Hospice Documentation in the Hot Seat!

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Objectives

Upon completion of this session, attendees will be able to:

• Identify at least three (3) government audit entities scrutinizing hospice documentation.
• Describe at least two factors that impact hospice eligibility.
• Describe how standardized documentation frameworks provide the foundation for hospice eligible documentation.
• Recognize examples of measureable hospice documentation as required for hospice levels of care.
• Discuss the use of the High Accountability Documentation Checklist.

In the News

$112 million claim filed against SD Hospice.
— UT San Diego, June 18, 2013

Hospice provider agrees to pay $150 million in settlement.
— New Hampshire Leader, January 11, 2014
“About 40% of hospice claims denied are due to documentation failing to support the terminal illness”

Latesha Walker with CMS
at the NAHC&H annual March on Washington Conference. And 39% of hospice claims denied are due to the diagnosis code not supporting the terminal illness, said Walker, director of CMS’s Division of Medical Review and Education.” Home Care Week, 2012: Vol 21, Number 14.

Hospice Focus 2014

REGULATIONS AND AUDITORS
Policies and Practices
• We will review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities (ALFs).
• We will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in (ALFs).
• Hospice care may be provided to individuals and their families in various settings, including the beneficiary’s residence, such as an ALF. ALF residents have the longest lengths of stay in hospice care. The Medicare Payment Advisory Commission has said that these long stays bear further monitoring and examination. (OEI; 02-14-00070; expected issues date FY 2014; work in progress; Affordable Care Act)

Quality of Care and Safety
• We will review the use of hospice general inpatient care.
• We will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
• We will also review hospice medical records to address concerns that this level of hospice care is being misused.
Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the agency assumes the responsibility for medical care related to the beneficiary’s terminal illness and related conditions. Federal regulations address Medicare conditions of participation for hospices. (42 CFR Part 418). Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. (42 CFR 418.28). (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2014; work in progress)

Recovery Audit Contractors

The Center for Medicare and Medicaid Services (CMS) will soon announce the name of the new recover audit program (RAC) contractor that will exclusively on home health. Under the plan, the four regional RACs will no longer handle improper payments for home health, hospice or durable medical equipment (DME). The new RAC Region 5 will handle all claims nationwide for home health agencies, hospices and durable medical equipment (DME) companies. It will cover more than 12,000 home health agencies.
RAC Updates

June 2, 2014 – CMS is pleased to announce the establishment of a Provider Relations Coordinator to help increase program transparency and offer more efficient resolutions to providers affected by the medical review process. The CMS Provider Relations Coordinator is: Latesha Walker.

- CMS established the Provider Relations Coordinator to improve communication between providers and CMS. Providers can raise larger process issues to Coordinator. For example, if a provider believes that a Recovery Auditor is failing to comply with the documentation request limits or has a pattern of not issuing review results letters in a timely manner, CMS would encourage the provider to contact the Provider Relations Coordinator.
RACs Hospice Audit Focus

- Hospice care, extensive length of stay-Jurisdiction A: the potential for overpayment exists when hospice care is rendered contiguously beyond a 20 month period lacks medical necessity and it is determined that the condition has improved and/or beneficiary is no longer considered terminally ill.

- Excessive Units of Physician Services-Hospice: each attending physician service should be dated separately indicating the date that each HCPCS code billed was delivered. Per diem physician codes can be billed once per day.

- Region C: Hospice Related Services-Part B: services related to a Hospice terminal diagnosis provided during a hospice period are included in the hospice payment and not paid separately.

Other Hospice Audit Players

- Medicare Administrative Contractors (MACs)
- Zone Program Integrity Contractors (ZPICs)
- Medicaid Integrity Contractors (MICs)
- Medicaid Recovery Audit Contractors (Medicaid RACs)
In the Future

UPICS
- UPICs will replace the MACs and ZPICs
- CMS will be combining integrity responsibilities into one agency (focus on both Medicare & Medicaid integrity issues)
- MICs will be phased out
- CMS will be consolidating Medicare and Medicaid data into one unified database

HOSPICE DOCUMENTATION
Hospice Documentation Risk

- Certification of Terminal Illness Requirements
- Face-to-Face Encounter Requirements
- GIP care level of care not supported
- Respite care level not supported
- Continuous care level of care not supported
- Nursing Facility Hospice Care
- ALF Hospice Care

What about coding in Hospice?

