Hospice Medical Review

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Agenda

• Physician Narrative
• Initial Certification vs Recert
• Physician Billing
• General Inpatient Care (GIP)
Physician Certification

- 42 CFR § 418.22  
  Certification of terminal illness

The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

Physician Certification

If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician’s signature.
Physician Certification

If the narrative exists as an addendum to the certification or recertification form, in addition to the physician’s signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

Physician Certification

The narrative shall include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient.
Physician Certification

The narrative must reflect the patient’s individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

Physician Narrative Ex. 1a

- Initial Cert:

“78 yo f with ES Progressive Supranuclear Palsy with significant weight loss, poor po intake, neuropathic pain and aspiration; all indicate prognosis of 6 months or less.”
Physician Narrative Ex. 1b

- Re-cert
78 yo f with ES Progressive Supranuclear Palsy. Pt with increased difficulty swallowing, increased pocketing of food and increased time in bed. Pt started on opioids for pain. Pt with end state disease and all coincide with prognosis of 6 months or less.”

Physician Narrative Ex. 2

- Initial Cert

“92 y M with multiple ED visits related to advanced dementia with increased weakness, decreased cognition and weight loss. HCP is activated and DNR is in place, all consistent with a prognosis of 6 months or less.”
Physician Narrative Ex. 3

- Initial Cert

“88 yo M with mild dementia, prostate CA with mets to bone with weakness, fatigue, poor appetite, all consistent with prognosis of 6 months or less.”

Physician Narrative Ex. 4a

- Initial Cert

“81 yo F with seizure disorder, Parkinson’s, recurrent UTI’s, ES dementia desiring DNR and CMO all consistent with prognosis of 6 months or less.”
Physician Narrative Ex. 4b

• 1st Re-cert
  “81 yo F with end-stage dementia, seizure disorder, Parkinson’s with marked weight loss. Pt with 24hr period last week poorly responsive and not eating with poor po since then. Pt also reportedly even less verbal, DNR, CMO; all consistent with prognosis of 6 months or less.”

Physician Narrative Ex. 4c

• 2nd Re-cert
  “81 yo F with seizure disorder, Parkinson's, advanced dementia with very poor po intake last benefit period, newly bedbound with increased rigidity, contractures, decreased po intake. Pt DNR and CMO all consistent with 6 month or less prognosis.”
Physician Narrative Ex. 5a

• Initial Cert

“77 yo F with OP/compression fractures, end stage pulmonary fibrosis. Pt with 02 sat 80% on 3.5L with min exertion, increased frequency of MD visits, marked worsening when Pred dose decreased. All consistent with prognosis of 6 months or less.”

Physician Narrative Ex. 5b

• 1st Re-Cert

“77 yo F with ES pulmonary fibrosis with significant worsening in last month. Pt now desating to 76% on 6L with 4 steps despite med changes. All consistent with prognosis of 6 months or less.”
Physician Narrative Ex. 5c

- 2nd Re-cert

“77 yo F with ES pulmonary fibrosis with significant worsening in last benefit period. Pt with increased SOB on 6 L now weaker w/ walking few steps desats to 70% on 6L. Requiring increased hha assistance due to SOB. All consistent with 6 month or less prognosis.”

Physician Narrative Ex. 6

- Initial Cert

“79 yo F with AODM, COPD, Graves and advanced, widespread lung Ca with decision for no further work-up. Poor p.o., DOE, DNR all consistent with 6 month or less prognosis.”
Physician Narrative Ex. 7

• Initial Cert
“84 yo M with CRF, CAD, dementia, recent likely UGIB by hosp d/c summary, gangrenous heel wounds. Pt eating small amounts, losing weight, dependent for all ADLs, bedbound. DNR/H, CMO, no ABX all consistent with 6 month or less prognosis.”

Initial Certification

• 42 CFR § 418.22

(a) Timing of certification — (1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods, as provided in §418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.
Initial Certification

(3) Exception. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

Initial Certification

• A true initial cert is required!

• If initial cert is invalid, any subsequent benefit periods are also invalidated
Physician Billing

• E&M code family chosen based on location of beneficiary

• Home, Hospital, Nursing Facility

• Free-Standing Hospice Facility > use Nursing Facility codes

Physician Billing

• Hospice may not bill Physician Services (E&M) for:

  • Visits to eval for eligibility (recert)
  • Visit or time for physician narrrative
  • Comprehensive Assessment
NP Billing

• Hospice may bill for an NP physician service only if...

• NP provides a true physician service and..

