AGENDA

• Introduction to Hospice Regulations, Regulatory Environment and Risk Areas
• Admission to Hospice Care
• Recertification of Terminal Illness
• Changes in Level of Care
• Physician's Role in the IDG
• Discharge from Hospice Care
Objectives

1. Name the laws/regulations that are foundational to hospices
2. Name two types of hospice scrutiny
3. Explain differences between RACs, MACs, ZPICs and MICs.
4. Name three types of hospice risk areas

HOSPICE STATUTE

The Social Security Act forms the statutory basis for hospice regulations.

It is the LAW that governs the provision of hospice care.

Hospice Regulations - 42 CFR 418

- Subpart A - § 418.1 - § 418.3 General Provisions and Definitions
- Subpart B - § 418.20 - § 418.30 Eligibility, Election, Duration of Benefits
- Subpart C - § 418.52 - § 418.78 Conditions of Participation: Patient Care
- Subpart D - § 418.100 - § 418.116 Conditions of Participation - Organizational Environment
- Subpart E - Reserved
- Subpart F - § 418.200 - § 418.205 Covered Services
- Subpart G - § 418.301 - § 418.311 Payment for Hospice Care
- Subpart H - § 418.400 - § 418.405 Coinsurance
Rule of Thumb:
Whichever regulations are more stringent are the ones that need to be followed.

State Laws and Regulations

Other laws/regulations:
HIPAA
OSA
etc.

Other laws/regulations:
HIPAA
OSHA
etc.

The Regulatory Environment

• Who is looking at hospices?

...and what do they want.

Types of Hospice Scrutiny

- Health & Safety
  (Conditions of Participation - Subparts C and D)
- Payment / Fraud Scrutiny
  (Subparts B, F, G, H)
- CMS
- State Surveyors
- Accrediting Bodies
- MACs
- ZPICs
- OCR
- OIG
- RACs
It's a New World

Hospice in the Crosshairs

ZPICs

- (formerly PSCs - Program Safeguard Contractors)
2012 AAHPM & HPNA Annual Assembly

**OIG**

Office of the Inspector General

**RACS**

Recovery Audit Contractors

**MICS**

Medicaid Integrity Contractors

**MRACs**

Medicaid Recovery Audit Contractors
Types of Hospice Risk Areas

Types of Hospice Risk Areas

- Payment Related Risk Areas
- CoP - Related Risk Areas
- OIG Risk Areas

- ADRs, ZPIC audits, fraud investigations, etc
- Surveys
- Complaints
- Fraud investigations
- Data-mining etc

Types of Hospice Risk

- Payment-Related Risk Areas
- What is the risk?
  - Improper payments
    - Usually overpayments

- Technical Risks
- Clinical Risks

- Payment Related Risk Areas

- Major Technical Risks
  - Election
  - Certification
  - Recertification
LOW HANGING FRUIT

Eligibility:
The #1 Hospice Risk Area

Discharges / Revocations

The hospice discharges.
The patient revokes.
RECENT OIG REPORTS

Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements
September 2009

82% of hospice claims for beneficiaries in nursing facilities did not meet at least 1 Medicare coverage requirement
Medicare Hospices That Focus on Nursing Facility Residents  
July 2011

• Describes the growth in hospice care from 2005 to 2009  
• Focuses on hospices that served a high percentage of nursing facility residents in 2009

Definition of “High-Percentage Hospice”

• Two-thirds or more of the hospice’s census resides in a nursing facility

What to Expect

• The OIG will audit:  
  – Marketing practices of “high-percentage” hospices  
  – Business relationships of “high-percentage” hospices with nursing homes

What to Expect (audits cont’d)

• Eligibility of patients residing in NH  
• Billing Medicare Part D for medications related to the terminal illness

Admission to Hospice Care

Objectives

Participants will be able to:  
1. Cite the required timeframe for completing the certification process  
2. Define and provide examples of secondary versus comorbid conditions  
3. Identify common end stage disease trajectories  
4. Identify risks related to non-compliance with admission-related requirements
Hospice Eligibility Requirements

- Entitled to Medicare Part A
- Certification based on physician’s medical judgment that prognosis is 6 months or less if the disease runs its normal course
  - Certified by hospice physician and attending physician (if any)
- Patient chooses palliative versus curative end-of-life care (i.e., waives regular Medicare)

Certification

“...certification shall be based on the physician’s...judgment regarding the normal course of the individual’s illness...there must be a basis for a certification. A hospice needs to be certain that the physician’s clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course...” (emphasis added)

Requirements – Admit

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<thead>
<tr>
<th>ROM</th>
<th>REQUIRED INFORMATION</th>
<th>COMMENTS</th>
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<tr>
<td>Area of Residence</td>
<td>Patients...admission to the facility...</td>
<td>Admit to care immediately, or provide care prior to, according to the terms of admission, or from cancel or deferment</td>
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<td>Certification</td>
<td>Захисний центр або відділення</td>
<td>If the patient’s medical condition is life-threatening or if the patient is in a critical state, the facility should have a certified nurse or other clinician to determine the medical necessity of the admission</td>
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<td>Physician</td>
<td>Acceptable Certification</td>
<td>The information shall be reviewed and validated by the facility auditors, and if satisfactory, the physician must be notified of the certification</td>
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<td>Legal Information</td>
<td>Required legal agreement, or prior to, according to the terms of the HHMAC Admissions Policies (includes compliance with the Medicare Admissions Policies)</td>
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Risks

<table>
<thead>
<tr>
<th>ROM</th>
<th>COMMON ISSUES / CHALLENGES</th>
<th>PATIENT IDENTIFICATIONS</th>
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</tbody>
</table>

MACs, Cont’d.

