

MASTER CLASS SERIES



UNLOCK HOSPICE BILLING SECRETS

REGISTER NOW FOR
LIVE VIRTUAL CLASSES

MAY 2024



EDUCATIONAL RESOURCES

Higher Levels of Care: Indicators, Charting, and Compliance

Joe Osentoski, BAS, RN, GERO-BC

Senior Consultant

Gateway Home Health Coding & Consulting

 HOME HEALTH



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Welcome

- We are so happy that you have chosen to attend today's webinar.
- We hope that you find the information useful in your hospice agency operations in managing and documenting higher acuity levels of care.
- Note that all regulatory guidance (CFR, CMS, each MAC) is taken from rules and regulations effective as of February 29, 2024.

Agenda

- Background on regulatory scrutiny of hospice General Inpatient (GIP) and Continuous Home Care (CHC) levels of care
- Current regulatory guidance on use of GIP and CHC
- Indicators for using GIP and CHC
- Charting guidance and tips when using GIP and CHC
- Key coverage needs and indicators for review of GIP and CHC
- Questions

Goals of the Presentation

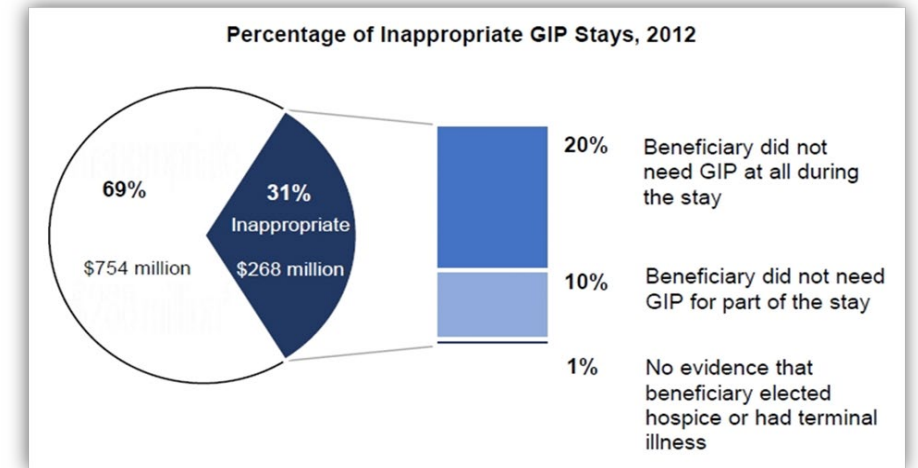
- Attendees will take back to their agency:
- Knowledge of key hospice coverage requirements
- Clear understanding of beneficiary status that supports GIP and CHC levels of care
- Specific charting components for each common GIP situation and CHC
- Reference material for staff education related GIP, CHC
- MAC checklist for GIP charting

Hospice Levels of Care

- Routine home care (RHC)
- Continuous Home Care (CHC)
- General Inpatient Care (GIP)
- Inpatient Respite Care (IRC)

HHS OIG Report (OEI-02-10-00491)

- Issued March 30, 2016
- Hospices were more likely to inappropriately bill for GIP provided in skilled nursing facilities than GIP provided in other settings.
- Medicare sometimes paid twice for drugs because they were paid for under Part D when they should have been provided by the hospice and covered under the hospice daily payment rate.
- Hospices did not meet all care planning requirements for 85 percent of GIP stays and sometimes provided poor-quality care.



Source: <https://oig.hhs.gov/oei/reports/oei-02-10-00491.asp> [accessed 1/29/24]

HHS OIG Report (OEI-02-10-00491) Recommendations

- Office of Inspector General (OIG) recommended that CMS:
 - increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries;
 - ensure a physician is involved in the decision to use GIP;
 - conduct prepayment reviews for lengthy GIP stays;
 - increase surveyor efforts to ensure that hospices meet care planning requirements;
 - establish additional enforcement remedies for poor hospice performance; and
 - follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.
- CMS concurred with all six recommendations.
- NOTE: The issues in 2016 continue to be found in 2024

