Hospice General Inpatient Care (GIP)

Using On24 Widgets

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- Slides (slide view)
- Media Player (Controls Volume)
- Q&A (Submit a Question)
- Resources (Handout, certificate etc....)
- **Survey**

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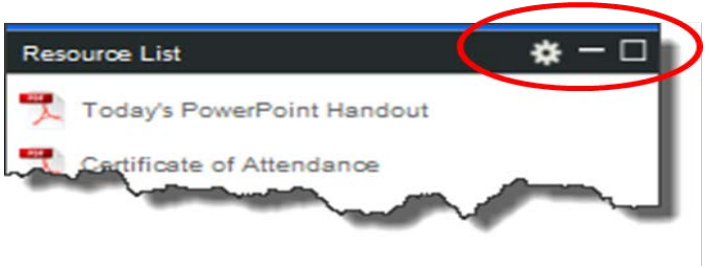

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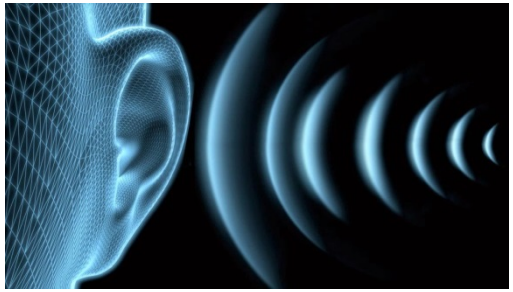

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Disclaimer

The information provided in this handout is current as of August 13, 2019. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates on or after August 13, 2019. The information will be posted at www.PalmettoGBA.com/hhh.

Please take a moment to use your widget and complete the pre-test

Agenda

- Hospice Levels of Care
- Background of GIP
  - Palmetto GBA's initiative
- GIP Documentation Requirements
- Billing
- Reminders
- Question and Answers

Levels of Care

- **Routine Home Care (RHC):** is paid the routine home care rate for each day the patient is under the care of the hospice
- **Continuous Home Care (CHC):** is paid the continuous home care rate when continuous home care is provided in the patient's home. This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. **Continuous home care is not intended to be used as respite care.**
- **Inpatient Respite Care (IRC):** hospice is paid at the inpatient respite care rate for each day in which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge.
- **General Inpatient Care (GIP):** hospice has a per day per diem and is only provided at a Medicare certified hospice facility, hospital or skilled nursing facility

What is GIP?

- GIP care is:
  - Short-term care that provides pain and symptom management that cannot be accomplished in another setting
- GIP may be provided in a Medicare participating hospital, skilled nursing facility (SNF) or hospice inpatient facility

GIP Initiative

- To determine potential causes for extended lengths of stay for GIP
- Palmetto GBA compiled comparative billing reports (CBRs) based on providers billing for the GIP level of care
- Letters were sent to all providers
- We educated provider groups and conducted teleconferences
- Three primary topics were identified and the goal is to help the provider community to avoid long lengths of stays
  - Evaluation
  - Discharge planning
  - Documentation

GIP Coverage Criteria

- Appropriate GIP include a patient in need of medication adjustment, observation or other stabilizing treatment

- Providers cannot bill Medicare for GIP care days for situations where the individual's caregiver support has broken down unless the coverage requirements for the GIP level of care are otherwise met

GIP Coverage Criteria

- Hospices must be able to deliver GIP to patients who qualify for the service
  - Hospices must either provide it directly in their own hospice inpatient unit or they must contract with one of the other acceptable facilities
    - Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110
    - Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas

GIP and Hospital Benefit

- GIP care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit
  - A brief period of GIP care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay
    - If a patient in this circumstance continues to need pain control or symptom management, GIP can be an appropriate option
    - If a hospice patient receives GIP for 3 days or more in a hospital and chooses to revoke hospice, then the 3-day stay would qualify the beneficiary for covered SNF services

GIP Discharge Planning

- Discharge planning begins on admission and continues throughout the GIP stay
- Patient may remain in a facility, but Medicare will not pay for GIP if the medicals records do not indicate a clear need for GIP level of care
- GIP is not intended to be custodial or residential
  - Once the patient's symptoms are stabilized or pain is managed, he or she must return to a routine level of care

GIP Documentation

- Office of the Inspector General (OIG) reports that more than one-third of hospice GIP stays lack the following information:
  - Hospice election statements did not include that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative
  - The physician did not meet requirements when certifying that the beneficiary was terminally ill and/or appeared to have limited involvement in determining that the beneficiary's condition was appropriate for hospice care

