or eDelivery
- For providers enrolled in eDelivery, a secure inbox message will be sent with a link to the letter
- There is an email notification option that allows the user to receive an email when new eLetters are available

eDelivery

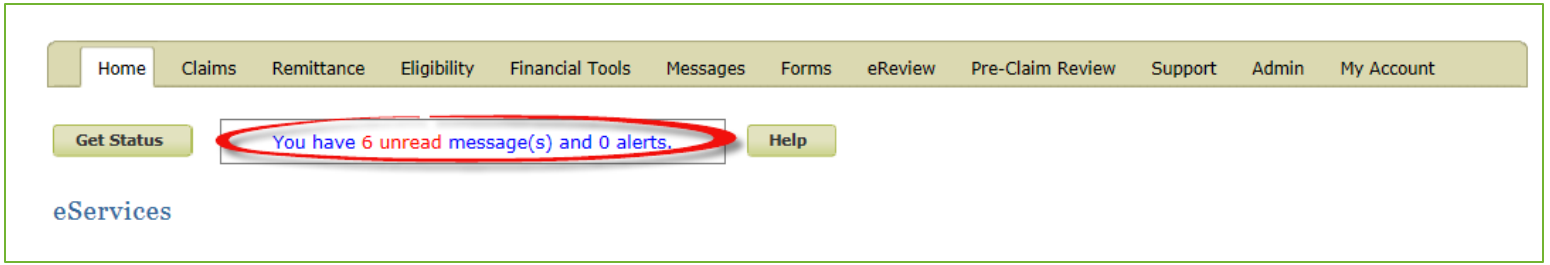

User Listing
Add New User
eDelivery Preferences
Provider Profile
Document
Delivered Via
Preference
Last Updated
User Pref Email Notification
Claims ADR, NPI TACS
PTAN
US Mail
Overpayment Demand Letter
NPI
eDelivery
Prior Auth Decision Letter, Ambulance
NPI
US Mail
Provider Enrollment Revalidation Request
NPI
US Mail
MR ADR
NPI
US Mail
Medicare Redetermination Notice
PTAN
US Mail
ZPIC ADR
NPI
US Mail
Claims ADR
NPI
US Mail
RAC ADR
NPI
US Mail
Prior Auth Decision Letter, General
PTAN
US Mail
General Inquiry Response
PTAN
US Mail
Overpayment Demand, RRM
PTAN
US Mail
Medicare Redetermination Notice, RRM
PTAN
US Mail
Appeal Acknowledgement Letter
PTAN and NPI
US Mail

eDelivery

- eLetters currently available for HHH providers
  - ADRs **(new)**
  - Provider Enrollment Revalidation
  - Overpayment Demand
  - Appeal Acknowledgement
- Articles posted to Palmetto GBA's website as new eLetters are implemented

eDelivery

- Once an eLetter is posted, you will be able to access it by
- Locating the message/alert applet from the homepage
- Selecting the numbered hyperlink to retrieve unread messages



Account Linking

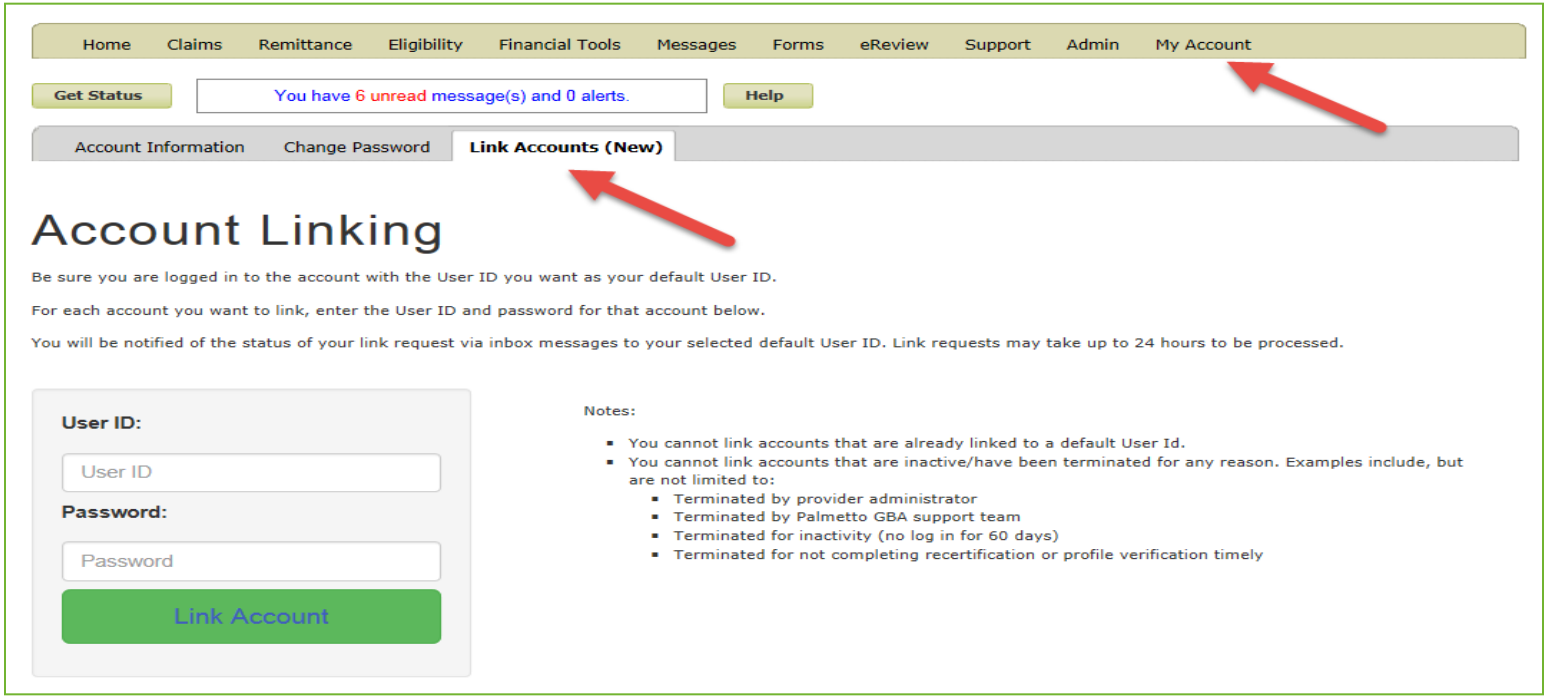
- Users do not need a separate login for each PTAN/NPI combination
- Users have the ability to link their previously assigned eServices user IDs under one default ID
  - Any additional PTAN/NPI combinations for which an account is not set up, a provider administrator must create the account before it can be linked

Account Linking

Getting started is simple

- Log into eServices with the user ID that you wish to designate as your default login ID
  - This is the user ID that will be used to access the linked accounts
- Once you have successfully logged into eServices, select the My Account tab and then access the Account Linking sub-tab
- Choose the accounts you wish to link