A. National Heritage Insurance Corporation (NHIC) - [http://www.medicarenhic.com/](http://www.medicarenhic.com/)
D. Noridian Administrative Services (NAS) – [https://www.noridianmedicare.com/](https://www.noridianmedicare.com/)
Identifying State-Specific LCDs

- Quick search by document type: National and Local Coverage documents
- Select Geographic Area/Region
- Enter ‘hospice’ into text box, and search
- Click on Local Coverage Determination (LCD) guideline title, accept terms, and click on ‘need a PDF?’ to print or email

LCD Guidelines

**UniPolicy (NHIC, CGS & NAS)**

- Part I (decline in clinical status): or
- Part II (Non-disease specific baseline guidelines) and Part III (disease specific baseline guidelines), combined

**ICF-Based (PGBA)**

1. Adult Failure to Thrive Syndrome
2. Alzheimer’s
3. Cardiopulmonary
4. HIV
5. Liver
6. Neurological
7. Renal

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**SECONDARY CONDITIONS**

...are related to, or caused by, the primary hospice diagnosis...

**COMORBID CONDITIONS**

...are unrelated to, or separate and distinct from, the primary hospice diagnosis...

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**SECONDARY CONDITIONS**

Primary hospice diagnosis: Alzheimer's Disease

- Delirium
- Agitation
- Weight loss
- Dysphagia
- Aspiration pneumonia
- Urinary tract infection
- Skin breakdown, etc...

**COMORBID CONDITIONS**

Primary hospice diagnosis: Alzheimer's Disease

- CHF
- COPD
- PVD
- CVA
- Diabetes
- Lupus, etc...
More Examples – Vascular Dementia

- Secondary
- A-Fib
- TIAs
- HTN, etc...

More Examples – ES Cardiac

- Comorbid
- Diabetes
- Liver disease
- Arthritis
- Lupus

- Secondary
- A-Fib
- TIAs
- HTN
- Renal disease???

- Comorbid
- Diabetes
- Arthritis
- COPD???
- Liver disease

Covered / Non-Covered

- If the care, treatment, or service (including meds, DME, etc.) is related to the patient's hospice-qualifying terminal diagnosis – or its related (secondary) conditions – and palliative rather than curative in nature, the hospice must pay for it
- Hospices are not responsible for costs incurred due to comorbid (unrelated) conditions

Making Covered / Non-Covered Determinations

- What's being treated?
- Is it related to the terminal diagnosis or secondary conditions?
- What are the goals of care?
- Whose goals are they?
- Are goals appropriate in hospice?
- Is the treatment palliative or curative? – Does the treatment improve QoL, manage symptoms, or prevent complications?

Eligibility Classifications

- What We Look At
  - Is disease terminal?
  - Is disease maximally treated?
  - Are there secondary conditions?
  - Are there comorbid conditions?
  - Is the disease progressive? At what rate?
  - What is the functional status?
  - What is the trajectory to death for this disease?
  - Are there psychosocial factors involved?
  - What are the goals of care?
  - What has changed in the last 1 month, 6 months?
Disease Trajectories

4 Predominant Patterns:
• Sudden Death – 10%
• Rapid Decline – 25%
  – Cancer is the standard in this category
• Organ Failure – 40%
  – Heart Failure and COPD fall in this category
• Frailty – 25%
  – Dementia, stroke, Parkinson’s fall in this category

How We Use Trajectories

• Where did the patient fall prior to admission?
• Is the pattern being followed by this patient consistent with their disease?
• Are they showing mild fluctuations or rapid?
• Do they return to baseline after interventions or exacerbations?

Functional Status

• Important to document on all patients at admission and throughout
• Helpful in determining prognosis
• ADLs: ambulation, bathing, dressing, transfers, feeding and grooming

Functional Status, Cont’d.

• Cancer
  – 3 months prior to death dependent of 4 ADLs
• Organ Failure
  – 3 months prior to death dependent on 3.66 ADLs
• Frailty
  – 12 months prior to death dependent 2.92 ADLs
  – 1 month prior to death dependent 5.84 ADLs
  -Lunney et al, JAMA 2003

Prognostication Tools

• LCDs
• Disease Specific Tools (FAST, MELD, NYHA, Albumin, Cr cl, BNP, CO2)
• BMI/weight
• ADLs
• MMSE/clock drawing
• PPS/Karnofsky
• Palliative Prognostic Index

Challenges

LCDs:
• Created in 1996 as a guide for physicians in determining hospice eligibility to be used in conjunction with clinical judgment
• Never intended to be used as public policy
• Intended to increase access, but has actually limited access
• Never validated
• Poorly predictive of prognosis
  -Fox et al, JAMA 1999:282:1638-1645
  -Schonwetter, AmJHPM, 2003
Challenges, Cont’d.

- **KPS / PPS:**
  - Often rated too high
  - Often not used correctly
  - Not understood by a lot of clinicians
- **FAST:**
  - Improper use
  - Should only be used with Alzheimer’s dementia

Challenges, Cont’d.

- Technical violations when executing forms
- Patient in need of urgent hospice admission for pain/symptom management but family not available to sign election
- Hospital demanding rapid hospice response and admission to reduce its mortality rate, yet patient lives only hours after admit
- Insufficient clinical data and/or inconsistent narrative to support eligibility

Recertification of Terminal Illness

Determining Continued Eligibility

Objectives

Participants will be able to:
1. Cite the required timeframe for completing the recertification process
2. Define “extraordinary circumstances” that would allow a 2-day extension for completing the Face-to-Face Encounter (F2FE)
3. Identify risks related to non-compliance with admission-related requirements

418.21 Duration of hospice care coverage—election periods

Patients may elect to receive hospice care during one or more of the following election periods:
- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of subsequent 60-day periods

418.102 Medical director
Recertification of the terminal illness

Before the recertification, the physician must review the patient’s clinical information, including:
1. The primary terminal condition;
2. Related diagnosis(es), if any;
3. Current subjective and objective medical findings;
4. Current medication and treatment orders; and
5. Information about the medical management of any of the patient’s conditions unrelated to the terminal illness (co-morbidities)
418.22 (Re)Certification of terminal illness--

Content

Certification will be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness. The physician must include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification or recertification forms.

