Live Discharges, Revocation, and Transfer
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National Hospice and Palliative Care Organization
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Objectives
• Examine the federal hospice regulatory requirements for hospice discharges, revocation, and transfer.
• Discuss application of regulations using case examples.

Discharge – the Regulations

Medicare regulations for hospices (42 CFR 418)

Subpart B

418.26 Discharge from hospice care

418.28 Revoking the election of hospice care

CoPs – Part D

§ 418.104 Condition of participation: Clinical records
418.26 – Discharge from Hospice Care

- **Reasons for hospice discharge:**
  - Patient moves out of the hospice’s service area or transfers to another hospice; patient enters non-contract facility (CR 7677).
  - The hospice determines that the patient is no longer terminally ill; or
  - The hospice determines that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative.

- **Discharge is a hospice decision**

Discharge Requirements

- **When discharging patient for these reasons:**
  - Hospice must obtain a written physician’s discharge order from the hospice physician.
  - Attending physician should be consulted before discharge and his or her review and decision included in the discharge note.
  - Discharge planning completed by hospice provider.
  - Hospice files the Notice of Termination/Revocation (NOTR) into the Medicare Common Working File within 5 calendar days of the effective date of discharge or revocation.

PEPPER Reports
Use of PEPPER Reports

• Program for Evaluating Payment Patterns Electronic Report (PEPPER)
  – Roadmap to help a provider identify potentially vulnerable or improper payments
  – Assist providers in identifying problem areas

• Free comparative report from CMS contractor

• Go to www.PEPPERresources.org

• Click on “PEPPER Distribution ... Get your PEPPER”

MO PEPPER Reports

Hospice Target Areas – 2017 PEPPER

• Live discharges – not terminally ill
• Live discharges – revocations
• Live discharges – 61-179 days
• Long length of stay
• Claims with single diagnosis coded
• CHC in assisted living facility
• RHC in assisted living facility
• RHC in nursing facility
• RHC in skilled nursing facility
• Episodes with no CHC or GIP
• Long General Inpatient Care Stays (> 5 days)
Live Discharges No Longer Terminally Ill
Sample Data

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

1. Increasing Target Percent over time resulting in greater risk of improper Medicare payments
2. Your Target Percent (first row in the table below) is above the national 80th percentile

<table>
<thead>
<tr>
<th>YOUR HOSPICE</th>
<th>10/1/13 – 9/30/14</th>
<th>10/1/14 – 9/30/15</th>
<th>10/1/15 – 9/30/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Area Percent</td>
<td>16.0%</td>
<td>18.7%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Target Count</td>
<td>110</td>
<td>146</td>
<td>152</td>
</tr>
</tbody>
</table>

Long Length of Stay
Sample Data

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

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</tr>
</thead>
<tbody>
<tr>
<td>Target Count (Numerator): count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)</td>
<td>110</td>
<td>146</td>
<td>152</td>
</tr>
<tr>
<td>Denominator Count (see Definitions worksheet for complete definition)</td>
<td>687</td>
<td>782</td>
<td>621</td>
</tr>
<tr>
<td>Target (Numerator) Average Length of Stay</td>
<td>460.4</td>
<td>434.7</td>
<td>477.1</td>
</tr>
<tr>
<td>Target (Numerator) Average Payment</td>
<td>$74,863</td>
<td>$70,374</td>
<td>$76,421</td>
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<tr>
<td>Target (Numerator) Sum of Payments</td>
<td>$8,234,904</td>
<td>$10,274,573</td>
<td>$11,616,037</td>
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</table>

COMPARATIVE DATA

<table>
<thead>
<tr>
<th></th>
<th>National 80th Percentile</th>
<th>Jurisdiction 80th Percentile</th>
<th>State 80th Percentile</th>
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</thead>
<tbody>
<tr>
<td>Target Area Percent</td>
<td>23.6%</td>
<td>23.2%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Denominator Count</td>
<td>17.2%</td>
<td>16.3%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Sum of Payments</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Suggested interventions when above 80th percentile

This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. The hospice should:
• review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria
• review medical record documentation should be reviewed for a sample of beneficiaries with long lengths of stay to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

Why do we care about PEPPER?