- Diagnosis Reporting on Hospice claims continues to be a challenge to many hospices

- CMS mandates in the Hospice Final Rule FY 2014 “that all providers should code and report the principal diagnosis as well as all coexisting and additional diagnoses related to the terminal condition or related conditions to more fully describe the Medicare patients they are treating.”

- More from the final rule, “analysis of current claims data does not allow us to appropriately determine whether case-mix adjustment, or other considered methods would or would not be a reasonable approach to, or part of, hospice payment reform.”
Hospice claims containing inappropriate principal or secondary diagnosis codes, per ICD-9-CM coding conventions and guidelines, will be returned to the provider and will have to be corrected and resubmitted to be processed and paid.

Debility and adult failure to thrive are no longer acceptable principal hospice diagnoses on the hospice claim form. Claims will be returned to provider for a more definitive principal diagnosis.

CMS will implement edits related to etiology/manifestation code pairs.

CMS will RTP claims using an inappropriate dementia code as a principal diagnosis -- including those that require that the underlying causal condition be coded first.

Abt Associates is the hospice contractor in charge of developing a new hospice payment model

U-shaped model (MedPAC recommended be adopted)

A hospice's costs typically follow a U-shaped curve, with costs being higher at the beginning and end of a stay, and lower costs in the middle of the stay.

Tiered System includes U-shaped payments, higher payments for extremely short stays, and lower payments for beneficiaries who die in hospice without skilled visits at the end of life.

As Abt collects more accurate diagnosis data, including data on related conditions, Abt will also evaluate whether case-mix should play a role in determining payments.
The CMS clinical collaborative effort solicited comments on defining "related conditions" to mean: "Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less".

Hospice Related Conditions

New Hospice Documentation

Requirements

- Hospice Quality Reporting Program (HQRP)
  - Affordable Care Act (ACA)
  - Data collected and submitted on ALL patient admissions (quality measures will be calculated on patients 18 years or older)
  - Hospice Item Set (HIS) implemented as part of the FY 2014 Hospice Wage Index Final Rule--Mandated Reporting
  - Financial Penalty for Not Participating (2% market basket penalty payment year 2016)
  - Public Reporting as soon as FY 2018

- Hospice Experience of Care Survey (HEC); now called the CAHPS-Hospice Survey January 2015
Hospices Understand

Why Documentation is So Important!

• 2014 was a turning point for Hospice administrative burden with regard to additional documentation requirements like never seen before in its history and it does not appear to be slowing down any time soon.
• The new face of Hospice resembles other health care sectors that have gone before them and documentation improvement is now a permanent fixture in the Hospice landscape!

CLINICIAN TRAINING

Training in the art of defensible documentation

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So why is documenting to decline challenging for Hospice Clinicians?

- Training in the art of defensible documentation and implementing a culture of documentation accountability/high accountability is lacking?
- Over dependence on canned documentation and check boxes (electronic documentation software systems) which lack objective and measurable terminology individualized to the hospice patient?
- Opposes tendency to document toward improvement of health status when medical interventions are utilized (clinicians are taught that health practitioners improve health=value)?

Building a Culture of High Accountability

Creating a Culture of High Accountability means changing things…this is harder than it looks!
Clinicians and High Accountability

Three Strategies to Transform Culture

- Set Expectations
  - Behavior-based expectations for event-free performance
- Educate & Build Skill
- Reinforce & Build Accountability
  - An accountability system to convert behaviors to work habits

How Behaviors and Process Impact Outcomes

Reliability Synergy

- Behavior Accountability
  - Behavior Expectations
  - Knowledge & Skills
  - Reinforce & Build Accountability
  - Integrated With
- Process Design
  - Evidence-Based Best Practices
  - Technology Enablers
  - Intuitive Work Environment
  - Resource Allocation
  - Continuous Quality Improvement

Optimized Outcomes
Start with how an adult learns and customize your training to them:

- Adults need to be involved in their instruction
- Experience (including mistakes) provides basis for learning activities
- Adults are most interested in learning about subjects that have immediate relevance to their job or personal life
- Adult learning is problem-centered rather than content-oriented

How to Maximize Effectiveness

- Tell a story!
- Share all denial examples with the IDT
- Remember experience learning impacts Adults more than content learning
- Sharing the back stories of other Hospices and their government audit experiences may touch a chord that imparts more meaningful learning than traditional training methods
• A crucial aspect of cognitive control and learning is the ability to integrate feedback, that is, to evaluate action outcomes and their deviations from the intended goals and to adjust behavior accordingly.

• Scientific studies demonstrate that there are actual differences in the brain activity of high learners vs. low learners.

• Results indicate that high- and low-learners differ not only on how they react to incorrect feedback, but also in relation to how their distant brain areas interact while processing both correct and incorrect feedback. This study demonstrates the neural underpinnings of individual differences in goal-directed adaptive behavior.

**High Learner vs. Low Learner**

**What to do for a Low Learner**

• Scaffolding technique: scaffolds are placed around buildings to give it additional support. As the building becomes more stable on its own, the scaffolds are removed, a few at a time. Eventually, the building stands independently of the scaffolds. Similarly, "scaffolding" lessons provides additional support to learners as they work toward understanding the content on their own.

• In order to grasp new concepts, a low learner needs more time, more repetition, and often more resources from trainers to be successful.
### Chronic vs. Terminal

#### Terminal Illness
“an illness because of it’s nature can be expected to cause the patient to die”

#### Chronic Illness
“of long duration, designating a disease showing little change or a slow progression”

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Source: Taber’s Cyclopedic Medical Dictionary

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#### Chronic vs. Terminal

- Many people suffer from chronic and debilitating illnesses, but are not terminally ill with a prognosis of 6 months or less to live if the disease runs its normal course
- A total care patient is not necessarily a terminally ill patient
- There are objective clinical data points that support hospice eligibility in the terminally ill patient based on the LCD guidelines
- The terminal disease progression, symptom palliation, secondary and comorbid conditions justify hospice eligibility for a terminally ill patient that will not be present (to degree/severity/progression) in a chronically ill patient

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Terminal disease progression

Custodial care patients require maximum assistance in order to exist; however, terminally ill patients will demonstrate disease progression despite optimal care. Although the documentation of the patient’s debility and ADL dependence is important, documentation of disease progression despite optimal care is essential to demonstrate a patient’s terminal prognosis.

The International Classification of Functioning, Disability and Health is published by the World Health Organization (WHO). It provides for a standardized language and framework for the description of health and health-related states. It looks at the body function, body structures, activities and participation and environmental factors.
Going Beyond Diagnosis® is based on the biopsychosocial approach, which is a coherent view of different perspectives of health:

- Biological
- Individual
- Social

Start with the visual presentation of your patient
A structural impairment is a significant deviation in the anatomical parts of the body—organ, limb, and their components (*muscle wasting, sunken cheeks, contractures etc.*)
A functional impairment is a significant deviation in the physiological (to include psychological) functions of body systems (problems with chewing, swallowing, breathing, etc.).

- An activity is the execution of a task or action by an individual
- An activity limitation is a difficulty an individual may have in executing activities
Activities and Limitations

- **Communication**: receiving and producing messages
- **Movement**: movement and mobility of joints, bones, reflexes and muscles
- **Self care**: eating, drinking, washing, and caring for one’s body and body parts.
- **Participation is involvement in life situations**
- **Participation restrictions are problems an individual may experience in involvement**

Environmental Factors

The physical, social, and attitudinal environment in which people live and conduct their lives.
Psychosocial

• If symptoms are impacting communication, note them specifically in documentation.

• Document evidence of memory deficits or ability to make judgments. Note behaviors that may be dangerous to others and self.

• Document inability to participate in activities that were once important to the patient.

Comorbid Conditions

Comorbid conditions may coexist and are distinct from the primary disease.