• NP is the beneficiary’s designated attending

General Inpatient Care
Inpatient Care

- Section 1861(dd)(1)(G) of the Act provides for short-term inpatient hospice care to be available when an individual's pain and symptoms must be closely monitored or the intensity of interventions that are required cannot be provided in any other settings.

Hospice and Palliative Care Federation of Massachusetts

- Patients should be evaluated on a case by case basis but in general may be admitted for short term general inpatient care when the physician and Hospice interdisciplinary team (IDT) believe the patient needs pain control or symptom management that cannot be feasibly provided in other settings. CMS clarification of selected Medicare hospice regulations and policies specify that in order to receive payment for “general inpatient care” the beneficiary must require an intensity of care directed towards pain control and symptom management.
Caregiver Breakdown

• Caregiver breakdown is the loss of the individual's support structure and should not be confused with the coverage requirements for medically reasonable and necessary care for pain and symptom management that cannot be managed in any other setting.

Hospice Wage Index for Fiscal Year 2008; Final Rule. Federal Register 8/31/07

Caregiver Breakdown

“Caregiver breakdown” should not be billed as GIP regardless of where the services are provided unless the intensity of skilled care requirement is met.
Criteria for Admission to GIP

**Pain Requiring:**
- Complicated technical delivery of medication requiring skilled nursing care for calibration, tubing change or site care
- Frequent evaluation by physician/nurse
- Aggressive treatment to control pain

**Admission to GIP**

**Symptom Changes:**
- Sudden deterioration requiring intensive nursing intervention
- Uncontrolled nausea and vomiting
- Respiratory distress that becomes unmanageable
- Traction and frequent repositioning requiring more than one staff member
Admission to GIP

**Symptom Changes:**

- Wound care requiring complex and/or frequent dressing changes that cannot 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 patient’s home setting

Admission to GIP

**Imminent Death:**

- Symptom management requiring frequent skilled nursing intervention. Imminent death alone is *not* a criterion for the GIP level of care.
Criteria for Continued GIP LOC

• Hospice is aggressively working to develop and provide a plan for safe discharge
• Symptoms continue to require active treatment and frequent assessment

Criteria for continued GIP LOC

• Symptoms such as intractable nausea/vomiting, respiratory distress, open lesions or ongoing deterioration related to the terminal illness continue to require active treatment and frequent assessment
• Ongoing mental status changes which require active treatment and frequent assessment
Criteria for continued GIP LOC

- Acute symptoms have stabilized but death is imminent within a short period of time as evidenced by clinical deterioration such as mottling of the skin, change in respiratory status, and level of consciousness
- Frequent skilled nursing care is required and the family is unable to cope

Criteria for D/C from GIP LOC

- Reason for admission stabilized
- Re-established family support system
- Appropriate discharge plan has been developed
- Transfer to another level of care
GIP Documentation Tips

• Document when the level of care changed and why. A reviewer should be able to identify the dates and times of changes in level of care and the reasons for the change.
• 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.

GIP Documentation Tips

• 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 NF (e.g., “patient requires frequent RN/NP/MD assessment and titration of medications to control pain.”)
GIP Documentation Tips

• Think of the note as a bill for Medicare reimbursement. Describe the services provided. Each note stands on its own in supporting the level of care.
• Identify the context and the precipitating event(s) that led to GIP status.
• Describe failed attempts to control symptoms/crisis that occurred prior to admission.

GIP Documentation Tips

• Describe care that the patient’s caregivers cannot manage at home (e.g., frequent changes in medication dose/route/schedule, IV medications).
• Document the precipitating events that resulted in the inability to provided skilled care in the home.
GIP Documentation Tips

• Identify specific symptoms that are being actively addressed (“uncontrolled nausea/vomiting,” “new delirium/agitation”). Also describe failed attempts to manage the symptoms in the home setting.

• Document progress/context/changes including “symptomatic imminent death that cannot be managed at home or in the NF.”

GIP Documentation Tips

• Document patient’s responses to interventions in the general inpatient setting. (Were they effective? Are they still effective?) The identified problems, scope and frequency of services should change as a result of the GIP.

• Create a “snapshot” note that paints a picture of who the patient is and what the care entails.
GIP Documentation Don’ts

• Use “patient is dying”, “end-of-life care,” “general decline,” “pain and symptom control” or “medication adjustment” to justify GIP stay unless you also document why these actions cannot take place in the home (or other setting if acute care hospital patient).

GIP Documentation Don’ts

• Document resolution of the precipitating event that led to GIP status without also documenting further criteria that maintains GIP status.
Thank You