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Hospice and Long Term Care: Challenges and Opportunities

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http://www.hms.com/our_services/services_program_integrity.asp

Objectives

- Identify the key items of government focus to help you identify potential risk areas
- Review the responsibilities of hospices that provide services to your residents
- Discuss areas of conflict and tension and approaches for potential resolution



Challenges and Tensions

- Regulatory differences between hospice and LTC
- Changing regulatory landscape
- Increased enforcement activity
- Increasing lengths of stay (LOS) cost more
- Poor prediction of 6-month survival probability for patients with dementia
- Poor discrimination of hospice referral guidelines



Medicare Hospice Requirements

- Patient must have Medicare Part A
- Patient must elect the hospice benefit by signing election statement (NOE) and give up the right to active treatment for their terminal illness
- Certification of terminal illness that patient has 6 months or less to live if illness runs its normal course
 - Initial must be written, signed and dated by hospice medical director and the patient's attending physician, if they have one
 - Only hospice medical director needs to recertify.
- Services must be provided under a Plan of Care (POC)

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Hospice Benefit Periods

- Two non-renewable 90-day hospice benefit periods (BPs) followed by unlimited number of 60-day BPs
- Patient must continue to meet hospice coverage criteria
- If patient revokes or is discharged, patient forfeits remaining days in BP
- Patient can re-elect at any time but must meet hospice coverage criteria

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Certification and Recertifications

- Certification of terminal illness (CTI) statement must contain:
 - Six month prognosis language
 - Clear certification date ranges
 - Signatures
 - Dates
- May be completed up to 15 days prior, or by the end of the third day after the benefit period begins
- Must be signed/**dated** prior to billing



Physician Certifications & Recertifications

- No check boxes or standard language used for all patients
- Narrative cannot be completed by other hospice personnel, it must be completed by the certifying physician
- Attestation under the physician signature, that attests to the fact that **by signing the form, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient**
- Specific clinical findings and other documentation supporting a life expectancy of <6 months



Face-to-Face Encounters

- Hospice physician/nurse practitioner encounter must occur no more than 30 calendar days prior to the start of patient's third benefit period (180 days) and each subsequent recertification
- Physician must attest that the encounter occurred
- Physician must include narrative describing how the clinical findings of the encounter support the patient's terminal prognosis of 6 months or less
- Both the narrative and the attestation must be part of, or an addendum to, the recertification



Discharge by Hospice

- Discharge allowed only when:
 1. Patient no longer fits Medicare definition of "terminally ill" with 6 month prognosis, or
 2. Patient moves out of service area, or
 3. Hospice determines, under the agency policy, that patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care is seriously impaired
- Must have adequate discharge plan and confer with attending physician



Discharge Planning

- Patient's attending physician should be consulted before discharge and his/her review and decision included in the discharge note
- Discharge planning process must take into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill
- Discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill

42 CFR §418.26



Hospice Diagnoses Changing: 2007

Diagnosis	Share of Total Hospice Cases	Cases w/ALOS > 180 Days
Cancer	32%	18%
Debility	9%	23%
Alzheimer's/ similar diseases	6%	33%
Unspecific symptoms/signs	6%	23%
Dementia	5%	29%
Organic psychoses	4%	29%
Nervous system	3%	31%
All hospice cases	100%	19%

HOSPICE ASSOCIATION OF AMERICA, 2010

Hospice Patients: 2006

Diagnosis	Institutionalized	Noninstitutionalized
Cancer	10.2	41.9
Debility	12.7	6.2
Alzheimer's/ similar diseases	11.8	4.1
Unspecific symptoms/signs	9.6	4.4
Dementia	10.5	2.7
Organic psychoses	7.2	2.3
Nervous system	3.4	2.2
All hospice cases	18%	82%

