



HPCAIA Update

Bi-weekly News for Hospice Professionals in Iowa

July 17, 2009

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Recovery Audit Contractors (RAC) Program

Last month HPCAIA Board President Chris Oleson, RN, who serves as Director of Great River Home Health Care and Hospice in West Burlington, attended a meeting of state hospice association leaders at the CMS Region VII office in Kansas City. The article below summarizes information shared at that meeting. Also in attendance representing the Association was HPCAIA Board President-Elect Lori Bishop, Clinical Manager with Iowa Health Hospice in Des Moines. Attached to this issue of the Update is the PowerPoint presentation given at the meeting.

Hospices in Iowa are targeted to be audited by this program at the end of this year. It is important that providers be knowledgeable about the RACs. The purpose of this program is to detect and correct past improper payments so that CMS and the Carriers/FIs/MACs can implement actions that will prevent future improper payments. The goal is to prevent providers from submitting claims that don't comply with Medicare rules so CMS can lower its error rate, and taxpayers and future Medicare beneficiaries are protected. Payments are made to the RAC program based on how much money they recover

Review process: RACs will review claims on a post-payment basis. They will use the same Medicare policies and the Fiscal Intermediaries, Carriers, and MACs. This includes the NCDs, LCDs, and CMS manuals. They will be able to "look back" three years from the date the claim was paid, but will not be able to review claims paid prior to October 1, 2007. Failure to submit a requested record within 45 days will result in a denial. RACs are required to employ a staff of nurses, therapists, certified coders and a physician medical director.

Collection process: This process is the same as for any Carrier/FI/MAC identified over payment. The Carrier/FI/MAC will issue a Remittance Advice with Remark Code N432: "Adjustment Based on Recovery Audit." RAC will issue a Demand Letter. The Carrier/FI/MAC will recoup by offset unless the provider has submitted a check or a valid appeal.

How is this process different? The demand letter is issued by the RAC. They will offer an opportunity for an interview to discuss the improper payment determination (outside the appeal process). This interview process is only available within the first 15 days of when the provider was notified of an improper payment. Providers wanting to protect their appeal rights should do this in

addition to the interview process. Issues reviewed by RAC will be approved by CMS in most cases prior to widespread review. Any approved issues will be posted to a RAC website for widespread review.

What are the provider's options?

If you agree with the RACs determination and do not appeal:

1. Allow recoupment (overpayment and interest) on Day 41
2. Pay on or before Day 30 and avoid interest
3. Request or apply for an extended repayment plan (overpayment and interest)

If you disagree with RACs determination:

1. Allow recoupment (overpayment and interest) on Day 41 and file appeal by Day 120
2. Pay by check on/before Day 30, avoid interest, and file an appeal by Day 120.
3. Stop the recoupment by filing an appeal prior to Day 31
4. Request or apply for an extended repayment plan and appeal by Day 120.

It is best to pay and then appeal.

Summary of Medical Record limits for FY2009 There is a limit on the number of medical record requests. For Inpatient hospitals, IRF, SNF, and Hospice the limit is 10% of average their monthly Medicare claims (max of 200) per 45 days per NPI. RAC requests for records will include specific dates of service to be audited. Providers may submit medical records via: mailed paper copy, fax or mailed CD/DVD.

Prepare to respond to RAC medical record requests: Notify your RAC of the precise address and contact person they should use when sending record requests. Decide who will be in charge of tracking medical record requests.

Recovery Audit Contractor for Region D which includes Iowa

- **HealthDataInsights, Inc. of Las Vegas, Nevada**

Phone: Part A: 1-866-590-5598

Part B: 1-866-376-2319

E-mail: racinfo@emailhdi.com

Subcontractor: PRG-Schultz

What can providers do to get ready?

- Look to see what improper payments were found by the RACS on www.cms.hhs.gov
- Look to see what improper payments have been found in OIG and CERT reports
OIG report: www.oig.hhs.gov/reports.html
CERT reports: www.cms.hhs.gov/cert
- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Identify corrective actions that need to take place for compliance
- Keep track of denied claims and look for patterns
- Determine what corrective actions you need to take to avoid improper payments.

CMS officials stated that RACs will look at hospice claims and choose providers that look unusual. (long lengths of stay, etc.) It is important to review benchmarking data to see where you may be at risk for these audits.

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CMS and HDI Representatives Will Present Program on Preparing for Audits

The Recovery Audit Contractor (RAC) program has created a new level of Medicare claims review that brings with it significant and potentially expensive challenges for health care providers including hospitals, health systems, clinics, and hospices. The program mission is to reduce improper Medicare

payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments. Nationwide implementation of the RAC process is scheduled to take place by January 1, 2010.

