

Eli's Hospice Insider

Your guide to compliance, payment, and successful hospice operations.

Inside this issue...

Visit Reporting Burden to Get Heavier for Hospices ..1

Hospices Fear Repercussions of New Visit Reporting Proposal1

Are You Up to Speed on the Interim Final Interpretive Guidance? You Can Bet Surveyors Will Be4

Develop a 'Win-Win' Situation With Nursing Homes to Ensure Optimal Outcomes5

Beware These Caveats When Using Transdermal Fentanyl6

IRS Pumps Up Collection Efforts: Beware Agency's New Powers7

Study Finds Hospice Restrictions May Penalize African Americans7

Editorial Page8

BILLING

Visit Reporting Burden to Get Heavier for Hospices

► *CMS wants to broaden data collection.*

Get ready for a lot more work to submit your hospice claims. Although it will be a hassle, the data could provide the feds with a clearer picture of hospice care.

At least partly in response to industry complaints, the Centers for Medicare & Medicaid Services has proposed a new phase of hospice visit data collection.

Then: In July, CMS began requiring hospices to report visit data on claims. The new requirement has caused hospices headaches as they figured out details such as how much to charge for visits and how to count visits in inpatient settings. In response to industry outcry, CMS backed down on requiring visit data for non-hospice staff in institutions.

Continued on page 2

REGULATIONS

Hospices Fear Repercussions of New Visit Reporting Proposal

► *Providers want better data, but this proposal may not achieve that aim.*

The Centers for Medicare & Medicaid Services is listening to hospices, but those providers may not like what the agency says in return.

CMS's proposal to broaden hospice visit data collection (*see the story above*) resulted from the industry's urging to paint a broader picture of hospice care. "On several occasions, industry representatives have communicated to CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care," CMS says in the proposal.

Continued on page 2

Billing, continued from cover

Now: CMS wants hospices to report visits in 15-minute increments for disciplines that already have NUBC revenue codes — physical, occupational and speech therapy, skilled nursing, aide, and clinical social work, the agency says in a proposal posted on its hospice Web site. Hospices will use the G codes currently used on home health agency claims to report hospice visits, CMS proposes. Reporting visit data in 15-minute units will require line-item billing, CMS points out.

Plus: CMS also suggests adding a new revenue code for social worker phone calls, also in 15-minute increments. “Only report phone calls made to the patient or to family members; do not report other administrative calls, even if those calls are related to

a particular patient’s case,” CMS instructs in the proposal. “Phone calls should only occur when visiting the patient or family in person is not possible or when the patient or family prefers not [to] have a visit.”

Exception: Hospices wouldn’t have to report visits for general inpatient (GIP) or inpatient respite levels of care, CMS adds. Instead, “to reduce burden on providers, for services provided as part of GIP or respite care, we suggest summing the visit time per day by discipline, and converting to 15 minute increments,” the agency says. “For GIP and respite care, the number of visits is not as relevant as the amount of time spent providing care to the patient.” CMS is also considering collecting visit data on other hospice team members like

volunteers and spiritual counselors, according to the proposal. But the agency might collect that data in the aggregate on the cost report rather than on claims.

Timeline: CMS offers no implementation date for expanded data collection. It took comments on the proposal until Nov. 22. That short timeframe for comments made it difficult for providers to digest the proposal and offer meaningful feedback, industry veterans say.

Note: The proposal is in the “Spotlights” section at www.cms.hhs.gov/center/hospice.asp. ■

Regulations, continued from cover

The HHS Office of Inspector General, the Medicare Payment Advisory Commission, and the Government Accountability Office also have urged CMS to adopt more comprehensive data collection for hospices, CMS notes. Hospices shouldn’t be surprised by this recommendation, says **Greg Martin**, president of the Alabama Hospice Organization and Hospice Family Care in Huntsville. As hospice utilization has grown and Medicare hospice spending has increased, the government wants the industry to be more accountable for those payments, Martin believes.

It’s actually surprising that CMS stayed as hands-off as it did for as

long as it did, observes **Jeff Towns** with the Michigan Hospice & Palliative Care Organization. Greater government oversight is inevitable as the industry grows.

Abuse of the hospice benefit as it grows exponentially has contributed to the need for more data too, Martin laments. Some hospices are not furnishing “competent visits,” he notes. “It’s sad, but that’s where we are as an industry.”

