Clinical Claim Review

Hospice Review

Confirming accurate eligibility thresholds in medical records

More than one in three patients are dropping hospice before dying – a disturbing trend in an industry designed to care for patients until death.

Possible causes for this include either inadequate care or enrolling patients who aren't really dying in order to pad a hospice's profits.

Hospices are paid a daily rate for every day a beneficiary is in their care, regardless of whether services are provided on a particular day. Therefore, a hospice provider stands to gain financially if it provides minimal services to a beneficiary over a long period of time, rather than more intensive services for a short period of time.

According to a study by the Office of the Inspector General of the Department of Health and Human Services, it was discovered hospice election statements lacked required information or had other vulnerabilities in more than one-third of hospice general inpatient stays.

To be eligible to elect hospice care under Medicare, the medical record must include:

- A statement that the individual is terminally ill with a prognosis of six months' life expectancy or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation that support a life expectancy of six months or less; and
- A brief narrative explanation of the clinical findings, composed by the certifying physician, and which supports a life expectancy of six months or less.

In addition, the individual must also sign a statement indicating that he or she elects the hospice benefit and waives rights to all other Medicare payment for services related to the treatment of the terminal condition. Medicare will continue to pay for covered benefits for services unrelated to the terminal diagnosis, but the hospice provider is responsible for all costs related to the terminal diagnosis.

Medicare pays hospice providers for home care based on either a routine home care rate, or a continuous home care rate. The continuous hospice rate is paid at a rate nearly six times that of the routine home hospice rate. The Centers for Medicare and Medicaid Services outlines specific criteria that need to be met in order to bill for continuous home care hospice services. Because of the higher reimbursement rate, there is an incentive for providers to bill for the higher level of service, even though not all of the criteria have been met.

Under the hospice review, HMS will review targeted hospice claims to confirm the following:

- A statement in the medical record that the individual is certified as terminally ill with a prognosis of six months' life expectancy or less if the terminal illness runs its normal course, including specific clinical findings and other documentation that support a life expectancy of six months or less;
- Overlapping claims paid by Medicare (outside of the hospice benefit) are not related to the terminal diagnosis; and
- Claims reimbursed for the higher-paying continuous home care service contain all criteria required to bill for this service.

Advantages

- Advanced analytics target high-value cases for review
- Clinical reviewers with knowledge of hospice services

Features

- Post-payment review approach, can be used on prepayment basis if client reimbursement allows
- No member liability associated with findings
- Customized to reflect your reimbursement policy and/or specific provider contract terms
- Full support for rebuttals and appeals

Contact HMS for more information about Hospice Review services.

hms.com

HMS provides the broadest range of cost containment solutions in healthcare to help payers and accountable care organizations improve performance. Using innovative and time-tested technology and analytics, we prevent and recover improper payments related to fraud, waste, and abuse. As a result of our services, customers recoup billions of dollars every year and save billions more through the prevention of erroneous payments.