

Hitting the Mark! General Inpatient Care Eligibility, Documentation and Compliance



Presenters

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Objectives

- Detail the regulations that underlie the provision of the GIP level of care and current concerns
- Identify patient eligibility requirements for GIP care
- Discuss effective documentation strategies to meet regulatory requirements

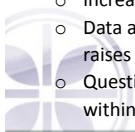


CURRENT REGULATORY & OVERSIGHT CLIMATE



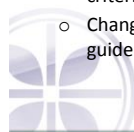
Reasons for Concerns

- Utilization trends – greater use of GIP due to more hospice facilities which leads to higher Medicare expense
- Current regulatory climate
 - More scrutiny of medical records
 - Increased analysis of hospice claims
 - Data analysis shows hospice behavior and trends that raises program integrity concerns
 - Questions about 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



CMS Contractors – Federal

- Abt Associates – CMS contractor
 - Established a Technical Expert Panel (TEP) to get industry input on hospice payment reform
 - Reviewed hospice claims and provides CMS with data analysis
 - Published publicly available reports on hospice claims
 - Published extensive literature review on hospice
 - Partnered with researchers for more in-depth study of certain points such as skilled visits in last 2 days of life

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MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)

MACs Audit Activity

- Provider Outreach and Education teams use audit findings to educate providers on appropriate billing practices
 - In person
 - Webinars
 - Articles
- Conduct medical review audits on an ongoing basis
 - Data analysis drives audit areas of focus
- Denials of GIP leads to claim reimbursed at Routine Home Care rate – reduction from ~ \$700 per day to ~ \$150 per day

CGS

- Conduct medical review audits on an ongoing basis
- Widespread edits

| Edit Number | Description |
|-------------|---|
| 5057T | This edit selects hospice claims with revenue code 0656 (General Inpatient Services [GIP]) with at least seven or more days in a billing period. |
| 59974 | This edit selects hospice claims with occurrence code 32 with revenue code 0656 (for General Inpatient Services) |

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National Government Services (NGS)

- Analyzing data to identify atypical claim submission patterns or trends that may indicate a potential problem
- Performing medical review of services billed to Medicare to validate that a problem exists
- Probe reviews may be conducted to verify if billing problems are present and to determine the level of additional education required to resolve these problems
- No widespread edits at this time

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Palmetto GBA

- Have been addressing GIP in skilled nursing facilities for some time - 20% denial rate in one study

| Hospice Audits April - June 2015 | | | |
|---|-------------|------------------------|---|
| General Inpatient Services Not Reasonable and Necessary - Documentation Did Not Support Medical Necessity | | | |
| Rank of Denials | Denial Code | Count of Claims Denied | Percent of Claims Denied to Total Claims Denied |
| 3 | 5CF01 | 36 | 17.9% |

- **Will conduct audits of GIP care in hospitals and hospice inpatient facilities due to findings with length of stay**

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Other Federal Contractors

- Comprehensive Error Rate Testing Contractor (CERT)
 - Medical record reviews to ascertain if MACs are paying claims correctly
- Zone Program Integrity Contractor (ZPIC)
 - Audit for fraud and abuse
 - Active in many states
 - Have reviewed GIP – both short and long stay
- Medicaid Integrity Contractor (MIC)
 - Active with audits – includes hospices with inpatient facilities

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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

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Abt Associates Analysis – Length of GIP Stays in 2012 (Total N=314,368)

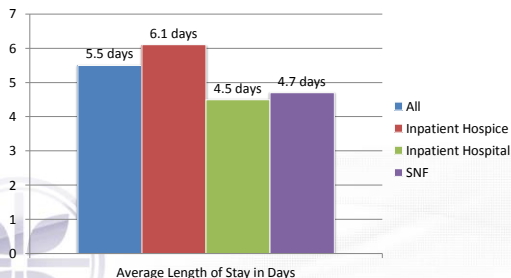
| Length of GIP Stays | % of Stays |
|---------------------|------------|
| 1 day | 11.2% |
| 2 days | 19.5% |
| 3 days | 14.9% |
| 4 days | 11.6% |
| 5-7 days | 21.4% |
| 8-10 days | 10.0% |
| 11-30 days | 10.7% |
| 30+ days | 0.6% |

DATA ANALYSIS ON GIP

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Length of GIP Stay by Location