GIP Documentation

- Five recommendations to help ensure that your documentation supports the GIP level of care
  - Describe the services provided
  - Identify the precipitating event that led to GIP status
  - Describe failed attempts to control symptoms that occurred prior to admission
  - Identify specific symptoms that are being actively addressed
  - 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

GIP Documentation

- The **pain/symptom management** needs being addressed
  - Interventions used to address the needs
  - Patient's response to the interventions and progress toward goals
  - Why the interventions cannot be provided in the home setting
  - Discharge planning

GIP Symptom Changes

- Sudden deterioration requiring intensive nursing intervention
- Uncontrolled nausea and vomiting
- Pathological fractures
- Respiratory distress which becomes unmanageable
- Transfusions for relief of symptoms
- Traction and frequent repositioning requiring more than one staff member
- Wound care requiring complex and/or frequent dressing changes that can not be managed in the patient's residence
- Severe agitated delirium or acute anxiety or depression secondary to the end-stage disease process requiring intensive intervention and not manageable in the home setting

Document the Patient GIP Needs

- Pain, despite numerous changes to medication
- Bleeding that would not stop
- Nausea and vomiting, despite changes to medication
- Terminal agitation, unresponsive to medication
- Medication adjustment that must be monitored 24/7
- Stabilizing treatment that cannot take place at home

Note: Document the patient GIP needs on a daily basis

Pain Documentation

Pain requiring

- Frequent evaluation by a doctor or nurse
- Frequent medication adjustment
- IVs or transfusions that cannot be administered at home
- Aggressive pain management
- Complicated technical delivery of medication requiring a nurse to do calibration, tubing, site care

Documentation Tips

- Discharge planning begins on admission and continues throughout the GIP stay
- Document the team's efforts to resolve patient problems at the lowest level of care
- Address discharge plans (or reason why the patient is still appropriate for GIP)
- Explain why care must be provided in the inpatient setting instead of at home or SNF (e.g., "patient requires frequent RN/NP/MD assessment and titration of medications to control pain")

Documentation Tips

- Describe the services provided
- Each note stands on its own in supporting the level of care
- Identify the context and the precipitating event that led to GIP status
- Describe failed attempts to control symptoms that occurred prior to admission
- Document care that patient's caregivers cannot manage at home (e.g., frequent changes in medication dose/route/schedule, IV medications)

Documentation Tips

- Identify specific symptoms that are being actively addressed (“uncontrolled nausea/vomiting,” “new delirium/agitation”)
- Document progress/context/changes including symptomatic imminent death that cannot be managed at home
- Document patient’s responses to interventions in the GIP setting
    - Were they effective and are they still effective?

Scenario One for GIP

- 85-year old female with liver cancer and a secondary diagnosis of dementia. Patient is bed-bound. She is incontinent of bowel and bladder and requires personal care throughout the day. Patient is lethargic but arouses to vigorous stimuli. The daughter request that her mother be transferred to an inpatient unit, she can no longer provide the care that is required.

- Her medication regimen includes Morphine Sulphate twice daily with sublingual morphine for break-through pain two hours prn. The patient has required increasing amounts of morphine for break-through pain over the past two days. She is having increased periods of agitation and anxiety.

- The patient begins having grand mal seizures and is started on intravenous medications to control the seizure activity. The patient is mottled and has developed Cheyne-Stokes respirations. She requires frequent suctioning and monitoring.

Scenario Two for GIP

72 year old female patient who resides in a nursing facility. Patient has a hospice diagnosis of End-Stage Alzheimer’s and comorbidities of Type II diabetes, congestive heart failure, and renal disease.

The patient is aphasic and lethargic. Patient requires frequent turning, mouth care, and personal hygiene. Patient has mottling in all extremities, and nail beds are cyanotic, Cheyne-Stokes respirations with a respiratory rate of ten. Pulse is 106 and faint. Blood pressure inaudible. Slight rales noted bilaterally.

