Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: **All Indiana Health Coverage Programs-Enrolled Hospice Providers**

Subject: **Release of Indiana Health Coverage Programs (IHCP) revised Hospice Provider Manual, IHCP Hospice Provider Trends and Indiana State Department of Health (ISDH) Hospice Survey Trends**

Overview

The purpose of this bulletin is to notify hospice providers about the release of the revised *IHCP Hospice Provider Manual* so that the IHCP hospice providers can ensure that copies are distributed to the appropriate staff within the hospice agency and the hospice reimbursement department. The newly revised *IHCP Hospice Provider Manual* will have a release date of July 1, 2000, reflected on the cover page and will replace the Medicaid Hospice Provider Manual (released February 1, 1999). In addition, the information regarding IHCP hospice trends and ISDH survey trends are intended to assist hospice managers in evaluating what trends are specific to their hospice agency so that these issues may be evaluated, addressed, and corrected within their hospice agency.

The Office of Medicaid Policy and Planning (OMPP), in coordination with the Health Care Excel, Inc.'s (HCE) Prior Authorization Unit, the EDS Hospice Agency Review Team, and EDS Provider Field Consultant Unit, has made extensive revisions to the *IHCP Hospice Provider Manual* so that the manual can better serve providers as the single source document for the IHCP hospice benefit. The OMPP has also obtained information from HCE and EDS staff regarding IHCP hospice provider trends as well as information regarding hospice survey trends as identified by the ISDH.

Release of Revised IHCP Hospice Provider Manual

Hospice corporate offices that opt to have all IHCP correspondence mailed to the corporate office should ensure that this information is distributed to appropriate staff at the corporate and Indiana service locations. If the Indiana service location serves as the "mail to" address, then the appropriate staff person at the hospice agency should ensure that a copy of the manual is sent to the hospice biller and the appropriate staff at the hospice corporate office if this office is located out of state. **Hospice providers must take responsibility to distribute this manual and provide the necessary in-service training to ensure program compliance.**

In the past, HCE prior authorization staff have mailed out numerous copies of the *IHCP Hospice Provider Manual* to facilitate provider education when hospice agency staff have indicated the agency does not have a copy of the IHCP Hospice Provider Manual. Effective immediately, the OMPP has instructed HCE to cease this practice since this practice is not an HCE contractual obligation. If a hospice provider must obtain a copy of the IHCP Hospice Provider Manual, then the hospice provider will be instructed to contact EDS Customer Assistance at 1-800-577-1278.

IHCP hospice providers are reminded that all IHCP bulletins released since 1998 can be located on the Web site at www.indianamedicaid.com.

Comparison of IHCP Hospice Authorization Return Trends First Quarter 1999 vs. First Quarter 2000

The current percentage of hospice authorization returns due to inadequate documentation has increased from 15 percent in the first quarter of calendar year 1999 to 21 percent in the first quarter of calendar year 2000.

However, there has been a marked improvement in IHCP hospice authorization compliance in the following areas:

- Missing or incomplete Plan of Care
- Missing or incomplete Election Form
- Missing MD signatures
- Missing diagnosis and/or ICD-9 codes (this may be due to the fact the HCE hospice analysts will now code the diagnosis unless there

is a noted trend by a hospice provider in regularly not providing the information).

To ensure that compliance with IHCP hospice authorization guidelines continues to improve, providers should review the following areas:

- Submission of requests before the nursing facility has an approved OMPP *450B* form
- Submission of the Medicaid *Hospice Discharge form* when the hospice member was never enrolled in the IHCP hospice benefit or hospice authorization was not completed for the preceding hospice benefit period (for example, there is no hospice level of care in Indiana*AIM* or there is a missing hospice level of care)
- Verification of eligibility to ensure individual is enrolled in the IHCP
- Requests for subsequent hospice benefit periods have been submitted when previous hospice benefit periods have not been approved
- Submission of incorrect forms for dually-eligible Medicare/IHCP members who live at home
- Submission of requests for hospice authorization for Medicaid-only members incorrectly submitted on the hospice agency's form rather than the required Medicaid hospice forms
- Request for re-election when no prior hospice discharge was received
- Submission of request form for PCCM or RBMC member by regular mail rather than faxing the Medicaid election form to HCE so that the HCE hospice analyst could coordinate with Lifemark (the managed care enrollment contractor) for the immediate disenrollment from managed care

The following table reflects authorization trends for the first quarters in calendar year 1999 and calendar year 2000.

