General Inpatient Level of Care: Managing Risks

Presenter
Annette Kiser, MSN, RN, NE-BC
Director of Quality & Compliance
The Carolinas Center
akiser@cchospice.org
Objectives

- List 3 agencies currently auditing the provision of GIP care
- Describe the areas of concern with GIP data
- Understand strategies to monitor & reduce risk with the provision of GIP care

Audits & Data Analysis
Reasons for Increased Attention

- Greater utilization of GIP, especially with building of hospice facilities
- Higher Medicare expense due to higher reimbursement
- Current state of affairs
  - Overall, more scrutiny of hospice claims and of medical records
  - Data analysis shows trends that raise concerns of fraud and abuse
  - Some question as to whether some hospices are operating within the intent of the Medicare Hospice benefit

Federal Regulatory Agency

- Centers for Medicare & Medicaid Services (CMS)
  - Conditions of Participation (CoPs) – Standards for provision of hospice care including requirements for hospice inpatient facilities
  - Medicare Benefit Policy Manual, Chapter 9 – outlines criteria for GIP
  - Change Requests – Set new policies and clarify guidelines
- Abt Associates – CMS contractor
  - Conducts data analysis and issues reports and literature review documents
Abt Associates Analysis – Length of Stay 2012 (Total N=314,368)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Average LOS</th>
<th>Length of GIP Stays</th>
<th>% of Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>4.5 days</td>
<td>1 day</td>
<td>11.2%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>4.7 days</td>
<td>2 days</td>
<td>19.5%</td>
</tr>
<tr>
<td>Hospice Inpatient Facility</td>
<td>6.1 days</td>
<td>3 days</td>
<td>14.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 days</td>
<td>11.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5-7 days</td>
<td>21.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-10 days</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11-30 days</td>
<td>10.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30+ days</td>
<td>0.6%</td>
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CMS Contractors – Federal

- **Comprehensive Error Rate Testing Contractor (CERT)**
  - Medical record reviews to ascertain if MACs are paying claims correctly

- **Zone Program Integrity Contractor (ZPIC) – AdvanceMed**
  - Audit for fraud and abuse
  - Active in many states including NC and SC
  - Have reviewed GIP – both short and long stay

- **Medicaid Integrity Contractor (MIC) – Health Integrity**
  - Active with audits in SC – includes hospices with inpatient facilities
CMS Contractors – Federal

- Medicare Administrative Contractor (MAC) – Palmetto GBA
  - Conduct medical review audits on an ongoing basis
  - Data analysis drives audit areas of focus
  - Will be conducting an audit of GIP care in hospitals and hospice inpatient facilities – possibly later this year
  - Denials of GIP leads to claim reimbursed at Routine Home Care rate – reduction from ~ $700 per day to ~ $150 per day

Palmetto GBA – GIP Length of Stay

<table>
<thead>
<tr>
<th>Service Location</th>
<th>Code</th>
<th>Average LOS</th>
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</thead>
<tbody>
<tr>
<td>SNF</td>
<td>Q5004</td>
<td>23.2</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Q5005</td>
<td>9.7</td>
</tr>
<tr>
<td>Hospice Facility</td>
<td>Q5006</td>
<td>15.2</td>
</tr>
<tr>
<td>All Locations</td>
<td></td>
<td>15.4</td>
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</table>
Medical Review Denials – Palmetto GBA

Hospice Audits April - June 2015
General Inpatient Services Not Reasonable and Necessary
- Documentation Did Not Support Medical Necessity

<table>
<thead>
<tr>
<th>Rank of Denials</th>
<th>Denial Code</th>
<th>Count of Claims Denied</th>
<th>Percent of Claims Denied to Total Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>5CF01</td>
<td>36</td>
<td>17.9</td>
</tr>
</tbody>
</table>

Oversight Agencies

- US Department of Justice (DOJ)
  - Conducts investigations
  - Works with OIG and others