418.22 (Re)Certification of terminal illness--

Content

The physician or nurse practitioner who performs the face-to-face encounter with the patient described in (a)(4) of this section must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

Recert Timing

- Recerts may be completed no more than 15 calendar days prior to the start of the subsequent benefit period, and up to 2 days after the recert date
- If it cannot be completed in this timeframe, the hospice may obtain and document an oral recertification from the hospice physician (within 2 days of the recert date)
- A written recert must be obtained prior to billing

Criteria for Recert

- Local Coverage Determination (LCD) guidelines apply to admissions and recerts
- 6-month prognosis starts on recert date, so ask “Would this patient be admitted today?”
- Consider the clinical and laboratory picture of the last 6 months in making a decision
- Only Medical Director or physician designee is responsible for recert, although consultation with PCP is expected prior to discharge

Face-to-Face Encounter

As of 1/1/11, a hospice physician or NP must have a F2FE with each patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The F2FE must occur prior, but no more than 30 days prior, to the 3rd benefit period recert, and every benefit period thereafter, to gather clinical findings to determine continued eligibility for hospice care.

LCD Guidelines for Recert / Discharge

“...If a patient improves and/or stabilizes sufficiently over time so that he/she no longer has a prognosis of six months or less, that person should be considered for discharge...On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care...”
F2FE
Readmission F2FE visits / recerts:
• Unless an “extraordinary circumstance” prevents it, the F2FE must be done before readmission and the hospice per diem starts (unlike admission, hospices may not “back bill”)
• The F2FE can be done within 2 days of admission in cases of “extraordinary circumstance”

Extraordinary Circumstances
• Common working file unavailable
• Emergency patient admission (that cannot wait for F2FE to occur)
• Don’t have to complete F2FE if patient dies within 2 days of “extraordinary circumstance” admission

F2FE and Recert
• 3 types of hospice employees may conduct the F2FE visit: the Medical Director, a hospice physician designee, or a Nurse Practitioner (NP)
• An NP may never write the recert narrative, nor order a patient discharged from hospice for stabilization
• Any hospice physician can both write the recert or discharge order, even if s/he did not conduct the F2FE visit (this is revised from initial rules)

Planning F2FEs
• Number of factors to consider, including geographic distribution of patients, allowing time for discharge planning and Quality Improvement Organization (QIO) appeals by families, and built-in contingency plans for illness, bad weather, etc.
• Will probably be coordinating with MD’s normal patient visits, readmission F2FE visits, and his/her education and marketing-related engagements, etc.

Planning F2FE, Cont’d.
• May need to order lab work (total protein and albumin), request repeat evaluation by specialist physician (ALS physician), or repeat radiological studies (CT scan, CXR)
• My goal is to do the current month’s F2FE visits during the last 2 weeks of the previous month and the first 2 weeks of the current month

F2FE Template
MD F2FE Recert Visit:
• Patient’s Name
• Date of Visit
• Recertification Period Dates
• Summarize pertinent clinical findings and other info from F2FE (physical exam, eligibility, limited prognosis, etc.)
F2FE Template, Cont’d.

- Hospice Physician Attestation: I confirm that I had a face-to-face encounter with this patient, and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.
- By signing, I confirm that I have composed the narrative based on my review of the patient’s medical record and examination of patient.

Recert Narratives

- Precisely define the functional, cognitive, nutritional, and clinical changes in the patient in the past 6 months
- Document pertinent physical findings and laboratory studies
- Not ‘patient weaker and sleeping more’ but ‘patient was ambulating with walker 3 months ago and now requires 2 people plus a Hoyer lift for transfers from bed to chair’

Narratives, cont’d.

- Highlight signs of disease progression, i.e. ‘patient has required a tripling in opioid dose over past 60 days to limit pain to desirable levels’
- Include relevant scales (i.e., PPS, FAST for dementia, etc.)
- Do NOT cut and paste from nursing or other documentation. Summarize Interdisciplinary Group (IDG) findings, including the aide (i.e., ‘patient played chess with hospice volunteer last month but now reports he’s too weak to concentrate and prefers listening to music’).

Recert (With Diagnosis Change)

87 yo w/worsening CHF and secondary DX of CAD, pacemaker, HTN, and PVD was admitted to hospice w/primary DX of prostatic carcinoma metastatic to bone. He also has Lewy body dementia. Pt’s bony pain has resolved s/p leuprolide therapy; however his CHF has worsened in past 90 days despite maximal medical treatment.

Narratives, cont’d.

Discharge at End of 1st 90-Day Period

In Oct 2011, her total protein and albumin were normal, at 6.0 and 3.6. She has moderate dementia (FAST 6E), is wheelchair bound, with HX of obesity, DM, past leukemia/lymphoma in remission, HTN, DJD, and glaucoma. She has had no intercurrent infections or aspirations, though in Sept she had Stage II coccyx ulcer which healed in 2 weeks. Pt’s daughter is happy with her mother’s improvement, and would welcome discharge from hospice. Patient’s PCP and nursing facility staff agree with decision.

