



# HOSPICE MEDICAL DIRECTORS confront demands of **HEIGHTENED REGULATION**

Larry Beresford

America's hospices, including their medical directors and clinical staff, may feel increasingly singled out by a growing array of time-consuming regulatory demands and second guessing of their coverage decisions by Medicare contractors that scrutinize hospices' claims.

But in an age of healthcare reform, with its focus on addressing waste, fraud, and abuse in the Medicare system and bringing costs under control, increased regulatory scrutiny is being experienced by providers across the healthcare spectrum, according to Sue Ramthun, principal and senior vice president at Hart Health Strategies, AAHPM's Washington, DC-based lobbying and government relations consulting firm. The Medicare Payment Advisory Commission (MedPAC) reports that between 2000 and 2007, Medicare hospice spending more than tripled to approximately \$14 billion. Ramthun explained that "growth in the benefit and the proportion of Medicare dollars invites additional scrutiny on everything from operating margins, quality measures, and patient interactions."

Although this kind of attention from Medicare and its contractors is not unique to hospice, growing compliance demands and claims reviews mean that the role and responsibility of hospice medical directors are also growing. They must ensure that medically sound, evidence-based eligibility and coverage determinations are being made—and appropriately documented—by the hospice. Medical directors need to engage with this brave new world of regulatory demands and get the training they need to keep up on behalf of their agencies as well as the patients and families they serve.

## Who Is Eligible for Hospice Care?

Much of the current attention is targeted at hospice eligibility and admissions decisions. Is this patient, in the best medical judgment of both the attending and the hospice physicians, terminally ill with a prognosis of 6 months or less to live, if the illness runs its expected course? And is the underlying justification for that medical judgment clearly captured in detail in the hospice's documentation?

"From my perspective, the real take-home message is that the Centers for Medicare & Medicaid Services (CMS) increasingly look to us as hospice physicians to support hospice eligibility determinations," says Gail Austin Cooney, MD FAAHPM, vice president of access for Hospice of Palm Beach County in West Palm Beach, FL, and chair of the recently formed Hospice Medical Director Certification Board (HMDCB; see page 18). "And that means the physician's administrative role is growing. The days of sitting at team meetings and just signing forms are gone," Dr. Cooney says.

"When the new hospice Conditions of Participation were adopted in 2008, CMS was very clear that it wanted more involvement in the care of hospice patients by physicians," adds Judi Lund Person, MPH, vice president for compliance and regulatory leadership for the National Hospice and Palliative Care Organization (NHPCO) and plenary speaker at AAHPM's Hospice Medical Director Conference in August. "I don't think that focus is going to change."

When it comes to determining eligibility and needed level of care, Lund Person points out that it not only falls to hospices to get medical directors more involved, but that all hospice stakeholders "have a responsibility to protect the physician's role in making those decisions."

## Diagnosis Reporting on Claims: Coding Comes to the Fore

In a May proposed rule updating the hospice payment rates and wage index for fiscal year 2014 (CMS-1449-P), CMS clarified how hospices are to report diagnoses on hospice claims, indicating certain ill-defined and “non-specific” diagnoses, such as debility unspecified and adult failure to thrive, should no longer be used as principal admitting diagnoses for hospice patients. In fact, for claims submitted on or after October 1, 2014, CMS has instructed the medicare administrative contractors (MACs) to return such bills to providers unpaid and require a more definitive diagnosis. In choosing a more definitive diagnosis, CMS has instructed hospice physicians to use their best clinical judgment as to the condition that most contributes to the terminal prognosis.

CMS also has directed hospices to be more comprehensive in providing related diagnoses or secondary conditions, rather than just listing a single terminal diagnosis on claim forms, as is now practiced by many hospices. “CMS wants to know who these patients are and to better understand hospices’ diagnostic case mixes,” Lund Person says. “They want to see ‘all coexisting conditions related to the terminal prognosis.’”

In its August final rule (CMS-1449-F), CMS referenced its 1983 regulation that established the Medicare hospice benefit and reiterated that “we require hospices 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 services would be considered related.”

“We want to be sure that the role and responsibility for determining relatedness stays with the medical director,” Lund Person says. She says this requires ongoing evaluation, assessment, and documentation, especially regarding drugs and treatments, and providing clear justification for what is related or unrelated. Experts point out that what is related can be a moving target, subject to change with the progression of the disease.

At the heart of the issue is proper coding, with CMS pointing out that HIPAA, federal regulations, and the Medicare hospice claims processing manual all require

that *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding guidelines be applied to the coding and reporting of diagnoses on hospice claims.