- Office of Inspector General (OIG)
  - Has had GIP care in its annual work plan for several years
  - Plans for 2015:
    - Assess appropriateness of hospices’ general inpatient care claims
    - Assess content of election statements
    - Review hospice medical records to address concerns that GIP is being misused
OIG Study – 2011 – All Settings

- Length of Stay (LOS) varied by setting
  - Hospital = 4.1 days
  - Skilled nursing facility (SNF) = 4.8 days
  - Hospice inpatient unit = 6.1 days

- Average LOS for hospice unit was 29% greater than in SNF and 50% greater than hospitals

OIG Study – 2011 – All Settings

- Concerns with those having longer LOS
  - 5+ days = 33%
  - LOS 10+ days = 11%
  - LOS 21+ days = 2%

- 40% of those in hospice unit exceeded 5 days, while only 27% of SNF and 22% of hospital did
Lawsuit & Settlement

- Whistleblower lawsuit against Alive Hospice – US Attorney investigated
- Alleged that claims to Medicare and TennCare were filed for patients who did not qualify for GIP care – 6/01/10-12/31/12
- Hospice disagreed but settled to avoid costly litigation
- Hospice repaid $1,548,220
- Former employee brought claims under whistleblower provisions of the False Claims Act (private citizens with knowledge of false claims can bring civil suits on behalf of the government and share in any recovery)
- Whistleblower will receive $263,197 as her share of the settlement

Other Areas of Focus
Hospital to Hospice GIP Admissions

- Some studies have raised concerns with the number of patients having GIP as their first day of hospice
- Abt Associates reviewed claims for 2010-2011
  - Nearly two-thirds (65%) of patients were not in hospice prior to GIP
  - Over two-thirds (68%) died during their GIP stay

Hospice GIP After Hospitalization

- OIG Work Plan – 2013 – Review “Acute-Care Inpatient Transfers to Inpatient Hospice Care”
- Significant occurrences of discharge from hospital after a short stay that is immediately followed by hospice care
- Medicare pays a full PPS rate to hospitals for discharges to hospice care
- OIG & MedPAC do not think hospitals should receive full DRG payment when patient is discharged “early” and then admitted to hospice GIP
- Think that CMS needs to evaluate hospital payments when patients are discharged to hospice facility
GIP in Skilled Nursing Facilities (SNF)

- Facilities may push for GIP due to higher reimbursement for them
- Lack of documentation by SNF RN
- Cannot be provided in a nursing facility – bed must be considered skilled by the facility
- Billing needs to use Q5004 for this level of care

Palmetto GBA Audit of GIP in SNF

- In 2014, reviewed 512 claims with Q5004 for GIP in SNF
- 127 claims were denied partially or totally
- 20.4% Charge Denial Rate (CDR)
- Top denial reasons:
  - Eligibility not supported
  - No Plan of Care submitted
  - MD narrative missing/invalid – must be detailed, labeled and signed
  - Face to Face encounter issues
Hospices Not Providing GIP Care

- Per OIG study, 953 hospices (27%) did not provide any GIP to Medicare beneficiaries in 2011
- Of those 953 hospices:
  - 12% provided only routine home care
  - 68% did not provide continuous care
  - 62% did not provide inpatient respite care
- OIG suggests that CMS ensure that these hospices are providing beneficiaries access to needed levels of care
- One option is for CMS to adopt a quality measure regarding hospices' ability to provide all hospice services

Data on Hospices With No GIP

- More likely to be for profit
  - 69% of for profit did not provide GIP
  - 54% of not for profit did not provide GIP
- More likely to be small
  - Defined as 90 or fewer Medicare beneficiaries served in 2011
  - 63% were small
Other Findings of No GIP Analysis

➢ OIG concerned that GIP was less likely to begin on the weekend
   ❖ Would expect needs to be similar as weekdays

➢ Those using inpatient units were more likely to provide GIP to their patients
   ❖ 35% of patients received GIP if hospice used inpatient facility
   ❖ 12% of patients received GIP if hospice used SNF or hospital

Mitigating GIP Risks
Important Actions to Manage GIP Care

 Educate administrative, clinical and marketing staff on proper utilization of GIP
 Educate referral sources on triggers and eligibility criteria for GIP
 Establish a process for review of each patient’s situation to determine if GIP is the most appropriate course of action
  ◆ Have interventions been implemented and proven ineffective?