Hospice Medical Reviewers

- Medicare Administrator Contractors (MAC):
 - National Government Services (NGS), Jurisdiction 6 (J6)
 - National Government Services, Jurisdiction K (JK)
 - Palmetto GBA, Jurisdiction M (JM)
 - CGS Administrators, Jurisdiction 15 (J15)
- Unified Program Integrity Contractors (UPIC):
 - AdvanceMed
 - UPIC Southwest Jurisdiction (Qlarant)
 - Safeguard Services
 - CoventBridge
- RAC: Performant (Region 5)
- Supplemental Medical Review Contractor (SMRC)
 - Noridian Healthcare Solutions
- CERT: CERT Review Contractor – AdvanceMed
- NOTE: all CMS review contractors may be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map> [accessed 12/5/23]

Current Typical MAC Hospice TPE Reviews

- General Inpatient Care (GIP)
 - Topic: General Inpatient Care (GIP)
 - Description: Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 656 and place of service codes Q5004–Q5009 [Q5004 – Skilled nursing facility (receiving skilled care). Q5005 – Inpatient hospital. Q5006 – Inpatient hospice facility. Q5007 – Long term care hospital. Q5008 – Inpatient psychiatric facility. Q5009 – Place not otherwise specified]

- Continuous Home Care (CHC)
 - Topic: 0652 [CHC]
 - Description: Hospice Services Continuous Home Care.
 - Review of claims submitted for hospice services continuous home care

Templates and Charting

- Medicare Program Integrity Manual (PIM), IOM Pub. 100-08, Chapter 3; §3.3.2.1- Progress Notes and Templates
- B. Guidelines Regarding Which Documents Review Contractors Will Consider
- The review contractor shall consider all medical record entries made by physicians and LCMPs [licensed certified medical professional]. See PIM 3.3.2.5 regarding consideration of Amendments, Corrections and Delayed Entries in Medical Documentation.
- The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service. See the applicable National and Local Coverage Determination for further details.
- **Some templates provide limited options and/or space for the collection of information such as by using “check boxes,” predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.**
- ...be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.

Regulations: Medicare Benefit Policy Manual

- MBPM, Publication 100-02, Chapter 9, Sections:
 - 40.1.5 – Short-Term Inpatient Care (GIP)
 - 40.2.1 – Continuous Home Care (CHC)
 - 40.2.2 – Respite Care (IRC)

MAC Local Coverage Determinations (LCD)

- National Government Services:
 - LCD L33393 Hospice – Determining Terminal Status
- Palmetto GBA:
 - L34566 Hospice - HIV Disease
 - L34544 Hospice - Liver Disease
 - L34547 Hospice - Neurological Conditions
 - L34559 Hospice - Renal Care
 - L34567 Hospice - Alzheimer's Disease & Related Disorders
 - L34548 Hospice - Cardiopulmonary Conditions
 - L34558 Hospice - The Adult Failure To Thrive Syndrome
- CGS Administrators:
 - LCD L34538 Hospice - Determining Terminal Status
- PROVIDES GUIDANCE FOR HOSPICE ROUTINE LEVEL OF CARE and TERMINAL PROGNOSIS DOCUMENTATION
- NOTE: does NOT address GIP, IRC, or CHC levels of care

Reminders When Using GIP and CHC

- Only use GIP or CHC level of care when the NEED for it is established
- Use guidelines and checklists to ensure charting captures specifics to support current and continued GIP/CHC level of care
- When the instability precipitating GIP/CHC level of care is no longer present transition the patient to most appropriate level of care
- Communication with facility and among staff is vital to managing GIP/CHC level of care service
- Collaborate with facility staff to ensure their charting is correctly identifying patient needs and is consistent with GIP/CHC level of need
- Ensure level of care status is communicated with the facility (GIP) to maintain accurate billing of service
- Hospice GIP and CHC level of care is for an ACTIVE condition
 - monitoring patient status without clear need or changes to the plan of care for any uncontrolled symptoms and keeping patients on GIP or CHC service without acute issues DO NOT QUALIFY for the higher level of care

What is GIP Level of Care?

- CMS Internet-Only Manual (IOM) Pub. 100-02, Medicare Benefit Policy Manual (MBPM), Chapter 9, Section 40.5, Short-Term Inpatient Care:
 - “General inpatient care is allowed when the patient’s medical condition warrants a short-term inpatient stay for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings.”
- Therefore, documentation must demonstrate that the services under GIP could not feasibly be provided in any other setting.

