The information provided in this handout was current as of January 30, 2017. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after January 30, 2017, posted at www.PalmettoGBA.com/hhh.
Part 1

Agenda

- Data Analysis
- Length of Stay (LOS)
- Screening New Patients for Hospice
- Interdisciplinary Group (IDG) Member Roles
  - Medical Director
  - Nurse
  - Social Worker
  - Pastoral Counselor
- Medical Review Program
- Medical Review Top Denials
- Dementia Patients
Data Analysis

Medicare as a Share of the Federal Budget 2015

Congressional Budget Office, Updated Budget Projections 2016 (March 2016)
Medicare Benefit Payments by TOS, 2015

Total Medicare Payments 632 Billion

- Medicare Advantage: 27%
- Hospital Inpatient Services: 13%
- Part D Prescription Drugs: 12%
- Physician Payments: 11%
- Skilled Nursing Facilities: 7%
- Home Health: 5%
- Other services: 3%

Congressional Budget Office, 2016 Medicare Baseline (March 2016)

Hospice Across the Nation

- **CGS Administrators**: Colorado, Delaware, Washington, DC, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming


- **Palmetto GBA**: Alabama, Arkansas, Florida, Georgia, Indiana, Illinois, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas
Number of Hospice Providers
April – September 2016

JM total – 1,929
Outside of 16 states – 87

Beneficiaries with Multiple Providers
April – September 2016

JM total – 10.1
Number of Hospice Beneficiaries
April – September 2016

JM Total – 459,132

Number of Claims
April – September 2016

JM total – 1,218,784
Disbursement Per Beneficiary
April – September 2016

JM total – 9,662

NCLOS
April – September 2016
Aggregate LOS
April – September 2016

JM total – 132 days

Hospice Drill Down

<table>
<thead>
<tr>
<th>Overview Category</th>
<th>Number of Claims Current</th>
<th>Number of Beneficiaries Current</th>
<th>Number of Providers Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>651 Hospice/Routine Home Care</td>
<td>2,173,735</td>
<td>591,069</td>
<td>1,944</td>
</tr>
<tr>
<td>656 Hospice/General Inpatient Care</td>
<td>208,198</td>
<td>175,232</td>
<td>1,323</td>
</tr>
<tr>
<td>652 Hospice/Continuous Home Care</td>
<td>60,666</td>
<td>49,639</td>
<td>718</td>
</tr>
<tr>
<td>657 Hospice/Physician Services</td>
<td>243,761</td>
<td>161,393</td>
<td>584</td>
</tr>
<tr>
<td>655 Hospice/Inpatient Respite Care</td>
<td>43,838</td>
<td>28,700</td>
<td>1,485</td>
</tr>
<tr>
<td>659 Hospice/Other</td>
<td>109</td>
<td>74</td>
<td>25</td>
</tr>
<tr>
<td>650 Hospice Services/General</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

January 2017
Palmetto GBA – Medicare Administrative Contractor (MAC)
Screening New Patients for Hospice

Are you admitting the right patient?

When is it Time for Hospice?

- Hospice care is appropriate when a beneficiary has a terminal illness with a life-expectancy of 6 months or less
- A beneficiary is ready for hospice when they have decided to pursue treatments meant only to promote comfort, not cure the illness
- Effective documentation of the terminal prognosis begins with a good screening process
Gather the Facts

- Does the referring source foresee the person’s life expectancy to be 6 months or less?
- What did they base the referral on?
- Is the referral source familiar with LCDs?
- Has something changed recently?
- How does the patient compare today to 6 months ago? 12 months ago?

What You Need to Know

- Admitting diagnosis
- Current medical findings
- Orders for medications and treatments
- Family and patient’s awareness of disease and prognosis
- Significant patient and family information/history
- History and physical

Hospice Care: A Physician’s Guide. Michigan Hospice and Palliative Care Organization 2006
Activity Limitations

- Ambulation
- Continence
- Transfer
- Dressing
- Feeding
- Bathing

Co-Morbidities

- COPD
- CHF
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease
- Renal failure
- Liver disease
- Neoplasia
- AIDS/HIV
- Dementia
Other Symptoms

- Weight loss (≥ 10% body weight in prior 6 months)
- ↓ anthropomorphic measurements (e.g., mid-arm circumference, abdominal girth)
- Observation of ill-fitting clothes, ↓ in skin turgor, ↑ skin folds
- ↓ serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake

Other Conditions

- Change in functional status
  - Decline in Palliative Performance Score (PPS)
  - Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST)
- Progressive stage 3–4 pressure ulcers
- History of increasing ER visits
- Hospitalizations or physician visits related to the hospice primary diagnosis prior to election of hospice

PPS Scale

PALIATIVE PERFORMANCE SCALE (PPS)

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity level</th>
<th>Evidence of disease</th>
<th>Self-care</th>
<th>Intake</th>
<th>Level of consciousness</th>
<th>Estimated median survival in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Normal</td>
<td>Full</td>
<td>108</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Normal</td>
<td>Full</td>
<td>98</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
<td>Full</td>
<td>80</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Full</td>
<td>As above</td>
<td>Full</td>
<td>Full</td>
<td>Full</td>
<td>70</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Can't do normal job or work</td>
<td>Occasional assistance needed</td>
<td>As above</td>
<td>Full or confusion</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Mainly stable</td>
<td>Can't do any work</td>
<td>Considerable assistance needed</td>
<td>As above</td>
<td>Full or confusion</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Mainly in bed</td>
<td>As above</td>
<td>Mainly assistance</td>
<td>As above</td>
<td>Full or drowsy or confusion</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Bed bound</td>
<td>As above</td>
<td>Total care</td>
<td>Reduced</td>
<td>As above</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Bed bound</td>
<td>As above</td>
<td>As above</td>
<td>Minimal</td>
<td>As above</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Bed bound</td>
<td>As above</td>
<td>As above</td>
<td>Mouth care only</td>
<td>Drowsy or coma</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

January 2017

Palmetto GBA – Medicare Administrative Contractor (MAC)

Stable

- 100–70% PPS
- Patient/family need for hope/understanding of disease
- Patient/family education re: disease management, medications, personal care, nutrition, symptom crisis/distress management plan
- Referrals to optimize functioning
  - Psychosocial assessment
  - Spiritual assessment – cultural/religious resources
### Transitional

- **60–40% PPS**
- Most difficult for patients – impacts on all spheres of life (need for holistic, patient and family–centered care)
- Requires greatest amount of nursing care
- Increasing care and educational needs

### End of Life

- **<30% PPS**
- Review medications/routes of administration, need for further investigations/lab tests/clinic visits
- Determine main contact in the community – family physician, homecare, palliative care physician
- Pain/symptom management
- Prepare family for death – what do they expect, what are their past experiences with death
- Ensure affairs are in order – e.g. POA, wills, custody arrangements for children, etc.
How to Use the PPS

- The PPS score is determined by reading horizontally at each level to find the “best fit” for the patient
- Leftward columns are “stronger” determinants, thereby taking precedence over others
  - Begin at the left column until the appropriate ambulation level is found
  - Read across to the next column until the correct activity/evidence of disease is located
  - Read across to the self-care column, intake and conscious level columns before assigning the PPS score to the patient

Making “Best Fit” Decisions

- Only use the PPS in 10% increments (e.g., cannot score 45%)
- Sometimes 1 or 2 columns seem easily placed at 1 level, but 1 or 2 columns seem better at higher or lower levels
- In these cases, use your clinical judgment and the leftward dominance rule to determine a more accurate score the patient
Example Case Study #1

- The patient spends the majority of the day sitting in bed or lying down due to fatigue from advanced disease
- She requires considerable assistance to walk even short distances
- She is fully conscious
- She has good nutritional intake

Example Case Study #2

- The patient is very weak and remains in a chair a couple of hours a day
- The rest of the time, he is in bed
- He has advanced disease and is requiring almost complete assistance with self-care and feeding
- He is experiencing decreased food intake, with a few small snacks that remain mostly unfinished
- He has adequate fluid intake
- The patient is drowsy but not confused
Example Case Study #3

- The patient is up and about on her own.
- She has experienced a recent recurrence of the disease.
- She can do household chores with adequate rest periods.
- The patient requires occasional assistance with self-care whereby her caregiver watches her get in and out of the shower.
- Her intake is reduced from normal but still adequate.
- The patient is fully conscious with no confusion.

Victoria Hospice Society
Example Case Study #5

- Mrs. Edith Smith is a 67 year old woman with metastatic breast cancer
- She has recently developed a pleural effusion that is causing her severe shortness of breath making it difficult to ambulate even within her small apartment
- Most days she sits in her lazy boy chair watching TV
- Once a great knitter, she is too weak to finish the sweater she is knitting for her granddaughter
- Recently homecare has begun providing services to help her with her Activities of Daily Living (ADLs) such as bathing and dressing
- Her two children who live close by check in on her each day and deliver her meals, but they noticed that she is eating only about half of the meals they are providing to her


Example Case Study #6

- Mr. Ennoch Birchstick is a 32 year old man with AML
- Despite aggressive chemotherapy, his disease has not gone into remission
- He lives with his wife and two young children
- They have remade their living room into a room for Ennoch because he is unable to ambulate to the bedroom he shares with his wife, and he would like to be part of the day to day household activities even if he is unable to actively participate
- For the past week, Ennoch has been totally bed bound, requiring total care for all of his ADLs
- While he still enjoys the food his family prepares, he is only able to eat a few bites
  - Mainly, he drinks Ensure throughout the day to maintain his nutrition
- He is usually fully alert and oriented but is sleeping more during the day

Interdisciplinary Group (IDG) Member Roles

- Doctor of Medicine or Osteopathy
- Registered Nurse
- Social Worker
- Pastoral or Other Counselor

42 CFR 418.68 The Medicare Conditions of Participation for Hospice Care
Role of IDG

- Participation in the establishment of the POC
- Provision or supervision of hospice care and services
- Periodic review and updating of the POC for each individual receiving hospice care
- Establishment of policies governing the day to day provision of hospice care and services

42 CFR 418.68 The Medicare Conditions of Participation for Hospice Care

Medical Director

The Medical Director is a Doctor of Medicine or Osteopathy who assumes overall responsibility for the medical component of the hospice’s patient care program

42 CFR 418.54 The Medicare Conditions of Participation for Hospice Care
Medical Director Responsibilities

- Consults with the attending physician
- Reviews patient eligibility for hospice services
- Acts as a medical resource for the IDG

Nursing Services

The hospice must provide nursing care and services by or under the supervision of a registered nurse

41 CFR 418.82 The Medicare Conditions of Participation for Hospice Care
Nursing Services

- Nursing services must be directed and staffed to assure that the nursing needs of patients are met
- Patient care responsibilities of nursing personnel must be specified

42 CFR 418.82 The Medicare Conditions of Participation for Hospice Care

Documentation Example 1

Vague documentation
- Patient having dyspnea on exertion

Detailed documentation
- Patient ambulates 10 feet between chair & bed before experiencing dyspnea and weakness; with 1 assist. One month ago, patient ambulated slowly from room to room with walker. Family reports that the patient is only able to sit up with family for 30 minutes before returning to bed.