Good: Providers and industry representatives support better data in general. “Our members welcome the broader data collection,” says **Melanie Ramey** with The Hospice Organization and Palliative Care

Experts of Wisconsin, that state’s trade group. “We have not felt the previous limited collection reflected the true picture of hospice.”

Virginia Association for Hospices members “are very supportive of measures that will demonstrate accountability, integrity, and transparency in hospice programs,” adds VAH’s **Brenda Clarkson**.

“Our members welcome more comprehensive and meaningful data collection that will lead to a more accurate understanding of hospice care,” agrees **Judy Brunger** with The Carolinas Center for Hospice and End of Life Care. “It can only benefit the patient and family at the end of life.”

Continued on page 3

Not so good: But the jury is still out on just how helpful CMS's proposal will be. Hospices want CMS to collect "real" data, says **Janet Neigh** with the National Association for Home Care & Hospice.

"CMS should design their reporting requirements to coordinate with providers' data collection systems, rather than reporting requirements that distort the results of those systems," maintains **Jane Evans** with the Arkansas State Hospice & Palliative Care Association.

"There are mixed feelings about CMS's data collection requests," says **Jennifer Hale** with the Georgia Hospice and Palliative Care Organization. Hospices recognize that more data will be necessary to justify hospice care provision under Medicare. But the industry is concerned about how the data is collected and, perhaps more importantly, used and interpreted. Hospices don't want data collection to lead to tampering with the hospice benefit, Clarkson says.

"The data alone, without comparison to outcomes, patient satisfaction, and fiscal sustainability, may lead to inaccurate recommendations," Hale warns. Another problem with the proposal is that not all hospices collect data the same way. CMS should define each data element better and create industry standards to make sure comparison is valid, Hale suggests.

And the increased data collection represents a significant increased expense for hospices, notes **Dan Hull** with the Utah Hospice & Palliative Care Organization. It costs "a lot more in labor to do that collection,"

Hull says. Hospices will likely have to make electronic medical record investments to make expanded data collection feasible, Hale expects.

"For the smaller hospice who is not computerized except to do billing, this requirement will be a huge burden," warns the National Hospice and Palliative Care Organization.

At least many hospices have sister home health agencies that have to do reporting in 15-minute increments, which should help them get used to it, Hull says.

"It's a pain in the neck, but hospices are not alone" in time-based reporting, Neigh tells **Eli**.

Beware: Martin worries that switching to a 15-minute increment reporting system could have a detrimental effect on medical record documentation. Clinicians trying to report what they did in every 15-minute increment may lose sight of painting a picture of the patient's overall condition and creating a cohesive narrative of patient care. NHPCO praises CMS

for adding social worker phone calls to the visit reporting list. But other disciplines also make important phone call visits. CMS should "count phone calls for all clinical disciplines as long as they are directly connected to providing care to the patient and family and documented as such in the clinical record," NHPCO's **Judi Lund Person** says.

NHPCO members also want to see a change to the time-tracking proposal for inpatient care. "We know of no other part of inpatient health care where this requirement exists," NHPCO says in a draft letter to CMS. "Tracking time spent for each discipline would take time away from patient care." Due to these and other problems, Georgia hospices are recommending that CMS test hospice data collection before adopting it for the entire industry, Hale says.

A demo project for the inpatient time-tracking issue may be enlightening, NHPCO offers. ■

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SURVEY MANAGEMENT

Are You Up to Speed on the Interim Final Interpretive Guidance? You Can Bet Surveyors Will Be

► *Home in on these key areas before surveyors beat you to the task.*

“Be prepared” is the best motto for dealing with interim final interpretive guidance for surveyors now in effect.

The new survey guidance is based on the Conditions of Participation or CoPs that went into effect on Dec. 2. And in terms of challenges posed by the guidance, “two big areas” keep coming up in industry discussions, says **Janet Neigh**, with the National Association for Home Care & Hospice. One involves the initial and comprehensive assessments — and the other involves the quality assessment and performance improvement (QAPI), “which is totally new for hospice,” she notes. For example, the initial

assessment isn’t a “meet and greet” visit but rather one to “gather the essential information necessary to begin the plan of care and provide

Hospices sometimes end up with more of a “cookie cutter approach” to care planning if staff aren’t properly trained — and don’t pay enough attention to the specific patient’s and family needs.