Where is GIP Care Provided?

- In order to provide for pain control, symptom management and care which cannot be managed at home, Hospice will make necessary arrangements for the patient to be admitted from home to inpatient status in:
 - An acute care hospital which Hospice has a contract for inpatient services;
 - A care center which Hospice has a contract for inpatient services, or;
 - A designated hospice inpatient unit which Hospice has a contract for inpatient services
- The patient may be moved from home or discharged from an acute hospital to a contracted facility to receive inpatient care (the facility must meet specific requirements).
- Unlike Continuous Home Care, GIP cannot be provided in the home.

Why is GIP Care Provided?

- General Inpatient care is provided when a patient requires skilled nursing care to manage acute medical crises which cannot be managed under RHC or CHC.
- Physical inpatient care is deemed necessary to address this acute medical crisis.
- Reasons a patient may require Inpatient Level of Care are similar to those that support Continuous Care—but they cannot be managed at home.
- Examples of GIP needs include an Aggregate of skills, agitation, bleeding, blood transfusion, cardiac failure, a condition requiring frequent assessment, decubitus management, intestinal obstruction, medication adjustments, mucositis, nausea/vomiting/diarrhea, pain management, respiratory distress, seizures, or wound care.

Indicators When GIP/CHC Is Needed (Part 1)

- Aggregate of skills: Imminently dying and/or without a caregiver
- Agitation: Requiring staff presence and/or medication titration
- Bleeding: Intractable, unresponsive to local measures
- Blood transfusion: Decreased hemoglobin and hematocrit with physician order for transfusion (usually a 24-hour GIP admission)
- Cardiac failure: Requiring frequent medication administration and also adjustments for stabilizing condition requiring frequent assessment
- Decubitus: Stage III or IV requiring frequent dressing changes
- Intestinal obstruction: Requiring systemic and local treatment
- Medication adjustments: Requiring patient monitoring

Indicators When GIP/CHC Is Needed (Part 2)

- Mucositis: Unable to eat or manage secretions
- Nausea/vomiting/diarrhea: Intractable, requiring medication changes for resolution
- Pain management: Intractable pain requiring intervention
- Respiratory distress: Compromised state requiring intervention (e.g., frequent suctioning, nebulizer treatments)
- Seizure: Intractable, requiring observation and/or medication titration
- Wound care: Draining, malodorous, and/or painful wound requiring frequent dressing changes
- CHC specific: breakdown of caregiver/patient support system
- Respite Inpatient Care (IRC): Patient care compromised by caregiver exhaustion, family emergency, caregiver illness or need to be out of town (maximum of 5 days allowed)

Goal of GIP/CHC

- The patient, family, physician and the hospice interdisciplinary team participate to place the patient in the setting best able to provide care: the home, nursing home, or in an inpatient setting.
- Patients who are in crisis may be transferred to an inpatient bed for controlled observation and symptom management.
- The goal: resolve the instability and uncontrolled symptoms.

A MAC on GIP/IRC

Source: www.ngsmedicare.com [accessed 1/29/24]

- Medicare covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient care which is for pain control and symptom management.
- **General Inpatient Care**
 - General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. The focus of general inpatient care is to provide an intensity of service in response to a crisis situation that cannot feasibly be provided in any other setting. A GIP level of service typically requires frequent monitoring of a patient, and/or medication or interventions by a physician or nurse.
 - If the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual's home, and if the individual's pain and symptom management can no longer be provided at home, then the individual may be eligible for a short-term general inpatient level of care. To receive payment for general inpatient care under the Medicare hospice benefit, patients must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting. It is the level of care provided to meet the individual's needs and not the location of where the individual resides, or caregiver breakdown, that determine payment rates for Medicare services.
- Payment at the inpatient rate is made when general inpatient care is provided at a Medicare certified hospice facility, hospital, or SNF.
- **General Inpatient Care and 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. Therefore, caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met.
- **General Inpatient Care at the End of a Hospital Stay--***IMPORTANT*****
 - General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot feasibly be provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate.