Table 1 – HCE Hospice Return Trends

Category	1st Quarter 1999	% of Total Returns	1st Quarter 2000	% of Total Returns
Miscellaneous	10	14%	92	28%
Plan of Care	41	56%	29	9%
MD signature missing	24	33%	10	3%
Incorrect or missing RID	3	4%	5	2%
Election Form missing or incomplete	17	23%	16	5%
Physician certification missing	18	25%	16	5%
Dates, no documented start of care	6	8%	9	3%
Provider ID missing	2	3%	9	3%
Discharge requested	0	0%	40	12%
Diagnosis and ICD9 missing	17	23%	12	4%
450B not yet approved	5	7%	58	18%
Total Hospice Requests	**502**		**1553**	
Total Returns	**73**	15%	**326**	21%

The information outlined in this chart is consistent with hospice authorization trends that were previously outlined in Medicaid update bulletin *E98-38* (released November 26, 1998).

IHCP Hospice Claims Denial Trends

The OMPP has been tracking hospice claims denial trends since the implementation of the IHCP Hospice Benefit. The following table reflects a three-month comparison of the hospice denial codes that were most frequently encountered by hospice providers for the first quarter of calendar year 1999 and for the first quarter of calendar year 2000. The table will also compare which error codes are represented when comparing the top 10 hospice denial codes for calendar year 1999 and calendar year 2000..

Table 2 – Hospice Denial Code Comparison

One Year Comparison (includes 1/99, 2/99, 3/99)	**Three-Month Comparison (includes 1/00, 2/00, 3/00)**
***The error codes listed below were identified in all three months reviewed**	****The error codes listed below were identified in all three months reviewed**
2024-Member not eligible for this hospice level of care for dates of service.	**2024-**Member not eligible for this hospice level of care for dates of service.
564-This revenue code is not allowed for this member's eligibility (QMB eligibility).	**564-**This revenue code is not allowed for this member's eligibility (QMB eligibility).
2003-Member not eligible for medical assistance benefits for dates of service.	**2003-**Member not eligible for medical assistance benefits for dates of service.
5001-This is a duplicate of another claim.	**5001-**This is a duplicate of another claim.
2026-Member not eligible for this level of care for dates of service and revenue code billed. (hospice + nursing home level of care required for room and board payment)	**2026-**Member not eligible for this level of care for dates of service and revenue code billed. (hospice + nursing home level of care required for room and board payment)
387-This service is not payable. The member has not satisfied spenddown for the month.	**387-**This service is not payable. The member has not satisfied spenddown for the month.
512-Claim was filed past the filing time limit without acceptable documentation	**512-**Claim was filed past the filing time limit without acceptable documentation
562-Hospice services have incompatible type of bill and revenue codes identified on the claim.	**562-**Hospice services have incompatible type of bill and revenue codes identified on the claim.
****The error code listed below was identified in two of the three months reviewed.**	****The error codes listed below were identified in two of the three months reviewed.**
1035-Billing provider is not member's listed hospice provider. Please verify provider number and resubmit.	**1035-**Billing provider is not member's listed hospice provider. Please verify provider number and resubmit.
	1030-Ancilliary services not covered.
	562-Hospice services have incompatible type of bill and revenue codes identified on claim

Medicaid update bulletin *E98-38* provided hospice providers with a summary of the most common hospice claims errors. The top 10 hospice claims denials in March 1999 were as follows:

- Error Code 2024
- Error Code 0564
- Error Code 2003
- Error Code 0512
- Error Code 2026

- Error Code 0387
- Error Code 0562

IHCP Hospice Agency Review Process Trends

At the direction of the OMPP, the EDS Long Term Care Unit started the IHCP Hospice Agency Review Process in January 2000. The purpose of the hospice agency review process is to conduct post payment review of hospice providers while also providing education to hospice providers regarding the IHCP hospice benefit and IHCP program guidelines. The hospice agency review process is thoroughly outlined in the July 1, 2000, edition of the IHCP Hospice Provider Manual.