Recert Narratives

85 yo admitted to hospice in Sept following a period of several weeks during which time she refused to eat or allow herself to be fed, and lost 15% of her body weight. Pt resides in NF since 2002, and now needs assistance for ADLs, though she feeds herself. She is incontinent of bladder and sometimes bowel. Patient is on mechanical soft diet. NF staff report she’s back to eating 100% of meals, although her insulin was titrated downward in Oct & Nov. In July 2011, her wt was 147# and in Sept it was 126#. Current weight is back up to 131.7#; BMI 23.1. (cont’d.)

Narratives, cont’d.

Discharge at End of 1st 90-Day Period

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Narratives, cont’d.
Recert (With Diagnosis Change)

He developed ascites with abdominal girth increasing by 4cm over 2 week period, is dyspneic at rest on 4L O2 and develops cyanosis of face, hands and feet on room air. He is only able to eat 25% of most meals, and PPS has decreased from 40 to 30% over past 90 days. He requires the care of a full time paid aide now. Pt & family continue to want focus to be on comfort care in his home, without further hospitalizations.

Narratives, cont’d.
Recert (With Diagnosis Change)

The patient was admitted with metastatic prostatic carcinoma because he was referred by oncologist. However, by recert it had become clear that he was likely going to die of his CHF, so we changed hospice diagnosis to ES cardiac disease. The point to be made is that the hospice diagnosis should reflect what the patient is dying of (what you are going to be writing on the death certificate).

Narratives, cont’d.
Uncertain Prognosis

84 yo who had CVA in Oct 2010 w/resultant left hemiparesis admitted to hospice in June 2011 because of weight loss of 9.8% over past 6 months, with BMI 26.6, and poor nutrition with protein 5.1 and 2.1. Six months later, after further weight loss of 13% (current weight 147#), his BMI is 23, total protein 5.8 and albumin 2.6. What are other factors that go into making decision to discharge or recert?

Narratives, cont’d.
Discharge for Clinical Stabilization

85 yo w/dementia (FAST 7A) and dysphagia, who no longer eats pureed food but enjoys taking high-calorie/protein supplement. Six months ago her weight was 125; 3 months ago 120; and currently 124. BMI 24.2. Hospice aide has been feeding the patient at noon 3 times/week.

Narratives, cont’d.
Discharge for Clinical Stabilization

There have been no order changes for 3 months, no facility nursing notes for 2 months, and total protein and albumin done last month were normal (6.6 and 3.4, respectively). Discharge for clinical stabilization was planned, but patient had apparent massive heart attack (sudden hypotension and unresponsiveness) 1 week prior to discharge and died within 24 hours.

Narratives, cont’d.
Discharge for Clinical Stabilization

89 yo w/cardiac disease, NYHA III, EF 25%, non-ischemic cardiomyopathy, and stage IV CKD whose main complaints continue to be daily episodes of dizziness, chest pressure and SOB. Prior to hospice admit, pt had 8 ER visits/hospitalizations in 6 months, on hospice she called the service twice in 1st month, but in past 8 months has not placed any urgent calls. Sequential trials of opioids, nitro, anti-anxiety medication, and antidepressants have not changed reported symptom frequency.
Narratives, cont’d.
Discharge for Clinical Stabilization
She now uses her oxygen only about 4 times/wk for short periods. She lives alone, with paid caregivers 25 hours/wk. She fixes her own breakfast and does most self-care, though she likes someone present when she takes a shower. She has not left the house in past 7 months, except for MD appts and 1 visit to family over Thanksgiving. When asked why she isn’t calling 911 anymore, she immediately states “I like being on hospice, because it makes me feel more secure…they are all so nice.”

TIME PERMITTING

BILLING-RELATED INFO

Billing for F2FE
• MD “administrative” services, including certification of prognosis, are included in the capitated per diem
  – “Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plan of care, and establishment of governing policies”

418.304 Payment for physician and nurse practitioner services
(a) The following services performed by hospice physicians and nurse practitioners are included in the rates described in 418.302 (Payment procedures for hospice care)
• General supervisory services of the medical director
• Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plan of care, and establishment of governing policies by the physician member of the IDG

Payment, cont’d.
(b) For services not described in paragraph (a) of this section, a specified Medicare contractor pays the hospice an amount equivalent to 100 percent of the physician under arrangements with the hospice. Reimbursement for these physician services is included in the amount subject to the hospice payment limit described in 418.309. Services furnished voluntarily by the physicians are not reimbursable.

Billing, cont’d.
• Would you be seeing patient if F2FE wasn’t needed?
• Did you discover/address new symptom issues or new physical signs that affect care plan?
• Did you do significant education, or have prolonged discussion with patient or family?
• Did you substantially change the plan of care?
Billing, cont’d.
- Two separate notes must be created if you intend to bill in addition to making the F2FE
- F2FE must address prognostic criteria, but not determine eligibility
- Billable visit must meet standard criteria for billing, either by time or complexity

Changes in Level of Care

Objectives
Participants will be able to:
1. Ascribe the correct level of care to patients with “caregiver breakdown” in the absence of any skilled needs
2. Explain the difference between needed and provided
3. List 3 challenges particular to higher levels of care

4 Levels of Care
1. Routine Home Care (RHC)
2. Inpatient Respite Care (Respite)
3. General Inpatient Care (GIP)
4. Continuous Home Care (CHC; CC; or Crisis Care)

General Inpatient Care
- Short-term care that cannot feasibly be provided in other settings
- Contracted Medicare facility with 24-hour RN
- Skilled need
- Physician order

GIP, Cont’d.
- Precipitating event (problematic if issue could/should have been anticipated but was not)
- Failed interventions prior to GIP (if any)
- Physician involvement is important to support the GIP level of care (LOC)
GIP, Cont’d.

• Documentation is not only about billing but also about supporting the LOC
• Physician visits support the need for higher LOC by summarizing the patient’s skilled need, providing new orders, evaluating response to treatment, etc…
• Not a requirement for medical director to be involved in changes in LOC but attending physician (if any) must be notified

GIP, Cont’d.