MAC Guidance on GIP/CHC Documentation

- Recommendations to help show documentation supports GIP/CHC level of care:
 - Describe the services provided.
 - Identify the precipitating event that led to GIP/CHC status.
 - Describe failed attempts to control symptoms that occurred prior to admission to higher LOC.
 - Identify specific symptoms that are being actively addressed.
 - Document care that patient's caregivers cannot manage at home.

GIP and CHC Documentation

- Documentation and charting requirements apply to the inpatient facility staff.
- These should be explained/reinforced at time of admission to GIP.
- Facility documentation is a crucial component for GIP care.
- The facility should have conducted training on hospice requirements.
- Medicare requires that Hospices can only bill 20% or less of all patient care days as Inpatient Level of Care and that all days are well-documented by the Hospice.
- CHC documentation is completed by hospice staff.
- The amount of hours of care provided by nursing and non-nursing service needs to be documented for coverage of CHC.
- CHC clinical interventions are similar to GIP actions.

Duration of GIP/CHC

- There is no specific limit to the duration of GIP or CHC.
- The length of stay under GIP/CHC is determined by:
 - Continued uncontrolled symptoms
 - Additional time is needed to achieve appropriate management of symptoms
 - Development of new symptoms and/or complications
- Once these symptoms are managed the patient must go back to routine homecare Level of Care (or other appropriate level of care).
- NOTE: Due to the instability that is required for continued eligibility for GIP/CHC level of care--it is unusual to be on GIP for a long period of time.
- Admission to GIP upon discharge from an acute inpatient facility must still be supported by patient need for GIP level of care (i.e., it is not simply to facilitate discharge from the facility).

Coming Off of GIP, CHC, IRC

- A patient should be discharged from GIP, IRC or CHC level of care when any of the following occur:
 - The problem that precipitated the higher LOC is managed
 - The goals for hospice intervention are met
 - Patient death
 - Respite days allowed have expired
- Respite inpatient level of care has the limit of five days per use
 - It has no specific limit to the number of times used or the frequency of use

Inpatient Respite Care (IRC)

- Inpatient **respite care** is provided to the patient only when necessary to relieve the family members or other caregivers that are caring for the patient at home.
- Coverage for respite care does not require that a worsening of the patient's condition precede the respite stay.
- **Respite** care is short-term inpatient care and is reimbursed for no more than five consecutive days at a time. This care is provided on an occasional basis.
- Any number of situations may necessitate respite care.
- Inpatient respite care may be provided directly by the hospice agency or indirectly under arrangements made by the hospice. Respite care must be provided by a hospice, hospital, or skilled nursing facility.
- Respite care cannot be provided to patients who live in a skilled nursing facility (i.e., there is no caregiver present that would need respite).

RN Care Manager GIP/IRC Admission Tasks

- Assess need for change to inpatient status; confer with interdisciplinary team when appropriate.
- Communicate with family to select appropriate facility for Inpatient care.
- Review financial responsibilities with the family and document this in progress notes.
- Contact Hospice supervisor to review status and obtain approval for change to Inpatient status.
- **IMPORTANT:** Obtain physician order for admission to care center, acute hospital, or hospice inpatient unit at Inpatient level of care. The order should read “Admit to __(facility)__ for hospice inpatient level of care for __(condition/symptom)___”.

GIP/IRC Admission Considerations

- When admitting to an acute care hospital attempt to bypass the emergency room by obtaining a physician order for admission directly to the appropriate unit/room.
- Hospice Care Manager notifies office and other IDT/IDG members of the change in Level of Care.
- For GIP in a nursing care center, a LOC form (agency specific document) should be completed and provided to the center. If no specific LOC form is used, Hospice Care Manager informs and documents the nursing care center of the LOC change.
- Make transportation arrangements for transferring the patient from home.
- Describe the reason for the change in LOC and the acute symptoms requiring inpatient care in the hospice chart. This creates baseline information to allow for determination of when the acute issue is resolved.
- When the patient is being admitted to a care center, obtain History & Physical (H&P) and chest x-ray prior to admission if possible (after hours and on weekends this may be provided to the care center on first working day). If there is no H&P available, the attending physician must be notified and must visit the patient in a care center within 48 hours of admission to meet federal requirements. Some centers may not accept without proof of TB screening.