As a result of the IHCP Hospice Agency Review Process, the EDS Hospice Agency Review Team has identified the following trends:

- Failure by hospice providers to send the *IHCP Hospice Discharge form* to HCE Prior Authorization Unit when a dually-eligible Medicare/IHCP hospice recipient or an IHCP-only recipient dies or is discharged from the IHCP hospice program.
- Pharmacy providers are billing the IHCP for medications included in an IHCP hospice member's plan of care that hospice providers have identified to the EDS hospice auditors as medications used to treat the hospice primary diagnosis. These medications are covered under the Medicare hospice per diem for dually-eligible Medicare/IHCP hospice members residing in nursing facilities and the IHCP hospice per diem for IHCP-only hospice members. This trend is evident regardless of whether the IHCP hospice member resides in his/her private home or in a nursing facility.
- Two transportation providers have been identified to date as billing for transportation services that are related to treatment of the terminal illness and as such must be included in the hospice plan of care according to the Balanced Budget Act of 1997. The IHCP anticipates identifying more recoupment from transportation providers as these providers take up to one year from the date of service to bill the IHCP.
- Failure to include the IHCP hospice plan of care in the IHCP member's nursing facility clinical records, particularly with the dually-eligible Medicare/IHCP hospice member. It is important to note that the EDS hospice auditors are seeing an increase in program compliance in this area.

As the IHCP Hospice Agency Review process is still relatively new, the IHCP does not have any quantifiable data to share with hospice providers at this time. Once a quantifiable amount of date is accumulated, it will be shared accordingly with hospice providers and the appropriate provider associations.

Indiana State Department of Health (ISDH) Hospice Survey Trends

The OMPP and ISDH have been collaborating as State agencies regarding the IHCP Hospice Benefit and state hospice licensure since the fall of 1999. The ISDH has provided the OMPP with language regarding the Indiana state hospice licensure process so that the OMPP could include this language in the IHCP Hospice Provider Manual. Since September of last year, the ISDH has been conducting surveys of all hospice agencies to ensure that these agencies are in compliance with state hospice licensure standards. ISDH has sent representatives to attend the quarterly IHCP Hospice Work Group meetings since November of 1999 in an effort to address questions on a regular basis from the provider associations that represent hospice providers.

As part of the ongoing collaboration between the two state agencies, the OMPP offered to incorporate the national hospice survey trends into this provider bulletin. The national survey concerns were noted in an April 20, 2000, memorandum from the Health Care Financing Administration (HCFA) to Associate Regional Administrators. The following charts will provide further information for hospice providers regarding surveyor concerns about hospice care in nursing facilities and the 10 most frequently cited tags.

Surveyor's Major Concerns With Hospice Care in Nursing Facilities

The State Operations Manual (SOM) for long term care surveyors states that the surveyor will review the care of a resident receiving hospice care based on the Medicare hospice conditions of participation in nursing facilities as outlined in *HCFA Publication 21*. *HCFA Publication 21* specifies that when a nursing facility resident elects the Medicare hospice benefit, the hospice and the nursing facility must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice care philosophy. The coordinated plan of care is based on an assessment of the individual's needs and unique living situation in the nursing facility.

HCFA issued a memorandum dated April 20, 2000, to Associate Regional Administrators that addressed HCFA's response to questions

from the Hospice Association of America. This memorandum stated that surveyors had major concerns with hospice care in nursing facilities as outlined in following table entitled "National Survey Issues Regarding Hospice Care in Nursing Facilities".

Table 3 – National Survey Issues Regarding Hospice Care in Nursing Facilities

National Survey Issues Regarding Hospice Care in Nursing Facilities
The provision of care and services which does NOT reflect the hospice philosophy
Problems with the coordination, delivery and review of the plan of care between the hospice and the nursing facility
Ineffective systems in place to monitor/assure that the hospice plan of care is meeting the nursing facility resident's needs in the area of pain management and symptom control
Poor communication between the hospice and nursing home staff **including** nursing home staff are often not aware of the hospice philosophy, the coordinated plan of care does not reflect the hospice care philosophy or adequately address pain management and symptom control, and hospice and nursing facility staff do not communicate problems encountered with the pain management assessments and make needed revisions to the plan of care in an effective and timely manner

The Top 10 National Hospice Survey Problems

According to HCFA, the 10 most frequently cited tags include regulations pertaining to the development and updating of the plan of care and required records. Surveyors found noncompliance with the following federal regulations for hospice care.