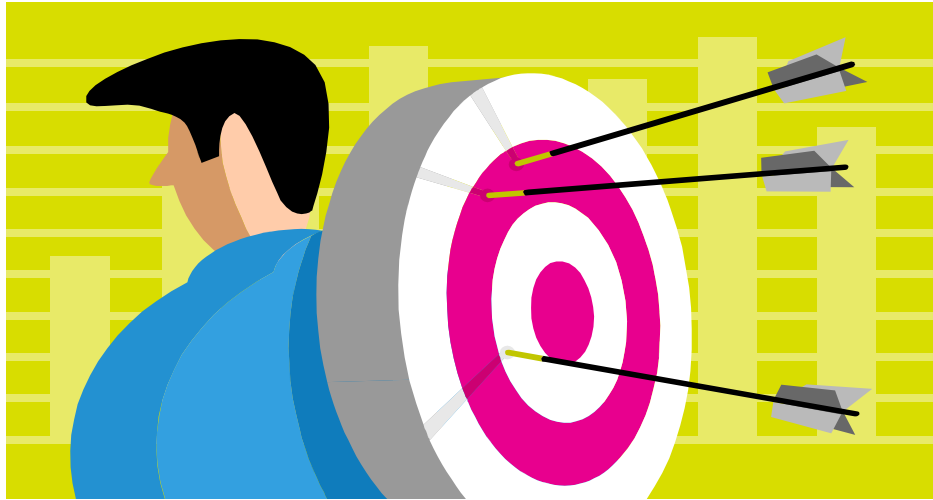
HOSPICE ASSOCIATION OF AMERICA, 2010

Hospice Use in LTC Increasing

	LTC Access 1999	LTC Access 2006	ALOS 1999 Days	ALOS 2006 Days	ALOS <1 Week	ALOS > 6 Months
Advanced Dementia	14.5%	42.5%	46.1	118.2	25%	20%
Mild/Mod. Dementia	13.2%	37.9%	38.7	79.5	31%	13%

Miller, Am J Alzheimer's Dis 2010

Government Focus Areas



FCA and Hospice Claims

- False certifications of terminal illness
- Billing for care that came from a kickback
- Underserving Medicare patients
 - Number of visits < plan of care
 - Services to SNF patients < services to patients at home
- Billing for substandard quality of care
- Billing when documentation lacks essential elements

OIG 2011 Work Plan: Hospice Utilization in SNFs

- *Data mining:* Hospice Medicare A claims and MDS
- Characteristics of nursing facilities with high hospice utilization
 - Prior report: 82% of SNF/hospice claims did not meet coverage requirements
- *Incentives to admit patients likely to have long stays*
- Examine business relations and marketing practices



OIG 2011 Work Plan: Hospice Services to SNF Residents

- Review hospice services
- Focus on hospice-based home health aides
- Review hospice/SNF medical records, care plans
- Determine how hospice/SNF coordinate care, services and payment arrangements
- Assess appropriateness of general inpatient care claims



OIG 2011 Work Plan: Duplicate Drug Claims for Hospice Beneficiaries

- Review appropriateness of drug claims comparing hospice Medicare A against Medicare D claims
- Determine if payments under Part D are correct, are supported, and are not duplicated in hospice per diem amounts
- Determine extent of duplication
- Determine controls to prevent duplication



OIG 2011 Work Plan: Medicaid Hospice Services

- Review whether services were provided in accordance with Medicaid reimbursement requirements
- FY 2009 Medicaid payments for hospice exceeded \$2.2 billion
- Conduct a medical record review of claims to see if services were reasonable and necessary



OIG Supplemental Compliance Program Guidance for Nursing Facilities

- Illegal referrals between SNFs and hospices
- Hospice nurse providing nursing services for non-hospice patients
- Hospice offering free goods or goods at below-fair-market value
- Hospice paying additional room and board payments for Medicaid patients



OIG Supplemental Compliance Program Guidance for Nursing Facilities

- Hospice paying above fair-market value for additional services that Medicaid does not consider to be included in its room and board payment to SNF
- Hospice referring its patients to SNF to induce SNF to refer its patients to the hospice
- Hospice providing free (or below fair-market value) care to SNF patients, for whom Sufis receiving Medicare payment
- under the SNF benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospice services from that hospice
- Hospice providing staff at its expense to SNF



OIG Supplemental Compliance Program Guidance for Nursing Facilities

- “Under certain circumstances, a nursing facility that knowingly refers to hospice patients who do not qualify for the hospice benefit may be liable for the submission of false claims.”