Hospice Service During GIP

- Visit patient/family daily (a hospice staff member makes a visit).
- Best practice is daily hospice RN visit—but not a regulatory requirement.
- Hospice Social Worker should visit at least once weekly and as needed.
- Follow charting guidelines for patients on inpatient status.
- Documentation every visit by members of the interdisciplinary team:
 - Care and treatment provided
 - Progress or lack of progress to care and treatment per plan of care
 - Skilled observations related to condition changes
 - Vital signs as appropriate to manage the terminal conditions
 - Significant patient/family interactions
 - Communications with physician and/or new orders
 - A summary statement supporting the need for inpatient level of care

Hospice Service During IRC and CHC

- IRC does not have a particular hospice visit requirement.
- CHC best practice is to follow GIP/CHC guidelines in narrative note format:
 - Care and treatment provided
 - Progress or lack of progress to care and treatment per plan of care
 - Skilled observations related to condition changes
 - Vital signs as appropriate to manage the terminal conditions
 - Significant patient/family interactions
 - Communications with physician and/or new orders
 - A summary statement supporting the need for CHC
 - Status of family support situation
 - Coordinate nursing/aide service to ensure hours are met

Coordination With Facility During GIP

- Ensure charting on patient is consistent and shared between inpatient facility and hospice.
- Place an appropriate charting guide (specific to the reason for GIP) in the care center chart.
- Review care center daily documentation for compliance.
- Copy the facility Nurses Notes/Progress Notes at least weekly for filing into the hospice record.
- Copy the care center Order to Admit to Inpatient Care and any Pressure Ulcer assessments and wound care.
- Copy a Wound Assessment if the patient is utilizing inpatient care for complex wound care.
- Copy those treatment and medication records and physician orders which support the reason for inpatient care.

Facility Staff Responsibilities During GIP

- Accept admission orders and assign appropriate room.
 - Verify admission orders include the reason for admission, e.g., “Admit for inpatient hospice care status due to uncontrolled pain in lieu of acute hospitalization”
- Review admission documentation and take report from Hospice Care Manager.
- Follow care center or hospice unit admission protocols.
- Review hospice plan of care and integrate into care center plan of care as appropriate.
- Clarify all orders, pain control regimen, etc.
- Follow charting guidelines for patients on inpatient status.

Facility Charting During GIP

- Required charting is similar to SNF Medicare Part A patients.
- Ensure admission order includes a reason for change to inpatient status.
- Chart a minimum of DAILY and include:
 - Treatment/care provided
 - Response or lack of response to care/treatment provided per plan of care
 - Skilled observations related to condition changes
 - Patient/family or significant other interactions
 - Physician visits and/or hospice team visits
- Refer to Inpatient Charting Guidelines – these are specific documentation guidelines for each reason a patient might be on inpatient status, i.e., uncontrolled pain, respiratory distress, etc.
- Notify Hospice Care Manager of any change in condition, patient/family concerns, and immediately in case of death.
- Coordinate discharge plan with hospice staff.

Charting Guidelines: Pain Management

- Document pain characteristics at least every 8 hours and more frequently as indicated
- For an alert, verbal patient:
 - Description by patient; Location; Intensity – use a scale – word or number; Duration of pain – how long it lasts, it is constant? What is the acceptable level of pain for the patient?
- For a non-alert, non-verbal, confused patient:
 - Consider non-verbal cues: Moaning, grimacing, vital signs, tension, response to movement; Estimate pain level based on intensity of non-verbal behaviors – use word or number scale (such as FLACC)
- Interventions, instructions, and patient's response to:
 - Medications – routine and PRN/breakthrough pain medications
 - Comfort measures – turning, repositioning, back-rubs, warm moist heat
 - Related symptoms: Sleep pattern; Constipation; Nausea; Other (headache, attention span, anxiety)
 - Any communication concerning pain issues with patient, patient's family, hospice staff, care center staff, and/or physician
 - Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Cardiac Failure