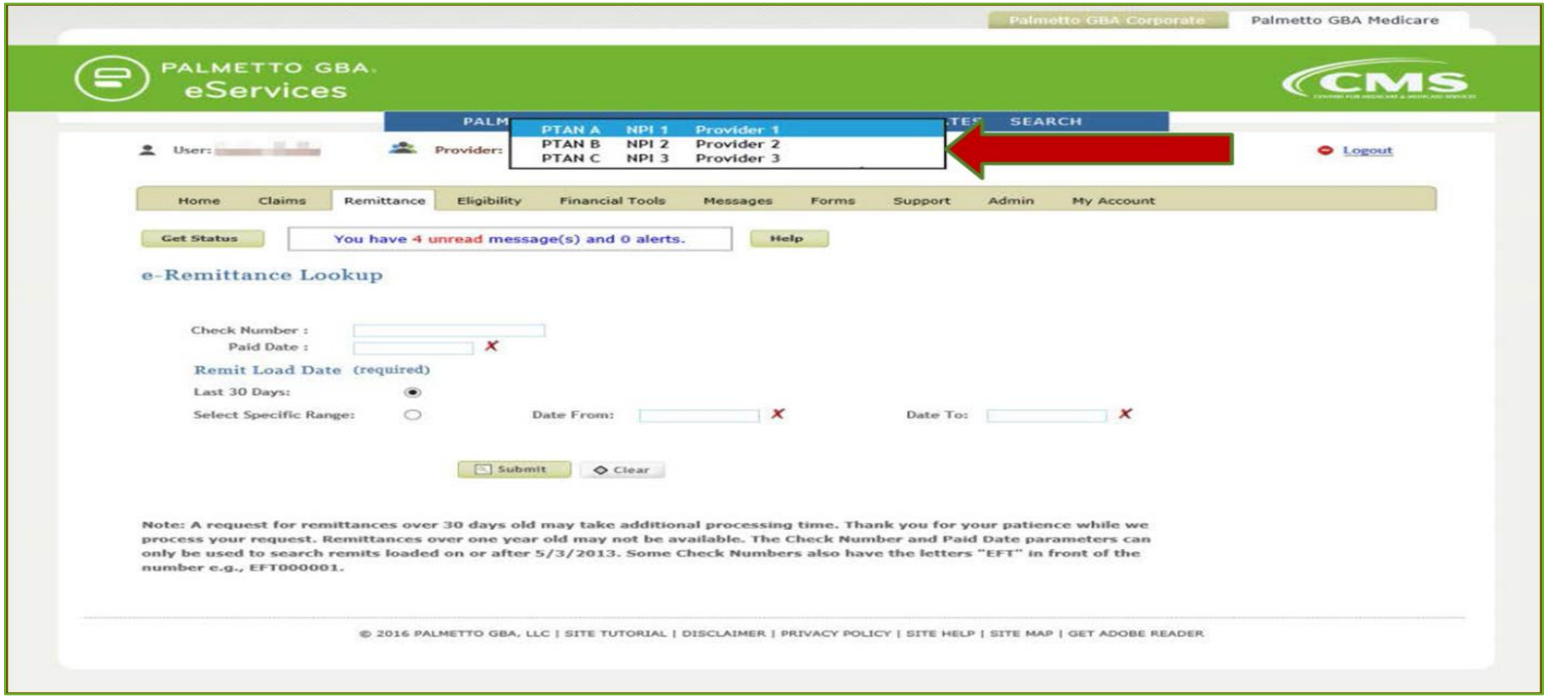
Account Linking



Account Linking

- Once user accounts are linked the user will
  - Be able to login once using the default user ID
  - Click a drop down menu that lists all linked PTAN/NPI combinations attached to the user ID
  - Select the individual account he/she would like to view
- Providers are only able to link active eServices accounts
  - You cannot link accounts that are already linked to a default user ID
  - You cannot link accounts that are inactive/terminated

Account Linking



Multi-Factor Authentication

- Multi-factor authentication is a mandatory extra layer of security
- Logging into your eServices account
  - You will enter your password as usual
  - Then, you will select your preferred method of delivery between email or a text message
  - Once you receive your verification code you will enter it in the verification box and you're in
    - Verification is valid for an eight-hour period of time

eServices References

Access eServices

Palmetto GBA is pleased to offer eServices, our free Internet-based, provider self-service portal.

eCBR

eCBR gives you with the ability to view and download your individual Comparative Billing Reports (CBRs) online.

eServices FAQs

Find answers to frequently asked questions about eServices.

eServices News

Check out the latest eServices information by viewing the eServices News bulletin.

eServices Tips

Find helpful tips on making the most of the eServices provider portal.

eServices User Manual

View the eServices User Manual for answers to your eServices questions.

Reminders

CERT

Provider Enrollment Revalidation

What is the CERT?

- The CERT program is a ***federally mandated*** program created by the CMS to calculate the improper payment rates in the Medicare Fee-for-Service (FFS) program. The CERT program
- Consists of two contractors
  - AdvanceMed is the CERT Review Contractor (CERT RC)
    - Requests and reviews medical records
  - The Lewin Group, Inc. is the CERT Statistical Contractor (CERT SC)
    - Designs sampling strategy and calculates the improper payment rates
- Ensures that the Medicare program is paying claims correctly based on Medicare coverage, coding and billing requirements
- Calculates ***national***, ***contractor-specific*** and ***service-specific*** improper payments

CERT Contractors Responsibilities

- Selects random sample of claims
- Issue ADR letters requesting medical records
- Review medical records for improper payments
- Answers questions concerning submission of documentation (call 888-779-7477)
- If an error is identified — submits request to the MAC to adjust the claim
- If no error is identified — no action is taken
- Compile data to determine improper payment rates nationally and by MAC
- Categorize errors into five error types — no documentation, insufficient documentation, medical necessity, incorrect coding and other types

CERT Letters and Contacts

The CERT contractor sends ADR letters to the provider at the address in their provider enrollment record

- Providers should ensure their provider enrollment records are up-to-date
  - All first ADR letters will go to the address on file with the MAC
  - Subsequent ADR letters can be sent to an address specified by the provider by contacting CERT at 888-779-7477

Responding to CERT ADR Letters

Documentation should be submitted to the CERT within 45 days of the first request letter

- Up to four request letters and three phone calls will be made to the provider if documentation is not received by the 60th day of the initial request
- If no documentation is received by the 76th day of the initial request letter, an error will be issued and an overpayment collected

CERT Letters and Contacts

After records are received by CERT, subsequent ADR letters are sent when missing information is identified by the reviewer

- Up to two letters and phone contacts are made for missing documentation that would affect payment of the claim
- If no provider response is received by the 16th day of the initial request for additional documentation, the review will be completed based on the documentation received

Submitting Records to CERT

- US Mail
  - CERT Documentation Center, 1510 East Parham Road, Henrico, VA 23228
- FAX to (804) 261-8100
- esMD — information on this process can be found at www.cms.gov/esMD
- Encrypted CD — via TIFF or PDF format with CMS approved encryption
  - Email the password to CERTMail@admedcorp.com or via fax
- Encrypted Email Attachment — via TIFF or PDF format with CMS approved encryption
  - The password with CID# must be provided by phone (888-779-7477) or via fax (804) 261-8100
- **Important Reminder** — Always include the barcoded cover sheet with the CID number on top of documentation

Palmetto GBA Role in Review Process

During the CERT review process, Palmetto GBA offers assistance as follows

- Phone contact if the provider does not respond with ADR after the 2nd ADR letter is issued by CERT
- Phone contact if the provider receives a subsequent request from CERT for missing documentation
- Education letter sent to the provider with detailed information about any error identified and a follow-up call for education may be conducted
  - Providers are encouraged to request a Redetermination if they disagree with the CERT decision

How Palmetto GBA Uses CERT Data

Internal monitoring of payment errors is conducted throughout the year and used to

- Identify areas of focus for our Provider Outreach and Education efforts
- Create educational articles related to the types of errors
- Issue CBRs when applicable
- Improve system edits
- Display CERT errors by state and ways to prevent errors
- Provide links to other educational resources