• With higher levels of scrutiny, Medical Directors may want to review GIP patients on a regular basis
• Important for Medical Directors to know who is appropriate for GIP
  – Pain / symptoms that cannot be managed in another setting
  – Symptomatic imminent death

Physician Documentation for GIP

• GIP visit template, and each GIP note, should include reason(s) for higher LOC
  – Patient admitted GIP due to rapidly progressing nausea and vomiting uncontrolled at home on multiple medications [list them] needing frequent assessment by nursing and physician-directed medication titration.
  – Patient admitted GIP with sudden severe abdominal pain requiring frequent medication dosing, physician-directed medication titration, and reassessment for possible acute small bowel obstruction.

Documentation, Cont’d.

• In addition to documentation reason for GIP admission, also need documentation of ongoing plan.
• Each note should reflect anticipated outcome:
  – Plan to transition patient to home / assisted living facility (ALF) / skilled nursing facility (SNF) once acute pain has resolved
  – Patient’s acute symptoms are due to imminent death and likely to die in unit
  – Ongoing reassessment by team needed to determine appropriate plan

Continuous Home Care

• A higher LOC for acute / chronic pain and symptom management
• For patients with a skilled need
• Can be provided in facilities but not if patient is accessing skilled SNF benefit

CHC, Cont’d.

• Requires interdisciplinary involvement with an official decision, start date and time, and physician’s order
• Cannot be initiated after-the-fact (e.g., because the nurse had to remain in the home for many hours after his/her routine visit due to unmet skilled needs)
CHC, Cont’d.

• Must be at least 8 of every 24 hours, ½ of which must be nursing (RN or LPN / LVN)
• Care need not be “contiguous”
• Clock stops when patient pronounced

Psychosocial / Caregiver Crisis…

…is not a reason for higher levels of care in the absence of a skilled need (although it may be a contributing factor in terms of the intensity of the services needed)

Skilled Need

1) Pain control;
2) Symptom management; and/or
3) Symptomatic imminent death.

Document all that apply, including a list of all symptoms, every shift

Needed v Provided “Test”

• All documentation for higher LOC must demonstrate that the level of care was both:
  – Needed by the patient
  – Provided by the hospice (and its contracted vendors)

Summary

• GIP & CHC are intended for “crisis stabilization”
• Once the pain / symptoms are controlled, it’s time for RHC LOC
• D/C planning from the higher LOC should be woven throughout GIP / CHC stay

Summary, Cont’d.

Do the following when changing LOC:
• Update the comprehensive assessment
• Communicate with attending physician (if any) and hospice physician
• Document physician / team discussions in the clinical record, including any new orders
• Update the Plan of Care (POC) & drug profile
Summary, Cont’d.

- Document the LOC every day / shift
- Communicate the LOC with physician(s), IDG, and billing department every day
- Cease CHC billing when the patient is pronounced regardless of any ongoing survivor-related needs
- Bill RHC if documentation does not justify higher LOC (needed & provided)

Real Quotes From Real Notes

- Patient actively dying
- General decline
- Needs pain and symptom control
- Needs medication adjustment
- GIP X 10 days for restorative ambulation so patient can be discharged to ALF
- GIP X 7 days for itching

Real Quotes, Cont’d.

- Patient/family requests Inpatient Unit (IPU) for patient’s end-of-life needs
- Patient resides in assisted living facility and cannot remain there without hospice/DNR/DNH/CMO
- Family doesn’t want patient to die at home

Challenges

- Realizing that most patients will not meet criteria for GIP before death
- Helping our colleagues understand the GIP benefit and that most patients will not need it
- Helping families understand when and why patients no longer meet the higher LOC criteria
- Defending why we feel patients required a higher LOC when the guidelines are very grey and records are often reviewed by non-clinical claims reviewers

Challenges

- Under-utilization or over-utilization of higher LOC
- Insufficient physician involvement
- Wide-ranging standing orders / overly generous medication ranges
- Inappropriate uses (e.g., hospital “step-down”)
- Incentives to refer / guarantees of higher LOC
- Long length of stay (LOS) at higher LOC

OIG Work Plan FY2012

Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care – We will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care and examine the relationship, either financial or common ownership, between the acute-care hospital and the hospice provider…A [GIP] care day is one on which an individual who has elected hospice care receives [GIP] care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.
OIG Work Plan FY2012

Medicare Hospice General Inpatient Care –
We will review the use of hospice [GIP]
care from 2005 to 2010. We will assess the
appropriateness of hospices’ [GIP] care
claims and hospice beneficiaries’ drug
claims billed under Part D...We will review
hospice medical records to address
concerns that this level of hospice care is
being misused...

Physician’s Role in IDG Meetings

Objectives

Participants will be able to:
1. Locate and discuss Medicare regulations
   that govern interdisciplinary care
2. Identify 3 major obstacles to appropriate
care planning during Interdisciplinary
   Group (IDG) meetings
3. List 3 solutions to assist with facilitation of
   highly functioning IDG meetings

418.54 Initial & comprehensive
assessment of the patient

• Update of the comprehensive assessment must be
  accomplished by the IDG – in collaboration with the
  individual’s attending physician (if any) – and must consider
  changes that have taken place since the initial assessment
• It must include information on the patient’s progress toward
desired outcomes, as well as a reassessment of the
patient’s response to care
• The assessment update must be accomplished as
frequently as the condition of the patient requires, but no
less frequently than every 15 days

418.56 IDG, care planning, & coordination
of services – Approach to service delivery

• The hospice must designate an RN that
  is a member of the IDG to provide
  coordination of care and to ensure
  continuous assessment of each
  patient’s/family’s needs and
  implementation of the interdisciplinary
  Plan of Care (POC)