- Document status at least once in 24 hours and more frequently as indicated
- Signs/symptoms of cardiac failure: severe shortness of breath, cyanosis, edema, excessive secretions, irregular heart rate, changes in Level of Consciousness
- Degree of comfort: assess pain, respiratory distress, agitation/restlessness
- Need for increased physical care: urinary catheter, safety measures, observation at bedside
- Increased need for psychosocial/spiritual support
- Document interventions, instructions, and patient's response to:
 - Medication administration
 - Addition of comfort measures
 - Increased psychosocial/spiritual support
 - Any other interventions related to management of cardiac failure (no CPR, no intubation)
- Any communication concerning cardiac issues with patient, patient's family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Family Teaching

- Document assessment and knowledge of family at least once in 24 hours and more frequently as indicated with teaching of:
 - Medication titration activities
 - Care of ostomies
 - Care of invasive tubes
 - Any new care modality
- Document interventions, instructions, and patient's response to:
 - Medication administration
 - Ostomy management
 - Invasive tubing management
 - New care modalities
- Any communication concerning teaching, response, and knowledge with patient, family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Blood Transfusion

- Document objective/subjective symptoms indicating transfusion:
 - Objective (with physician order): CBC count; Blood type; Cross match
 - Subjective: Profound weakness/lethargy; Profound shortness of breath; Ecchymosis (bruising)
- Document interventions, instructions, and patient's response to:
 - Inserting intravenous catheter
 - Blood transfusion procedure (per facility protocol)
 - Length of time for transfusion
 - Signs of transfusion reaction
- Any communication concerning blood transfusion issues with patient, family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Aggregation of Skills

- Often used when the patient is actively dying (but not required if RHC is addressing needs)
- Document status at least once in 24 hours and more frequently as indicated.
- Signs/symptoms of impending death: changes in Level of Consciousness, confusion/agitation, changes in pulse and blood pressure, changes in breathing pattern, condition of skin – color, presence of coolness, mottling, presence/absence of incontinence
- Degree of comfort: assessment of pain, respiratory distress, agitation/restlessness, oral mucosa
- Need for increased physical care (related to incontinence, diaphoresis, restlessness, confusion, safety factors, etc.)
- Increased need for psychosocial/spiritual support
- Assessment of family/significant others: Need for increased psychosocial/spiritual support; Need for information related to dying process, after death arrangements, etc.

Charting Guidelines: Aggregation of Skills, cont.

- Document interventions, instructions, and patient's response to:
 - Administration of medications or additional care (i.e., increased oral hygiene) related to maintaining comfort during actively dying phase
 - Manipulation of environmental factors (maintaining warmth, control of auditory and visual stimuli)
 - Increased counseling/supportive measures to patient/family
 - Any other interventions related to management of actively dying phase
- Any communication concerning actively dying phase with patient, family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Bleeding

- Document status of hemorrhaging at least once in 24 hours and more frequently as indicated.
- Based on source of bleeding, include:
 - Information pertinent to dressing changes: frequency of dressing changes, amount, color, consistency and odor of drainage. Include number of 4x4s, ABDs, etc. that are saturated.
 - Information pertinent to drainage collection tube or bag: type of tube/bag, amount of drainage collected, color, consistency and odor of drainage. Include use of NG tube to suction for GI bleed and Foley catheter in presence of GU bleeding.
 - Information pertinent to other types of bleeding problems (e.g., for rectal bleeding, document amount—measured or estimated, frequency, color, consistency, odor.
- Related factors:
 - Vital signs – observe for changes in blood pressure and pulse
 - Changes in level of consciousness
 - Skin color and turgor
 - Fluid intake and urinary output
 - Change in endurance/activity level

Charting Guidelines: Bleeding, cont.