Representatives of the Centers for Medicare & Medicaid Services (CMS) and HealthDataInsights, Inc. will conduct a briefing for Iowa hospice, hospital and health system representatives on August 25. This briefing is intended to provide information on the organization and implementation of the RAC effort. In addition to the CMS's introduction, there will be a time dedicated for questions and answers.

The briefing will be offered in two repeat sessions, a morning session from 9:30 am to 12:30 pm and an afternoon session from 1:30 to 4:30 pm. Both sessions will be held at the Thompson Auditorium at Iowa Methodist Medical Center in Des Moines.

A detailed brochure is attached. For more information and to register, [click here](#).

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University of Iowa Hosts Nationally Known Palliative Care Speaker

Mark your calendars now to attend a presentation by Dr. Diane E. Meier, director of the Center to Advance Palliative Care (CAPC). CAPC is a national organization devoted to increasing the number and quality of palliative care programs in the United States.

The presentation will be held September 23 at 4:00 pm in the Sahai Auditorium, Medical Education and Research Facility. A reception will be held immediately before the presentation in the Atrium of the Medical Education and Research Facility. Both the reception and the presentation are free and open to the public. [Click here to view the event flier](#).

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Hospice News Network

House Proposes Reductions to Most Medicare Providers – NHPCO Calls for Lobbying Effort

In its Tri-Committee health reform proposal, the House of Representatives proposes “across-the-board reimbursement reductions to most, if not all, Medicare provider communities,” [NHPCO](#) said in a communication to its members last week. For hospice, the Committee’s draft proposal has “an additional \$2.3 billion in cuts over the five-year period and \$9.8 billion over the ten-year period.” These cuts are in addition to the pending BNAF reductions.

NHPCO says, “When you take these proposed cuts, and place them on top of the BNAF scheduled cuts, it is simply untenable. In light of this new information, our primary goal right now must be to stop the BNAF cuts from going into effect in just 84 days. Please take a few moments today do everything that you can to stop the BNAF cuts by visiting the [NHPCO Legislative Action Center](#). Keeping the pressure on the White House is critical over the next several weeks.”

The *Congressional Quarterly Healthbeat* says that House Democratic committee leaders expect the overall Medicare cuts to save more than \$500 billion over the next 10 years. The Congressional Budget Office cautions, however, that the estimate is preliminary, and that some items could require additional spending which would cut that figure to around \$152 billion. (*Congressional Quarterly Healthbeat*, 7/8; *NHPCO Action Alert*, 7/9)

Guidelines Say No to NSAIDs for the Elderly

In May, the American Geriatrics Society issued a new pain guideline which recommended avoiding NSAIDs for chronic pain for those aged 75 and older. The current recommendation, which calls for

acetaminophen as the initial therapy and then opioids, is discussed in “New Pain Guideline for Older Patients” in the current *JAMA*.

The guideline says that NSAIDs for older patients should be “considered rarely, and with extreme caution, in highly selected individuals.” This guideline, which contradicts the last AGS guideline, “reflects evidence about serious cardiovascular and gastrointestinal tract risks associated with this class of drugs that has emerged since 2002,” the chair of the panel that created the guideline said. *JAMA* adds that the drugs “also may complicate the treatment of common conditions in this population, such as hypertension and congestive heart failure.”

There are also problems associated with the use of opioids, but Dr. Marcus M. Reidenburg, of Weill Cornell Medical College, addresses these. Patients who experience anorexia, nausea or vomiting when starting on opioids can be treated with an antiemetic, and these side effects may wane with time. Stool softeners may work for some who experience opioid-related constipation, but “many will require stronger laxatives.” Delirium can be addressed by lowering the opioid dosage.

Dr. Bruce Ferrell, professor of medicine and geriatrics at the University of California, Los Angeles, recognizes that some doctors have avoided using opioids, and that many continue to use NSAIDs in spite of “an improved understanding of the risks” associated with them. Ferrell said, “We feel the NSAIDs, in many cases, are more risky than many of the opioid treatment strategies.” The guideline advises physicians to monitor patients for any adverse effects, and to assess whether the therapy is working. Treatments for breakthrough pain should be established. Only physicians who are skilled in the proper dosing and titration of methadone should prescribe it.

