



EXECUTIVE SUMMARY

NATIONAL HOSPICE AUDIT 2023 SURVEY REPORT

LeadingAge, the National Association for Home Care & Hospice (NAHC), the National Hospice and Palliative Care Organization (NHPCO), and the National Partnership for Healthcare and Hospice Innovation (NPHI), in late 2023 surveyed their hospice provider members to gather insights into the auditing and adjudication processes of Medicare hospice benefit claims. The survey covered a range of issues, including technical denials, audit focus and time commitment required during a survey, and contractor and audit staff knowledge.

The findings, shared with the Centers for Medicare & Medicaid Services (CMS) and members of Congress in early 2024, draw on 133 provider responses to a survey fielded from September 27 through October 31, 2023. Participants were hospice providers, in most cases represented by one or more of the four associations sponsoring the survey.

Participant queries centered on various audits of hospice claims, with a particular focus on technical documentation denials. Respondents were asked to provide anonymized hospice audit examples with detailed information (with no protected health information), as well as additional information including, but not limited to, the respondent's applicable Medicare Administrative Contractor (MAC), covering a range of issues including, but not limited to, incidents of multiple audits; whether the respondent was subject to a Targeted Probe and Educate (TPE) review in the past five years, whether the respondent has been subject to a Supplemental Medical Review Contractor (SMRC) audit, and how burdensome audit documentation requests were for the respondent's organization.

KEY FINDINGS SUMMARY

Improper targeting of surveys results in sector inefficiencies and provider burdens, ultimately impacting beneficiary care.

- The majority of survey respondents indicated that they have been subject to more than one audit simultaneously: in most cases, a MAC TPE concurrent with a SMRC. Many respondents reported having audits in close succession conducted by two different contractors as well as having the same record reviewed under more than one audit type. Over three-quarters (77%) of respondents indicated that they have been subjected to a TPE audit over the past five years. Of these hospices, 32% were under the TPE audit for an extended period (18 months to 2 years) to meet the 40-claim minimum threshold. About 80% of these audits were for the General Inpatient (GIP) level of care.

- More than half of survey respondents (52.9%) reported having multiple audits, each of a different type, within six months of one another. Thirty-one percent of respondents indicated they needed to submit the same charts for the two different audits.

Contractors' inability to properly target providers for surveys harms beneficiaries.

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Poorly trained auditors exhibit limited knowledge of critical aspects of hospice operations and do not follow proper policies and procedures, leading to inaccurate, error-riddled audits.

- Multiple respondents reported routinely receiving denials of physician visits that occur on the same day as a face-to-face encounter, even when there is separate documentation and evidence supporting a billable evaluation and management (E&M) code because the auditor indicated a physician visit at the time of a face-to-face is not billable. CMS billing guidance related to hospice physician professional services clearly establishes that physician service billing may be appropriate if reasonable and necessary and separately documented from the face-to-face encounter.
- Other common denials reported by respondents were due to the absence of an interdisciplinary group (IDG) meeting even though there is no requirement for an IDG meeting, requiring a physician to countersign the initial certification of a patient's terminal illness, a reliance upon Local Coverage Determinations (LCDs) as strict criteria instead of clinical guidelines intended to aid certifying physicians, among other considerations.
- Multiple respondents indicated that denial reasoning appears to have been copied and pasted from one claim to the next and/or appears as if the review contractor did not actually examine the documentation that was sent.

Audit contractor activities, processes, and application of policy are opaque, inconsistent, and uneven— which results in significant inefficiencies for providers and impacts beneficiaries' access to care.

- Several cases of untimely review processing were reported. For example, the results of a TPE review conducted in spring 2022 were not generated until the end of summer 2023, or records submitted for a SMRC audit in August 2020 were not issued results until April 2021.
- Several survey respondents reported they received untimely results of audit reviews. For example, one respondent reported that the results of a recovery audit contractor (RAC) review were communicated more than 90 days past when the results were stated to be available.
- Respondents also reported unclear instructions from audit contractors. For example, one respondent reported that RAC language used on requests is confusing to hospices, which may be standard language in other care settings.

- One respondent reported that claims were denied while under a Comprehensive Error Rate Testing (CERT) audit on the basis that the patient was not terminally ill, even though the patient expired during the audit.

Inefficient resolution processes for technical claim denials leave providers no option other than to engage in lengthy, time-consuming appeals processes.

- Many survey respondents indicated that MACs provided varied and inconsistent information on how to resolve a technical billing issue, such as how to process a correction to missing information on an election statement or election addendum. For example, respondents indicated that one MAC might say that the provider could use a non-billable code for days not covered and obtain a corrected election statement, while another would say that the patient must be “administratively discharged” but with no instruction on which discharge reason code to use.

RECOMMENDATIONS

1. CMS should re-focus its audit contractors on patterns and practices characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are required under the hospice benefit and fully reimbursed through the per diem payment.
2. CMS should require substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies.
3. CMS should increase transparency of audit contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, top denial reasons and compliance with required timeframes for notification and review.
4. CMS should implement an informal mechanism to enable MACs and hospice providers to resolve technical claims denials prior to engaging in the formal appeal process.
5. CMS should require audit contractor medical reviewers to have an equivalent level of expertise and training in hospice care as the hospice medical director who certified a patient’s terminal illness.