CERT Resources

CERT resources on JM HHH website

www.PalmettoGBA.com/HHH

CMS CERT website

www.cms.gov/CERT

CERT Provider website

https://www.certprovider.admedcorp.com

CMS Program Integrity Manual

www.cms.gov/manuals/downloads/pim83c12.pdf

Publication 100-08

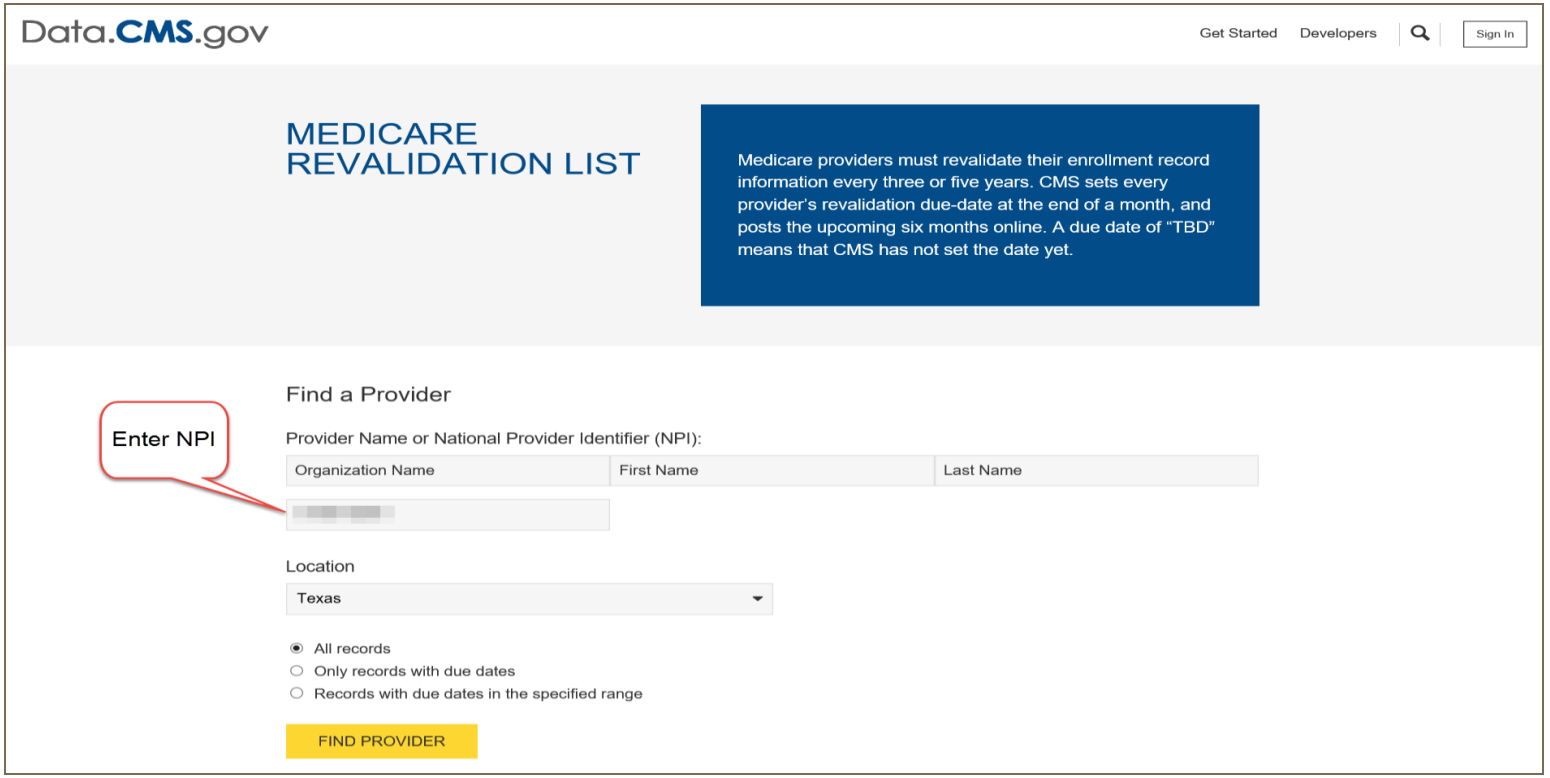
Provider Enrollment Revalidation

- Requires all providers/suppliers to resubmit and recertify the accuracy of enrollment information
- All providers/suppliers must be revalidated under the new enrollment screening criteria
- CMS has established dates by which providers/suppliers must revalidate

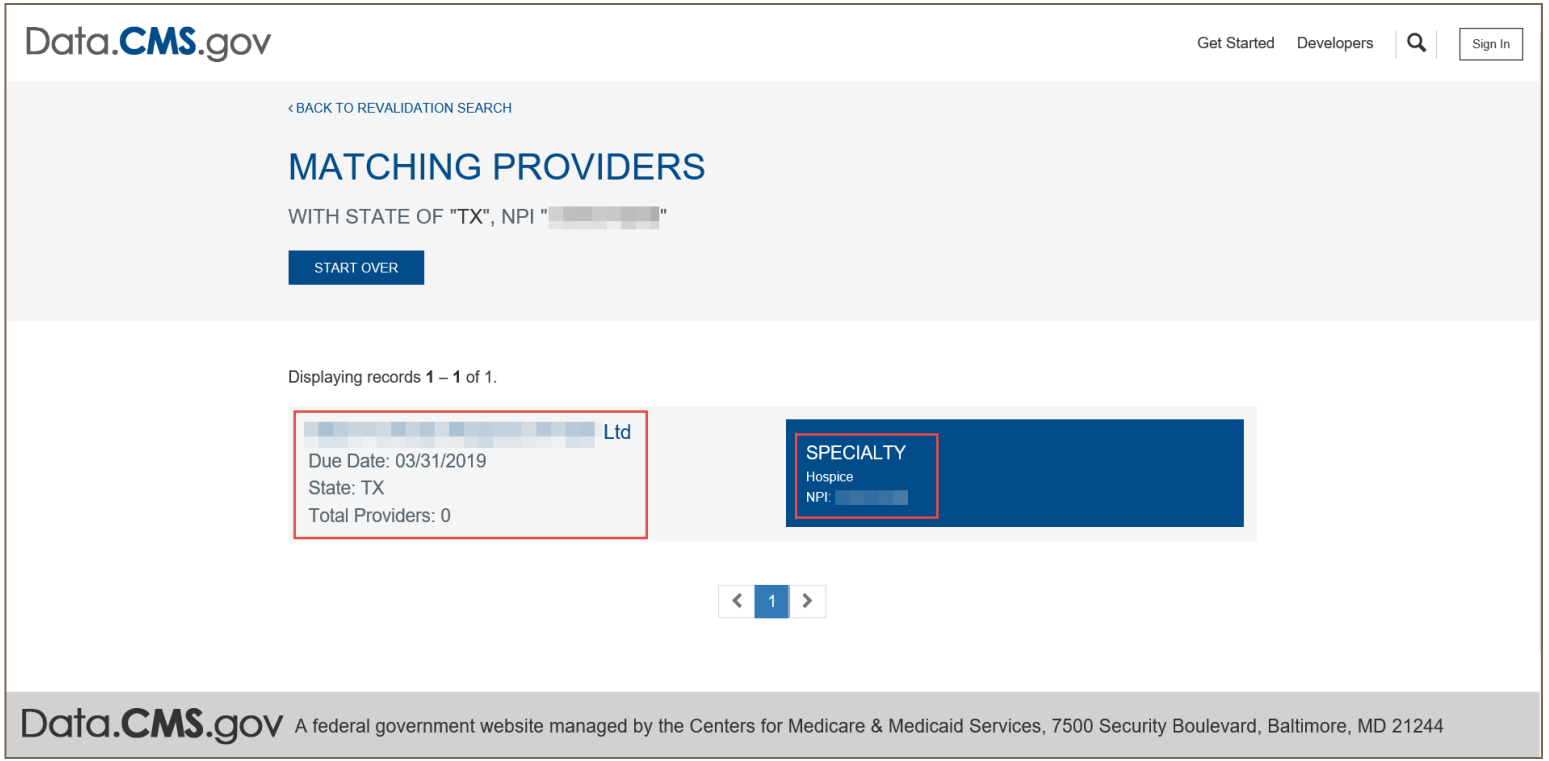
Provider Enrollment Revalidation – Due Dates