The guideline, which can be found on the [American Geriatrics Society web site](#), will be published in the *Journal of the American Geriatrics Society* later this year, along with a discussion of the evidence supporting the recommendation. (*JAMA*, 2009;302(1):19; *American Geriatrics Society Website*)

NEJM on For-Profit Hospice and the Medicare Hospice Benefit

In “A New Era for For-Profit Hospice Care – The Medicare Benefit,” *NEJM* correspondent John Iglehart reviews the history of the Medicare hospice benefit and discusses the recent MedPAC recommendation to change the reimbursement system to reflect longer length of stays in hospice.

MedPAC noted in its recommendation that, between 2000 and 2007, the number of hospices participating in Medicare increased by nearly one-third, to more than 3200, and that most of those hospices were for-profit. It attributed the growth in supply in part to increasing demand but added that a large part may also have been due to financial incentives in Medicare’s hospice payment system, under which long stays are more profitable than short stays. The MedPAC commission noted that “a strong correlation exists between length of hospice stay and profitability. The concern is that some new hospice providers, which are predominantly for-profit, may be pursuing a business model based on maximizing length of stay, and thus profitability.”

The new guideline recommends that the Medicare per diem payments, which are currently generally constant through a patient’s hospice enrollment, be adjusted. Payments would be higher during the first 30 days of enrollment and during the last days of an enrollment, with reduced payments for any interim 30-day periods. *NEJM* says, “Under this system, as modeled by MedPAC, aggregate Medicare payments to hospices with the longest stays would be reduced by 6.6 to 10.8%, whereas hospices with the smallest share of long stays would see gains of 16.6 to 24.1%.”

The recommendation also includes changes to recertification policies, as well as an investigation of financial relationships between long-term care facilities and hospices “that may represent a conflict of interest and influence admissions to hospice.”

After the publication of the *NEJM* article, NHPCO issued a press release, taking the occasion of the *NEJM* article to “restate beliefs shared by the hospice community and involving hospice care in the U.S.” Those beliefs are:

“All eligible patients should have access to quality hospice care and the field supports the preservation and enhancement of the Medicare hospice benefit.”

“High-quality care for patients and families facing life-limiting illness is provided by non-profit, for-profit, and government owned organizations throughout the nation.”

“All providers should follow quality standards for care.”

“Transparency and fair regulatory scrutiny in the field is called for and endorsed.”

“Increased access and awareness to quality hospice and palliative care should be promoted through collaboration and expansion.”

In its release, NHPCO further added that “NHPCO has stated that any changes in the benefit should be framed in the context of a comprehensive review of the various and complex components of end-of-life care.”

Dottie Deremo, president and CEO of the nonprofit Hospice of Michigan, was quoted in an article in *Aging & Elder Health Week*. Deremo says, “Hospice of Michigan supports MedPAC’s endeavor to weed out the ‘bad actors’ in our field and to modernize the benefit taking into account intensity of care. We do, however, have concerns about the MedPAC proposed changes in the hospice reimbursement model which could have unintended consequences of creating incentives to shorten hospice lengths-of-stay, a devastating consequence to patients and families. Current ‘bad actors’ would simply change their business model to maximize profits under the new rules.”

Deremo added that Hospice of Michigan believes “that adding quality, evidenced-based outcomes, and case-mix adjusters (an increased reimbursement adjustment for complex hospice cases) to the reimbursement model would be a better way to weed out ‘bad actors’ in the hospice sector. ... It is in the interest of patients, families and the delivery of quality care that the hospice benefit be modernized. ... It is essential that all hospice providers be accountable to the public and Medicare for their business practices, and to use their resources wisely.” (*NEJM*, 2009;360:2701-2703; *NHPCO News Release*, 6/25; *Aging & Elder Health Week*, 7/12)

HNN is sponsored by Glatfelter Insurance Group that provides property and liability insurance for hospices and home healthcare agencies through their Hospice and Community Care Insurance Services division. Ask your insurance agent to visit their website at www.hccis.com.

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Member News

Congratulations to Carolyn Sullivan, director of Hospice of Jasper County in Newton, on earning the designation of Certified Hospice and Palliative Care Administrator (CHPCA). The certification is administered by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN).

And as a reminder to members – HPCAI lists the individuals who have earned certification through NBCHPN on the HPCAI [Web site](#). To add names to the list, please email [Stacey Nay](#).

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HPCAI Calendar

July 21

District 4 Meeting, 1-3pm, CCMH, Atlantic

September 23

Parkin Memorial Lecture on Aging, Dr. Diane E. Meier, University of Iowa, Iowa City

October 28 – 29

HPCAI Fall Conference, *Scheman Building, Ames*

To add items to the HPCAI Calendar, send information to [Stacey Nay](#).

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