Vague documentation

- Patient having dyspnea on exertion

Better documentation

- Observed patient communicating only 2–3 words without shortness of breath, previously was able to talk 10–15 minutes during last week (2 weeks ago). Patient tries to use a communication board with occasional frustration.

Documentation Example 2

Vague documentation

- Patient is eating less, appetite declining

Better documentation

- Appetite declined from eating 50% of a sandwich 1 month ago, now eating 2–3 bites at a meal. Family is concerned that the patient refuses his favorite meal.
Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician

- Assessment of the social and emotional factors related to the beneficiary's need for care, response to treatment and adjustment to care
- Assessment of the relationship of the patient’s medical and nursing requirements to the patient’s home situation, financial resources and availability of community resources
- Appropriate action to obtain available community resources to assist in resolving the patient’s problem

CMS Manual System, Pub 100-02, Medicare Benefit Policy, Chapter 9, Section 40.1.2
Social Work Assessment

Areas for consideration in the comprehensive assessment include

- Relevant past and current health situation (including the impact of problems such as pain, depression, anxiety, delirium, decreased mobility)
- Family structure and roles
- Patterns/style of communication and decision making in the family

Social Work Assessment

- Stage in the life cycle, relevant developmental issues
- Spirituality/faith
- Cultural values and beliefs
- Client's/family's language preference and available translation services
- Client's/family's goals in palliative and end of life treatment
Social Work Assessment

- Social supports, including support systems, informal and formal caregivers involved, resources available, and barriers to access
- Past experience with illness, disability, death, and loss
- Mental health functioning including history, coping style, crisis management skills


5 Questions Model

- Tell me about your family member
- What do you understand about your family member’s illness?
- Given what we know about your family member’s illness, what are your hopes?
- Given what we know about your family member’s illness, what worries you most?
- Where do you find your strength?
Tell Me About Your Family Member

- Quality of life
- Baseline function/ADLs
- Ideas to improve hospital quality of life
- Living situation/family composition
- What is important to child and family

What do You Understand About Your Family Member’s Illness?

- Family’s understanding of disease process/illness trajectory
- Family’s state of processing/coping
- Family’s education/cognition level
- Which providers/services does family identify with rely on for information
What Are Your Hopes?

- Family’s understanding of disease process/illness trajectory
- Family’s priorities/goals of care
- Align with family/build rapport
- Intervention plan/strategy

What Worries You Most?

- Family’s understanding of disease process/illness trajectory
- Family’s priorities/goals of care
- Identification of distressing symptoms
- Align with family/build rapport
- Intervention plan/strategy
Where do You Find Your Strength?

- Religious/spiritual preferences
- Sources of family support/resources
- Family’s relationship with medical providers

Giving the Note Shape: Example Documentation

- Reason for Consult
- Participants
- Family Composition
- Coping and Support
- Cultural/Spiritual Formulation
- Communication and Decision-Making
- Hopes/Goals
- Worries/Suffering
- Clinical Impressions
- Plan
The Social Work Assessment Tool was developed by the Social Work Outcomes Task Force of the Social Work Section, National Hospice and Palliative Care Organization, National Council of Hospice and Palliative Professionals.

Pastoral Counseling

“Pastoral Counseling is a unique and challenging career. Individuals must develop and maintain skills in two distinct areas – counseling and ministry. It is a major challenge to maintain professional competence in these two unique fields. This dedication to service speaks highly of those who choose to walk this path…..”

The National Board for Certified Pastoral Counselors
Guidelines for Chaplain Documentation

- What are the patient’s issues related to life, faith, illness, dying, and death?
- What needs or concerns were expressed or observed?
- Recording unique cultural or religious preferences associated with the end-of-life. Was this communicated to the IDG?

Guidelines for Chaplain Documentation

Record the story that tells
- Who is this patient? Family?
- Significant relationships? Dynamics?
- Coping styles?
- Religious preferences? Its meaning?
- Spiritual perspectives? Its meaning?
- Beliefs, thoughts, feelings toward afterlife?
- Views of the future?
- What the patient/family wants in the days ahead?

Assessment: An Example Based on Needs/Hopes/Resources Model

- Pt. expressed moderate spiritual, emotional and relational distress re: feeling abandoned/punished by God through his illness and neglected by his faith community while hospitalized. (needs)

- Pt. reported strong support from his wife of 30 years. However, he stated “we don’t talk about God stuff.” His two adult children live out of state. He identified no intimate friendships. (needs & resources)

- Pt. expressed intermediate hope he will be well enough to attend his daughter’s wedding in June. Pt. expressed little sense of ultimate hope at present. (hopes)

- Pt. self-identified as an “old philosopher” and seems willing and able to explore issues as long as his pain is controlled. (resources)

- Pt. is receptive to and would benefit from continued chaplaincy care to address providence, theodicy, grief, hope & reconciliation. (needs & resources)


Intervention Words and Phrases

- Directed
- Encouraged
- Identified
- Explored
- Facilitated
- Validated
- Reframed
- Normalized

- Educated
- Modeled
- Provided spiritual guidance
- Provided spiritual reading _________
- Engaged in life review
- Sang/played/listened to hymns
Outcome Oriented Chaplaincy
Lucas: Discipline for Pastoral Care Giving

Arthur M. Lucas MDiv and BCC. Introduction to The Discipline for Pastoral Care Giving Journal of Health Care Chaplaincy Volume 10, 2000 – Issue 2

Routine Visit Narrative Documentation Example

- CH made routine visit (purpose) for spiritual and emotional support of pt. (goal)
- Patient has hospice Dx of COPD. (note diagnosis)
- CH spoke with charge nurse Lisa and reviewed pt.'s chart to ensure continuity of care. (coordination of care)
Routine Visit Narrative Documentation Example

- Upon arrival, pt. lying on back in bed, slightly inclined, with O₂ on. Pt. said, “I stay in bed because I’m so tired all the time.” Pt. was up in wheelchair at previous visit 2 weeks ago. Pt. reported discomfort related to increased swelling in legs. (symptoms and decline related to diagnosis)

- CH notified NF charge nurse Lisa, as well as hospice RN case manager, about pt.'s report of discomfort. (coordination of care)

Routine Visit Narrative Documentation Example

- Pt. reported feeling anxious about family’s well-being after pt.'s death. CH provided active listening and validation of feelings for emotional support. (needs and interventions)

- Per pt. request, and based on POC, CH facilitated prayers with pt. for spiritual support. (need and intervention)

- Upon CH’s offer, pt. requested that CH provide communion for pt. at next visit. (need)
Routine Visit Narrative Documentation Example

- Pt. appeared comfortable and peaceful at end of visit AEB saying, “I feel so much better after your visits,” and expressing no verbal complaints or non-verbal sx of pain/discomfort. (outcomes)

- CH to provide communion for pt. at next visit, and continue POC of 1–2 visits per month + 1 PRN visit for support. (summary of planned interventions)

Powerpoint presentation: Documenting to Dazzle” Greg Volpitto, MDiv Support Services Director, Crossroads Hospice Chaplain Core Curriculum Track 2 Seminar April 17, 2015

Basic Skills and Techniques in Providing Spiritual Care Assessment

- All team members are involved in spiritual assessment

- All team members listen, utilize visual cues, and ask about patient and family spiritual/religious practices, frameworks, and needs

- The chaplain or social worker often takes the lead

- The chaplain or social worker customarily conduct an in-depth assessment at the start of care and develop a plan of spiritual care directed by patient and family goals meditation, or prayer help relieve pain. “Are any of these something you would find helpful?”

http://endlink.lurie.northwestern.edu
Helpful assessment strategies include

- Asking open-ended questions
  - “Is there anything you are hoping for during this time?”
  - “Where do you turn for strength?”

Providing options

- “Some persons find that music, meditation, or prayer help relieve pain. Are any of these something you would find helpful?”

