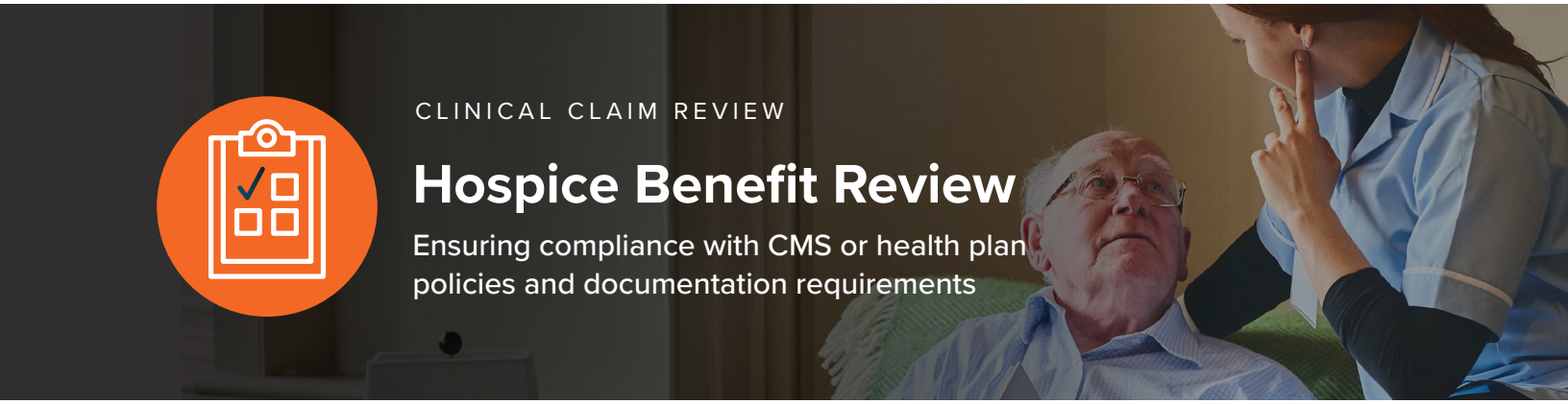

CLINICAL CLAIM REVIEW

Hospice Benefit Review

Ensuring compliance with CMS or health plan policies and documentation requirements

A health plan's hospice benefit is designed for patients requiring end-of-life care. This important benefit for patients and their families is provided when curative measures have been exhausted and life expectancy is estimated at six months or less.

The HMS Hospice Benefit Review verifies CMS, state, or client health plan policy criteria were met for hospice level of care.

Hospice care is an interdisciplinary approach including services such as physician care, nursing care, social services, aide services and medical supplies. When a health plan customer requests HMS perform a medical record review of claims for hospice benefits, the purpose is to ensure provider compliance with Centers for Medicare and Medicaid Services (CMS) regulations, applicable health plan or state Medicaid payment policies and documentation requirements for hospice level of care.

Hospice providers are paid a daily rate for every day a member is in hospice care, regardless of whether services are provided on a particular day. For home-based hospice care, providers are reimbursed on either a routine or continuous rate. The continuous hospice rate is intended for brief periods of crisis, and CMS outlines specific criteria that must be met in order to bill for this higher level of care.

Hospice Benefit Review Scope

The HMS Hospice Benefit Review verifies CMS, state, or client health plan policy criteria were met for hospice level of care, such as:

- The medical record contains documentation the individual is certified as being terminally ill with a prognosis of six months or less if the terminal illness runs its normal course, and specific clinical findings supporting this statement are documented in the medical record;
- Face-to-face requirements were met;
- Documentation requirements such as certifications, recertifications, and an individualized plan of care were present in the medical record and contain all required elements; and
- Claims reimbursed for higher-paying continuous home care service contain all criteria required to bill for this service.

CMS sets the standard for reimbursement and coverage guidelines. Therefore, most payers follow CMS criteria. For those health plans with specific hospice policies or state Medicaid policies that may differ from CMS, HMS will ensure the reviews reflect the applicable policies.

Hospice services are a covered benefit in §§1861(dd), 1812(a), and 1814(a)(i) of the Social Security Act, are only considered by CMS to be reasonable and necessary if the patient meets all of the requirements outlined in 42 CFR 418, subpart B, and as interpreted in the Medicare Benefit Policy Manual, Chapters 9 and 11.

What to Expect if You've Been Notified of a Hospice Review

Claim audits are an important tool health plans use to control cost and ensure compliance with regulations and policies. When submitted claims are selected for Hospice Benefit Review, you will receive a medical record request letter regarding medical records relevant to the claims in question.

The medical record request will include:

- Additional information on the audit being performed
- List of medical record documentation needed in order to complete the audit
- A time frame explaining when the medical record must be received
- Instructions on the best way to submit medical record documentation to HMS

The medical record request letter you receive will also include contact information for our Provider Relations team, who is ready to answer any questions and help with the audit process.

After the requested medical records are received, an experienced team consisting of coders, nurses and physicians will perform an in-depth review of the submitted documentation. The type of audit HMS conducts on any group of claims can vary and is determined by the criteria set by the health plan.

Based on our findings, a determination is made, and a notice is mailed informing you of the results. If the notice is for an overpayment, we'll provide the claim information and the rationale for the determination. It's possible you may disagree with the audit findings and rationale. Detailed instructions for appealing the determination are also included.

Visit hms.com/cai if you have questions about a request for medical records you've received or would like to learn more about the HMS Clinical Claim Review.

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