GIP Visit Reporting Requirements

- GIP billing in hospice inpatient units
  - Report the total number of visits performed by nurses, aides, and social workers who are employed by the hospice each week while in the GIP level of care
  - For each week, beginning on Sunday and ending on Saturday
    - Indicate the number of services/visits provided by nurses (registered, licensed and/or nurse practitioner), aides, and social workers

Billing for Hospice

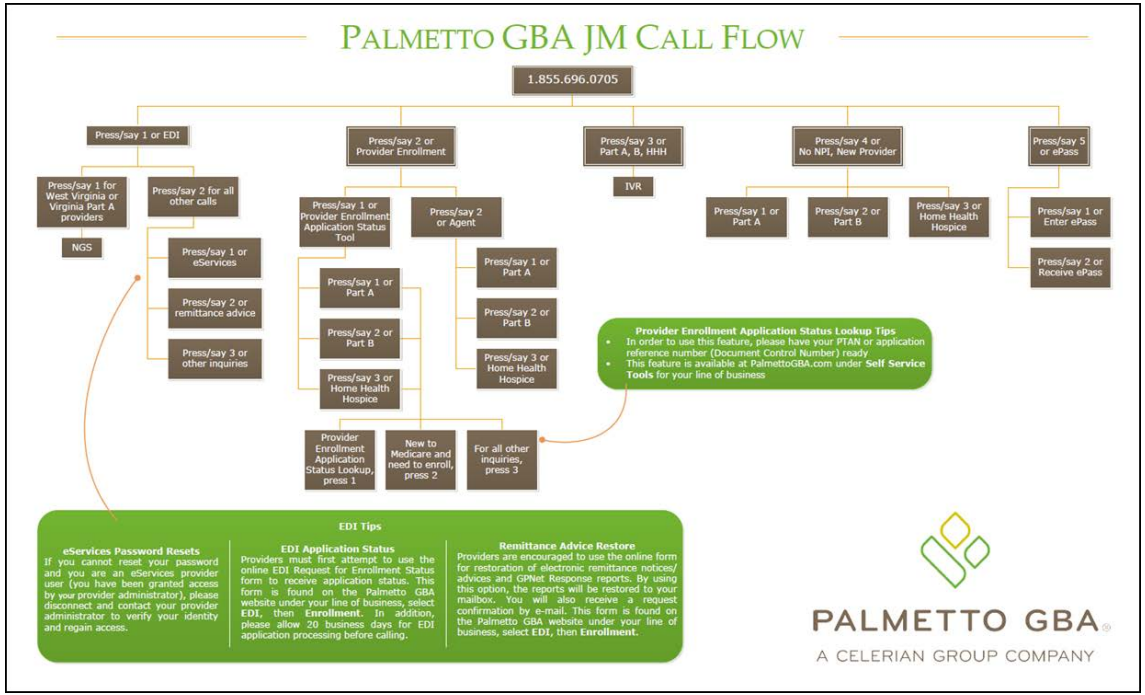
- **The GIP level of care is reported with revenue code 0656**
- Billing begins with a notice of election for an initial hospice benefit period; followed by claims with types of bill 81X or 82X
- If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, occurrence code 42, should be submitted by the provider so that the beneficiary's medical care and payment is not disrupted

Resources

New JM Call Flow to include ePass

- Palmetto GBA has simplified the Jurisdiction M Call Flow when contacting the PCC at 855–696–0705
- Allows callers to quickly navigate through the main menu for faster access to the information you need
- A new Call Flowchart is now available
- ePass is an eight-digit code providers can elect to receive once per day for each NPI and PTAN combination, following their first-time authentication
- The code can then be used for the remainder of the day in order to authenticate
- Through the IVR, follow the first-time authentication steps by selecting Option 5 for ePass and then Option 2 to receive ePass; or
- Request your ePass verbally while speaking with a Customer Service Agent (CSA) following first-time authentication

New Palmetto GBA JM Call Flow



New Educational Resources

- Articles>Hospice
  - The “Hospice Change Request (CR) 8358 Questions and Answers” was revised and the name was changed to “Timely Filing of Hospice Notice of Elections (NOEs) and Notice of Terminations/Revocations (NOTRs) Questions and Answers”

New Job Aids for Hospice

- Five updated and redesigned Hospice Notice of Election job aids:
  - Hospice Notice of Election • TOB 8XA
  - Hospice Notice of Termination/Revocation of Election • TOB 8XB
  - Updated and Redesigned: Hospice Notice of Transfer • TOB 8XC
  - Hospice Notice of Cancelation • TOB 8XD
  - Hospice Notice of Change of Ownership • TOB 8XE