Ongoing assessment is crucial

- As the patient’s health status changes
- As new symptoms arise or are not relieved
- If the dying process is prolonged
- When death draws near
Progressive Corrective Action (PCA)

The Medical Review program is designed to promote a structured approach in the interpretation and implementation of Medicare policy.
PCA Process

Includes

- Data analysis
- Medical review of claims
- Provider education and feedback

Service-Specific

- Based on a specific service (code)
- An article is posted on the Palmetto GBA website to notify the providers
- Random sampling among all providers billing the service in question
- 100 total claims for the initial probe are selected for review from the specific state(s)
- Notify the provider community of the results by way of a website article
Provider–Specific

- Provider is notified via individual letter
- A predetermined percentage of claims billed will be selected for medical review every time the provider bills
- Sampling of up to 40 claims for the initial probe
- Provider notified of results via individual letter after claims are reviewed and processed

Pre–Pay Review

- A percentage of claims is selected after services are rendered and billed
- An edit is established through the claims processing system
- Requests are generated and medical records are reviewed before claim processing is completed
- If the medical records meets the requirements, the claim is paid
Post-Pay Review

- Involves claims that have previously paid through the processing system
- When a determination results in a denial of services, the claims will be adjusted or an overpayment letter is sent to recover the overpayment amount
- Written notification of the results is sent to the provider upon completion of the review

Type of Review

<table>
<thead>
<tr>
<th></th>
<th>Service-Specific</th>
<th>Provider-Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-pay</td>
<td>Service-Specific Pre-pay</td>
<td>Provider-Specific Pre-pay</td>
</tr>
<tr>
<td>Post-pay</td>
<td></td>
<td>Provider-Specific Post-pay</td>
</tr>
</tbody>
</table>
Data Analysis of Review Results

- Medical review data analysis for the reviewed and processed claims is expressed as a Charge Denial Rate (CDR)
- The CDR will determine whether the medical review will be continued or discontinued

CDR

\[
\text{Total } \$ \text{ denied for the claims reviewed} \quad \frac{\text{Total } \$ \text{ for the claims reviewed and processed}}{\text{Multiplied by 100} = \text{CDR}}
\]
PCA Decision Criteria

- Minor
- Moderate
- Major

Minor

CDR = 0% – 33%

- Education provided
- Potential follow-up sample review if warranted by trending or data analysis
- Potentially removed from edit
Moderate

CDR = 34% - 66%

- Education provided
- Initiate a Targeted Medical Review
- May request CAP

Major

CDR = 67% - 100%

- Education provided
- Initiate a Targeted Medical Review edit
- Request CAP
## Medical Review Top Denials

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Code Description</th>
<th>Claims Denied</th>
<th>Percent of Claims Denied to Total Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>56900</td>
<td>Auto Denial - Requested Records not Submitted</td>
<td>191</td>
<td>86.0</td>
</tr>
<tr>
<td>55503</td>
<td>LCD Denial - no medical necessity</td>
<td>11</td>
<td>5.0</td>
</tr>
<tr>
<td>5CF01</td>
<td>General Inpatient Services Not Reasonable and Necessary - Beneficiary Liable</td>
<td>7</td>
<td>3.2</td>
</tr>
<tr>
<td>5CFNP</td>
<td>No Plan of Care Submitted</td>
<td>5</td>
<td>2.3</td>
</tr>
<tr>
<td>5CF36</td>
<td>Not Hospice Appropriate</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>5CFH4</td>
<td>Initial Certification Not Signed</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>5CF91</td>
<td>Hospice GIP Reduction - Services Not Reasonable/Necessary</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>5CFH6</td>
<td>Initial Certification Not Timely</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>5FFH6</td>
<td>Initial Certification Not Timely</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>
Certification Denials

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5FFH2</td>
<td>No certification present</td>
</tr>
<tr>
<td>5FFH3</td>
<td>No certification for dates billed</td>
</tr>
<tr>
<td>5FFH4</td>
<td>Initial certification not signed</td>
</tr>
<tr>
<td>5FFH5</td>
<td>Subsequent certification not signed</td>
</tr>
<tr>
<td>5FFH6</td>
<td>Initial certification not timely</td>
</tr>
<tr>
<td>5FFH7</td>
<td>Subsequent certification not timely</td>
</tr>
<tr>
<td>5FFH8</td>
<td>No prognosis statement</td>
</tr>
<tr>
<td>5FFH9</td>
<td>Physician narrative statement not present or not valid</td>
</tr>
</tbody>
</table>

Narrative Requirements

- The narrative must reflect the patient’s individual clinical circumstances
- The narrative must not contain check boxes or standard language used for all patients
- Include a statement indicating 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, examination of the patient
Elements of a Physician Certification

- Beneficiary name
- 6 month prognosis statement
- Diagnosis
- Reference benefit period
- Documentation accompanying certification to support why the patient is certified terminally ill
- Dated physician signature(s)

POC Denials

- 5FFNP – No plan of care submitted
- 5FFIP – Invalid plan of care submitted
Hospice Appropriateness Denial

5FF36 – Documentation does not support the terminal prognosis

Paint the Picture

Admitted for end stage cardiac disease

Powerpoint. Ensuring Clinical Documentation Reflects Care and Meets Requirements. National Hospice and Palliative Care Organization, 2010
Paint the Picture

- Admitted for end stage cardiac disease
- Poor response to standard treatment
- Desires palliative care

Powerpoint. Ensuring Clinical Documentation Reflects Care and Meets Requirements. National Hospice and Palliative Care Organization, 2010

Paint the Picture

- Admitted for end stage cardiac disease
- Poor response to standard treatment
- Desires palliative care
- Is NYHA Class IV with significant symptoms of angina at rest & inability to carry on any physical activity w/o discomfort
- Ejection fraction of ≤20%, significant ventricular arrhythmias, & unexplained syncope episodes

Powerpoint. Ensuring Clinical Documentation Reflects Care and Meets Requirements. National Hospice and Palliative Care Organization, 2010
Not Responding to a Request for Medical Records Denial

56900 – Requested medical records were not received within the 45 day time limit

Responding to Hospice Documentation Requests

- Signed Notice of Election
- Signed physician’s certification to cover the dates of service billed
- Statement when the hospice medical director is the attending physician
- POC pertinent to the dates of service billed
Responding to Hospice Documentation Requests

- Documentation to substantiate terminality and medical necessity
- Documentation as required in the LCD

If continuous care is billed, include
- Notes for all hours that care is rendered
- Who rendered services (nurse or aide)
- Documentation of when the continuous care began and ended
Responding to Hospice Documentation Requests

Ensure

- Documentation is for the beneficiary and dates of service indicated on the request
- Copies are legible, not too light, too dark or blurred
- No portion of the page has been cut off or omitted

If documentation includes 2-sided forms, submit both sides

Compare copied medical records to original medical records

Suggestions

- Number the pages
- Keep second copy
Dementia Patients

End of Life Dementia

Dementia Statistics

Copyright © 2009 The research Foundation of State University of New York
http://www.textmap.com
Types of Dementia by Percentage

- Alzheimer's: 47%
- Alzheimer's mixed: 9%
- Vascular: 28%
- Frontotemporal: 9%
- Parkinson: 2%
- Mixed Other: 5%

Semin Reprod Med ©2009 Thieme Medical Publishers

Distribution of Diagnoses

Young Onset Dementia

- Alzheimer's Disease: 21%
- Vascular Disease: 5%
- Frontotemporal Disease: 13%
- Alcohol-related Disease: 13%
- Dementia with Lewy Bodies: 11%
- Other: 3%

Dementia Occurring Later in Life

- Alzheimer's Disease: 35%
- Vascular Disease: 13%
- Mixed Alzheimer's disease and vascular dementia: 1%
- Dementia with Lewy Bodies: 28%
- Frontotemporal Dementia: 11%
- Parkinson's Disease: 7%
- Other: 0.7%


What is Dementia?

- Dementia is a broad term that describes a set of symptoms that develop as a result of damage to the brain
- Dementia is progressive and irreversible, and there is no cure for the condition


Symptoms

- Communication
- Memory loss
- Loss of mobility
- Eating and weight loss
- Problems with continence
- Unusual behavior
Communication

- Problems with communication are a feature of the later stages of dementia
- The person will generally have limited or no speech
- They will also have reduced ability to understand what is being said to them
- Relying only on verbal communication can lead to difficulties understanding what the person is trying to communicate, possibly missing basic needs such as pain, hunger and thirst

© Copyright 1998-2016 Alzheimer’s Society

Memory Loss

- Memory loss is likely to be very severe in the later stages of dementia
- People may be unable to recognize those close to them or even their own reflection
- They may no longer be able to find their way around familiar surroundings or identify everyday objects
- However, they may occasionally experience sudden flashes of recognition
- The person may believe that they are living in a time from their past, and may search for someone or something from that time

© Copyright 1998-2016 Alzheimer’s Society
Loss of Mobility

- Many people with dementia gradually lose their ability to walk and to perform everyday tasks unaided.
- One of the first signs of this is that they shuffle or walk unsteadily.
- They may also seem slow or clumsy and be more likely to bump into things, drop objects or fall.
- Some people with dementia eventually become confined to a bed or chair.

Eating and Weight Loss

- Most people with dementia lose weight in the later stages of the illness, although occasionally people eat too much and put on weight.
- Weight loss can affect the immune system, making it harder for the person to fight infections.
Many people lose control of their bladder in the later stages of dementia. Some also lose control of their bowels.

This may happen all or most of the time, or may just be a case of occasional leakage.

Incontinence is not an inevitable symptom of dementia, but there are a number of reasons why someone with dementia could become incontinent. These include various medical conditions, a number of which are treatable.

Possible causes include:
- Urinary tract infection
- Severe constipation
- Side-effects of medication
- Prostate gland trouble
- Forgetting to go to the toilet or forgetting where the toilet is
- Not recognizing the need to go to the toilet
Unusual Behavior

- People in the later stages of dementia sometimes behave in ways that others find unusual or puzzling.
- The person may react aggressively if they feel threatened or cannot understand what is going on around them.
- The person may rock backwards and forwards, use repetitive movements or keep calling out the same sound or word.