418.56 IDG, care planning, & coordination
of services

• The IDG must include:
  – A doctor of medicine or osteopathy (who is
    an employee of or under contract with the
    hospice)
  – A registered nurse
  – A social worker
  – A pastoral or other counselor
418.56 IDG, care planning, & coordination of services – Content

• The POC must reflect patient/family goals and interventions based on problems identified in assessments...POC must include:
  – Interventions to manage pain and symptoms
  – A detailed statement of the scope and frequency of services necessary to meet the specific patient/family needs
  – Measurable outcomes anticipated from implementing and coordinating POC

• Drugs and treatment necessary to meet the needs of the patient
• Medical supplies and appliances necessary to meet the needs of the patient
• IDG’s documentation of the patient’s/representative’s level of understanding, involvement, and agreement with POC – in accordance with hospice’s own policies – in clinical record

418.56 IDG, care planning, & coordination of services

Coordination of services:

• Ensure that the IDG maintains responsibility for directing, coordinating, and supervising the care and services provided
• Ensure that the care and services are provided in accordance with POC
• Ensure that the care and services provided are based on all assessments of patient/family needs

• Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement
• Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions

MD Role in IDG Meeting

• Consistently and continually raise the standard of medical care for patients/families
• Work with clinical team leader to systematically address team weaknesses and enforce team strengths
• Be aware of documentation/eligibility issues for your particular hospice
• Be a role model for the team
• Demonstrate the enhancement of clinical care produced by team care planning and good documentation

Challenges—Pre-IDG Announcement Time

• IDG frequently starts late (and MD can be main offender!)
• Mundane announcements and To Do reminders starts the “tune-out” process
• Friends cluster together & begin side-bar conversations
• The group scatters around the room searching for Ethernet lines and plugs, or space for all their paperwork
• Complaints about workspace, or staffing, or this and that, build around the room
### Raise the Standard—Pre-IDG Announcement Time

- Be on time, start the meeting on time, expect everyone to be there and ready to participate
- Brief announcements
- Consider “First Fifteen” teaching by team members (though MD often responsible)—review a new article, report on a talk attended—6 or so slides
- This shows respect for the team, supports notion that IDG is bonus time, not wasted time, and reinforces that patients and their care are the focus

### Challenges—Bereavement

- Team members often still drifting in (including MD, who sometimes doesn’t see a point in being there for this portion)
- Emphasis is on how much the patient meant to the team (or how little)
- Nurses do all the reporting, including the bereavement risk assessment, even if they aren’t trained to do that
- Mistakes and/or bad outcomes are pointedly not discussed
- Rare mention of the primary physician, nursing facility staff, or impact on team members not present (HHA & volunteers)

### Raise the Standard—Bereavement

- Bereavement should be a natural part of the care planning process
- Assessment of the success or failure of the patient’s care plan should be conducted
- Role of all members of the team should be acknowledged, including those outside hospice
- Bereavement risk assessment should be primary focus, and should be done by those most qualified

### Challenges—New Patients

- This is often the first time the Medical Director has heard about the patient
- Nurse presentation is an unorganized monologue of everything wrong with the patient with no reference to why (or if) the patient is dying
- Admitting person reports that ‘the patient has refused all services but nursing’
- The healthcare proxy hasn’t been invoked, but family wants patient ‘enrolled’ on hospice without the word spoken
- The social worker or chaplain haven’t seen the patient yet

### Raise the Standard—New Patients

- Teach prognosis as a way of helping patients/families make decisions, rather than being an irritating Medicare rule for hospice
- Emphasize that knowing a patient’s medical history can help team prepare for clinical challenges ahead
- Help team develop individualized POC
- Be inclusive of all team disciplines
- Identify areas that need more teaching in the “First Fifteen” or other in-service/education opportunity
- Be specific about role of physicians in admitting patients to hospice, in certification, and in care planning
Challenges—Recertifications

• The social worker, chaplain, aide, volunteer, PCP, family, and nursing facility (if involved) have no clue the patient was nearing recertification, or what that means
• Team can’t differentiate between non-terminal and terminal decline (they don’t know what criteria to use for recert)
• There’s no objective data—no weights, lab work (‘when they came on hospice we stopped all that’)  
• Recert start dates are missed
• There is confusion about what to do for non-Medicare patients
• Comparative rather than descriptive words are used in team reports (e.g., ‘the patient is sleeping more’)
• All the recert narratives sound the same

Raise the Standard—Recertifications

• Using Local Coverage Determination (LDC) guidelines will aid in decision making
• Teach newer prognostic guidelines
• Be specific about who is going to contact whom (and make sure it gets done) to gather data and communicate decision
• Insist in getting complete input before making decision, realizing that hospice MD will be final determiner
• Discuss ways of re-integrating patient/family into community in cases of live discharge
• Defer discussions regarding census, budget, staff re-assignments, etc. to another forum

Challenges—Care Plan Review

• For 45 minutes, you hear ‘The POC is effective’ or ‘no new changes’
• Every review sounds the same (e.g., there’s no difference if the patient is on 1.5mg methadone a day or 150mg/day)
• The review starts with a lengthy dissertation on everything that has happened since (and possibly before) hospice admission
• You can’t tell if your psychosocial staff is leaving phone messages for, or actually visiting, family members

Raise the Standard—Care Plan Review

• Teach and model that IDG meeting is a time to bring challenges to your team members and get valued input
• Reports should have enough detail that the patient can be ‘recognized’ and that other team members can learn about clinical successes and failures
• Care plans should change as the condition of the patient improves or declines (e.g., visit frequencies, meds, etc.)
• Insist on respect for all team members — everyone who has had contact with the patient/family should contribute and not be interrupted