Medicare Hospice Care For Beneficiaries In Nursing Facilities: Compliance With Medicare Coverage Requirements

- 82% claims did not meet at least 1 coverage requirement
 - Election statements
 - Plans of care, services
 - Certifications of terminal illness
 - 1% claims undocumented
- \$1.8 billion
- Non-profit errors 89%/for-profit error 74%
- OIG (9/2009)



Medicaid Hospice Reviews: NY OMIG 2011 Work Plan

- Medical record review to determine whether hospice services were:
 - Properly authorized
 - Appropriately provided and documented
 - If third-party coverage was pursued
- Auditors will review personnel records to verify that provider staff met all regulatory, educational, medical and experience requirements
- Auditors will perform a documentation review to determine whether the recipient met the hospice admission criteria



Case Studies



U.S. v. Dreyfuss (E.D. Mich. 2000)

- Donald Dreyfuss, DO, pleads guilty to criminal fraud, including receiving kickbacks from a hospice for recommending that hospice to staff of his nursing home
 - Paid \$2 million, 2 years home confinement/ 5 yr probation



Faith Hospice, Inc. 2005

- Settlement with DOJ for \$599,000
- Allegations of submitting fraudulent claims
- Investigation started when a review of a sample of medical records showed that more than half of its patients were ineligible for hospice care



Odyssey HealthCare 2006

- Paid \$12.9 million to resolve allegations that it billed for services to *patients* who were not terminally ill and ineligible for hospice
 - Whistleblower (former regional vice president) got \$2.3 million
- 5 year corporate integrity agreement
 - IVO audits 2 samples annually
 - Eligibility at admission
 - Appropriateness for long LOS



True or False?

To identify a SNF resident who may benefit from hospice ask yourself, “Would I be surprised if this person died?” If the answer is no, the person may be appropriate for hospice and should be evaluated for those services by a hospice nurse.

_____ True

_____ False



We Care Hospice, California 2009

- 6 charged by California Attorney General
- Hospice lost license and closed
- Typically, 80% of patients die during their first six months in hospice
 - Between 2004 and 2007, at We Care, only 11% of the 362 Medicare beneficiaries and 4% of the 143 Medi-Cal beneficiaries died
- Staff paid "cappers" a finder's fee for identifying and enrolling relatively healthy beneficiaries into hospice care



SouthernCare Inc., 2009

- Paid \$26.7 million, 5 year CIA
 - 2 whistleblowers (ex-employees) got \$4.9 million
- Allegations that it had a pattern and practice to falsely admit patients to hospice care who did not qualify
 - Lacked documentation of terminal illnesses and extended length of stay issues
 - Illegally marketed to potential patients by promising free medications, supplies and home health aides



NOTES/COMMENTS:
Please sign verbal order and fax back today.

Facility Name _____ Address _____ 3
 VERBAL ORDER TELEPHONE ORDER

Empty Name _____ First Name *Andrew* Admission Number _____ Room Number _____ Prescribing Phys/Clin # *Dr*

*06/24/09 medical prognosis is that h/o
or her life expectancy is 6 months
or less if the terminal illness
runs its normal course.*

Physician/Prescriber Signature _____ Title _____ Date _____

Signature of Transcribing Nurse _____ Date *6/25/09* Time _____

RECEIVED JUN 25'

Kaiser Foundation Hospitals, 2009

- Paid \$1.83 million
- Failed to obtain written certifications of terminal illness signed by hospice director and primary physicians

US v. Home Care Hospice

(E.D. Pa. 2010)

- Complaint alleges the following, including \$46 million in alleged fraud
- Grew from 15 patients in 2000 to >300 patients in 2006
- Services provided to patients who were not eligible
- Services never performed
- Falsified medical records