Unusual Behavior

- Some people experience hallucinations, in which they see, smell, hear, taste or feel things that are not really there.
- Others develop delusions, in which they experience distorted ideas about what is happening.
- Excessive hand activity becomes more common.
- The person may constantly wring their hands, pull at their clothes, tap or fidget, or touch themselves inappropriately in public.
- The person may have long periods of physical inactivity where they remain still, with their eyes open but not engaged in any other activity.
Types of Dementia

- Alzheimer’s Disease
- Vascular Dementia
- Lewy Body Dementia
- Frontotemporal Dementia

Anatomy of the Brain

Alzheimer's Disease LCD

Hospice Alzheimer's Disease & Related Disorders (L34567)

Projected Number with Alzheimer's (in thousands)

<table>
<thead>
<tr>
<th>State</th>
<th>2016</th>
<th>2025</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>89</td>
<td>110</td>
<td>23.6</td>
</tr>
<tr>
<td>Arkansas</td>
<td>54</td>
<td>67</td>
<td>24.1</td>
</tr>
<tr>
<td>Florida</td>
<td>510</td>
<td>720</td>
<td>41.2</td>
</tr>
<tr>
<td>Georgia</td>
<td>130</td>
<td>190</td>
<td>46.2</td>
</tr>
<tr>
<td>Illinois</td>
<td>220</td>
<td>260</td>
<td>18.2</td>
</tr>
<tr>
<td>Indiana</td>
<td>110</td>
<td>130</td>
<td>18.2</td>
</tr>
<tr>
<td>Kentucky</td>
<td>69</td>
<td>86</td>
<td>24.6</td>
</tr>
<tr>
<td>Louisiana</td>
<td>84</td>
<td>110</td>
<td>31.0</td>
</tr>
</tbody>
</table>

### Alzheimer's Statistics

**Projected Number with Alzheimer's (in thousands)**

<table>
<thead>
<tr>
<th>State</th>
<th>2016</th>
<th>2025</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>52</td>
<td>65</td>
<td>25.0</td>
</tr>
<tr>
<td>New Mexico</td>
<td>37</td>
<td>53</td>
<td>43.2</td>
</tr>
<tr>
<td>North Carolina</td>
<td>160</td>
<td>210</td>
<td>31.3</td>
</tr>
<tr>
<td>Ohio</td>
<td>210</td>
<td>250</td>
<td>19.0</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>62</td>
<td>84</td>
<td>35.5</td>
</tr>
<tr>
<td>South Carolina</td>
<td>84</td>
<td>120</td>
<td>42.9</td>
</tr>
<tr>
<td>Tennessee</td>
<td>110</td>
<td>140</td>
<td>27.3</td>
</tr>
<tr>
<td>Texas</td>
<td>350</td>
<td>490</td>
<td>40.0</td>
</tr>
</tbody>
</table>

**Number of Deaths and Mortality Rates per 100,000 due to Alzheimer's 2013**

<table>
<thead>
<tr>
<th>State</th>
<th>Number of deaths</th>
<th>Mortality rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>1,398</td>
<td>28.9</td>
</tr>
<tr>
<td>Arkansas</td>
<td>918</td>
<td>31.0</td>
</tr>
<tr>
<td>Florida</td>
<td>5,093</td>
<td>26.0</td>
</tr>
<tr>
<td>Georgia</td>
<td>2,048</td>
<td>20.5</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,919</td>
<td>22.7</td>
</tr>
<tr>
<td>Indiana</td>
<td>2,104</td>
<td>32.0</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1,462</td>
<td>33.3</td>
</tr>
<tr>
<td>Louisiana</td>
<td>1,505</td>
<td>32.5</td>
</tr>
</tbody>
</table>

---


Alzheimer’s Statistics

Number of Deaths and Mortality Rates per 100,000 due to Alzheimer’s 2013

<table>
<thead>
<tr>
<th>State</th>
<th>Number of deaths</th>
<th>Mortality rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mississippi</td>
<td>925</td>
<td>30.9</td>
</tr>
<tr>
<td>New Mexico</td>
<td>339</td>
<td>16.3</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2,872</td>
<td>29.2</td>
</tr>
<tr>
<td>Ohio</td>
<td>3,798</td>
<td>32.8</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1,145</td>
<td>29.7</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1,623</td>
<td>34.0</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2,536</td>
<td>20.0</td>
</tr>
<tr>
<td>Texas</td>
<td>5,293</td>
<td>20.0</td>
</tr>
</tbody>
</table>


Ages of People with Alzheimer's in the US

Projected Changes Between 2000 and 2025 in Alzheimer's Disease Prevalence by State


Alzheimer’s Disease Mortality by State

The number of deaths per 100,000 total population

In 2016, total payments for health care, long-term care and hospice are estimated to be $236 billion for people with Alzheimer's and other dementias, with just under half of the costs borne by Medicare.

Medicare and Medicaid are expected to cover $160 billion, or 68 percent, of the total health care and long-term care payments for people with Alzheimer's disease and other dementias.
In the final stage of this disease, individuals lose the ability to respond to their environment, to carry on a conversation and, eventually, to control movement.

They may still say words or phrases, but communicating pain becomes difficult.

As memory and cognitive skills continue to worsen, personality changes may take place and individuals need extensive help with daily activities.

Require full-time, around-the-clock assistance with daily personal care.

Lose awareness of recent experiences as well as of their surroundings.

Require high levels of assistance with daily activities and personal care.

Experience changes in physical abilities, including the ability to walk, sit and, eventually swallow.

Have increasing difficulty communicating.

Become vulnerable to infections, especially pneumonia.

### Functional Stages in Normal Human Development and Alzheimer’s Disease

**FAST Stages 3 – 7**

<table>
<thead>
<tr>
<th>APPROXIMATE AGE</th>
<th>ACQUIRED ABILITIES</th>
<th>LOST ABILITIES</th>
<th>ALZHEIMER STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+ years</td>
<td>Hold a job</td>
<td>Hold a job</td>
<td>3 - INCIPIENT</td>
</tr>
<tr>
<td>8 – 12 Years</td>
<td>Handle simple finances</td>
<td>Handle simple finances</td>
<td>4 - MILD</td>
</tr>
<tr>
<td>5 – 7 Years</td>
<td>Select proper clothing</td>
<td>Select proper clothing</td>
<td>5 - MODERATE</td>
</tr>
<tr>
<td>5 years</td>
<td>Put on clothes unaided</td>
<td>Put on clothes unaided</td>
<td>6 - MODERATELY SEVERE</td>
</tr>
<tr>
<td>4 Years</td>
<td>Shower unaided, Toilet unaided</td>
<td>Shower unaided, Toilet unaided</td>
<td>*</td>
</tr>
<tr>
<td>3 – 4.5 Years</td>
<td>Control urine, Control Urine</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>2 – 3 Years</td>
<td>Control Bowels, Control Bowels</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>15 Months</td>
<td>Speak 5 – 6 words, Speak 5 – 6 words</td>
<td>7 - SEVERE</td>
<td></td>
</tr>
<tr>
<td>1 Year</td>
<td>Speak 1 word Walk, Speak 1 word Walk</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>6 – 10 Months</td>
<td>Sit up, Sit up</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>2 – 4 Months</td>
<td>Smile, Smile</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>1 – 3 Months</td>
<td>Hold up head, Hold up head</td>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

---

### Frontotemporal Dementia

Frontotemporal dementia (FTD) is the clinical presentation of frontotemporal lobar degeneration, which is characterized by progressive neuronal loss predominantly involving the frontal and/or temporal lobes, and typical loss of over 70% of spindle neurons, while other neuron types remain intact.

FTD

Frontal Lobe
Temporal Lobe


Alzheimer’s vs FTD

Alzheimer’s Disease  Frontotemporal Dementia
frontal lobe

http://medschool.ucsf.edu/sites/medschool.ucsf.edu/files/ADvsFTD_450x350.jpg
FTD

- Frontotemporal dementia or FTD (sometimes called Pick’s disease) is a relatively rare form of dementia
- FTD is thought to account for less than 5% of all dementia cases
- It usually affects people between the ages of 45 and 64, but three out of every 10 people with FTD develop the condition at an older age

Prevalence of FTD

[Map showing prevalence of FTD across the United States]

Copyright © 2008 The Research Foundation of State University of New York, http://www.rf.org
The frontal lobes regulate our personality, emotions and behavior, as well as reasoning, planning and decision-making.

The temporal lobes are involved in the understanding and production of language.

These include:
- Behavioral variant FTD (bvFTD)
- Semantic dementia (SD) (the word semantic means the meaning of language)
- Progressive non-fluent aphasia (PNFA) – aphasia is a language disorder where people have problems speaking and writing
- FTD associated with motor neuron disease

Semantic Dementia (SD)

SD, which has also been called "temporal variant FTD," accounts for 20% of FTD cases.

Language difficulty, the predominant complaint of people with SD, is due to the disease damaging the left temporal lobe, an area critical for assigning meaning to words.

The language deficit is not in producing speech but is a loss of the meaning, or semantics, of words.

http://www.alzheimersresearchuk.org/about-dementia/types-of-dementia/frontotemporal-dementia/ftdabout/

http://memory.ucsf.edu/ftd/overview/ftd/forms/multiple/sd
Progressive Non–Affluent Aphasia (PNFA)

- PNFA has an insidious onset of language deficits over time as opposed to other stroke–based aphasias, which occur acutely following trauma to the brain.
- The specific degeneration of the frontal and temporal lobes in PNFA creates hallmark language deficits differentiating this disorder from other Alzheimer type disorders by the initial absence of other cognitive and memory deficits.
- This disorder commonly has a primary effect on the left hemisphere, causing the symptomatic display of expressive language deficits (production difficulties) and sometimes may disrupt receptive abilities in comprehending grammatically complex language.


Symptoms

- Personality changes
  - This may include a change in how people express their feelings towards others or a lack of understanding of other people’s feelings.
  - They may also show a lack of interest or concern, become disinhibited or behave inappropriately.
- Lack of personal awareness
  - People may fail to maintain their normal level of personal hygiene and grooming.
- Lack of social awareness
  - This might include making inappropriate jokes or showing a lack of tact.
- Diet
  - Changes in food preference, over–eating or over–drinking.