Challenges—Care Plan Review

• You hear more about a patient’s bowel movements than his or her existential crises
• The POC never changes
• You never hear the PCP or RNP mentioned
• You notice that the care plan documents are completed before team meeting and never changed during or after IDG

Raise the Standard—Care Plan Review

• Keep the focus on patient/family ‘goals’ not ‘problems’
• Progress should be made over time
• Be aware of inconsistent medical practice (e.g., do all the patients at a certain facility get overlay mattresses whether or not they have a decubitus; is there an uneven distribution of aide hours between home patients and nursing facility patients; etc.)
Raise the Standard—Care Plan Review

• Take note of the patients who seem to be improving or stabilizing
• Note when a care plan has changed as a result of the discussion and ask how that change is going to be incorporated into the actual document
• Make suggestions on how to include PCP, NP, and others in the patient’s care

Discharge From Hospice

Objectives

1. Cite the 3 allowable reasons a hospice can discharge a patient from its service
2. Explain the difference between discharge and revocation
3. Discuss the impact of non-compliance with discharge-related regulations

Medicare Benefit Policy Manual

There may be extraordinary circumstances in which a hospice would be unable to continue to provide care...These situations would include issues where patient safety or hospice staff safety is compromised. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge...All efforts...must be documented in detail...and the hospice must notify the Medicare contractor and State Survey Agency...The hospice may also need to make referrals...(i.e., Adult Protective Services)...

418.25 Discharge From Hospice Care Reasons For Discharge

Medicare regs specify 3 allowable reasons for hospice discharge:
1. The patient moves out of the hospice’s service area or transfers to another hospice
2. The patient is no longer terminally ill
3. Discharge for cause

Transfers

• Patients may transfer from one Medicare-certified hospice program to another, at any time throughout the course of care and for any reason; however, this may only occur once per benefit period
• The transfer must be documented
• The sending hospice must provide a discharge summary (including Plan of Care, etc.)
• The receiving hospice must validate eligibility
Discharge for Clinical Stability

- Accurate prognostication is one of the mainstays of medical director practice, especially in today’s regulatory environment.
- However, the demands and expectations placed on hospice physicians in this regard exceed the available science.
- Thus, ‘mistakes’ are inevitable and we need to be prepared for them and learn from them.

Clinical Stability – Patient/Family Considerations

- Hospice team should lay the groundwork at admission (16.4% of hospice patients were live discharges in 2010).
- Patients/families need to know that Medicare requires periodic reevaluation (recert.), especially if the patient’s course doesn’t follow the usual path.
- Patients/families should be informed of face-to-face encounter (F2FE) requirement.

Patient/Family Considerations, Cont’d.

- I no longer refer to ‘hospice graduation’ just as I no longer use the term ‘bad news’ because both presuppose a certain emotional response from the patient/family.
- Being discharged from hospice can be a positive thing for some families, devastating for others.
- It helps to teach patients/families that discharge does not necessarily mean that the patient won’t die in the next 6 months, but that we can’t predict that death will occur in the next 6 months.
- Talk about when hospice readmission would be indicated, and reassure them that the team can act quickly.

Patient/Family Considerations, Cont’d.

- Families are frequently frustrated if they are seeing their loved one decline functionally (‘but she doesn’t recognize me anymore’), but are being told that the decline is so gradual a prognosis of 6 months can’t be given.

Outcome

- Most hospices would discharge this patient, but some wouldn’t.
- What would yours do?

For Instance:

- Patient with a FAST score of 6 has weight loss and aspiration pneumonia leading to hospitalization with hospice referral at discharge. Upon return to nursing facility, diet is downgraded, aggressive supplementation occurs, and extra time is spent feeding. The patient has no further infections, no symptoms of aspiration, regains weight, and has normal protein and albumin. The patient may have also gone from walking with walker and 1-person assist to pedaling in a wheelchair, and become less communicative.
Clinical Stability – Hospice Team Considerations

- Hospice teams can become very 'involved' with patients/families, and often live discharges are difficult for them.
- They worry about the patient/family, particularly if they have a 'co-dependent' relationship that has led to relative isolation from previous physicians, community resources, even friends and neighbors.

Clinical Stability – Hospice Physician Considerations

- Doing face-to-face visits has made me realize how much the nurse presentation and documentation affected my decision to keep a patient on vs. discharge them.
- Live discharges have an immediate effect on census; whereas payment denials for 'inappropriate' patients may not occur for years.
- In the past, some Medical Directors had almost no say in who was admitted or discharged.
- Although the F2FE requirement is improving this, there may be unspoken messages from administrators that the purpose of the F2FE is to 'find a reason to keep the patient on hospice.'

Hospice Team Considerations, Cont’d.

- There are 'self-serving' reasons that tip the team toward keeping or discharging a patient. These can’t be avoided, but should be named and acknowledged as possible influencers.
- The patient is: ‘…at the edge of my geographic region…very demanding…calling all the time…non-compliant’
- Or, 'I have too many patients’...
- Or, ‘…Our census is going down…staff will be cut…that’s the last patient in this facility…it took us forever to talk the PCP into allowing hospice…I enjoy talking with this patient/family…they need me…they will end up back in the hospital within a month…’

Hospice Physician Considerations, Cont’d.

- It's important to know your own biases/weaknesses/insecurities around prognostication and discharge.
- Try and be transparent and consistent in how you approach the discharge decision-making process.
- Admit when you've made a mistake.
- Establish some sort of HIPPA-compliant tracking system for discharged patients so the team and you can learn.

Hospice Physician Considerations, Cont’d.

- Name and discuss with team any predictably hard situations (e.g., family attempting to care for totally dependent patient at home, and what resources other than hospice are available).
- Reinforce the right of patients/families to have as accurate a prognosis as possible, to help them in their planning.