- To assist providers, CMS developed a Lookup Tool at https://data.cms.gov/revalidation
- It will display
  - All currently enrolled providers/suppliers
  - A due date or an indication of a “TBD” in the due date field
    - To Be Determined (more than 6 months until your due date)
    - Due dates will be posted up to 6 months before revalidation due date and are updated periodically

Revalidation – Lookup Tool



Revalidation – Lookup Tool



Revalidation Letters

Palmetto GBA will issue revalidation letters within 2 to 3 months of a given provider's established due date

- Notices will be sent 1 of 2 methods
  - eServices for providers currently enrolled in Palmetto GBA's self-service portal
  - Standard mail
- Pay close attention to the due date and plan accordingly to revalidate by the due date
- Revalidate your Medicare enrollment record through www.PECOS.cms.hhs.gov, or appropriate form CMS-855

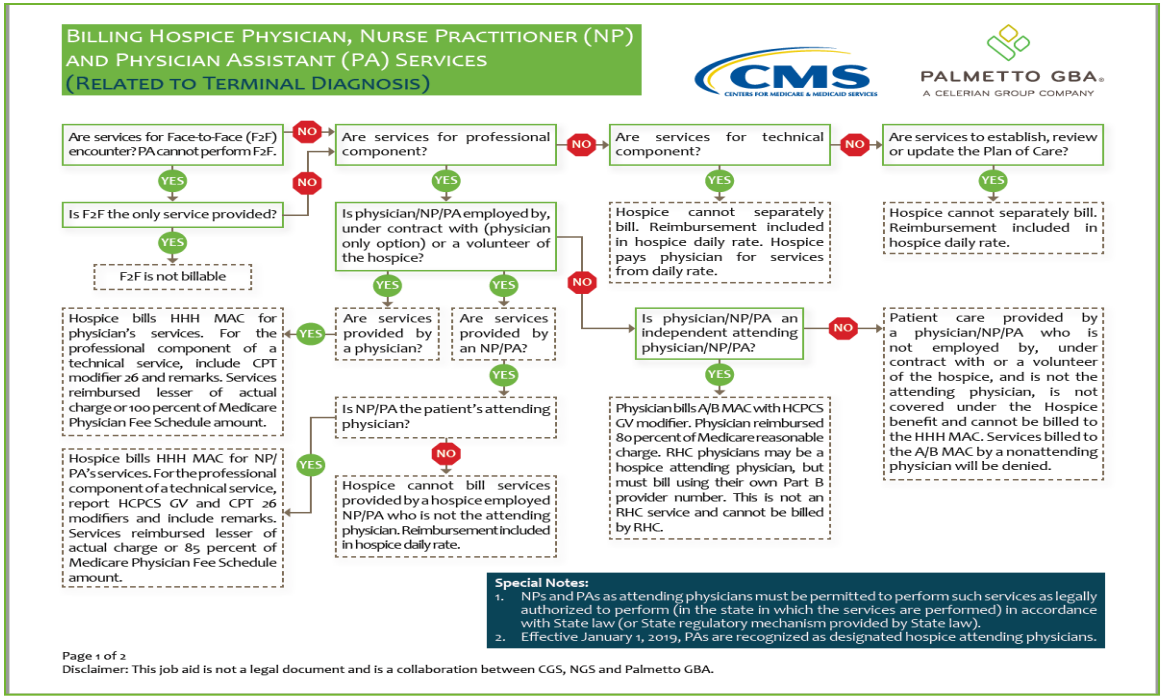
Reminders

- Each provider/supplier is required to revalidate their **entire** Medicare enrollment record
- Failure to take necessary actions to complete revalidation when requested, could result in a hold on Medicare payments and possible deactivation of your Medicare billing privileges
- Providers/Suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges

Provider Resources/Self-Service Tools

- Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services Job Aid
- Status Tools
- JM Call Flow
- CMS Resources
- Top Links
- Forms/Tools
- Social Media
- Education/Events

Billing Hospice Physician, NP and PA Services Job Aid



BILLING HOSPICE PHYSICIAN, NURSE PRACTITIONER (NP) AND PHYSICIAN ASSISTANT (PA) SERVICES (RELATED TO TERMINAL DIAGNOSIS)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

PALMETTO GBA. A CELERIAN GROUP COMPANY

Are services for Face-to-Face (F2F) encounter? PA cannot perform F2F.

NO → Are services for professional component?

NO → Are services for technical component?

NO → Are services to establish, review or update the Plan of Care?

YES → Is F2F the only service provided?

NO → Is physician/NP/PA employed by, under contract with (physician only option) or a volunteer of the hospice?

YES → Hospice cannot separately bill. Reimbursement included in hospice daily rate. Hospice pays physician for services from daily rate.

YES → Hospice cannot separately bill. Reimbursement included in hospice daily rate.

YES → F2F is not billable

YES → Are services provided by a physician?

YES → Are services provided by an NP/PA?

NO → Is physician/NP/PA an independent attending physician/NP/PA?

NO → Patient care provided by a physician/NP/PA who is not employed by, under contract with or a volunteer of the hospice, and is not the attending physician, is not covered under the Hospice benefit and cannot be billed to the HHH MAC. Services billed to the A/B MAC by a nonattending physician will be denied.

YES → Hospice bills HHH MAC for physician's services. For the professional component of a technical service, include CPT modifier 26 and remarks. Services reimbursed lesser of actual charge or 100 percent of Medicare Physician Fee Schedule amount.

YES → Is NP/PA the patient's attending physician?

NO → Hospice cannot bill services provided by a hospice employed NP/PA who is not the attending physician. Reimbursement included in hospice daily rate.

YES → Hospice bills HHH MAC for NP/PA's services. For the professional component of a technical service, report HCPCS GV and CPT 26 modifiers and include remarks. Services reimbursed lesser of actual charge or 85 percent of Medicare Physician Fee Schedule amount.

YES → Physician bills A/B MAC with HCPCS GV modifier. Physician reimbursed 80 percent of Medicare reasonable charge. RHC physicians may be a hospice attending physician, but must bill using their own Part B provider number. This is not an RHC service and cannot be billed by RHC.

Special Notes:

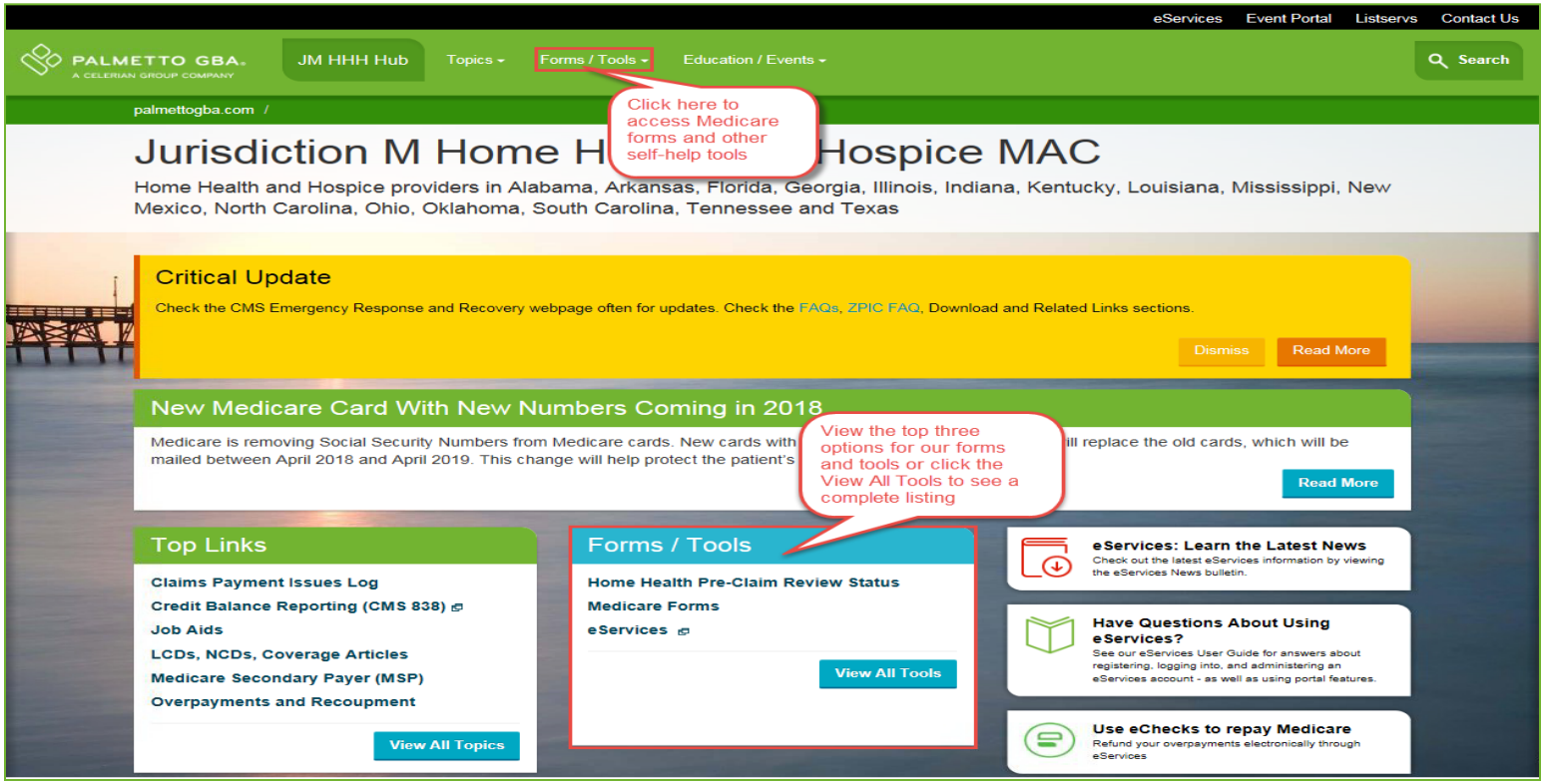
1. NPs and PAs as attending physicians must be permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law).
2. Effective January 1, 2019, PAs are recognized as designated hospice attending physicians.

Page 1 of 2

Disclaimer: This job aid is not a legal document and is a collaboration between CGS, NGS and Palmetto GBA.

[Billing Hospice Physician, NP and PA Services Job Aid]

Forms/Tools


eServices
Event Portal
Listservs
Contact Us
PALMETTO GBA
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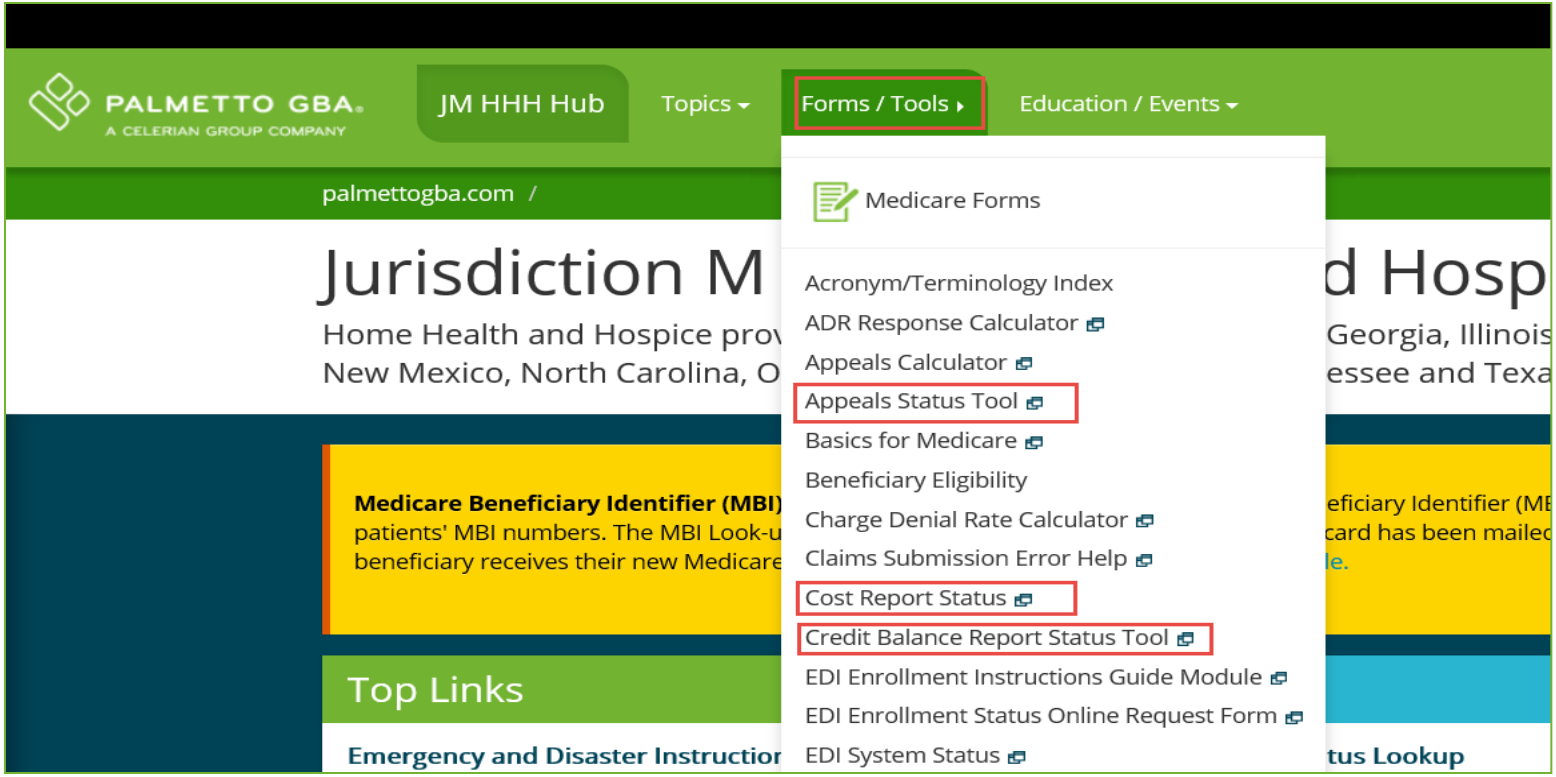
JM HHH Hub
Topics
Forms / Tools
Education / Events
Search
palmettogba.com /
Click here to access Medicare forms and other self-help tools
Jurisdiction M Home H Hospice MAC
Home Health and Hospice providers in Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas
Critical Update
Check the CMS Emergency Response and Recovery webpage often for updates. Check the FAQs, ZPIC FAQ, Download and Related Links sections.
Dismiss
Read More
New Medicare Card With New Numbers Coming in 2018
Medicare is removing Social Security Numbers from Medicare cards. New cards with
ill replace the old cards, which will be
mailed between April 2018 and April 2019. This change will help protect the patient's
Read More
View the top three options for our forms and tools or click the View All Tools to see a complete listing
Top Links
Claims Payment Issues Log
Credit Balance Reporting (CMS 838)
Job Aids
LCDs, NCDs, Coverage Articles
Medicare Secondary Payer (MSP)
Overpayments and Recoupment
View All Topics
Forms / Tools
Home Health Pre-Claim Review Status
Medicare Forms
eServices
View All Tools
eServices: Learn the Latest News
Check out the latest eServices information by viewing the eServices News bulletin.
Have Questions About Using eServices?
See our eServices User Guide for answers about registering, logging into, and administering an eServices account - as well as using portal features.
Use eChecks to repay Medicare
Refund your overpayments electronically through eServices