Table 4 – Top 10 National Hospice Survey Problems

Top 10 National Hospice Survey Problems
L137--Plan states scope and frequency of services needed*
L136--Plan includes assessment of individual needs*
L135--Plan is reviewed and updated at intervals
L134--Plan established prior to providing care *
L210--RN visits the home at least every two (2) weeks*
L133--Written plan of care established
L200--Plan of care for bereavement service
L209--Home health aide and homemaker services available
L211--RN prepares written instructions for home health aide
L185--Record contains documentation of all services

> * *Designates the top four Indiana hospice survey problems as identified by Indiana State Department of Health based on surveys as required by IC 16-25-1.1*

Medicaid update bulletin *E98-30* was released on September 30, 1998, to all IHCP-enrolled hospice and nursing facility providers and provides significant information regarding reimbursement and survey issues related to the IHCP hospice benefit. For further information regarding State hospice licensure and case-specific survey issues, hospice providers may contact the Acute Care Section of the Indiana State Department of Health at (317) 233-7474.

Limitations on Payments for Inpatient Care

State regulations at *405 IAC 1-16-3* specifies a limitation on payment for inpatient days for a hospice member. These payment limitations are outlined in detail in Section 6 of the *IHCP Hospice Provider Manual*. Myers and Stauffer, the OMPP's long term care rate-setting contractor, performed an analysis for the payment periods November 1, 1997, through October 31, 1998, and November 1, 1998, through October 31, 1999. The analysis indicates that no hospice provider has exceeded the limitation on payments for inpatient care. Therefore, no repayments are due to the IHCP from hospice providers.

Hospice Provider's Contractual Responsibilities

Federal regulations at *42 CFR Section 418.56* specify that the hospice provider is the professional manager of the hospice member's hospice care. As such, the hospice provider's responsibilities include coordinating the plan of care and ensuring that the plan of care is consistent with the hospice philosophy of care.

If at any point, the hospice patient requires care from another health professional, outpatient clinic, or inpatient clinic for treatment of the terminal illness or related conditions, it is the responsibility of the hospice to obtain a contract with that health professional/other health provider for the arranged services. The contract should contain the minimum criteria outlined at *42 CFR Section 418.56 (a)* through *(d)* and it is the responsibility of the hospice to pay for the arranged services. Furthermore, the hospice provider should ensure that the contracted provider understands that it would be inappropriate for the contracted provider to bill Medicare or the IHCP directly for those contracted services. Under no circumstances should the hospice provider delegate hospice core services to a health professional or

another healthcare provider that does not have a contract with the hospice agency to provide those services.

Short Absences for Hospice Patients

Palmetto Government Benefits Advocates (GBA) released a June 2000 Medicare Advisory that provided policy clarification to questions raised by the National Hospice and Palliative Care Organization, Inc., (NHPCO, Inc) regarding short absences for patients.

The Medicare Advisory stated that if a hospice patient visits someone in another service area for a short period of time or plans to visit several times within a benefit period, **the hospice cannot contract with another hospice in the location where the patient will be living.** This must be handled as a transfer regardless of the number of days in the visit. Patients can only transfer once during each hospice benefit period. Moving back from hospice 2 to hospice 1 must be done by discharge from hospice 2 and readmission back to hospice 1. Upon discharge from hospice 2, the patient will lose all days remaining in that benefit period and the readmission to hospice 1 would commence a new hospice benefit period.

The IHCP will mirror this Medicare policy for short absences for dually-eligible Medicare/IHCP and IHCP-only hospice members. The hospice provider is required to take the following steps with regard to Medicaid hospice forms completion and submission to HCE:

- When the hospice member opts to change from the current hospice provider (hospice 1) in the remaining of the bullet points) to another hospice provider (hospice 2) in the remaining bullet points) due to a short absence, hospice 1 must complete and obtain the hospice member's signature on the *Hospice Provider Change Request Between Indiana Hospice Providers form* and submit the form to the HCE Prior Authorization Unit
- When the hospice member returns after his visit to his original place of residence and opts to resume hospice care from hospice 1, hospice 2 must complete the *Medicaid Hospice Discharge form and submit the form to the HCE Prior Authorization Unit.* Time remaining in this current hospice benefit period is forfeited.
- Readmission to hospice 1 requires re-enrollment of the IHCP hospice member. Hospice 1 must submit to HCE the following forms to ensure that the HCE hospice analyst properly enrolls the IHCP member into the next hospice benefit period:
  - Cover sheet that briefly explains the short absence situation

- *Signed Medicaid Hospice Election form*
- *Physician Certification form, and*
- *Current hospice plan of care.*

The HCE hospice analyst may accept the hospice agency forms for the dually-eligible Medicare/IHCP member as long as the hospice agency forms meet the documentation requirement specified in the *IHCP Hospice Provider Manual.*

Further inquiries regarding the IHCP hospice benefit may be directed to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.