Stroke Survivor May Also Have:
• HTN
• CHF
• CAD
• A-fib
Secondary Conditions

Secondary conditions are directly related to the primary conditions

Common Secondary Conditions:
- UTI’s
- Contractures
- Bed Sores
- Malnutrition
- Anemia
- Generalized Muscle Weakness

Document Measures Of Cognition

- Memory
- Attention
- Judgment
- Comprehension
- Orientation

- Learning
- Calculation
- Problem Solving
- Mood
- Behavior
Document Measures
Of Nutritional Status

- **Appetite**: remember in quantifiable and specific terms (mls, percentages, description of the meal, etc.)
- **Body Mass Index (BMI)**
  - English BMI = (Weight in Pounds/ (Height in inches x Height in inches)) X 703; Metric BMI = (Weight in Kilograms/Height in Meters X Height in Meters)); BMI calculators with accurate height and weights on chart
- **History of weight loss**
  - Actual weight loss over specific time period or % of weight loss over specific time period
- **Clinical Laboratory Tests**
  - Serum Albumin <2.5

Other Documentation
of Disease Progression

- **Spiritual decline**: patient is no longer able to pray, request prayer, or participate in bible study/scripture reading
- **Note increasing dependence** on others for ADLs and loss of simple movements like touching or reaching. Extended periods of time sleeping and staying in bed versus up in chair, etc.
- **Family/caregiver quotes that support decline**, “Does not recognize me any longer for past 2 weeks or Does not remember my name since last visit, etc.”
- **Medications changes** (increased or decreased or changed) and reason why as well as how patient has responded to the change.
Documenting to Decline

Documentation to decline demonstrates:
• History, illness progression, recent changes, current status as compared with prior status
• Acuity or the trajectory that supports the 6-month prognosis
• Utilize Local Coverage Determinations (LCD) when available
• Beware of simple checkboxes
• Still must be patient specific

Local Coverage Determinations

• Cardiopulmonary Conditions
• Renal
• Liver
• Alzheimer’s Disease
• Neurological Conditions
• HIV
Hospice Documentation Tools
That Promote Objectivity

- Karnofsky and Palliative Performance Scales
- Functional Assessment Scale
- Vital signs
- Weights, BMI
- Narrative summaries with measurable/objective terms (use of ICF worksheets strongly advised, where applicable)
- Body mass measurements (arm circumference, abdominal girth, etc.)
- Pain Scale
- Meal percentages/calorie counts
- Quotes from caregivers that reflect decline
- Comparisons to baseline or previous time periods

Lab Values

- Albumin for Liver disease
- Prothrombin time or INR for Liver disease
- pCO2 to show hypercapnia in Pulmonary disease
- Vital capacity for Pulmonary or Neuro disease
- pO2 by ABG or O2 sats in Pulmonary disease
- Creatinine clearance for Renal Failure
- CD4 count or Viral load for HIV
- Tumor markers for stabilized Cancer patients
**Documentation of Decline**
along LCD criteria

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Date: 3/27/14</th>
<th>Date: 5/24/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karnofsky Score/PPS</td>
<td>40%/40%</td>
<td>30%/40%</td>
</tr>
<tr>
<td>Edema</td>
<td>3+-4+ at ankles</td>
<td>4+ and progressing to knees; unresponsive to treatment</td>
</tr>
<tr>
<td>Respiratory LCD (L13653) Decline in clinical status guidelines “dyspnea with increasing respiratory rate.”</td>
<td>Respiratory rate: 20; SOB with minimal exertion.</td>
<td>Respiratory rate: 28; SOB with talking.</td>
</tr>
<tr>
<td></td>
<td>SOB at rest noted on 4/2 and 4/23.</td>
<td>5/10 wife giving Roxanol and Ativan more frequently for dyspnea.</td>
</tr>
<tr>
<td>FAST score</td>
<td>3</td>
<td>6D</td>
</tr>
<tr>
<td>Functional limitations</td>
<td>Dependent on wife for all ADLs.</td>
<td>Becoming more difficult for wife to handle; considering aides.</td>
</tr>
</tbody>
</table>

**Examples of Documentation that is Not Measurable**

1. “The patient is more short of breath.”
   *(not measurable-as compared to what?)*