Managing the Provision of GIP

 Ensure patients who are imminently dying have symptom management issues warranting GIP
 Ensure decisions are made based on clinical need and not economic need, i.e., to keep hospice inpatient facility beds at capacity
 Maintain contracts to provide respite when the issue is caregiver fatigue/breakdown
Documentation To Support Eligibility

- Must address what led up to the need for GIP
- Staff must make attempts to manage needs at a lower level of care
- As soon as the decision is made for GIP care be sure that the patient and family are aware the care is short-term
- Address discharge planning – remember it begins on admission and continues throughout the GIP stay
- Each note needs to stand on its own in supporting the level of care

Documentation of GIP Care

- Palmetto GBA notes that five topics need to be addressed to help ensure documentation supports GIP level of care:
  1. Identify the precipitating event that led to GIP status
  2. Describe failed attempts to control symptoms that occurred prior to admission
  3. Identify specific symptoms that are being actively addressed
  4. Describe the services provided
  5. Document care that patient’s caregivers cannot manage at home. Some examples are frequent changes in the dose or schedule of medications or the need for IV medications.
Internal Audits

- Establish criteria for audits
- Have experienced staff review GIP documentation
- Utilize pre-bill audits to determine if level of care should be billed
- Consider auditing 100% of long stay patients – set agency threshold
- Audit a defined % of all lengths of stay
- Use Palmetto GBA audit tool to ensure all elements documented
- Share results of audits with all staff and provide additional education

Eligibility for GIP in Other Settings

- Need to ensure that higher level of care is warranted
- What care is needed that can’t be managed in another setting or at a lower level of care?
- Remember that imminent death without skilled care or symptom management needs is not a reason for GIP
- Document what interventions were tried in the hospital and what symptom management needs remain
- Visit patient before transferring to hospice facility to ensure eligibility
Important Points for GIP in Other Settings

- Educate hospital and facility staff on important elements to document
- Audit to ensure that SNF and hospital documentation supports eligibility
- Ensure that the SNF RN documents care every shift – must have RN on duty 24/7 to provide direct patient care
- Must be clear distinctions between documentation at RHC and at GIP level
- Obtain discharge summary of care provided

Monitor Agency Data

- Monthly data analysis
  - Location of GIP
  - Average and Median LOS
  - Number of long stay patients – set a threshold
  - Setting and level of care day before GIP admission
  - Variations in GIP utilization by RN case manager
  - Utilization of GIP in each SNF
Monitor Agency Data

- Review reports from OIG, Abt Associates, etc.
  - Abt Associates reports are on Hospice Center page of CMS website
  - OIG reports are published online
- Compare agency statistics to national statistics
- If red flags are raised consider performance improvement project

Contracting for GIP Care

- General inpatient care is required for compliance with CoPs
- A hospice that doesn’t have its own inpatient facility must contract with a hospital, SNF or other hospice inpatient facility
- Make regular attempts to negotiate contracts
- Document efforts to obtain contracts if you are having difficulty
- Consider if continuous home care is an alternative to meet needs
Patient Choice of Attending

- Must document the patient’s choice of attending MD
- CMS noted concerns with change in attending when the patient moves to an inpatient setting for inpatient care, often to a nurse practitioner
- Attending physician must be chosen by the patient (or his or her representative) and not by the hospice
- Since the hospice MD is responsible for meeting the medical needs in the absence of the attending physician, there is not a need to change attending when admitted to the hospice facility

Resources
CMS Resources


Other GIP Resources


Data Analysis Resources


The Carolinas Center is the leading voice for quality end of life care in the Carolinas, representing an extensive number of hospice and palliative care providers in North and South Carolina. Since 1977, TCC has provided visionary leadership, pertinent education, technical assistance, advocacy, and resources to end of life care providers across the two states.

800.662.8859
www.cchospice.org