Source: CMS CY 2012; FY2015 Hospice Wage Index Final Rule

OIG Study – 2011 – All Settings

- Average LOS for hospice unit
 - 29% greater than in SNF
 - 50% greater than hospitals
- 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
- Need further review to ensure that hospices are using GIP as intended

Source: Medicare Hospice: Use of General Inpatient Care, published by the HHS Office of Inspector General, 5-03-2013

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Lawsuits & Settlements

- Whistleblower lawsuit
- Alleged that claims 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

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MEDICARE CONDITIONS OF PARTICIPATION & POLICIES FOR GENERAL INPATIENT CARE

§418.108 Short-term Inpatient Care

- Inpatient Care for Symptom Management and Pain Control
- Inpatient Care for Respite Purposes
- Inpatient Care Provided under Arrangements
- Inpatient Care Limitation
- Exemption from Limitation

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§418.110 Hospices that Provide Inpatient Care Directly

- | | |
|------------------------------|---|
| a) Staffing | j) Sanitary Environment |
| b) 24 Hour Nursing Services | k) Linen |
| c) Physical Environment | l) Meal Service and Menu Planning |
| d) Fire Protection | m) Restraint or Seclusion |
| e) Patient Areas | n) Restraint or Seclusion Staff Training Requirements |
| f) Patient Rooms | o) Death Reporting Requirements |
| g) Toilet/Bathing Facilities | |
| h) Plumbing Facilities | |
| i) Infection Control | |

Note: (b) and (e) apply to all settings

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GIP Definition

- Per Medicare Benefit Manual: "A general inpatient care day is a day in which a patient receives general inpatient care in an inpatient setting for pain control or acute or chronic symptom management which cannot be managed **in any other setting.**"
- The **IDG** determines that symptoms cannot be managed in a home or residential setting
- **Need a defined process to make decisions**

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What Is Short-Term?

- Regulations do not dictate the length of stay
- Length of stay varies from few days to weeks
- Shorter length of stay tends to be seen when the majority of referrals are from hospitals
- Must continually assess need and be working toward a return to a lower level of care

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Potential Indicators of GIP

- Uncontrolled pain
- Unmanaged respiratory distress
- Severe delirium
- Complicated wound care
- Imminent death with symptom management issues – **only** if skilled nursing needs are present
- Other symptoms not managed effectively by changes in the treatment plan at home or in another setting

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Scenario 1

- Patient seen at home by hospice MD at request of RN. Patient had been using increased doses of opioid for reported pain and respiratory distress. Based on opioid use patient was changed to methadone equivalent. Patient became somnolent and it was assessed that she was declining. Family uncomfortable with care at home. Patient was admitted to the inpatient facility for question of terminal care and/or medication management.
- **GIP appropriate for close observation and potential titration of medications**

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When GIP Is Not Appropriate

- When Continuous Home Care is more appropriate
- Caregiver breakdown in the absence of skilled needs
- Imminent death in the absence of skilled need
- Unsafe home situation
- Awaiting placement in another facility

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Scenario 2

- Call from weekend on-call nurse for a home care patient: Patient is actively dying, family adamant that death cannot occur in the home. Patient using minimal medications. Requesting an inpatient bed.
- **GIP not appropriate – consider respite**

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DOCUMENTATION AND COORDINATION OF GIP

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

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Care Coordination

- CoP 418.56 (e)(4) – must share information among all staff in all settings
- Team members must coordinate internally prior to the transfer
- While at GIP level, IDG must coordinate care, education and discharge planning
- IDG must coordinate with facility staff if care provided in hospital or SNF

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Scenario 3

- Patient was being cared for in an LTAC for osteomyelitis and sepsis. Plan of care reassessed and patient requested no further aggressive measures nor antibiotics. No longer eligible to remain in the LTAC.
- Patient has multiple wounds requiring pre-medication, 3 staff to change dressing requiring approximately 45 minutes for each dressing change. Admitted to SNF at GIP level. Wound care nurse consulted to assess for simpler dressing protocol.