Hospice Physician Considerations, Cont’d.

- Be prepared (and try not to be defensive) when others review your decisions.
- Families seem to be appealing discharges more (and win if your documentation doesn’t truly support the decision).
- Some hospices have a policy to review all discharges (and try and ‘salvage’ them).
Hospice Physician Considerations, Cont’d.

• Nationally, there’s a lot of money riding on Medical Director decisions about discharge (why would we not be expected to be influenced by this just like other areas of medicine?)
• But please resist, and make an individual decision for each patient and family based on the best literature evidence and clinical experience you can muster

Discharge For Cause

• The hospice determines, under a policy set by the hospice…that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired

Discharge For Cause, Cont’d.

• The hospice must do the following before it seeks to discharge a patient for cause:
  – (i) advise the patient that a discharge for cause is being considered;
  – (ii) make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;
  – (iii) ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and
  – (iv) document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

Discharge For Cause, Cont’d.

• This should be done only rarely, usually when the physical health of the hospice staff is threatened
• It comes up when someone in the family is violent, mentally unstable, or using alcohol/drugs in excess and threatens the staff in some way
• Sometimes the threat can be managed with a change in hospice personnel
• At other times, a policy of joint visits may help
• In extreme cases, a police escort or restraining order may be necessary

Discharge For Cause, Cont’d.

• The patient refuses to allow the hospice staff in to take care of him/her
• Often patient is a recluse, has major psychiatric disorder, or is using alcohol/drugs in excess
• They may have previously been reported to the State for self-neglect
• If the right combination of hospice staff ‘hang in there’ with the patient, they can frequently establish a relationship that works for both parties

Discharge For Cause, Cont’d.

• Actions of the patient/family threaten the lives of others
• This comes up when a declining patient (often on oxygen and opioids) refuses to give up smoking, and the patient lives with others who aren’t free to leave (e.g., grandchildren) or in a multi-unit dwelling
• Unless the patient can be continually and reliably observed, the hospice team may have to discharge and/or report the situation to others (e.g., landlord, protective services, police, fire department) in order to keep innocent lives safe
Hospices Cannot Discharge For:
- Costly “related” care (e.g., non-formulary medications, etc.)
- Claim denials due to substandard documentation
- Long length of stay
- Dislike / discrimination
- Frequent on-call visits
- Exceeding its per patient cap
- The contracted facility (e.g., SNF, ALF, etc.) did not inform the hospice that the patient was going to the ER
- Refusal to sign a revocation form, etc…

Discharge Planning
- Hospices must have a discharge planning process that takes into account the prospect that a patient’s condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill
- The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill

Discharge Order
- Prior to discharging a patient for any reason, the hospice must obtain a written physician’s discharge order from the hospice medical director
- If a patient has an attending physician, s/he should be consulted before the discharge and the consultation should be documented in the discharge note

418.28 Revoking the election of hospice care
- To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:
  - A signed statement that the revocation is for the remainder of that election period
  - The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made)

Revocation, Cont’d.
- Hospices cannot “revoke” patients from service (hospices discharge; patients revoke)
- Revocation can occur at any time and for any reason; however, frequent revocation with subsequent readmission is problematic

Revocation, Cont’d.
- The subject of revocation generally arises when the patient either goes to the ER/hospital, or elects some treatment not in the hospice plan of care (e.g., further chemo)
- ‘Stickiest’ problems with revocations revolve about use of language (i.e., ‘hospice is revoking the patient’), and inaccurate dating of the revocation form / note
Revocation, Cont’d.

- Electing hospice involves a limited prognosis and waiving Medicare Part A / hospital coverage in exchange for the hospice benefit
- Patients/families must know that they have no insurance coverage if they go to ER/hospital; therefore, it’s in their best interest to notify hospice before they go so revocation can be done promptly (if appropriate)

Revocation, Cont’d.

- Nursing facility staff also need to understand the “waiver” of Part A coverage
- A “Do Not Hospitalize” order may need to be written to remind the staff to notify hospice of changes in condition so appropriate care can be offered

Revocation, Cont’d.

- Despite its best efforts, a patient may be hospitalized without the hospice’s knowledge
- In these cases, there may be pressure on the Medical Director or interdisciplinary group to ‘backdate’ the revocation
  - Revocations cannot be backdated
  - Hospices can work with the hospital / family to resolve any payment-related issues

Revocation, Cont’d.

- Revocations must be documented in the clinical record
- Blank (undated) revocation forms cannot be signed at admission for potential use at a later date
- Revocation forms cannot be backdated
- Hospices cannot pressure patients/families to revoke – this is an Office of the Inspector General (OIG) risk area

Non-Coverage Scenarios

- Hospices must provide a Notice of Non-Coverage prior to discharge (and for other reasons)
  - Specific items and/or services that are billed separately from the hospice per diem are not reasonable and necessary (e.g., physician services)
  - The level of care is determined not reasonable or medically necessary

Appeals

- Patients have the right to appeal the hospice’s decision to discharge
- Quality Improvement Organization (QIO) will request & review the patient’s clinical record to determine hospice appropriateness and eligibility prior to rendering a decision
- Disconnect between QIO decision and Medicare Administrative Contractor (MAC) denials
Problematic Discharge Patterns

- High number or percentage of discharged patients when compared to State, regional, or national benchmarks
- Discharging patients only to readmit them after they’ve received costly treatments
- Discharging when the patient chooses to go to the hospital

Problematic Discharge Patterns, Cont’d.

- Discharging after the fact when a skilled nursing or assisted living facility has transferred the patient to a hospital
- Only discharging at the end of the current certification period
- Recertifying “for the purpose of discharge planning”