US v. Home Care Hospice

(E.D. Pa. 2010)

- Forged documents
- Back-dated hospice revocation requests
- Charged for untrained and unqualified staff as if they were trained and qualified
- Falsely certified that its claims were true, correct and complete as required under Medicare laws and regulations



US v. Home Care Hospice

(E.D. Pa. 2010)

- State surveyor issued report saying 11 of 20 patients had been inappropriately placed in hospice care
 - Gov't alleges 30% never met eligibility criteria
 - Defendant ordered certain patients be certified as hospice-eligible
- Fraudulent general inpatient care claims because symptoms did not require pain control or acute or chronic symptom management
- Fraudulent continuous care claims: actual services were consisted with routine level of care

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US v. Home Care Hospice

(E.D. Pa. 2010)

- Revoked hospice care prior to hospitalizations and then re-admitted to hospice care post-hospitalization
- Paid kickbacks to physicians and other healthcare professionals
 - Created compensated positions: medical director, hospice physician, patient advisory committee, speakers committee but got little or no services
 - Monthly payments from \$300-\$5000 per doctor

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US ex rel Landis v. Hospice Care of Kansas, LLC (D. Kan. 2010)

- Whistleblower is a current employee
- Allegations involve business practices that caused admission, retention and submission of claims for ineligible patients
- Setting aggressive census targets with staff incentives and monetary bonuses
 - Threatening staff with terminations or reductions in hours if census fell below targets
- Ineffective training and compliance programs made it likely they would submit false claims for ineligible patients



US ex rel Landis v. Hospice Care of Kansas, LLC (D. Kan. 2010)

- Instructing staff to inaccurately document patients' condition to make them look "hospice appropriate" and to avoid detection upon Cahaba medical review
- Implementing procedures that delayed or made it difficult to discharge ineligible patients
 - Challenging or ignoring staff/physician recommendations to discharge patients
 - Disregarding or ignoring compliance concerns raised by outside consultants



Moving Forward

- Assess your relationships with hospices
- What are you asking them to do?
- What do they do?
- How involved is your medical director?
- Who is your point of contact, internally and with hospice?
- Review your hospice census
- Monitor trends



Minimize Risks

- Review your contracts
- Build stronger/closer relationships with hospice partners
- Enhance collaborative efforts
- Strengthen care conferences
- Assure monitoring and auditing processes are functioning properly
- Be prepared for the government's knock



Suggested Activities

- Review policies, procedures *and practices*
- Periodically assess billing and claims reimbursements staff competency (ie, knowledge of applicable program requirements and claims/billing criteria)
- Periodically compare documents with claims submitted
 - Start with patient's admission and end with the submission of the claim to the government or third party payor



Remember the Common Errors

- No documentation
- Insufficient documentation
- Medically unnecessary services or treatment
- Incorrect coding errors
- Improper documentation errors
- Missing dates
 - All entries must be dated—date stamps no longer acceptable



Remember the Common Errors

- Signature issues
- Missing signature
- Illegible, unrecognizable handwritten signatures or initials
- Unsigned 'typewritten' progress notes with a typed name only
- Unverified or unauthorized electronic signatures
- No indication of the rendering physician or practitioner



Resources And Useful Information



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- *United States ex rel. JoAnne Russell v. Odyssey Healthcare, Inc.*, C.A. No. 2:30-cv-00865-AEG (E.D. Wis., 2006)
- *Nancy Romeo ex rel. United States v. Southerncare, Inc.*, C.A. No. 2:07-cv-2325-IPJ (N.D. Al., 2009)



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- *Faith Hospice, Inc.*, referenced in “The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report For FY 2006 “(last accessed on January 1, 2011 at <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2006.pdf>



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- Cahaba LCD L13653 “Hospice—Determining Terminal Status
- https://www.cahabagba.com/rhhi/coverage/lcds/lcd_active.htm



QUESTIONS????

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