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Transfer Documentation

- Documentation prior to and at transfer must include the following:
 - The precipitating crisis – Why is GIP required?
 - Interventions tried at home or at lower level of care that did not manage needs
 - Involvement of the IDG and attending MD in the decision to change to GIP
- Be aware that any GIP care provided in another location must be considered before transfer to the hospice facility

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Inpatient Documentation

- Documentation during the GIP stay must include the following:
 - Supportive data that the crisis is ongoing – symptoms being managed, education provided
 - Ongoing measures utilized to meet the needs
 - The patient's response to interventions
 - Quantitative data - Weight, vital signs, meal % eaten, calories counts, intake/output, pain ratings and quotes from the patient and/or family
 - Education to the patient and family

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Narrative Comments

- Must individualize documentation
- Check boxes can be used for symptoms and interventions
- BUT, narrative information is critical to help further support the need for GIP
- Must show specifics of each patient's situation
- Since various disciplines document individually, a clinical note can help pull it all together
- **Documentation must support each day of GIP**

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Narrative Comment Focus Areas

- Specific reason for GIP beyond generic terms
- Symptoms – to what extent are pain or other symptoms impacting comfort – include physical, mental, and emotional symptoms
- Frequency of nausea, shortness of breath, or other distressing symptoms
- Frequency of need for staff intervention to monitor behavior
- Summary of interventions to manage symptoms and patient's response

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Narrative Comment Focus Areas

- Symptoms – frequency, severity, impact on comfort and quality of life
- Medications – frequency of PRNs used, changes in orders, effectiveness of changes
- Wounds – specify location, size, drainage, treatment, changes in appearance, what makes the care complex
- Other Interventions – Suctioning, positioning, spiritual support

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Narrative Comment Focus Areas

- Extent of education needed to patient and family, including response to education
- Details of staff involvement in discharge planning and family response to discussion
- Reason why GIP LOC is needed for a longer length of stay patient – address the care being provided that cannot be managed at a lower level of care

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Sample Documentation

- GIP Note: “Patient continues to rate pain at an 8, with a desired pain level of a 4 or below. IV Morphine and Promethazine initiated 2 hours ago (see medication flow sheet). Has vomited 75 ml clear liquid since Promethazine was given, no oral intake. Will continue to monitor pain and vomiting and titrate medications to alleviate symptoms.”

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Suggested Language

| Not Enough Detail | Alternate Example |
|-------------------------|--|
| No Complaints | Interventions effective in managing (insert symptom) |
| Patient Stable | Care needs being managed by (insert intervention) |
| Patient sleeping | Patient resting quietly after earlier (insert intervention) |
| GIP for pain management | GIP to manage uncontrolled pain in (insert location); continues to require titration of (insert med) |
| Requires monitoring | Condition monitored ongoing for (insert symptom) |
| Patient nonverbal | Requires skilled nursing assessment for nonverbal signs of pain/discomfort |

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Suggested Language

| Not Enough Detail | Alternate Example |
|-----------------------------------|--|
| Interventions effective | Effectiveness of symptom management is continuously re-evaluated to achieve optimal comfort |
| Support Given | Listened to patient express fear of dying; provided education on disease process |
| Complaints of shortness of breath | Voiced complaint of SOB with evidence of use of accessory muscles, pursed lip breathing, unable to carry on conversation |
| Patient Anxious | Patient asks not to be left alone, fidgeting with buttons on shirt, talking rapidly |
| Education provided | Explained medication changes to wife – purpose, expected outcome, side effects |

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Social Worker & Chaplain Notes

- Full IDG needs to document to support GIP
- Chaplains and SWs can address family coping, education, support systems
- Also need to note symptom management issues they identify or that are reported by family
- Increase visits when patient at GIP level of care as indicated
- Assist with care coordination – facility staff, clergy
- Assist with financial and legal issues

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Plan of Care Documentation

- Revise the plan of care – include the problems, interventions and expected outcomes
- Ensure that assessments and the plan of care correlate
- A physician order for GIP must be in place
- Involve attending MD in discussion of GIP prior to transfer

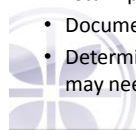


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Education & Discharge Planning

- Need ongoing documentation of education to the patient/family to help prepare them to resume care
- Communicate the short-term nature of GIP is communicated prior to and during the stay
- **Begin DC planning at admission** – discuss options to return pt. to another setting or lower level of care
- Document patient and family response to education
- Determine options if patient cannot return home – may need to change to RHC

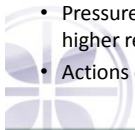


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Ethical Considerations

- Caregiver issues vs. symptom management needs
- Family doesn't want death to occur at home
- Drug diversion issues
- Hospital relationships – using hospice facility as a step-down unit before transfer home
- Pressure from referrals for higher level of care due to higher reimbursement
- Actions of competitors