- Document interventions, instructions, and patient's response to:
 - Pressure dressing/cold compresses if appropriate and ordered by physician.
 - Irrigation of tubes/collection devices if appropriate and ordered by physician.
- Encourage fluids if appropriate to patient condition.
- Document any other measures taken to control bleeding.
- Any communication concerning actively dying phase with patient, family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Agitation

- Signs/symptoms: Severe agitation/ hyperactivity; hallucinations; paranoia; combative/danger to others; confusion/ disorientation; psychosis; danger to self/ suicide risk
 - Document at least once every 24 hours and more frequently as indicated, assessment of factors related to inpatient status:
- Mental/emotional status (level of consciousness, orientation, mood, ability to communicate thoughts and feelings, thought content, speech patterns).
- Behavioral factors: description of identified problem, behaviors, frequency of occurrence, severity
- Conditions which decrease or increase identified unmanageable problematic behaviors:
 - Environmental factors – noise, light, music
 - Interaction with others
 - Specific activities
- Safety factors:
 - Removal of harmful objects from environment
 - Use of restraints/side rail padding
 - Continuous or frequent observation

Charting Guidelines: Agitation, continued

- Any other interventions related to identified problem
- Document any communication concerning agitation, dysfunctional/unmanageable behavior with patient, patient's family, hospice staff, care center staff, and/or physician
- Document changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Seizures

- Document status of seizure activity at least once in 24 hours and more frequently as indicated.
- Characteristics:
 - Description of seizure (body parts involved, length of time seizure lasts, severity of activity)
 - Identifiable signs/symptoms that occur before/after the seizure
 - Injuries resulting from seizure activity
- Related factors:
 - Post-seizure: Level of consciousness, orientation, vital signs, incontinence
 - Other factors that increase or decrease seizure activity
 - Safety factors (removal of harmful objects from environment, side rail padding, continuous or frequent observation)
- Document interventions, instructions, and patient's response to:
 - Administration of anti-seizure medication
 - Manipulation of environmental factors
 - Any other interventions related to seizure control
- Document any communication concerning seizure activity with patient, patient's family, hospice staff, care center staff, and/or physician
- Document changes in patient's acuity level (general improvement or deterioration in condition)

Charting Guidelines: Respiratory Distress

- Document status of respiratory distress at least every 8 hours and more frequently as indicated.
 - Rate and quality of respirations and lung sounds (shallow/deep, normal/labored, wheezing, crackles, gurgling, rattling), coughing, secretions.
 - Assess other vital signs: pulse, blood pressure, and temperature; assess skin color, nail beds
- Alert, verbal patient:
 - Description by patient (suffocating, chest feels tight)
 - Intensity – use a scale—word or number (use same scale consistently)
 - Number scale: 0,1,2,3,4,5
 - Word scale: No distress (0), Mild distress (1), Moderate distress (2), Very distressing (3), Severe distress (4), Unable to breathe (5)
- Non-alert, non-verbal, confused patient: consider non-verbal cues (anxious appearance/restless behaviors)
- Effect of respiratory distress on ability to eat, speak, sleep, perform ADLs and other activities

Charting Guidelines: Wound/Decubitus

- Document assessment of wound at least weekly and more frequently as indicated.
 - Location, size, stage, description of drainage, wound surface and surrounding tissue
 - Related factors; Vital signs, presence of elevated temperature, discomfort related to wound
- Document at least once in 24 hours:
 - Interventions, instructions, and patient's response to:
 - Wound care (include physician's order for care and frequency). Describe old dressing (saturation, number of dressings, etc.)
 - Administration of medications related to wound management (antibiotics, topical medications)
 - Use of special mattresses or devices related to wound management
- Any communication concerning wound management with patient, patient's family, hospice staff, care center staff, and/or physician
- Changes in patient's acuity level (general improvement or deterioration in condition)
- Related factors:
 - Patient's position related to pressure ulcer (i.e., "left hip ulcer. Patient refers lying on left side due to difficulty breathing when on right side").
 - The number of persons needed to perform wound care, or other difficulties related to the wound care that would make it impossible to care for

Charting Guidelines: Gastrointestinal

- Document status of nausea and/or vomiting in last 24 hours and more frequently as indicated.
- Characteristics:
 - Patient's report of nausea: severity, frequency, and duration
 - Episodes of emesis: frequency, amount, description, characteristics
- Related factors: Abdominal assessment: bowel sounds, distension, abdominal discomfort
- Bowel function: presence of constipation or diarrhea
- Nausea/emesis increases or decreases with intake, time of day, activity, medications, or pain
- Fluid and urinary output
- Hydration status: skin turgor, mucous membranes