Reminders

Credit Balance Reporting

- Due quarterly — no later than 30 days after the end of the quarter
- Due regardless of whether any credits need to be reported
- When report is not submitted timely, payments are withheld until the report is received
- Credit Balance Reporting (CMS 838)

Electronic Comparative Billing Report (eCBR)

- eCBR information is located under the eReview tab

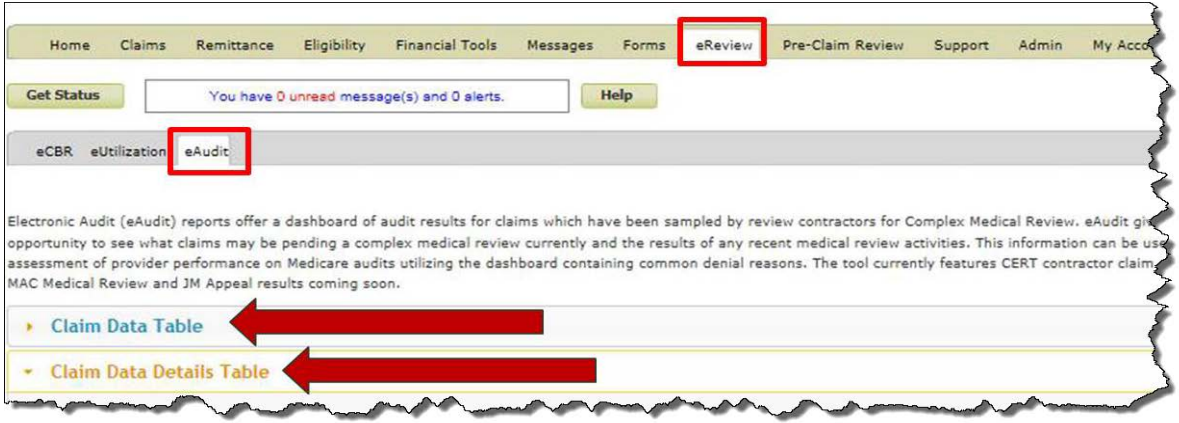
- One of the many tools used to assist individual providers to become proactive in addressing potential billing issues and performing internal audits to ensure compliance with Medicare guidelines

Electronic Comparative Billing Report (eCBR)

- Did you know you can view your latest eCBR in eServices?
  - Be sure to check them out today!
  - Current eCBR topic includes
    - Hospice: Non-Cancer Length of Stay (NCLOS) rates

Electronic Audit (eAudit) Information

- eAudit is located under the eReview tab



- Allows providers the ability to access personal reports of audit results for claims which have been chosen for Complex Medical Review by various Medicare review contractors

eAudit Information

- Gives providers the opportunity to see what claims may be pending Complex Medical Review currently and the results of any recent review decisions
- Information can be used for self-assessment of provider performance on Medicare audits utilizing a dashboard which contains the most common denial reasons
- Currently features CERT audit data by error code category

Provider Enrollment Revalidation

- Requires all providers/suppliers to resubmit and recertify the accuracy of enrollment information
- All providers/suppliers must be revalidated under the new enrollment screening criteria

Provider Enrollment Revalidation — Due Dates

- To assist providers, CMS developed a Lookup Tool
- The Lookup Tool will display:
  - All currently enrolled providers/suppliers
  - A due date or an indication of a “TBD” in the due date field
    - To Be Determined (more than 6 months until your due date)
    - Due dates will be posted up to 6 months before revalidation due date and are updated periodically
- https://data.cms.gov/revalidation

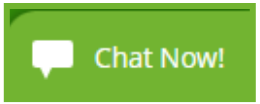
Revalidation Letters

- Palmetto GBA will issue revalidations letters within 2–3 months of a given provider's established due date
- Notices will be sent one of two methods
  - eServices for providers currently enrolled in Palmetto GBA's self-service portal
  - Standard mail

Reminders

- Each provider is required to revalidate their **entire** Medicare enrollment record
- Failure to take necessary actions to complete revalidation when requested could result in a hold on Medicare payments and possible deactivation of your Medicare billing privileges

Questions

- **For claim-specific or other questions <u>not related</u> to the content of this presentation**
  - Use our Secure eChat 

    - Available on our website at www.PalmettoGBA.com/hhh or through our eServices online provider portal
  - Call the Provider Contact Center (PCC)
    - 855–696–0705

Thank You for Attending

You may continue to submit your questions via the Q & A widget and please take a moment to complete the survey (post test).