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Scenario 4

- Newly admitted patient with a non-cancer diagnosis is cared for by a daughter who is managing care fairly well. Other family members question her ability to provide care based on a past substance use issue. One family member removed medications from the home. Medical Director requests an inpatient bed.
- **GIP may be appropriate, but need more information**



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MITIGATING RISKS

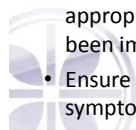


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Managing the Provision of GIP

- Educate administrative, clinical and marketing staff on proper utilization of GIP
- Educate referral sources on triggers 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?
- Ensure patients who are imminently dying have symptom management issues warranting GIP



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Managing the Provision of GIP

- Address the need for staff of contracted providers, i.e., hospitals and skilled nursing facilities, to document to support GIP need
- 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

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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

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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

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Documentation of GIP Care

- 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.

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Documentation from Contract Facilities

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

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Monitor Agency Data

- Compare national data to agency statistics
- 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

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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 continuous home care if it is an alternative to meet needs

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Risks with GIP in Skilled Nursing Facilities

- 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

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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
- Similar issues seen with audits with other MACs

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Auditing GIP Provided in SNF

- Must be clear distinctions between documentation at routine home care and that of the GIP level
- GIP notes need to show the more extensive interventions and more frequent monitoring
- Obtain discharge summary of care provided
- Include these records in audits prior to billing

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ZPIC CASE STUDY

ZPIC Decision 1

- **Dates of GIP Reviewed:** October 3 – 13
- **Diagnosis:** End-stage Dementia
- **History:** Transferred from dialysis to the emergency department on 10/3. Found to have a hemoglobin of 4 and possible pneumonia. Family opted for comfort measures only. Transferred to hospice facility for end of life care. Had multiple Stage III decubiti – sacrum and bilateral heels. SNF had been providing extensive wound care.

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ZPIC Decision 1 (cont.)

- **Documentation:**
 - The inpatient nursing notes indicated that he would yell out if touched but otherwise lying in bed with no signs or symptoms of pain.
 - Received scheduled Morphine concentrate per PEG tube prior to wound care. Dressing changes required two staff members due to patient not able to assist with turning and packing required.
 - No other documentation of interventions necessitating GIP level of care noted.

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ZPIC Decision 1 (cont.)

- On 10/11, patient was moaning, had prolonged periods of apnea and terminal congestion necessitating suctioning multiple times per shift.
- Atropine drops added to regimen.
- 10/12-13, required Ativan, Morphine concentrate and/or Atropine drops every two hours for comfort. Patient died on 10/13.
- **Decision: Partially Favorable – 8 days denied at GIP, 3 days GIP paid**

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RESOURCES

CMS Resources

- Medicare Benefit Policy Manual, 100-02, Chapter 9 – Coverage of Hospice Services: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>
- CMS Guidance to Surveyors – Interpretive Guidelines for CoPs: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- Medicare Hospice Regulations: <http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-part418.pdf>

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CMS Resources

- Caregiver Breakdown in FY2008 Wage Index Final Rule: <http://www.gpo.gov/fdsys/pkg/FR-2007-08-31/pdf/07-4292.pdf>
- Demand Billing of Hospice General Inpatient Level of Care MLN Matters: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8371.pdf>

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Data Analysis Resources

- Medicare Hospice: Use of General Inpatient Care: <http://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf>
- Medicare Hospice Payment Reform: A Review of the Literature (2013 Update) – Abt Associates: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/MedicareHospicePaymentReformLiteratureReview2013Update.pdf>
- Medicare Hospice Payment Reform: Analyses to Support Payment Reform – Abt Associates: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/May-2014-AnalysesToSupportPaymentReform.pdf>

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Other GIP Resources

- The Carolinas Center General Inpatient Level of Care Resource Guide: <http://cchospice.org/gip-level-of-care/>
- NHPCO Tip Sheet – Managing General Inpatient Care for Symptom Management: http://www.nhpc.org/sites/default/files/public/regulatory/GIP_Tip_GIP_Sheet.pdf
- Palmetto GBA Hospice GIP Audit Tool: [http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Hospice_GIP_Audit_Tool.pdf/\\$File/Hospice_GIP_Audit_Tool.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Hospice_GIP_Audit_Tool.pdf/$File/Hospice_GIP_Audit_Tool.pdf)
- Hospice Denial Fact Sheet, CGS Medicare: https://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_5PRLM_FactSheet.pdf

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