STATE HOSPICE ORGANIZATION AND PALMETTO GBA COALITION MEETING SUMMARY

For meeting held on March 6, 2014

Included in this report:

- Comments on CR 8358
- Dialogue with PalmettoGBA's medical directors on the topic of relatedness and impact on prognosis
- Update on NCLOS
- Overview of the new Health Information Supply Chain (HISC) committee and its progress
- Update on ICD-10 readiness activities

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03/06/14

The following is a summary of the information gathered at the meeting. It includes data from the conversations, dialogue and discussion as well as information provided in any handouts. No information provided in this summary is intended for legal or operational advice but merely as information for planning and awareness. This summary is created entirely by the Georgia Hospice and Palliative Care Organization's coalition member in attendance at the time of the meeting and statements have not been evaluated or approved by Palmetto or the other members of the coalition. Questions submitted to Palmetto GBA by hospice coalition members with the responses provided will be published separately when they are made available electronically from Palmetto GBA.

Planned audits

- **NCLOS rates continue to be an area of focus**
- **Other areas targeted include:**
  - **Live discharges – specifically, data gathering and analysis to identify trends or aberrant provider behaviors regarding live discharges and/or revocations**
  - **Length of stay overall – beyond NCLOS, all dx types >180 d**
  - **Post pay audits are likely**

CAP discussion

- **2012 CAP report is complete and work will begin on the 2013 CAP data**
- **In 2012, 79% of calculations were completed using pt-by-pt proportional method and 29% were completed using the streamlined method**
- **Of particular concern to PGBA is the upswing in CAP overpayments for 2012 which reversed the trend of steadily decreasing overpayments**

(TABLE on Following Page)

Tennessee Hospice ORGANIZATION

The following table represents those 16 states within the Palmetto RHHI jurisdiction for 2012 CAP.

State	Total Providers	Total completed	% completed	% completed with Overpayment	Total CAP overpay amt
Alabama	121	121	100%	16%	$6,907,771
Arkansas	39	39	100%	5%	$440,864
Florida	40	40	100%	5%	$2,464,504
Georgia	158	158	100%	27%	$23,975,491
Illinois	99	99	100%	4%	$946,824
Indiana	80	80	100%	5%	$399,333
Kentucky	25	25	100%	0%	$0
Louisiana	131	131	100%	19%	$4,384,556
Mississippi	109	109	100%	28%	$17,589,592
New Mexico	38	38	100%	5%	$802,967
North Carolina	77	77	100%	3%	$958,329
Ohio	111	15	100%	3%	$8,156,246
Oklahoma	129	129	100%	18%	$6,826,222
South Carolina	83	83	100%	30%	$18,123,730
Tennessee	57	57	100%	9%	$1,134,383
Texas	365	365	100%	13%	$20,057,968

Discussions with PGBA Medical Directors

- Introductions of new medical directors
  - Dr. Atul Goel
  - Dr. Atonietta Sculimbrene
- Health Information Supply Chain (HISC)
  - Focus on various pieces of the HISC which impact documentation, delivery of services and proper claims processing
  - New physician advisory group will be named the Hospice and Palliative care HISC Committee to support this effort – clarification that this is not restricted to physicians, looking for CFOs, COOs, field operations experts and end-users to provide input
  - Drilling down to processes around certification and F2F to identify and replicate best practices
  - Have applied for grant support via the Operational Process Improvement Coaching Project (OPICP) which will permit participation by one large, one medium and one small hospice in pilot and demonstration projects to sort out processes and seek efficiencies and work flows which correlate to improvement – the participating hospices must already have a high error rate for narrative summaries and F2F documentation
- Relatedness, impact on hospice plan of care and prognosis
  - Dr. Feliciano addressed a question about co-morbid and secondary conditions and a discussion ensued regarding how an illness or an intervention for an illness impacts the hospice plan of care versus its impact on the patient's prognosis
    - The hospice plan of care should reflect all of the care needs identified during the assessment of the patient and includes the medication profile which lists all medications whether or not the medication or the need is related to the terminal condition
      - EXAMPLE: A patient with glaucoma may have limited vision due to this condition and this would be identified on the plan of care in order to ensure staff providing care are aware of the limitation and to implement interventions which improve the patient's safety and comfort
    - The hospice prognosis may or may not be impacted by a particular illness or intervention for that illness which has the primary bearing on determining whether or not the hospice will list that diagnosis on the claim form or pay for a particular intervention

- EXAMPLE: Glaucoma is not a terminal illness and does not significantly impact the patient's prognosis so the hospice would not pay for medications for glaucoma management

- Dr. Feliciano reiterated the necessity for hospices to accurately document and describe all of the patient's comorbid or secondary conditions as they relate to the hospice terminal diagnosis
  - A secondary condition is one that is directly related to the terminal illness and could be described in such terms:
    - Bone pain secondary to breast and lung cancer with metastasis
    - Anxiety secondary to COPD
  - Although not all comorbid conditions are related to the terminal illness, they may coexist with the terminal illness and impact the prognosis:
    - Coronary heart disease with COPD (and the impact is in respiratory symptoms and reduced endurance, etc)
    - Chronic renal failure with CHF (and the impact is to fluid volume overload)
  - Coding these conditions on the claim form in the proper order and according to their interrelated status is important now but will become critical as we transition to ICD-10

Update on CR8358

- Go-live date of April 1, 2014 unchanged
- Hospitals have indicated they do not have a method for extracting the information requested by hospices in the data format needed and this may limit contracting
- This CR applies to all settings and in all levels of care
- Currently, claims are not rejecting via the voluntary and test process if they do not contain all of the NDC and fill information for medications – PalmettGBA comments that this MIGHT change after 4/1/14 but there is no way to know that until a claim is processed after that date
- An FAQ document is in process as a collaborative among the 3 MACs (Palmetto, CGS and NGS) which will provide common answers to many (but not all) questions

Q&A (full Q&A will be published by Palmetto separately)

Are there examples of what dementia codes are acceptable for use on the claim form now?

A: CMS reported that the top 20 claims-reported principal hospice diagnoses includes codes under the classification of "Mental, Behavioral and Neural Development Disorders" which are not appropriate for principal diagnoses per ICD-9-CM coding guidelines. Instead,

codes in the category, “Diseases of the Nervous System and Sense Organs” encompass diagnoses such as dementia, Alzheimer’s disease and stroke and are acceptable as principal diagnoses per ICD-9-CM coding guidelines. In essence, diagnosis codes which start with 290 or 294 are NOT appropriate in the primary (principal) placement on the hospice claim form. Conditions with codes beginning with 290 or 294 are only acceptable in positions on the claim form AFTER the primary diagnosis code.