2. “Continues to decline.”
   *(not measurable-how is the patient declining from prior visit or time point?)*

3. “Patient is weaker.”
   *(not measurable-what is the patient doing differently or not doing that makes them weaker than prior visit or time point?)*

4. “Appears to be losing weight.”
   *(not measurable-what is weight or body mass measurements from last visit or time point as compared to this visit/time point?)*

5. “No change; still terminal.”
   *(demonstrates stability and does not support decline or limited prognosis)*
Examples of Same 5 Examples with Measurable Content

1. “Patient demonstrates increased shortness of breath as evidenced by respiratory rate averaging between 32-36 breathes per minute as compared to 24-28 last month with an increased use of O2 between two to three this month versus one to two last month.”

2. “Patient continues to decline; refusing PO intake with a 7 lb. weight loss noted from prior month. Ht. 6’6, Wt. 143, mid arm circumference R 25.5 cm, L 28.0 cm; Karnofsky 10%, Fast score 7E as compared to 30% and 60 3 weeks ago.”

3. “Patient continues to grow weaker as evidenced by a PPS score of 50% last month that has now has fallen to 40% this month. Patient is now mainly in bed and only sitting up in chair 1-2 X per day for 15-20 minutes due to poor toleration.

4. Patient lost 5 pounds from last cert. period and now weighs 88 lbs; Ht. 5’7, BMI16, Albumin 2.0. Patient is refusing PO intake and tube feedings.

5. “Respiratory symptoms are abated with medication regime. Effectively using positioning techniques taught by nurse. Use terms that reflect the positive effect the Hospice team is having on the patient’s condition/outcomes. Explain any improvements from the same posture…the temporary improvement or stabilization is the result of Hospice interventions, etc. and then follow with how the patient is still eligible for Hospice.”

RN met with patient and explained home hospice care. Patient states he wants assistance with comfort care-does not want to go back to hospital. Pt. admitted with end stage lung disease. He is SOB with any exertion and O2 dependent. Hx also includes CAD and HTN. RN starting HHA 1x weekly to begin assisting patient.”
87 year old white male admitted to hospice after suffering an acute ischemic stroke, with resultant left-sided paralysis, facial droop, incomprehensible speech and is unable to swallow/refusing feeding tube. Patient is total care patient requiring around the clock assistance. Patient has the following comorbidities: COPD, CHF, A-fib, DM, HTN. Patient presents with bilateral heavy crackles throughout lung fields, yellow phlegm and a productive cough. Mucous membrane in mouth is peeling/requires removal. Ht.6', Wt. 143, mid arm circumference. R 26 cm, L 29 cm, Karnofsky 10%, FAST score 7E.

• When a level of care changes, the medical record must show the date, time and reason why the level of care changed

• Levels of care in Hospice include: Routine Home Care (RHC), General Inpatient Care (GIP), Continuous Care (CHC) and Respite Care (RC).
Continuous Care

- Continuous home care is provided only during a period of crisis

- A period of crisis is a period when a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms

Continuous Care

- Nursing care in the can include skilled observation and monitoring when necessary and skilled care needed to control pain and other symptoms

- Although Continuous Care is billed in 15 minute increments, the supportive documentation is not required to be every 15 minutes

- In addition, the services provided by other disciplines such as medical social workers or pastoral counselors are an integral part of the care provided to a hospice patient, however, these services are not included in the statutory definition of continuous care and are not counted towards total hours of continuous care

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Continuous Care

Documentation

- The crisis requiring the use of continuous home care needs to be clearly documented.
- Provide the date and time the interventions were performed. Include the title of the care giver (registered nurse, licensed practical nurse, or hospice aide).
- A log or a sign in sheet that includes the actual times, name and title of the health care provider rendering care is beneficial for accounting for the continuous home care hours billed.
- If the documentation submitted for review supports the terminal prognosis, but does not provide evidence that continuous care services were reasonable and necessary, the claim may be reduced to the routine home care rate.