Mary Michal, JD

the immediate necessary care and services,” the guidance instructs.

Surveyors will focus on individualized care planning, predicts

attorney **Mary Michal**, with Reinhart Boerner Van Deuren in Madison, Wis. In fact, “we are telling our clients that they have to be absolutely meticulous about an individualized hospice care plan ...”

Sidestep this pitfall: Hospices with electronic charting systems sometimes end up with more of a “cookie cutter approach” to care planning if staff aren’t properly trained — and don’t pay enough attention to the specific patient’s and family’s needs, Michal cautions. (To review the elements of a comprehensive assessment, see the sidebar on the left below.)

Prepare for QAPI

The guidance focuses heavily on how hospices should perform quality assessment and performance improvement or QAPI.

Key point: Hospices shouldn’t limit their QAPI data collection efforts to information gleaned from patient assessments. Instead, the guidance directs hospices to evaluate “all patient services and all activities that may impact patient/family care ...” The list includes patient-care and related services (medical social work, nursing, physician, hospice aides, pharmaceutical, DME), patient rights, administrative services, volunteers, adverse events, and more. Since hospices don’t have quality measures, it’s up to the individual

Use This Checklist for Completing the Comprehensive Assessment

Your hospice may tailor the comprehensive assessment to include a range of information, but make sure it covers these key areas listed by the hospice final interim interpretive guidance for surveyors.

- | | |
|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Skin integrity |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Emotion distress |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Spiritual needs |
| <input type="checkbox"/> Restlessness or anxiety | <input type="checkbox"/> Support systems |
| <input type="checkbox"/> Sleep disorders | <input type="checkbox"/> Family need for counseling and education |

The guidance notes that the assessment isn’t limited to the above. Also, hospices should then gather “additional information, as necessary” to meet the patient/family’s needs, the guidance instructs (see the article on this page).

Continued on page 5

hospice to decide what to measure as part of performance improvement, says **Judi Lund Person**, with the National Hospice & Palliative Care Organization. NHPCO has developed several measures, including one that rates patients' pain at admission and at 48 hours, to see how well the hospice has the pain under control, Person notes.

Another NHPCO-developed performance improvement measure looks at whether patients died where they choose, says Person. Doing a chart

review, the hospice looks at "self-determined life closure," Person says, to see if the person had the experienced they wanted.

Good news: The January version of the guidance gives surveyors latitude for evaluating a hospice's QAPI program rather than just looking at the QA committee minutes, Person notes.

Expect these questions: The guidance directs surveyors to ask the hospice "how it uses the data analysis to select performance improvement proj-

ects, how it implements such projects, and how it uses the data to evaluate the effectiveness of those projects."

Resource: Download the January 2009 advance interpretive guidance at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf. CMS says it will publish the guidance "eventually" in Appendix M of the State Operations Manual, which may differ slightly from the advance copy. ■

COORDINATION OF CARE

Develop a 'Win-Win' Situation With Nursing Homes to Ensure Top-Notch Outcomes

► *4 strategies can help you — and the nursing home — get on the same page.*

Talk about a potential dilemma: Providing hospice services in a nursing home requires you to partner with facility staff who may fear a hospice patient's decline or palliative care will get them in hot water with surveyors. But the hospice interim final interpretive guidance stresses coordination of care between hospice and nursing homes like never before.

Solution: This four-pronged approach will help your hospice get in synch with nursing facilities.

Strategy No. 1: Know How to Coordinate the Care Plan

The new Conditions of Participation (CoPs) talk about nursing homes and hospice having one care plan, notes **Cherry Meier, RN, MSN**, with VITAS Innovative Hospice Care in Flat Rock, N.C. As many in the industry had hoped, however, the January 2009 interim final

interpretive guidance clarifies that the hospice and nursing home can divide the coordinated care plan into two parts. "CMS folks expect the hospice plan of care to relate to the terminal illness — and the nursing home plan of care to relate to every other part of care provided to the resident," says **Judi Lund Person**, with the National Hospice & Palliative Care Organization.

"The two plans should reflect each other ...," counsels **Beth Carpenter**, president of **Beth Carpenter & Associates** in Lake Barrington, Ill. "This isn't new," she adds. But the hospice CoPs make that more clear than previous terminology that "connoted to some extent that the two didn't step on each other's toes."