• Identifies providers whose data suggests risk of inappropriate Medicare billing
• When hospice’s % is at or above the national 80th percentile is red and bold
• Data identified by PEPPER contractor is shared with
  – MACs
  – ZPIC contractors or other auditors for data mining and follow up
  – Department of Justice for follow up

Discharge for Leaving Service Area
Examples of Patient Leaving Service Area

- When a hospice patient moves to another part of the country.
- When a hospice patient leaves the area for a vacation (optional... not required).
- When a hospice patient is admitted to a hospital or SNF that does not have a contractual arrangement with the hospice.

Notice of Termination/Revocation (NOTR)

- The hospice files a notice of termination/revocation of election with the MAC within five (5) calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.
Documentation

Discharge planning
• Inform Part D plan of patient discharge (optional).
• Refer to follow up medical services; examples could include:
  – Attending physician, home health care, outpatient therapy.

Documentation
• Refer to follow up counseling services.
• Educate patient/ family regarding:
  – Medications, treatments, supplies, etc...
  – Follow up with referrals and attending physician.
  – Reelection of hospice services in the future.

Patients and the ED
• If a patient seeks emergent care at an ED related to terminal illness does the hospice discharge the patient from hospice services?
  – This situation is not an “automatic” discharge
  – Consider your education to the patient:
    • Did your hospice educate the patient that all care related to the terminal illness must be approved by the hospice prior to its provision?
    • Did your hospice educate the patient that the patient would be liable for all cost if they sought care related to the terminal illness without hospice approval?
Patients Seeking Emergent Care

- When a hospice patient goes to a hospital for care for the terminal illness or related conditions without the hospice arranging for it, who is responsible for the bill?
  - For the duration of an election of hospice care, an individual waives all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. If a beneficiary seeks hospital care for the terminal illness or related conditions without the hospice arranging it, then the beneficiary is liable for the cost of that hospital stay.

(CMS FAQ7645)

Add To Patient Information

- Statement that all care related to the terminal illness must be approved by the hospice prior to its provision
- Statement that the patient would be liable for all cost if they sought care related to the terminal illness without hospice approval
- Provide a list of contracted facilities
- Review information at start of care and periodically thereafter
  - Especially if family is anxious or dysfunctional

Document

- Patient unapproved care
- Follow up counseling with patient/family about plan of care and hospice goals of care
- If you will not unapproved cover care
ABN or NOMNC?

- Neither the Advance Beneficiary Notice (ABN) or the Notice of Medicare Non Coverage forms are issued for the patient leaving the service area.

Discharge - No Longer Terminally Ill

Live Discharge

- National Hospice and Palliative Care Organization - 2013 National Data Set.

- Non-death Discharges As a Percentage of Total Discharges = 24.4% (mean).
  - Hospice-initiated Discharge = 57.9% (Percent of total).
  - Patient-initiated Discharge = 42.1% (Percent of total).
Subpart B – Eligibility, Election & Duration of Benefits

§ 418.20 Eligibility requirements.
• In order to be eligible to elect hospice care under Medicare, an individual must be--
  (a) Entitled to Part A of Medicare; and
  (b) Certified as being terminally ill in accordance with § 418.22.

Discharge – No Longer Terminally Ill

• If a hospice physician determines that the patient no longer meets Medicare eligibility requirements, the patient must be discharged.
  – Should never be a last minute event for patient and hospice.
  – Consistent evaluative lead up to determination to discharge for this reason should have been over a period of time.
  – Discussion of disease plateau should have been discussed with patient and family prior to notice of discharge.

Discharge Process

• CMS notes, “Discharge is not expected to be the result of a single moment that does not allow time for some post-discharge planning”.
  – When IDG is following their patient, and if there are indications of improvement in the individual’s condition such that the patient may soon no longer be eligible, then discharge planning should begin.
Notice of Termination/Revocation (NOTR)

- The hospice files a notice of termination/revocation of election with the MAC within five (5) calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.

Discharge Notice

- The Notification:
  - A two-day minimum notice of discharge provided to patient / family.
    - If state regulations require more than two (2) days discharge notice, then the hospice follows the more stringent requirement.