“It’s becoming clear that we need to follow ICD-9 guidelines. Most hospices don’t have professional coders, and most doctors haven’t been trained in proper coding guidelines,” says Janet Bull, MD, chief medical officer at Four Seasons, a hospice organization based in Flat Rock, NC. “I didn’t really know much about it until I started delving into it.” For instance, vascular dementia is not a proper principal diagnosis; the coding instructions say to list cerebral atherosclerosis as a principal diagnosis, with vascular dementia as secondary, she says.

“Authoritative sources of coding instruction are minimal, at best, for hospices and hospice physicians,” explains Emily L. Graham, RHIA CCS-P, vice president for regulatory affairs at Hart Health Strategies and a consultant to AAHPM. “Few publications on hospice coding topics from the professional coding associations, coupled with conflicting guidance between CMS and local Medicare contractors, create confusion for hospices and hospice physicians attempting to comply with the rules.”

To address this lack of resources, in AAHPM’s June comments on the hospice proposed rule, the Academy offered to co-convene with CMS a Palliative Medicine and Hospice Coding and Documentation Learning Network. The Academy suggested that a core group of AAHPM leaders and staff engage in an ongoing, dialogue with CMS subject matter experts, including contractor medical directors, to improve palliative medicine and hospice coding. AAHPM offered to coordinate calls and face-to-face meetings of the network and other key stakeholders and to cohost provider calls and webinars. In its August final rule, CMS cited the Academy’s proposal and restated its commitment to collaborating with all stakeholders to remain aware of issues affecting hospice providers. In addition, CMS encouraged all interested stakeholders to participate in the CMS Home Health and Hospice Open Door Forums where questions, concerns, and

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issues can be addressed with specialists within CMS (information regarding Open Door Forums can be found at [www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html](http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html)).

The move to ICD-10 in October 2014—with its longer list of disease codes to master—is another transition that hospice providers have been slow to embrace, says Lund Person. “This issue has been a real sleeper. We just haven't spent enough time on it. We're all responsible to pay more attention than ever before.”

### The Importance of Narratives

Hospice medical directors' responsibilities have been growing since 2008, when the government began requiring a physician's narrative statement in support of a patient's eligibility for hospice, Dr. Cooney notes. In 2011 came the added requirement of a documented face-to-face encounter with patients entering their third eligibility period (following two 90-day periods), and every subsequent benefit period, to recertify their continuing eligibility for hospice care. Physicians or nurse practitioners can make this visit, but the hospice physician must compose and attest to the summary of the face-to-face meeting.

“The narrative is one of the biggest, most important jobs we have in hospice compliance,” Dr. Cooney says. “We have to learn how to support eligibility in our narratives and not let surveyors or other staff in our agencies use the regulatory changes to deny care to patients. Our job is to help them to see the patient's eligibility as we see it.”

The essentials of a good narrative statement, Dr. Cooney says, include the patient's age and diagnosis as well as nutritional, functional, and cognitive status. “You need to be clear on what the diagnosis is—and not just that the patient has 6 months to live, but why. Include objective measures whenever you can,” such as body mass index, Karnofsky score ([www.pennmedicine.org/homecare/hcp/elig\\_worksheets/Karnofsky-Performance-Status.pdf](http://www.pennmedicine.org/homecare/hcp/elig_worksheets/Karnofsky-Performance-Status.pdf)), Palliative Performance Scale ([www.eperc.mcw.edu/EPERC/FastFactsIndex/ff\\_125.htm](http://www.eperc.mcw.edu/EPERC/FastFactsIndex/ff_125.htm)), and other measures that capture the patient's changing status over time.

Hospice medical directors also have an increasing responsibility for practicing best medical judgment. “Best medical judgment is a critical exercise, not just rubber stamping,” says Joan Harrold, MD MPH FACP FAAHPM, vice president for medical services at Hospice and Community Care of Lancaster, PA. “We should look at the narrative requirement as a gift, because it's the place to explain what we're thinking.”

Dr. Harrold says the physician's role on the team includes reminding staff to think about how best to summarize their observations of the patient's changing condition over time, rather than just focusing on current status in their daily notes. She recommends four questions that can help focus these observations: What are you monitoring? What symptoms are you anticipating? What are you trying to prevent? And what are you managing? “The narrative should have a prognostic focus, rather than trying to capture the complete medical history. But it's the place to say why we believe this patient is appropriate for hospice care.”