Tools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JM HHH Hub
Topics
Forms / Tools
Education / Events
palmettogba.com /
Medicare Forms
Acronym/Terminology Index
ADR Response Calculator
Appeals Calculator
Appeals Status Tool
Basics for Medicare
Beneficiary Eligibility
Charge Denial Rate Calculator
Claims Submission Error Help
Cost Report Status
Credit Balance Report Status Tool
EDI Enrollment Instructions Guide Module
EDI Enrollment Status Online Request Form
EDI System Status
Jurisdiction M
d Hosp
Home Health and Hospice prov
Georgia, Illinois
New Mexico, North Carolina, O
essee and Texa
Medicare Beneficiary Identifier (MBI)
patients' MBI numbers. The MBI Look-u
beneficiary receives their new Medicare
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Top Links
Emergency and Disaster Instructior
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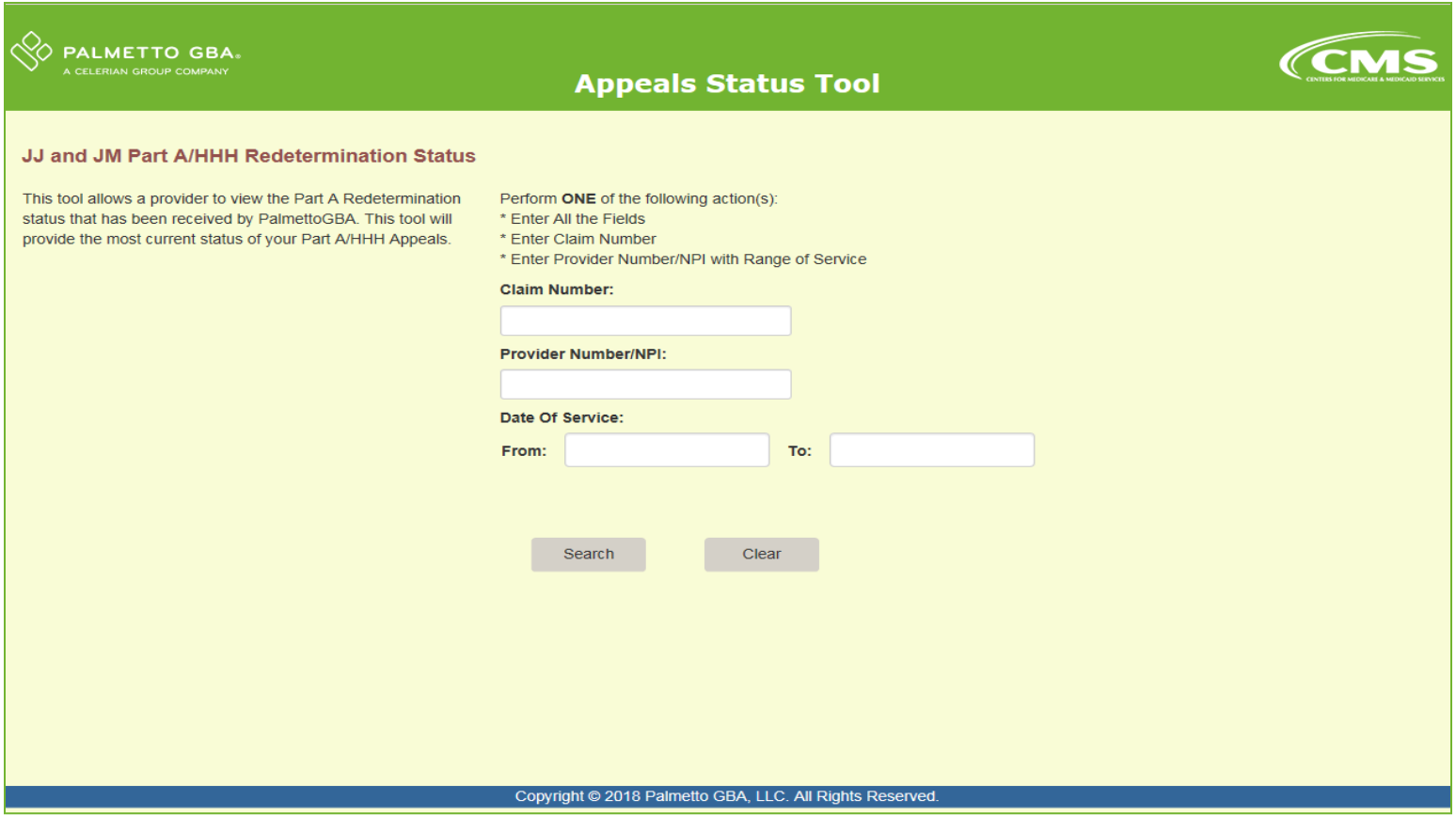
PALMETTO GBA
A CELERIAN GROUP COMPANY
Appeals Status Tool
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
JJ and JM Part A/HHH Redetermination Status
This tool allows a provider to view the Part A Redetermination status that has been received by PalmettoGBA. This tool will provide the most current status of your Part A/HHH Appeals.
Perform ONE of the following action(s):
* Enter All the Fields
* Enter Claim Number
* Enter Provider Number/NPI with Range of Service
Claim Number:
Provider Number/NPI:
Date Of Service:
From:
To:
Search
Clear
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Cost Report Status
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
PALMETTO GBA HOME
JM HHH Cost Report Status
This application provides the status of your JM HHH Cost report. Please enter your Provider Number (CCN) and the Fiscal Year End (FYE) for the Cost Report you want to inquire regarding the receipt and status of the acceptance and click Search. You will be able to see the Received Date, Status of Acceptance and if applicable, the Decision Date.
Search for Cost Report Status
Provider Number(CCN) *
XXXXXX
FYE of Cost Report *
MM/DD/YYYY
Search
Clear
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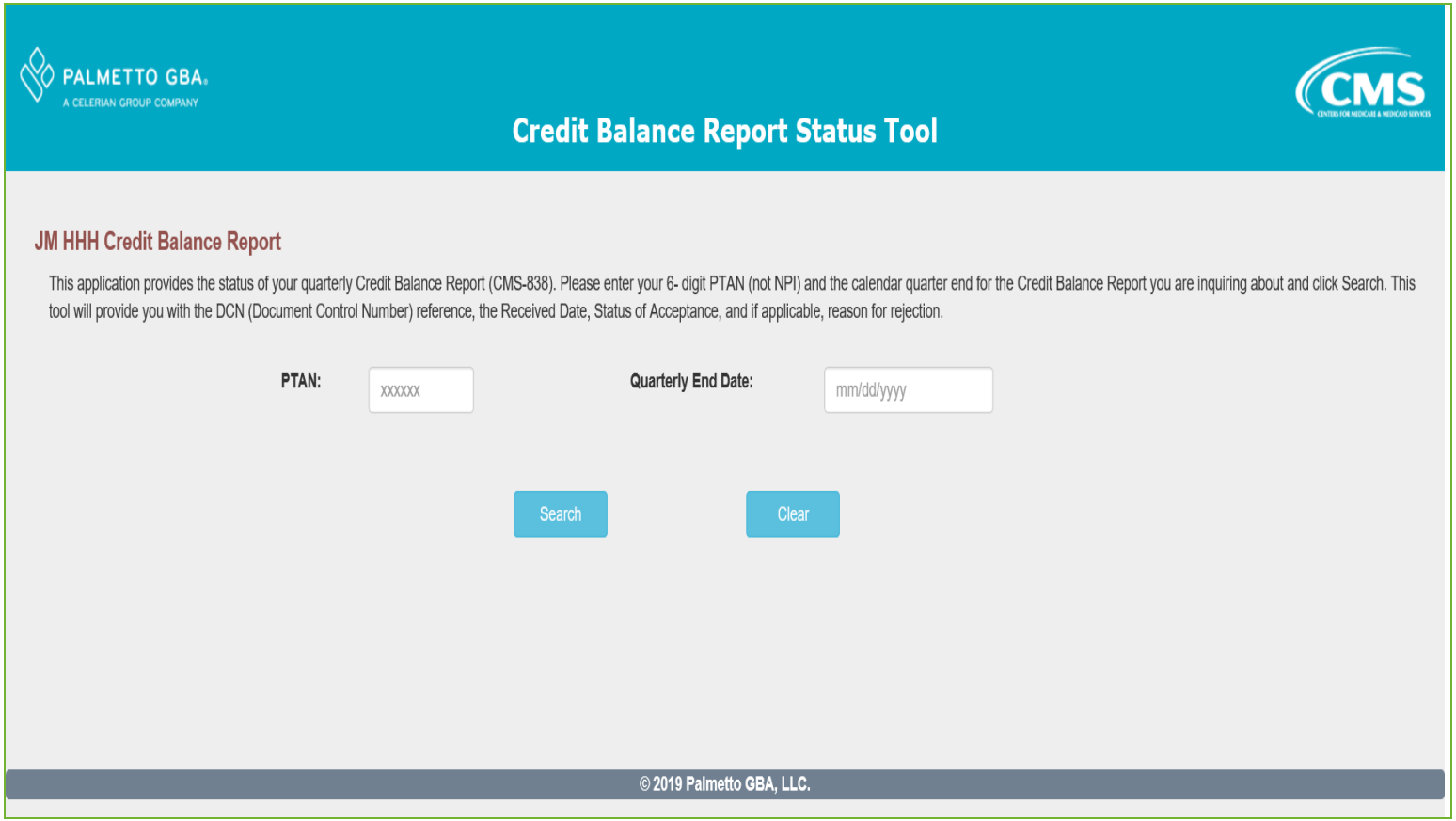
PALMETTO GBA
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Credit Balance Report Status Tool
CMS
JM HHH Credit Balance Report
This application provides the status of your quarterly Credit Balance Report (CMS-838). Please enter your 6- digit PTAN (not NPI) and the calendar quarter end for the Credit Balance Report you are inquiring about and click Search. This tool will provide you with the DCN (Document Control Number) reference, the Received Date, Status of Acceptance, and if applicable, reason for rejection.
PTAN:
xxxxxx
Quarterly End Date:
mm/dd/yyyy
Search
Clear
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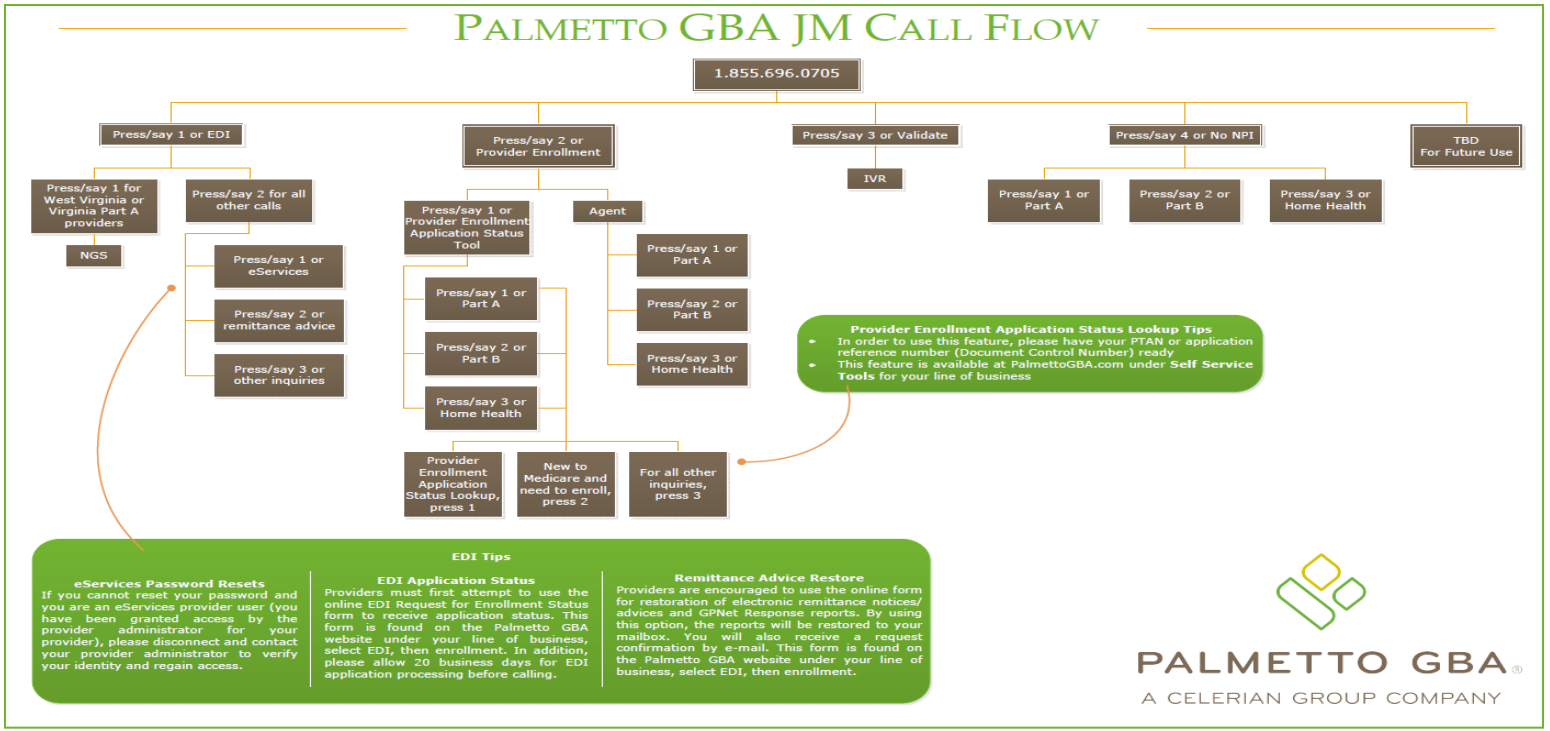
New Palmetto GBA JM Call Flow