Generic NOMNC is Issued

- Hospice consults with patient’s attending physician
- Hospice provides NOMNC CMS 10123
- Patient/family agrees with discharge
- Hospice completes discharge planning; hospice physician writes discharge order

NONMC issued (Form CMS 10123)
NO Advance Beneficiary Notice (ABN) issued
Notice of Medicare Non-Coverage

- Hospice issues the UPDATED Notice of Medicare Non-Coverage form (NOMNC) Form CMS-10123
  - This notice informs the patient that Medicare probably will not pay for hospice because they no longer meet hospice criteria
  - Form must be verbally reviewed with beneficiary/representative and signed by such
  - Applicable forms:

Patient wishes to appeal discharge, detailed NOMNC is issued

- Hospice consults with patient's attending physician
- Hospice provides NOMNC CMS 10123
- Patient/family do not agree with discharge and file an appeal with QIO
- Hospice holds discharge planning until opinion from QIO issued
- Hospice issues Detailed Explanation of Non-Coverage (Form CMS 10124)

Notice of Medicare Provider Non-coverage - Detailed

- The UPDATED Detailed Explanation of Non-coverage form -- Form CMS-10124
  - Provided to the beneficiary/representative by the hospice when the family has appealed to the state’s Quality Improvement Organization (QIO)
  - Form must verbally reviewed with beneficiary/representative
  - The decision from the QIO is binding
  - Form and instructions are available at:
Expedited review

- The QIO is responsible for immediately contacting the provider if a beneficiary requests an expedited review and then making a decision no later than 72 hours after receipt of the beneficiary’s request.
- The provider is responsible for providing the QIO with a detailed explanation of why coverage is ending.
- The provider may need to present additional information to the QIO for the QIO to use in making a decision.

Expedited Review, cont...

- If the QIO sustains the decision to terminate/discharge services, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification.

- Expedited reconsiderations are to be conducted by the “appropriate” Qualified Independent Contractor, or QIC.

Expedited Review, cont...

- CMS clarified that the decision of the QIO is not legally binding when the QIO disagrees with the hospice when a patient is discharged and appeals the discharge.

- Hospice physician could confer with QIO Medical Director regarding differing medical judgment.
Issuance of the ABN and discharge

• Mandatory use of the ABN is very limited for hospices.
• If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the non-covered care to the beneficiary.
• The ABN must be verbally reviewed and any questions raised during that review must be answered before it is signed.

Issuance of the ABN and Discharge

• Must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice (2 day minimum).
• Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative.
• In all cases, the notifier must retain the original notice on file.

Discharge-No Longer Terminally Ill; Patient Wishes Services to Continue

1. Hospice consults with patient’s attending physician
2. Hospice provides NOMNC
3. Patient/ family appeals and QIO upholds but, P/F wishes to continue care
4. Hospice completes discharge planning; hospice physician writes discharge order

NOMNC issued (Form CMS 10123) and ABN (Form CMS-R-131) issued
The ABN form

* The Advance Beneficiary Notice form
  * Form CMS-R-131
  * The latest version of the ABN (with the release date of 3/2011 printed in the lower left hand corner) is now available for immediate use
    * Revised ABN CMS-R-131 Form and Instructions [zip, 58kb]
    * Revised ABN Manual Instructions [pdf, 316kb]
    * Revised ABN CMS-R-131 Implementation Announcement [pdf, 9kb]

Document Discharge Planning

* Inform Part D plan of patient discharge (optional).
* Refer to follow up medical services; examples could include:
  ✓ Attending physician, home health care, outpatient therapy.
* Refer to follow up counseling services.
* Educate patient/family regarding:
  ✓ Medications, treatments, supplies, etc...
  ✓ Follow up with referrals and attending physician.
  ✓ Reelection of hospice services in the future.

Discharge for Cause
Rationale for Discharge

- The hospice determines that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the point that hospice care cannot be delivered to the patient.

Discharge for Cause

- Before discharging a patient for cause, the hospice must:
  ✓ Advise the patient that a discharge for cause is being considered.
  ✓ Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation.
  ✓ Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

- Discharge for cause can never be for:
  ▪ Financial issues (i.e.: costs for care are high).
  ▪ Because the hospice does not like the patient or family.