What is frontotemporal dementia?
Symptoms

Behavior changes
- Humor or sexual behavior may change
- May become more aggressive, develop unusual beliefs, interests or obsessions
- May become impulsive or easily distracted

Decision making
- Difficulty with simple plans and decisions

Awareness
- Lack of awareness of any changes in their personality or behavior

Language
- Decline in language abilities
- Might include difficulty getting words out or understanding them
- May repeat commonly used words and phrases, or forget the meaning of words

Recognition
- Difficulty recognizing people or knowing what objects are for

Memory
- Day-to-day memory may be relatively unaffected in the early stages, but problems with attention and concentration could give the impression of memory problems

Movement problems
- Around one in every eight people with behavioral variant FTD also develops movement problems of motor neuron disease
- This can include stiff or twitching muscles, muscle weakness and difficulty swallowing

What is frontotemporal dementia?
Preserved Abilities

The following abilities in the person with FTD are preserved

- Perception
- Spatial Skills
- Memory
- Praxis

FTD vs Alzheimer's

<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>Frontotemporal Dementia</th>
<th>Alzheimer’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at onset</td>
<td>Rarely &gt; 75 years</td>
<td>Increases markedly with age</td>
</tr>
<tr>
<td>Early behavioral problems</td>
<td>Common</td>
<td>Unusual</td>
</tr>
<tr>
<td>Socially inappropriate behavior</td>
<td>Common early in course</td>
<td>Usually in severe case</td>
</tr>
<tr>
<td>Memory impairment</td>
<td>Less prominent in early course</td>
<td>Early and profound impairment</td>
</tr>
<tr>
<td>Language problems</td>
<td>May have isolated problems without memory impairment</td>
<td>Usually associated with memory impairment</td>
</tr>
<tr>
<td>Visuospatial defect</td>
<td>Rare in mild to moderately impaired case</td>
<td>Less common</td>
</tr>
<tr>
<td>Motor signs</td>
<td>More common (motor neuron disease)</td>
<td>Less common</td>
</tr>
<tr>
<td>Mood</td>
<td>Marked irritability, anhedonia, withdrawal, difficulties in understanding, processing or describing emotions; euphoria, lack of guilt, apathy or suicidal ideation</td>
<td>Sadness, tears, anhedonia</td>
</tr>
<tr>
<td>Psychotic features</td>
<td>Rare persecutory delusion, usually jealous, somatic, religious and bizarre behaviors</td>
<td>Usually have delusion of misidentification or persecutory type and usually occur in middle or late stage</td>
</tr>
<tr>
<td>Appetite, dietary change</td>
<td>Increased appetite, carbohydrate craving 80%, weight gain</td>
<td>Less common: anorexia and weight loss</td>
</tr>
</tbody>
</table>

W Muangpaisan clinical differences among Four common Dementia syndromes. Geriatrics 7 Aging July/August 2007 volume 10 Number 7

Dementia with Lewy Bodies (DLB)

- DLB is a type of progressive neurodegenerative dementia closely associated with Parkinson's disease primarily affecting older adults
- Its primary feature is a more rapid cognitive decline than with Parkinson's, which may lead to hallucinations, as well as varied attention and alertness when compared to a person's baseline function

http://www.lbda.org/node/14
Prevalence of DLB

Lewy Bodies


Brain Anatomy

Substantia nigra

http://www.sheffieldneurogirls.com/our-brain/substantia-nigra-1

What is Dopamine?

Dopamine is a neurotransmitter that helps control the brain's reward and pleasure centers

Dopamine also helps regulate movement and emotional responses, and it enables us not only to see rewards, but to take action to move toward them

https://www.psychologytoday.com/basics/dopamine

https://www.psychologytoday.com/blog/evolutionary-psychiatry/201105/dopamine-primer
The hallmark brain abnormalities linked to DLB are named after Frederick H. Lewy, M.D., the neurologist who discovered them while working in Dr. Alois Alzheimer's laboratory during the early 1900s.

Most experts estimate that dementia with Lewy bodies is the third most common cause of dementia after Alzheimer's disease and vascular dementia, accounting for 10 to 25 percent of cases.


Many people with Parkinson's eventually develop problems with thinking and reasoning, and many people with DLB experience movement symptoms, such as hunched posture, rigid muscles, a shuffling walk and trouble initiating movement.
## Symptoms

- Changes in thinking and reasoning
- Confusion and alertness that varies significantly from one time of day to another or from one day to the next
- Parkinson's symptoms, such as a hunched posture, balance problems and rigid muscles
- Visual hallucinations

---

## Symptoms (Continued)

- Delusions
- Trouble interpreting visual information
- Acting out dreams, sometimes violently, a problem known as rapid eye movement (REM) sleep disorder
- Malfunctions of the "automatic" (autonomic) nervous system
- Memory loss that may be significant but less prominent than in Alzheimer's
Memory loss tends to be a more prominent symptom in early Alzheimer's than in early DLB, although advanced DLB may cause memory problems in addition to its more typical effects on judgment, planning and visual perception.

Movement symptoms are more likely to be an important cause of disability early in DLB than in Alzheimer's, although Alzheimer's can cause problems with walking, balance and getting around as it progresses to moderate and severe stages.

Hallucinations, delusions, and misidentification of familiar people are significantly more frequent in early-stage DLB than in Alzheimer's.

REM sleep disorder is more common in early DLB than in Alzheimer's.

Disruption of the autonomic nervous system, causing a blood pressure drop on standing, dizziness, falls and urinary incontinence, is much more common in early DLB than in Alzheimer's.
### DLB vs Alzheimer’s

<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>Lewy Bodies</th>
<th>Alzheimer’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolated Memory impairment</td>
<td>93.8%</td>
<td>31.3%</td>
</tr>
<tr>
<td>Parkinsonism</td>
<td>More common</td>
<td>Less common and usually develops later in the course</td>
</tr>
<tr>
<td>Psychiatric symptoms</td>
<td>More likely to occur with dementia symptoms early in the course</td>
<td>Less likely</td>
</tr>
<tr>
<td>Fluctuation of cognitive function</td>
<td>50–75%</td>
<td>When delirious</td>
</tr>
<tr>
<td>Verbal memory</td>
<td>Better</td>
<td>Worse</td>
</tr>
<tr>
<td>Type of memory impairment</td>
<td>Semantic memory</td>
<td>Episodic memory</td>
</tr>
<tr>
<td>Executive function</td>
<td>Poor early in the course</td>
<td>Less severe in early phase</td>
</tr>
<tr>
<td>Attention, visuospatial function, constructional abilities</td>
<td>More impairment</td>
<td>Less impairment</td>
</tr>
<tr>
<td>Visual hallucinations</td>
<td>Common since early phase</td>
<td>Less prominent in early course</td>
</tr>
<tr>
<td>Autonomic involvement</td>
<td>Common</td>
<td>Less common</td>
</tr>
<tr>
<td>Neuroleptics response</td>
<td>Extrapyramidal side effect, may cause mortality</td>
<td>Behavioral response</td>
</tr>
</tbody>
</table>

W Muangpaisan clinical differences among Four common Dementia syndromes. Geriatrics 7 Aging July/August 2007 volume 10 Number 7

---

### Vascular Dementia

- Vascular dementia is dementia caused by problems in the supply of blood to the brain, typically a series of minor strokes, leading to worsening cognitive decline that occurs step by step.

- Consists of a complex interaction of cerebrovascular disease and risk factors that lead to changes in the brain structures due to strokes and lesions, and resulting changes in cognition.

- The temporal relationship between a stroke and cognitive deficits is needed to make the diagnosis.

Cunningham, EL; McGuinness, B; Herron, B; Passmore, AP (May 2015). "Dementia.". The Ulster medical journal. 84 (2): 79–87
Prevalence of Vascular Dementia

Vascular Dementia Symptoms

- 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

http://www.mayoclinic.org/diseases-conditions/vascular-dementia/basics/symptoms/con-20029330
Vascular Dementia

https://www.healthtap.com/user_questions/111973

Hachinski Ischemia Score

<table>
<thead>
<tr>
<th>Feature</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrupt onset</td>
<td>2</td>
</tr>
<tr>
<td>Stepwise deterioration</td>
<td>1</td>
</tr>
<tr>
<td>Fluctuating course</td>
<td>2</td>
</tr>
<tr>
<td>Nocturnal confusion</td>
<td>1</td>
</tr>
<tr>
<td>Relative preservation of personality</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Somatic complaints</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL SCORE ______


January 2017  Palmetto GBA – Medicare Administrative Contractor (MAC)
# Vascular Dementia vs Alzheimer's

<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>Vascular Dementia</th>
<th>Alzheimer’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of atherosclerotic disease</td>
<td>TIAs, strokes, atherosclerotic risk factors (diabetes, hypertension)</td>
<td>Less Common</td>
</tr>
<tr>
<td>Onset</td>
<td>Sudden or gradual</td>
<td>Gradual</td>
</tr>
<tr>
<td>Progression</td>
<td>Slow or stepwise progression</td>
<td>Slow, progressive decline</td>
</tr>
<tr>
<td>Neurological examination</td>
<td>Neurological deficits</td>
<td>Normal</td>
</tr>
<tr>
<td>Gait</td>
<td>Often disturbed early</td>
<td>Usually normal</td>
</tr>
<tr>
<td>Memory</td>
<td>Mild Impairment in Early phase</td>
<td>Prominent in early phase</td>
</tr>
<tr>
<td>Executive Function</td>
<td>Marked impairment and early</td>
<td>Impaired later</td>
</tr>
<tr>
<td>Type of dementia</td>
<td>Subcortical</td>
<td>Cortical</td>
</tr>
<tr>
<td>Hashinski Ischemic Score</td>
<td>$\geq 7$</td>
<td>$\leq 4$</td>
</tr>
<tr>
<td>Neuroimaging</td>
<td>Infarction or white matter lesions</td>
<td>Normal or Hippocampal atrophy</td>
</tr>
</tbody>
</table>

W Muangpaisan clincial differences among Four common Dementia syndromes. Geriatrics 7 Aging July/August 2007 volume 10 Number 7

---

# Dementia Documentation

- Memory impairment
- Disorientation to place
- Impairment of judgement
- Language impairment
- Decline in capabilities and routine activities of daily living
- Change in personality and/or marked difficulty maintaining social function
- Changes in expressions of feelings
- Thinking disturbances
- Questions to ask for memory loss
- Orientation to place
- Judgement
- Language
- Capabilities and activities of daily living
- Sociability
- Expression of feelings
- Thinking
### Hospice Goals for Dementia Patients

- Promotes comfort and quality of life without use of life extending measures
- Focuses on close, collaborative working relationships between health care team, family, and patient
- Provides education that will allow the family to make informed decisions about the patient’s healthcare needs
- Involvement of spiritual and religious counsel
- Assistance with the grieving process
- Knowledge that dementia is a terminal illness
- Offers diverse comfort measures to promote end of life care and quality of life

Smith, M. (2007). Hospice Approach to End of Life Dementia Care. University of Iowa College of Nursing Iowa Geriatric Education Center

### Barriers to Providing Hospice Services

- Terminal phase of dementia may be prolonged and difficult to predict
- People with end stage dementia lack the decision making skills to elect hospice services independently
- Patient's did not make their wishes known prior to becoming incompetent
- The patient may not appear as if they are terminal
- Lack of education that dementia is a terminal illness
- Medicare hospice eligibility requirements

Smith, M. (2007). Hospice Approach to End of Life Dementia Care. University of Iowa College of Nursing Iowa Geriatric Education Center
Brief Cognitive Rating Scale (BCRS) Axis 1: Concentration