It is eminently reasonable, Dr. Harrold says, to include in the narrative statements a medical literature citation in support of the physician's best medical judgment whenever this is pertinent and helpful, especially if the patient would not be obviously eligible to a reviewer who will never see that patient. “A citation can provide some real evidence for the case you're making, and if you later need to write an ADR (Additional Data Request) response or appeal letter, it could be very helpful.”

**Large and Small Hospices Face Same Challenges**

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Hospices large and small struggle with the same compliance and eligibility challenges, although with different resources to draw upon. Ronald J. Crossno, MD FAAFP FAAHPM, Texas-based senior national hospice medical director for Gentiva Health Services, says he has been challenged recently to incorporate

new coding and compliance requirements into the training for Gentiva's 400 part- and full-time hospice medical directors. "We developed a webinar for our entire clinical staff, and we also provide in-person trainings at our 160-plus hospice locations" using the company's four regional medical directors.

For Juliette Kalweit, MD, full-time medical director of Serenity Hospice and Home, an agency with 50 patients in Oregon, IL (population 4,000), "we're very aware of compliance issues, and we're very proactive about them. We have a nurse educator devoted full time to compliance issues."

Dr. Kalweit was hired 4 years ago, ahead of the face-to-face physician visit requirement, and devotes much of her time to seeing patients in the hospice's eight-bed inpatient unit as well as making home visits across a largely rural service area 120 miles wide. That means a lot of her time is spent on the road. "A typical day for me is 80 to 150 miles." Dr. Kalweit carries a pager 24/7 and says the growing paperwork demands are taking her away from patient care. "This is costly for my hospice, but we've been doing it," she says. "If the patient is not appropriate for hospice care, we discharge them. We all see it on the team. My nurses know what to look for, and it's a group discussion."

The hospice industry has been frustrated by many of these recent changes in regulatory requirements, notes Todd Coté, MD FAAFP FAAHPM, chief medical officer for Hospice of the Bluegrass in Lexington, KY, and chair of AAHPM's Hospice Medical Director Education Committee. "At the same time that rates are being cut, it costs us all more to meet the new requirements. But feeling sorry for ourselves isn't the way to go. Hospice is such an important service, and hospice physicians need to look within themselves—and learn—and teach others. It seems like our biggest challenge these days is to find enough physicians to see all of our patients," he says.

"The message from CMS is clear. Don't be an armchair practitioner. Go out and see the patients," Dr. Coté says. Hospice medical directors need to understand prognostic science and integrate it into the work of the hospice team. "It demands expertise at the consultant level from hospice medical directors. It really demands the highest level of practice that is evidence-based."

### Tools and Resources for Medical Directors


In addition to holding a Hospice Medical Director Conference, AAHPM offers webinars (also available as recordings) to help practitioners keep up to date on ever-changing billing and coding requirements.

Other groups offering "boot camps" and training opportunities for hospice professionals include Hospice Fundamentals ([www.hospicefundamentals.com](http://www.hospicefundamentals.com)) and Four Seasons Hospice's HPC Solutions ([www.fourseasonscenterofexcellence.com](http://www.fourseasonscenterofexcellence.com)).

Hospice Medical Director Board Certification ([www.hmdcb.org](http://www.hmdcb.org)) will be offered beginning in the spring of 2014, but the process is not primarily focused on physician education, Dr. Cooney says. Instead, it is an opportunity for physicians to earn recognition for their skills and experience and demonstrate they are up to date on the key regulatory issues. "Clearly the role of the hospice medical director in patient care is changing. Everyone is looking for us to take a great role in decision making about our patients' eligibility and care, and I think this board certification offers an opportunity to really document your expertise in the care of patients under the Medicare hospice benefit," she says.

### Advocate for Your Patients

"Physicians and their patients are facing much change in the healthcare system, and it will be important to communicate to Congress what physicians see working and not working for their patients," notes Ramthun. Not only is the Affordable Care Act (ACA) being implemented and making available new insurance choices but changes are taking place in the Medicare Hospice Program. She explained that "physicians are the 'reality check' for policymakers" as they try to meet new requirements for quality reporting and payment reforms. However, Ramthun cautioned that the "message is best conveyed in terms of how it affects the patient in terms of access and quality of care."

The Academy's monthly *Health Policy and Advocacy Update* e-newsletter provides members with legislative and regulatory updates and alerts readers to opportunities to comment on proposed rules. AAHPM's online Legislative Action Center makes it easy for members to contact their lawmakers in Congress, highlighting priority issues for the field. Hospices that join NHPCO and their state hospice organizations also have access to regulatory notices, guides, and tools. In addition, AAHPM and NHPCO each provide opportunities for physicians to become more engaged in health policy and advocacy activities. 

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