Discharge for Cause (cont’d)

- Each hospice must formulate its own discharge policy and apply it equally to all patients.

- A hospice has to determine what does “patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired” mean.
Examples of Discharge for Cause

- Cases where patients consistently refuse to permit the hospice to visit or deliver care.
- It is dangerous for staff to visit the home.
- Patient repeatedly leaves the service area without letting the hospice know.

Notice of Termination/Revocation (NOTR)

- The hospice files a notice of termination/revocation of election with the MAC within five (5) calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.
**Discharge for Cause**

- CMS requirement—effective January 2009 required to identify discharge for cause on hospice claim form.
  - H2 condition code
- Providers required to report patients discharged for cause to:
  - State survey agency
  - MAC
- Part of ongoing effort to collect additional data on hospice.

**ABN or NOMNC?**

- Neither the Advance Beneficiary Notice (ABN) or the Notice of Medicare Non Coverage forms are issued for this discharge for cause.

**Document Discharge Planning**

- Inform Part D plan of patient discharge (optional).
- Refer to follow up medical services; examples could include:
  - Attending physician, home health care, outpatient therapy.
- Refer to follow up counseling services.
- Educate patient/family regarding:
  - Medications, treatments, supplies, etc...
  - Follow up with referrals and attending physician.
  - Reenrollment of hospice services in the future.
418.28 Revoking the Election of Hospice Care

- A patient may **revoke** their election of the hospice benefit at **any time** by filing a signed statement and the date the revocation is to be effective which can be no earlier than the date the revocation is made.
  - Upon revocation the patient resumes Medicare coverage of benefits waived at election of hospice.

❖ **Revocation is a patient decision**

**Important Points - Revocation**

- Can only be done by the patient or his/her representative.
- Must be done in writing—no accommodation for a verbal revocation.
- Cannot be backdated.
- A hospice may never “revoke a patient’s” hospice benefit.
- A hospice has a responsibility to counsel the beneficiary on the availability of revocation.
Important Points – Revocation (cont’d)

• The beneficiary does not have to provide a reason for revocation.
• Hospice documentation should include the circumstances around the revocation.
• The patient is free to re-elect hospice at any time.
  – There must be at least one calendar day between as CMS Common Working File cannot accommodate same day revocation and reelection.

Notice of Termination/Revocation (NOTR)

• The hospice files a notice of termination/revocation of election with the MAC within five (5) calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.

Document Discharge Planning

• Inform Part D plan of patient discharge (optional).
• Refer to follow up medical services; examples could include:
  – Attending physician, home health care, outpatient therapy.
• Refer to follow up counseling services.
• Educate patient/ family regarding:
  – Medications, treatments, supplies, etc...
  – Follow up with referrals and attending physician.
  – Reelection of hospice services in the future.
Change in Designated Hospice Provider

418.30 Change of Designated Hospice

• A patient may **change or transfer** hospices once in a benefit period by filing a statement with the current and new hospice and the effective date.

• Cannot transfer hospices again in the same period.
  – Must revoke from the current hospice and elect with the new hospice.

For Consideration in a Transfer

✓ Patient remains in same benefit period
✓ Patient remains in same payment period
✓ Transferring hospice must enter a transfer in the FISS system v. discharge
✓ Receiving hospice may use F2F from transferring hospice (as applicable)
✓ Receiving hospice must enter NOE into FISS system
✓ Receiving hospice must obtain new informed consent for care
What is the impact on quality of patient/family care?

Who Initiates?

- Discharges
  - Hospice takes action
- Revocations
  - Patient takes action
- Transfers
  - Patient takes action

Questions?
Resources

CMS Hospice Center
  - Hospice Care Amendments (CMS-1022-F) (issued November 22, 2005)
  - Conditions of Participation Hospice
  - Medicare Benefit Policy Manual; Chapter 9 - Coverage of Hospice Services

CMS Beneficiary Notices Initiative

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http://www.nhpco.org/resources/regulatory

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  Email us at regulatory@nhpco.org for answers to your regulatory questions

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  Email us at quality@nhpco.org for answers to your quality questions