<table>
<thead>
<tr>
<th>Axis Rating (Circle Highest Score)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No objective or subjective evidence of deficit in concentration</td>
</tr>
<tr>
<td>2</td>
<td>Subjective decrement in concentration ability</td>
</tr>
<tr>
<td>3</td>
<td>Minor objective signs of poor concentration (e.g. on subtraction of serial 7s from 100)</td>
</tr>
<tr>
<td>4</td>
<td>Definite concentration deficit for persons of their background (e.g. marked deficit on serial 7s; frequent deficit in subtraction of serial 4s from 40)</td>
</tr>
<tr>
<td>5</td>
<td>Marked concentration deficit (e.g., giving months backwards or serial 2s from 20)</td>
</tr>
<tr>
<td>6</td>
<td>Forgets the concentration task. Frequently begins to count forward when asked to count backwards from 10 by 1s</td>
</tr>
<tr>
<td>7</td>
<td>Marked difficulty counting forward to 10 by 1s</td>
</tr>
</tbody>
</table>


Axis 2: Recent Memory

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – No objective or subjective evidence of deficit in recent memory</td>
</tr>
<tr>
<td>2 – Subjective impairment only (e.g., forgetting names more than formally)</td>
</tr>
<tr>
<td>3 – Deficit in recall of specific events evident upon detailed questioning. No deficit in the recall of major recent event.</td>
</tr>
<tr>
<td>4 – Cannot recall major events of previous weekend or week. Scanty knowledge (not detailed) of current events, favorite TV shows etc.</td>
</tr>
<tr>
<td>6 – Unsure of weather: may not know current President or current address</td>
</tr>
<tr>
<td>7 – Occasional knowledge of some recent events. Little or no idea of current address.</td>
</tr>
<tr>
<td>8 – No knowledge of any recent events</td>
</tr>
</tbody>
</table>
**Axis 3: Past Memory**

1. No subjective or objective impairment in past memory
2. Subjective impairment only. Can recall two or more primary school teachers.
3. Some gaps in past memory upon detailed questioning. Able to recall at least one childhood teacher and/or one childhood friend.
4. Clear cut deficit. The spouse recalls more of the patient's past than the patient. Cannot recall childhood friends and/or teachers but knows the names of most schools attended. Confuses chronology in reciting personal history.
5. Major past events sometimes not recalled (e.g., names of schools attended)
6. Some residual memory of past (e.g., may recall country of birth or former occupation)
7. No memory of past

**Axis IV: Orientation**

1. No deficit in memory for time, place. Identity of self and others.
2. Subjective impairment only. Knows time to nearest hour, location.
3. Any mistake in time > 2 hrs: day of week > 1 day; date > 3 days
4. Mistakes in month > 10 days or year > 1 month
5. Unsure of month and/or year and/or season: unsure of locale
6. No idea of date. Identifies spouse but may not recall name. Knows own name.
7. Cannot identify spouse. May be unsure of personal identity.
**Axis V: Functioning and Self–Care**

1 - No difficulty, either subjectively or objectively
2 - Complains of long forgetting location of objects, subjective work difficulties
3 - Decreased job functioning evident to co–workers. Difficulty in traveling to new locations.
4 - Decreased ability to perform complex tasks (e.g. planning dinner for guests, handling finances, marketing, etc.).
5 - Requires assistance in choosing proper clothing.
6 - Requires assistance in feeding, and/or toileting, and/or bathing, and/or ambulating
7 - Requires constant assistance in all activities of daily living

Total Score \[ \text{divide by } 5.0 \] = Stage on Global Deterioration Scale

---

**Guidelines for Scoring BCRS**

Ratings: Taking into account the subject’s level or education cultural background, etc. the interviewer rates each clinical axis on the BCRS on a scale ranging from 1 to 7. These scale points define the degree of impairment on each axis as follows.

1 - **Normal**: No cognitive decline present. Average or better performance
2 - **Very mild**: Subjective impairment in comparison with 5 or 10 years previous
3 - **Mild**: Minimal impairment which is clinically verifiable with detailed questioning
4 - **Moderate**: Marked impairment which is readily evidenced clinically
5 - **Moderately Severe**: Severe impairment on assessment
6 - **Severe**: Very severe impairment; some residual capacity in some assessment areas
7 - **Very severe**: Very severe impairment; little residual capacity elicited in assessments
The Global Deterioration Scale for Assessment of Primary Degenerative Dementia


Copyright © 1983 by Barry Reisberg, M.D. Reproduced with permission.
**Mini Suffering State Exam**

|-------------------------------------|-------------|------------|---------|---------------------|-----------------|--------------------|---------------------|------------------------|----------------------------------------|----------------------------------------|


---

**BLESSED DEMENTIA-SCALE**

<table>
<thead>
<tr>
<th>Change in performance of everyday activities</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A inability to perform household tasks</td>
<td></td>
</tr>
<tr>
<td>B inability to cope with usual sums of money</td>
<td></td>
</tr>
<tr>
<td>C inability to remember shortlist of items</td>
<td></td>
</tr>
<tr>
<td>D inability to find way about indoors</td>
<td></td>
</tr>
<tr>
<td>E inability to find way about familiar streets</td>
<td></td>
</tr>
<tr>
<td>F inability to interpret surroundings</td>
<td></td>
</tr>
<tr>
<td>G inability to recognize whether in hospital or at home</td>
<td></td>
</tr>
<tr>
<td>H discrimination between patients, doctors, nurse, relatives, other hospital staff, etc.</td>
<td></td>
</tr>
<tr>
<td>I inability to recall recent events; for example, recent outings, visits of relatives or friends to hospital, etc.</td>
<td></td>
</tr>
<tr>
<td>J tendency to dwell in the past</td>
<td></td>
</tr>
</tbody>
</table>

**Changes in habits**

<table>
<thead>
<tr>
<th>Change in habits</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Eating</td>
<td></td>
</tr>
<tr>
<td>(0) clean, with proper utensils</td>
<td></td>
</tr>
<tr>
<td>(1) messy, with spoon only</td>
<td></td>
</tr>
<tr>
<td>(2) simple solids (for example, biscuits)</td>
<td></td>
</tr>
<tr>
<td>(3) has to be fed</td>
<td></td>
</tr>
<tr>
<td>B Dressing</td>
<td></td>
</tr>
<tr>
<td>(0) unaided</td>
<td></td>
</tr>
<tr>
<td>(1) occasionally misplaced buttons, etc.</td>
<td></td>
</tr>
<tr>
<td>(2) wrong sequence, commonly forgetting items</td>
<td></td>
</tr>
<tr>
<td>(3) unable to dress</td>
<td></td>
</tr>
<tr>
<td>C Bladder control</td>
<td></td>
</tr>
<tr>
<td>(0) complete control</td>
<td></td>
</tr>
<tr>
<td>(1) occasional wet bed</td>
<td></td>
</tr>
<tr>
<td>(2) frequent wet bed</td>
<td></td>
</tr>
<tr>
<td>(3) doubly incontinent</td>
<td></td>
</tr>
</tbody>
</table>


© University of New South Wales as represented by the Dementia Collaborative Research Centre – Assessment and Better Care; Brodaty et al, JAGS 2002; 50:530–534
<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problems with judgment (e.g., making decisions, bad financial decisions, problems with thinking)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Less interest in hobbies/activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Repeats the same things over and over (questions, stories, or statements)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Trouble learning how to use a new appliance or gadget (e.g., VCR, computer, microwave, remote control)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Forgets correct month or year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble remembering appointments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Daily problems with thinking and/or memory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL AD8 SCORE**

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005;65:559–564

Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer’s Disease Research Center, Washington University, St. Louis, Missouri. All Rights Reserved

---

**Part 2**
What You Need to Know for 2017

Data Driven Topics

- Hospice Election Statement
- Medicare Secondary Hospice Election
- Transfer Requirements
- Billing Dispute Resolution Requests
- Comparative Billing Report (CBR)

CERT Program

Provider Enrollment Revalidation

eServices Online Provider Portal

Provider Resources/Self Service Tools

- Secure eChat
- Tools and Calculators
- Social Media
- E-Mail Updates
- Hospice Basics Modules
What You Need to Know for 2017

Fiscal Year (FY) 2017 Hospice Final Rule

Hospice Center

FY 2017 Final Rule – Key Points

The 2017 Hospice Final Rule includes

- Hospice wage index for all four levels of care and hospice cap amount
  - Implemented October 1, 2016, with CR 9729
- Hospice Quality Reporting Program (HQRP), including two new quality measures and enhancements for the Hospice Item Set (HIS)
  - Awaiting further direction from CMS
- Information regarding the Medicare Care Choices Model (MCCM)
  - Informational only
Data Driven Topics

Hospice Election Statement – OIG Report OEI-02-10-00492
Medicare Secondary Hospice Election – Inquiry Analysis
Transfer Requirements – Inquiry Analysis
Comparative Billing Report (CBR)

Hospice Election Statement – OIG Findings

Hospice election statements
☐ Did not specify Medicare
☐ Required waiver information was missing or was stated inaccurately
☐ Required information about palliative care was missing
☐ Revocation or discharge information was inaccurate or unclear

https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf
## Inside the OIG Findings

Election statements did not specify that the beneficiary was electing was **Medicare** hospice

- Patient/Representative must elect to receive the benefit
- Patient/Representative must sign an election statement acknowledging that he/she wishes to enroll in the MHB
- Patient/Representative must acknowledge understanding of coverage for hospice care under the Medicare program

[https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf](https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf)

---

## Inside the OIG Findings

Required waiver information was missing or was stated inaccurately (e.g., beneficiary waives the right to “all” other benefits under the Medicare program while receiving hospice benefits)

- Patient must understand that once the MHB is elected, payment of Medicare benefits for services related to the terminal illness is only made to the hospice
- Coverage of services not related to the terminal illness are paid under the traditional fee-for-service program
- Hospice is responsible for maintaining and facilitating any care the patient needs

[https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf](https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf)
Inside the OIG Findings

Required information about palliative care was missing

- The patient must acknowledge understanding that hospice care is palliative and not curative
  - Palliative care means the patient and family-centered care that optimizes the quality of life by anticipating, preventing, and treating suffering
  - Patients that choose to receive curative treatments do not qualify for the MHB

https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf

Inside the OIG Findings

Revocation or discharge information was inaccurate or unclear

- Some election statements indicated that if patient chose care or treatment that was not preauthorized by the hospice or was not included in the plan of care, patient would immediately be removed from the MHB
  - The patient must choose to revoke the MHB, and must do so in writing
  - Hospices must notify the patient in advance if they are discharging
- Information on revocation and discharge not required on election statement
- If revocation and/or discharge information is included on the election statement, it must be clear to the patient that Medicare payment for hospice care ends

https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf
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

CMS IOM Publication 100–02, Chapter 9, Section 20.2.1
MLN Matters® Article – SE1631

Disclaimer: Election Statement Example

- 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

Example:

I, ___________________________ choose to elect the Medicare hospice benefit and receive Hospice services from ___________________________.