More than a paper exercise: "When the care plans don't coincide, it probably leads to poor care," cautioned **Harold Bob, CMD, MD**, a

nursing home and hospice medical director, in a presentation on palliative care and survey regulations at the **2008 American Medical Directors Association** annual meeting.

Do the side-by-side test: Lay the nursing home and hospice care plans side by side to make sure they seem like the same patient, experts advise.

Strategy No. 2: Help the Nursing Home Develop Palliative Solutions

Set the tone for promoting a unified approach and palliative care from the get-go. For example, Meier advises a hospice nurse caring for patients in nursing homes to make the facility's minimum data set (MDS) coordinator her "very best friend." The hospice nurse can review the MDS and the problems triggered for care planning. Then the nurse should compare those to the problems identified by the hos-

Continued on page 6

pice assessment, and discuss these with the MDS coordinator, Meier says. The “hospice nurse can then help the MDS team with the care plan and work on finding palliative care solutions to the patient’s problems.”

Focus on these key areas: Nursing homes tend to differ from hospice in how they address weight loss, pressure ulcers, and pain, notes Meier. Thus, make sure nursing home staff knows to give patients their PRN medication for break-through pain, and to report instances where the patient seems to be requiring more PRNs than usual.

Strategy No. 3: Develop Standard. 2-Way Communication Systems.

The hospice staff should collaborate with the nursing department to provide their assessment information for the MDS, including pain, says **Gail Robison, RN, RAC-CT**, a consultant with **Boyer & Associates** in Brookfield, Wis. That strategy will improve the accuracy of care plans, as well as nursing home pain quality measures, which help the nursing

home spot inadequate pain management efforts. “The hospice staff should also communicate to the nursing staff any changes they’ve observed in the patient,” Robison says. Ditto for the hospice, adds Carpenter.

Tip: Make sure the nursing home knows to notify the hospice if it plans to send the person to the hospital or if the patient dies.

Strategy No. 4: Identify, Address Nursing Home Staff Concerns

In some cases, your hospice team may also have to educate or work with nursing home staff to allay their survey or care concerns.

This may help: The CoPs and interim final interpretive guidance requires the hospice to give the nursing facility a copy of the patient’s hospice election, and the physician’s initial and subsequent certifications of the terminal illness, Meier says. And nursing home staff members can show surveyors these documents if they

express concern about a hospice resident receiving certain types of care — or whether someone is terminally ill.

Look for this: Sometimes nursing homes may balk at the hospice’s palliative approach due to their own grief reaction, observes Meier. “It can be hard for the staff to let the dying resident go sometimes,” which is a sign of compassionate care, she adds. And hospice can come in “and help staff cope and let go.”

Provide a reality check, if needed: If all else fails, you might give a particular facility or staff member(s) a heads up that nursing home surveyors are getting more with the hospice philosophy for end-of-life care.

NHPCO’s Person says the word is that surveyors on both sides are looking for communication and coordination of care between the two providers related to the plan of care, documentation, and communication about changes in the patient’s condition. ■

MEDICATION MANAGEMENT TIPS

Beware These Caveats When Using Transdermal Fentanyl

► *This 2-point assessment can stave off problems.*

Fentanyl patches can be an effective pain management approach. But you might improve outcomes by asking these two key questions before or when providing the medication.

1. Is the patient thin or febrile?

Either condition can affect absorption of transdermal fentanyl, according to **Mary Lynn McPherson, PharmD, BCPS**, professor and vice chair in the

Department of Pharmacy Practice and Science at the University of Maryland in Baltimore. Fentanyl is a very fat soluble drug, and thus may not work well for thin patients, although the mechanism for this isn’t clearly understood, she says. On the other hand, if someone has a fever, he will absorb more of the medication, McPherson adds — “that’s true for any dermal application. The

heat is going to make any drug come out of the patch more quickly.”

2. Is the patient’s pain stable? If not, McPherson advises against transitioning the person to transdermal fentanyl. “It’s too difficult to chase a changing pain picture with a delivery system that takes three to six days to achieve a steady state.” ■

MANAGEMENT

IRS Pumps Up Collection Efforts: Beware Agency's New Powers

► *Don't let this catch you off guard.*

If you owe back taxes, the IRS can now come calling in non-traditional ways — in fact, it might just garnish some of your Medicare reimbursement until you've paid back what you owe.