- Implemented on December 10, 2018
- From your feedback, our customers, we have simplified the Jurisdiction M Call Flow when you contact us at 855-696-0705
- Allows callers to quickly navigate through the main menu for faster access to the information you need
- A new Call Flowchart is now available
- Be on the lookout for future additional changes to the Interactive Voice Response (IVR) system to improve the customer experience

New Palmetto GBA JM Call Flow



CMS Resources – www.CMS.gov

- Publication 100-02, Chapter 9
- Publication 100-04 , Chapter 11
- Publication 100-08 , Chapters 3, 4, and 15

Internet Only Manuals

Regulations & Guidance

- Change Requests
- MLN Matters® Articles

Transmittals

Regulations & Guidance

- Final Rule
- Wage Index
- Home Health, Hospice and DME Open Door Forum
- All transmittals

Hospice Center

Outreach & Education

- Get Training
- Earn Credit
- Attend Events for Medicare through the Medicare Learning Network® such as Web-based training
- MLN Connects®

Learn

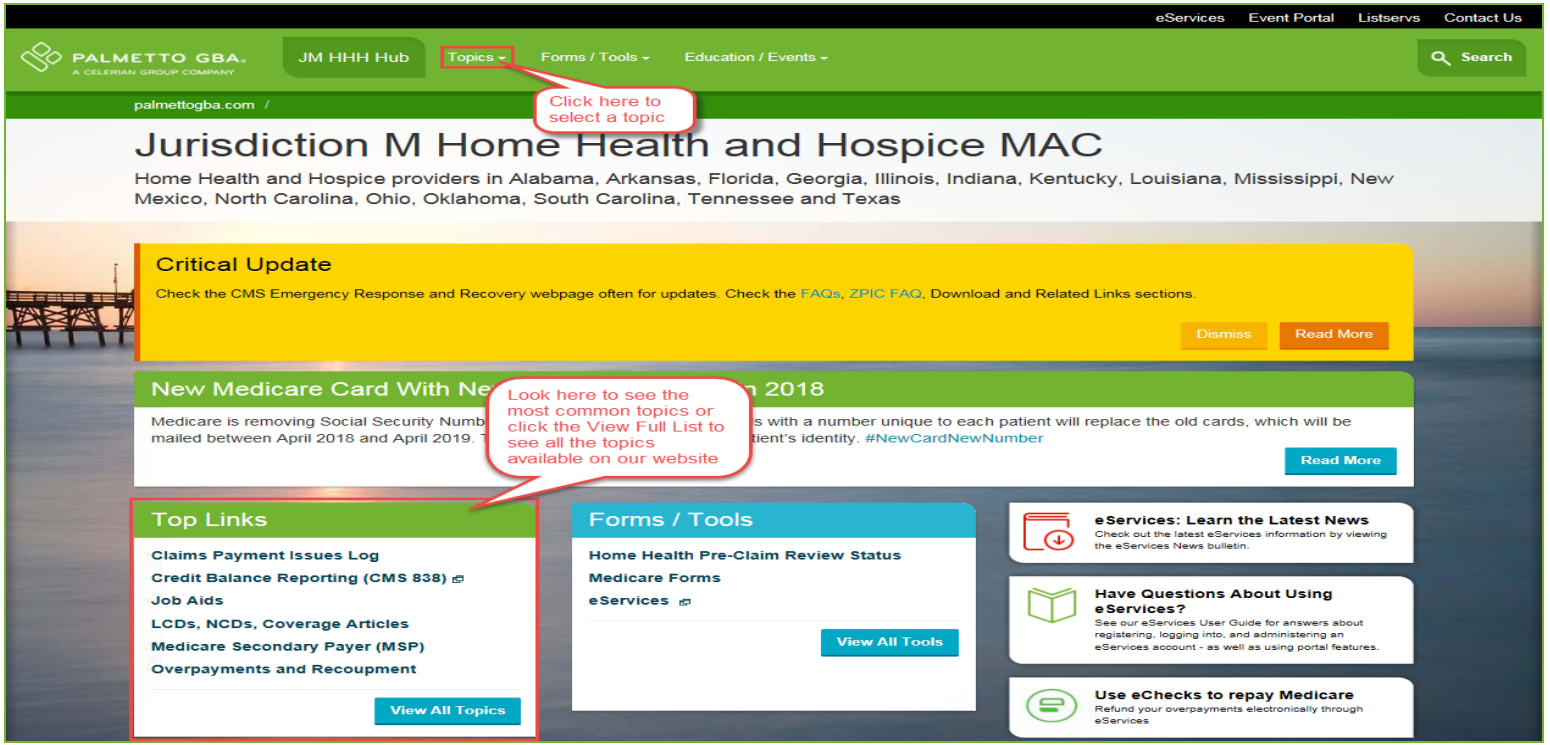
Outreach & Education

- Find tools to help you and others
- Get digital media

Reach out

Regulations & Guidance

Top Links – www.PalmettoGBA.com/hhh



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Social Media

- Look us up on Facebook

@PalmettoGBA

- Follow us on Twitter

@PalmettoGBA

- Find out more about us on LinkedIn®

www.PalmettoGBA.com

- View our YouTube education videos

www.PalmettoGBA.com/HHH

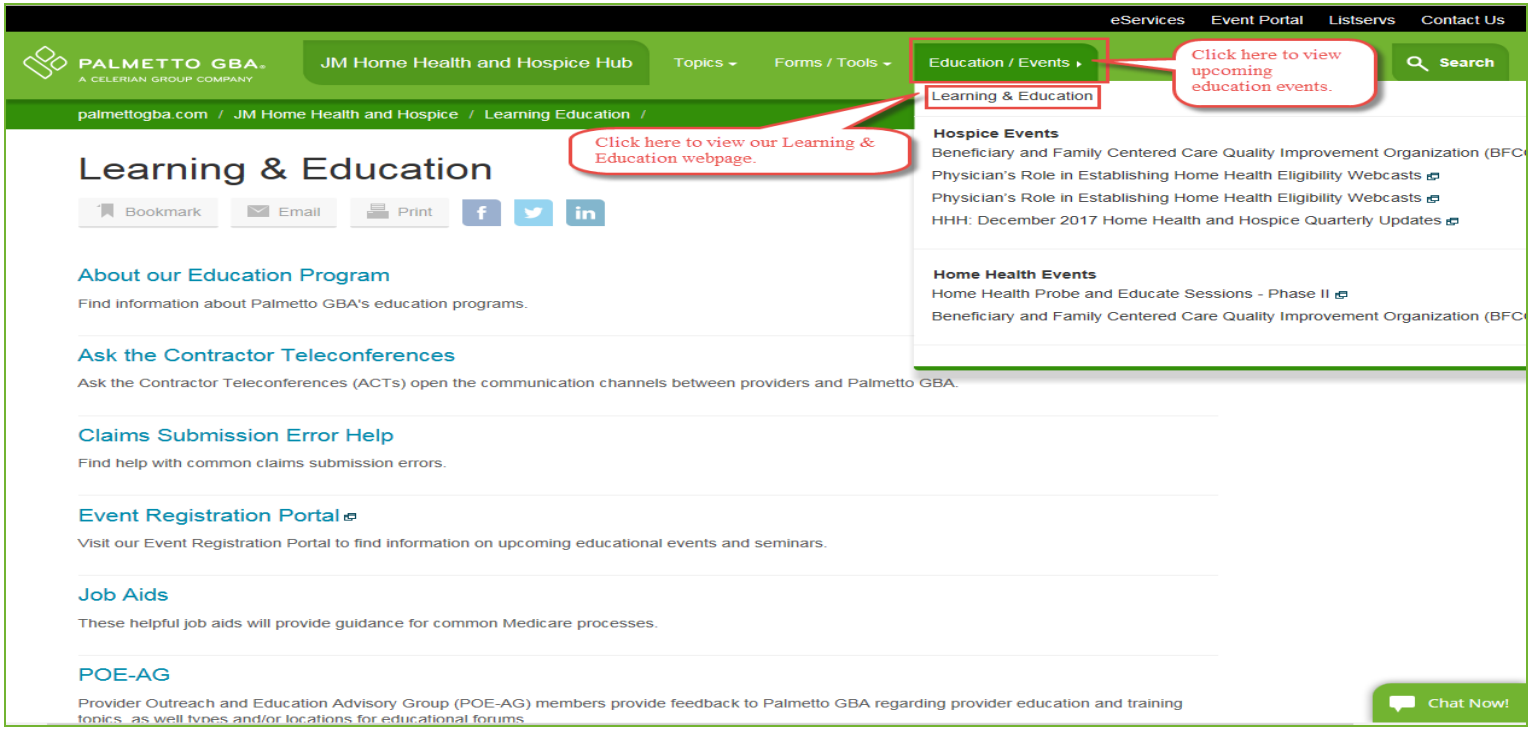
- Register to receive email updates

www.PalmettoGBA.com/HHH

- Subscribe to our RSS feed

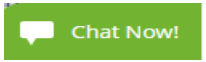
www.PalmettoGBA.com/HHH

Education/Events



Contacting Palmetto GBA

All questions such as claim status and general inquiries should be directed to our Provider Contact Center

- By Phone — 855-696-0705
- Secure eChat 

- Written — Palmetto GBA
  HHH PCC
  Mail Code: AG-840
  P.O. Box 100238
  Columbia, SC 29202-3238

Thank you for your attention