(Beneficiary Name)

(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

Example:

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)

Example:
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.

MLN Matters ® Article – SE1631
January 2017
Palmetto GBA – Medicare Administrative Contractor (MAC)

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

Example:
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

MLN Matters ® Article – SE1631
January 2017
Palmetto GBA – Medicare Administrative Contractor (MAC)
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

Example:
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

Example:
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

**Example:**

<table>
<thead>
<tr>
<th>Signature of Beneficiary/Representative</th>
<th>(Date)</th>
</tr>
</thead>
</table>

- Beneficiary is unable to sign

| Reason: | |
|---------| |

<table>
<thead>
<tr>
<th>Witness signature</th>
<th>(Date)</th>
</tr>
</thead>
</table>

**Medicare Secondary Payer (MSP) and the Hospice Election**

- Beneficiaries that have other health insurance that is primary to Medicare may elect the MHB
- If the beneficiary elects the MHB, the hospice must submit the NOE and subsequent claims
  - Regardless of whether or not the primary pays 100% of the charges
- The existence of a primary payer source does not negate the Medicare requirements for the MHB
MSP and the Hospice Election

- The agency submits the NOE as normal
- All claims subsequent to the NOE are submitted to the primary payer first
- Upon receipt of the primary payer’s EOB/RA, the hospice submits the claim to Medicare

The claims processing system will calculate as applicable any payment that is due to the provider
- Payments are calculated based on the data submitted on the claim
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.

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.

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

Change Request 9114
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.

Receiving Agency Requirements

The hospice agency receiving the patient must perform a complete admission:
- Physician Certification
- Election Statement
- Plan of Care
- A new F2F 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)
      - Patient will receive RHC
    - 51 – Discharged/transferred to hospice (medical facility)
      - Patient will receive GIP or inpatient respite LOC
  - 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 included
  - 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 (if available)
- Copy of the communication(s) between the hospices (telephone call log, emails, etc.)
  - Transfer situation does not end the patient’s enrollment in the MHB
  - 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)
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

After the research is completed

- When appropriate, a letter is mailed to the provider/organization needing to
  - Complete or back out billing
  - Adjust the end (transferring hospice) or start (receiving hospice) date
  - Provide a copy of the transfer agreement
- If a response to the letter is not received within 10 business days of the date of the letter, Palmetto GBA will
  - Cancel claims, NOE/Notice of Change
  - Adjust the end date on the final claim (transferring hospice)
CBR

- CBRs show providers how they compare to their peers in billing for certain risk areas
- This report does not contain patient specific data
If you receive a CBR

- It is not intended to be punitive, or sent as an indication of fraud
- It is a tool for providers to proactively self-audit in order to identify potential errors in their billing and documentation practices
- If an error is identified which results in a Medicare overpayment, providers should notify the MAC and submit a voluntary refund

What is the CERT Program?
CERT

Federally mandated program created by the Centers for Medicare & Medicaid Services (CMS) to measure the paid claims error rate for Medicare claims submitted to MACs

- CMS receives in excess of 2 billion claims per year
- Ensures that the Medicare program is paying claims correctly
- The CERT program measures national, contractor-specific, and service-specific paid claim error rates

The CERT program uses a random and a service-specific sampling of claims

- AdvanceMed is the CERT contractor responsible for administering the CERT program on behalf of CMS
  - The CERT contractor selects samples of claims from Palmetto GBA
  - For each claim selected, the CERT contractor requests medical records, from the providers, physicians or suppliers that billed for the services, and prepares the documentation for review
CERT ADR Letters

- CERT ADR letters are mailed to the provider at the address in their provider enrollment record
  - Letter will contain a “CID” number that should be included with the response
- Providers should ensure their provider enrollment records are up-to-date

CERT Contact Information

Providers may update the contact information that CERT uses
- Contact Name
- Address
- Phone
- Fax
- Email
  - Go to www.certprovider.admedcorp.com and select Address Update at the top of the page
    - Providers may enter a valid National Provider Identifier or a valid contractor ID and valid Provider ID
      - Valid Contractor ID: 11001
      - Valid Provider ID: Enter the six-digit Medicare provider number
CERT Documentation Submission

- **Electronic Submission of Medical Documentation (esMD)**
  - For more information about esMD, see [https://www.cms.gov/esMD](https://www.cms.gov/esMD)
- **Fax**
  - 804-261-8100
- **CD**
  - If mailing a CD, it MUST contain only images in TIFF or PDF format. Please be sure that all information is encrypted and protected by a password.
  - Send the password via email to certmail@admedcorp.com.
- **Paper**
  - Attn: CID XXXXXXX
  - CERT Documentation Center
  - 1510 East Parham Road
  - Henrico, VA 23228

CERT Contractor Responsibilities

- **Identify Improper Payments**
- **Submit Claim Adjustment to MAC When Error Identified**
  - If No Error Identified – No Action is Taken
- **Respond to any audit specific questions you may have, such as their rationale for identifying the potential improper payment**
MAC Contractor Responsibilities

- Perform claim adjustments based on the CERT’s review if improper payment was identified
  - CERT adjusted claims are identified by type of bill (TOB) \textit{xxH}

- Issue demand letters for overpayments generated for improper payments
  - Demand letters will be sent to the provider’s physical address

- Handle administrative concerns such as timeframes for payment recovery and the redeterminations

Medicare A/B MAC CERT Task Force

- Joint effort of the Part A/B Medicare Administrative Contractors (MACs)

- Share common goal of reducing the national improper payment rate as measured by the Comprehensive Error Rate Testing (CERT) program

- Designated Task Force members from each MAC work together to educate and communicate national issues of concern regarding improper payments to the Medicare program

- Task Force education intended to complement CMS and MAC individual error-reduction activities
CERT Task Force

The Medicare A/B Contractor CERT Task Force is a joint effort to communicate national issues of concern regarding improper payment and to educate Medicare providers on numerous topics affecting improper payment rates as measured by the Comprehensive Error Rate Testing (CERT) and other national error reduction activities within its jurisdiction. Palmetto GBA has designated task force members on the A/B Contractor Program Integrity Manual as it becomes available.

Latest Articles

- Case for Medicare Patients as a Partnership
- Compliance With Medicare Record Documentation Requirements
- Task Force Scenarios: Documenting Therapy and Rehabilitation Services
- CERT A/B MAC Compliance & Education Task Force: Emphasis on Compliance & Education to Reduce Errors
- New Home, New MAC: Understanding the New Form of Part A and B MACs
- A Nation United With a Shared Goal: All MACs As Forces

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
  Publication 100-08
Provider Enrollment Revalidation

MLN Matters® Number: SE1605

January 2017

Palmetto GBA – Medicare Administrative Contractor (MAC)

- 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.

To make it easier, when a provider is asked to revalidate, the due date assigned will always be on the last day of the month specified (e.g. June 30, July 31, August 30).

With subsequent revalidation cycles, provider’s due dates will generally remain the same.

To assist providers, the CMS developed a Lookup Tool.

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

https://data.cms.gov/revalidation
Medicare Revalidation List

Medicare providers must revalidate their enrollment records every three or five years. CMS sets every provider's revalidation due-date at the end of a month, and posts the upcoming six months online. A due date of "TBD" means that CMS has not set the date yet.

CMS offers several ways for you to view and group the revalidation dates of every provider:
- This data was last refreshed on November 1st, 2016
- Revalidation due dates included on this list range between March 1, 2016 and May 31st, 2017
- The next data refresh is tentatively scheduled for January 1st, 2017
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DMR Due Dates between November 1st 2016 and March 30th, 2017

Search all records

Individual Last Name or Organization Name
Individual First Name
NPI
State
Search

Online tables

Browse, search, and filter the entire list online, then save to a file. Sorts alphabetically. Top search terms are highlighted for data specialties:
1. Group practice members only
A-D | E-L | M-R | S-Z
2. Entire list of providers and suppliers
Search for all providers and suppliers, regardless of specialty.
3. Reassignments and PA Employment relationships
For data specialists: Export this table to Excel (2 columns) to create an alphabetical list of states by NPI.
How to use the online tables:
- Select a column by clicking its gray header.
- Sort the list by clicking its gray header.
- Filter the list by clicking the sort (gray) button.
- Download the file by clicking the gray [Export] button.

Matching Providers or Suppliers

Search results as of November 1st, 2016.
* Includes Reassignments and PA Employment relationships

You searched for providers that match the following criteria:
NPI is [ ]
Hospice Incorporated
Revalidation Due Date: TBD
State: NC
Specialty: Hospice
NPI: [ ]

Hospice Incorporated
Revalidation Due Date: TBD
State: NC
Specialty: Clinic/Group Practice
NPI: [ ]
Total Providers: 20
When you receive your Cycle 2 Revalidation letter

- Pay close attention to the due date and plan according to revalidate by the due date
- Revalidate your Medicare enrollment record through [www.PECOS.cms.hhs.gov](http://www.PECOS.cms.hhs.gov), or appropriate form CMS–855

Palmetto GBA will issue revalidations letters within 2–3 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
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.