Documentation Tips

- A dying patient is NOT a crisis, unless symptoms are so severe that without continuous care the patient will need to be hospitalized.
- When continuous care is in place, it must be documented that the entire team is working with the patient and family to manage effectively without continuous care.
- Documentation should be hourly and describe: ongoing symptoms, symptom management and effectiveness of interventions.
Continuous Care

Documentation Tips
• Continuous care is meant to be for very brief periods of time, generally just a few days
• The documentation for starting and maintaining continuous care must reflect the crisis
• Continuous care is not: for every dying patient, respite care, an alternative to a nursing home, and an alternative to private duty care for a patient who cannot be left alone

Documentation Should Include:
• Reason for continuous care
• Vital signs (as appropriate)
• Observations of the patient’s condition
• Interventions used to achieve palliation of physical or emotional symptoms
• Services provided to the patient
• Medications given and the patient’s response
• Treatments completed and the patient’s response
• Contacts made to the hospice and/or attending physician
• New or changed orders received
• Family response to care (as indicated)
• Detailed discharge planning to transfer the patient back to routine home care as soon as the crisis subsides. There is no specified frequency of documentation for CHC in the regulations or guidance. However, since CHC is for acute symptom management or some other crisis and billing occurs in 15-minute increments, the best practice standard is to document at least every hour.
General Inpatient Care

Patients (in general) may be admitted for short-term general inpatient care when the physician and hospice interdisciplinary team believes the patient needs pain control or symptom management that cannot feasibly be provided in other settings.

GIP Documentation

Upon transfer to GIP, documentation should include:
- Precipitating event (onset of out of control symptoms)
- Interventions tried in the home that have failed
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 Daily

Why the Patient Still Needs GIP

- Pain, despite numerous changes to medication
- Bleeding that won’t 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
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

GIP 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”)
- Each note stands on its own in supporting the level of care
GIP 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 general inpatient setting
  • Were they effective?
  • Are they still effective?

Inpatient Respite Care

• Provided when families or caregivers need respite or relief
• Provided in a participating hospice inpatient unit, participating hospital, Skilled Nursing Facility (SNF) or Nursing Facility (NF) or Intermediate Care Facility
• Services provided in the facility must conform to the Hospice’s POC
• Respite level of care is for the caregiver. The reason needs to be documented clearly—for example, why did the caregiver need respite? If more than one respite care admission in a short period of time, documentation must indicate why multiple admissions were necessary.
Inpatient Respite Care

- Maximum of 5 days at a time
- The Hospice agency remains the professional manager of the patient’s care
- The agency will need to provide the name of the facility the beneficiary is receiving respite care, and the dates of service provided. Respite care may be made for a maximum of 5 days at a time which includes the date of admission, but not counting the day of discharge alive (payment for 6th and subsequent days will be made at the routine care rate).

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Inpatient Respite Care

- The patient can receive more than one respite episode per billing period
- The day of discharge is billed routine care, provided the beneficiary does not expire in the facility
- Again, if more than one respite episode occurs during the billing period, document the need
- Units are reported in days

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High Accountability Documentation Self-Checklist

My Hospice Clinical Note:

- **Is free** from non-specific phrases like: "continues to decline", "getting worse", "remains terminal"? Describe in detail.

- Contains measurable data: **weights**, **portion sizes**, **calorie counts**, **deltoid measurements**, **number of hours tolerated out of bed**, etc.?

- **Does not** contain phrases like: "stable", "doing fine", "states does not need visit" without specific clarification?
High Accountability Documentation Self-Checklist

My Hospice Clinical Note:

- Contains multiple examples of activity/performance changes from prior time point to present visit: "patient no longer able to tolerate bathing in tub since last visit", etc.?
- Contains specific information/detail about symptom palliation: Zofran ordered for continued problems with uncontrolled N/V, etc.?
- Contains evidence of communication, collaboration and education: “taught caregiver repositioning d/t new pressure ulcer”, “contacted SW for provider assistance services referral”?  

My Hospice Clinical Note:

- Justifies GIP level of care: “patient requiring IV Dilantin for uncontrolled grand mal seizures”, etc.?
- Justifies CHC level of care: “increased periods of apnea, continuous n/v and increasing pain”, etc.?
- Contains specific criteria of the LCD: “ESRD calciphylaxis wounds”, etc.?
Conclusion

Keep Calm and Document On

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