According to Centers for Medicare & Medicaid Services Transmittal 368, with an effective date of Oct. 1, 2008, businesses that owe tax money to the IRS may face levies.

"CMS may reduce federal payments subject to the levy by 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment," the transmittal indicates. "The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt."

What this means to you: If you owe back taxes, the IRS will arrange to take 15 percent of your Medicare reimbursement until your levy has been satisfied, says attorney **Michael Schaff** with Wilentz, Goldman and Spitzer in Woodbridge, N.J.

This means that you will continue collecting reimbursement, but the payment will be reduced by 15 percent until you no longer owe the IRS money.

Some providers will say, "I can't afford to pay these back taxes yet, I have to pay my ... staff first," suggests **Randall Karpf** with East Billing in East Hartford, Conn. "But the CMS transmittal confirms that the government will make that decision for you.

Some [providers] may have to cut back on other expenses until their levies are paid off."

Medicare's signal: If the government has garnished part of your Medicare reimbursement, you'll see the code "WU" in the PLB03-1 data field, along with Medicare's phone number in case you have questions about the adjustment.

To read the complete CMS transmittal, visit the CMS Web site at www.cms.hhs.gov/transmittals/downloads/R367OTN.pdf. To review the related MLN Matters article, visit the CMS Web site at www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf. ■

INDUSTRY NOTES

Study Identifies Reasons for Differences Seen in Hospice Use

► *Researchers suggest a key change to the hospice benefit.*

White patients are more likely to use hospice than African Americans — a known fact that recent research may help explain.

In a study designed to explore racial differences in cancer patients' use of hospice, University of Pennsylvania researchers found that African-American patients expressed stronger preferences for continuing their cancer care, as well as greater perceived needs for hospice services, according to a press release from the American Cancer Society. The greater

perceived needs appeared largely tied to the patients' economic status, with more financially strapped patients desiring additional services. "These findings suggest that the hospice eligibility criteria of Medicare and other insurers requiring patients to give up cancer treatment contribute to racial disparities in hospice use," the authors wrote. "Moreover, these criteria do not select those patients with the greatest needs for hospice services." The study results suggest that changes in hospice eligibility criteria to make

them more "directly need-based" could even the playing field in terms of hospice access. The investigators suggested, for example, determining eligibility criteria by assessing needs for specific hospice services such as pain or symptom management. The study findings were reported in the online Dec. 22, 2008 issue of *CANCER* (print issue date: Feb. 1, 2009). Read the release at www.eurekalert.org/pub_releases/2008-12/acs-ecc121708.php. ■

INDUSTRY NOTES, cont.

The hospice community recently got on the same page about key hospice issues, including payment.

A newly released consensus statement from numerous end-of-life organizations points to “broad agreement that the Medicare hospice benefit has been a resounding success.” The statement quotes from a recent independent economic study from Duke University that notes “...the Medicare program appears to have the rare situation whereby something that improves quality of life also appears to reduce costs.” Yet, the consensus statement also cautions that payment policy needs to stay up to date to recognize changes related to patient demographics and treatment protocols. And in that regard, the groups recommend that the Medicare Payment Advisory Commission (MedPAC), which is reviewing the hospice benefit in order to make recommendations to Congress, consider these principles:

- Advancing hospice and palliative care providers as the recognized providers of end of life care;
- Preserving and enhancing the Medicare hospice benefit.

- Recognizing high quality as the standard to which all providers must subscribe.

- Ensuring accountability through transparency and fair regulatory scrutiny, and
- Promoting increased access through expansion and collaboration.”

The statement also includes responses to draft MedPAC November 2008 recommendations for revamping the hospice benefit. (For details, see “MedPAC Targets Length of Stay to Curb Rising Costs” in *Eli’s Hospice Insider*, Vol. 1, No. 3, available in the Online Subscription System.) The following organizations participated in creating the consensus statement: the American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, National Association for Home Care & Hospice, National Hospice and Palliative Care Organization, National Hospice Work Group, and Visiting Nurses Association of America.

Read the entire consensus statement at www.nhpco.org/i4a/pages/Index.cfm?pageID=5803. ■

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