Reminders

- 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.
- Use the CMS Lookup Tool to view the due date.
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
- Claims Status
- Remittances Online
- 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)
- Secure Forms – Appeals, Cost Report Form (Part A and HHH only), Medical Review ADR Response Form, and General Inquiry form

EReview – Electronic Review

- eCBR New! – Electronic Comparative Billing Report (eCBR)
  - Non–Cancer Length of Stay (NCLOS) rates from April 1, 2016 to September 30, 2016
- eAudit New! – Electronic Audit
  - CERT audit data by error code category
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 that
  - Grants access for additional users to access
  - Views and prints information from eServices related to registered provider

The provider administrator’s responsibilities include the following
- Creating and maintaining user profiles
- Assigning application permissions to the provider user
eServices Administrator

- Create additional provider administrators
  - Ensure you have at least 1 back-up 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

NEW!!! – 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
- Personalized NCLOS eCBR results
  - April 1, 2016 to September 30, 2016
  - Only available in eServices
NEW!!! – 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 audit data by error code category
NEW!!! – Account Linking

- Users no longer need a separate login for each PTAN and NPI combination
- Users have the ability to link their previously assigned eServices user ID’s 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

☐ Once user accounts are linked the user will
   ▪ Be able to login one time
   ▪ Click a drop down menu that lists all linked NPI and PTAN 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
Account Linking

- User cannot link accounts that are already linked to a default user ID
- User cannot link accounts that are inactive or have been terminated for any reason such as:
  - Terminated by the provider administrator
  - Terminated by Palmetto GBA
  - Terminated for inactivity (no login for 60 days)
  - Terminated for not completing recertification or verification timely
Multi-Factor Authentication

- Multi-factor authentication is an extra layer of security
- Logging into your eServices account will work a little differently
  1. You'll enter your password as usual
  2. Then, you'll select your preferred method of delivery between email or a text message
  3. Once you receive your verification code you will enter it in the verification box and you're in
- Mandatory April 1, 2017
eServices References

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

eServices FAQs
Find answers to frequently asked questions about eServices.

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.

Provider Resources/Self Service Tools

Secure eChat
Tools and Calculators
Social Media
Email Updates (Listserv)
Hospice Basics Training Modules
Secure eChat

- During certain business hours, secure eChat is available on Palmetto GBA’s website
- Look for the icon at the bottom right side of the screen
  - The icon will be displayed when our eChat feature is available
- This feature gives providers
  - A method to ask questions about Medicare regulations and guidelines
  - Request assistance with finding information on Palmetto GBA’s or CMS’ websites
  - Discuss claim specific information to include PHI because it is a secure connection

Tools and Calculators

- Latest Articles
  - ADR Response Calculator
  - Medicare Provider Enrollment Status Look-Up
  - EDI Enrollment Status Request Form
  - EDI Related Topics
  - Interactive忾
  - Interactive ESI Agreement
  - Interactive ESI Application
  - Interactive ESI Provider Authorization
  - Interactive Part B Compliance Advice
  - Interactive UB-04
  - HIP Conversion Tool
  - Medicare Advantage Plan Directory
  - Medicare Advantage Plan Eligibility
- Search

January 2017

Palmetto GBA – Medicare Administrative Contractor (MAC)
Forms

Provider Contact Center
Contact Palmetto GBA about an issue not addressed by any of the forms above

- Provider Contact Center - Written Inquiry Request Form
- Billing Dispute Resolution Request

Provider Outreach & Education
Find educational information for Medicare providers

- Ask the Contractor Teleconference (ACT) Request: Submit a Question Education Request Form
- Provider Outreach & Education Advisory Group (POE-AG) Membership Request Form
- Speaker Request Form

Note: Please complete the form online


**ADR Response Calculator**

If you have received an Additional Documentation Request (ADR) for one or more claims, you will have 45 days from the date of the letter to submit supporting records. If we do not receive your documentation within 40 days, your claim will be denied for lack of a response.

Our ADR Calculator can help you submit your documentation timely. Just enter the date found on your ADR letter and click ‘Calculate’. The tool will tell you the last date your records can be received in our office.

If you have questions about how to read your ADR letter, please call the Home Health and Hospice Provider Contact Center at 855-569-0705. Representatives are available from 8 a.m. to 5 p.m. ET.

Enter the date of the ADR letter: 01/01/2017

Return requested information by: Feb 15, 2017

(C)2016, Palmetto GBA, LLC

---

**Appeals Calculator Self Service Tool**

Providers may appeal claims that are partially or fully denied, as long as the claim has appeal rights. Different levels of appeals have different timelines in which the appeal rights are valid.

Select Level of Appeal:
- Level 1: Redetermination

Enter the date of the initial determination notice:
- (i.e. date of Medicare Remittance Advice)
  - 01/01/2017

Deadline:
- The Redetermination request must be received by:
  - Tuesday, May 2, 2017

Note: If the deadline date falls on a Saturday, Sunday or holiday, the appeal request must be received the previous work day.
**CHARGE DENIAL RATE (CDR) CALCULATOR**

The Remittance Advices (RAs) will reflect the decision made on the reviewed claim. Use the calculator to determine your Charge Denial Rate (CDR).

- **Total Dollars Reviewed**: 25625
- **Total Dollars Denied**: 9541

Your CDR is 37%

**Total Dollars Reviewed**: Determine what the Medicare reimbursement amount would have been for each claim if it were paid as billed.

**Total Dollars Denied**: Is based on the 'reviewed charges.' For example, if a partial payment were allowed on the claim, the denied charges would equate to the difference between the amount that would have been paid if the claim had paid as billed and the amount that was actually paid.

To obtain the information needed to calculate the CDR, you will need to have your Remittance Advices (RAs), and access to the Direct Data Entry (DDE) system.

---

**Provider Enrollment Application Status Lookup**

Please enter your PTAN or Reference Number/DCN to find the status of your enrollment application.

Search

If you do not receive status information using the number you entered, please call the Palmetto GBA Provider Contact Center at 855-550-3703. We will research the status of your enrollment application.

Please note: Status information is updated approximately 24 hours after each transaction.

**Search Results:**

- **Date Application Received**: 01/06/2017
- **NPI**
- **PTAN**
- **Reference/Tracking number or CCN**: 1700500900004632
- **Application Status**: Closed 01/10/2017
- **Application Type**: Email - Email Inquiry
- **Contact Name**
Hospice Rate Calculator

Rate Period: OCTOBER 1, 2016 TO SEPTEMBER 30, 2017
Quality Data: Yes
State: SC

Hospice Payment Rates for South Carolina

<table>
<thead>
<tr>
<th>County</th>
<th>CBSA Name</th>
<th>CBSA Code</th>
<th>Wage Index</th>
<th>RHC Rates Days 1 Thru 60</th>
<th>RHC Rates Days 60+</th>
<th>Cost Home Care</th>
<th>Inpt Respite Care</th>
<th>Gen Inpt Care</th>
<th>Service Intensity Add-on</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONAL</td>
<td></td>
<td></td>
<td></td>
<td>$190.55</td>
<td>$149.82</td>
<td>$954.63</td>
<td>$170.97</td>
<td>$734.94</td>
<td></td>
</tr>
<tr>
<td>WAGE PORTION</td>
<td></td>
<td></td>
<td></td>
<td>$136.93</td>
<td>$102.94</td>
<td>$662.80</td>
<td>$92.55</td>
<td>$470.44</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NON-WAGE PORTION</td>
<td></td>
<td></td>
<td>$59.62</td>
<td>$46.88</td>
<td>$301.83</td>
<td>$78.42</td>
<td></td>
<td>$264.50</td>
</tr>
<tr>
<td>Aiken</td>
<td>Augusta-Richmond County, GA-SC</td>
<td>12260</td>
<td>0.9372</td>
<td>$182.33</td>
<td>$143.36</td>
<td>$923.01</td>
<td>$165.16</td>
<td>$705.40</td>
<td>$38.46</td>
</tr>
<tr>
<td>Edgefield</td>
<td>Augusta-Richmond County, GA-SC</td>
<td>12260</td>
<td>0.9372</td>
<td>$182.33</td>
<td>$143.36</td>
<td>$923.01</td>
<td>$165.16</td>
<td>$705.40</td>
<td>$38.46</td>
</tr>
<tr>
<td>Berkeley</td>
<td>Charleston-North Charleston</td>
<td>16700</td>
<td>0.8884</td>
<td>$175.94</td>
<td>$138.33</td>
<td>$890.66</td>
<td>$160.64</td>
<td>$682.44</td>
<td>$37.11</td>
</tr>
<tr>
<td>Charleston</td>
<td>Charleston-North Charleston</td>
<td>16700</td>
<td>0.8884</td>
<td>$175.94</td>
<td>$138.33</td>
<td>$890.66</td>
<td>$160.64</td>
<td>$682.44</td>
<td>$37.11</td>
</tr>
<tr>
<td>Dorchester</td>
<td>Charleston-North Charleston</td>
<td>16700</td>
<td>0.8884</td>
<td>$175.94</td>
<td>$138.33</td>
<td>$890.66</td>
<td>$160.64</td>
<td>$682.44</td>
<td>$37.11</td>
</tr>
</tbody>
</table>

Social Media: Facebook

See more of Palmetto GBA, LLC by logging into Facebook. Message this Page, learn about upcoming events and more. If you don’t have a Facebook account, you can create one to see more of this Page.
Social Media: Twitter

 January 2017
Palmetto GBA - Medicare Administrative Contractor (MAC)

YouTube

 January 2017
Palmetto GBA - Medicare Administrative Contractor (MAC)
Stay Up-to-Date with Email Updates

- Not registered? – Click Register Now, complete the fields and hit “Register” button at the bottom of the page
- Be sure to follow the instructions when you receive the confirmation email to finalize your registration

Hospice Basics Training Modules

- Use the Hospice Basics Training Modules for your basic training needs
- From the HHH Homepage
  - Click on the arrow next to Learning & Education from the options in the drop down
  - Select Self-Paced Learning
  - Click on Hospice Basics Training Modules
Hospice Basics Training Modules

Palmetto GBA has developed a Hospice Basics educational series that consists of the training modules below. These modules provide an overview of hospice eligibility, Notice of Elections (NOEs), claim submission and much more.

- Hospice Basics – Eligibility
- Hospice Basics – Elections
- Hospice Basics - Certification and Recertification
- Hospice Basics - POC & Contracts/Agreements
- Hospice Basics - Levels of Care and Room and Board Denials
- Hospice Basics - Claim Requirements
- Hospice Basics: Transfer, Revocation and Discharge
- Hospice Basics: Adjustment, Cancellation and Void

Questions???