Charting Guidelines: Gastrointestinal, continued

- Document interventions, instructions, and patient's response to:
 - Administration of anti-emetic medication
 - Use of NG tube if ordered by physician
 - Carbonated beverages, dry toast/crackers, small servings of bland room temperature food if appropriate
 - Comfort measures (positioning, environmental control (i.e., decreased stimuli, use of music, relaxation techniques))
- Document any communication concerning GI status with patient, family, hospice staff, care center staff, and/or physician
- Document changes in patient's acuity level (general improvement or deterioration in condition)
- NOTE: Obstipation is severe or complete constipation. It is one step further than constipation and is characterized by the inability to pass the accumulation of dry hard feces.
- NOTE: Mucositis is mouth or esophagus sores

GIP Charting Checklist

- Identify the precipitating circumstances necessitating the need for GIP level of care:
 - Pain, Dyspnea, Nausea/vomiting, Uncontrolled bleeding, Seizures, Respiratory Secretions, Other
- Is there an order to admit to GIP?
- Is there documentation that treatments tried in the home were ineffective?
- Is the patient moving from an inpatient hospital stay to a hospice facility?

GIP Charting Checklist

- Identify the precipitating circumstances necessitating the need for GIP level of care
 - Pain, Dyspnea, Nausea/vomiting, Uncontrolled bleeding, Seizures, Respiratory Secretions, Other
- Is there an order to admit to GIP?
- Is there documentation that treatments tried in the home were ineffective?
- Is the patient moving from an inpatient hospital stay to a hospice facility?
- Does the documentation clearly show there is a need for continued GIP level of care?
- Does the plan of care reflect the interventions to be used to manage the patient's needs?
 - Are there new treatment orders?
 - Are there new medication orders?
 - Are the changes effective?

GIP Charting Checklist, continued

- Do the members of the IDT/IDG visit the patient on an ongoing basis to determine continued eligibility for GIP level of care and to assess needs of the patient and family?
 - Does discharge planning show efforts made to transition the patient to a lower level of care?
 - Description of pain, shortness of breath, or other symptom
 - Documentation of interventions to control symptoms
 - Structural and functional impairments
 - Justification for a longer length of stay is needed: Is there documentation of the patient's response to treatment?
- Is there documentation of assessment of GIP symptoms at least every (inpatient) shift?
- Is there an ABN when the provider feels the patient does not meet GIP criteria but the patient or family wants GIP?

MBPM 100-02, Chapter 9, CHC

- 40.2.1 - Continuous Home Care (CHC)
 - (Rev. 12400; Issued: 12-06-23; Effective: 01-01-24; Implementation: 01-02-24)
- Continuous home care may be provided only during a period of crisis as necessary to maintain an individual at home.
- A period of crisis is a period in which a patient requires continuous care which is predominantly nursing care to achieve palliation or management of acute medical symptoms.
- If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver.
- This type of care can also be given when a patient resides in a long-term care facility. However, Medicare regulations do not permit CHC to be provided in an inpatient facility (a hospice inpatient unit, a hospital, or SNF).

CHC Guidance

- Continuous Home Care (CHC)
 - The supportive documentation should:
 - Show the beneficiary's condition warranting the interventions provided by the hospice staff at this higher level of care
 - Describe the beneficiary's response to care
- Although CHC is billed in 15-minute increments, the supportive documentation is not required to be every 15 minutes. Supportive documentation should be as frequent as necessary to support continued CHC and is suggested at least hourly.
- All nursing, aide and homemaker services must be counted into the continuous home care time. Hospices cannot choose to count fewer aide hours than were actually provided to increase the percentage of nursing hours. When aide hours exceed the nursing hours, routine home care must be billed.
- Care that spans midnight (e.g., 4 hours of skilled nursing care is provided from 8:00 p.m. to 12:00 a.m. and from 12:00 a.m. to 4:00 a.m.) cannot be billed as continuous care hours.

Staffing Continuous Home Care

- The hospice must provide a minimum of 8 hours of nursing, hospice aide, and/or homemaker care during a 24-hour day, which begins and ends at midnight (per calendar day period).
- This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening.
- In addition to the 8-hour minimum, the services provided must be predominantly nursing care, provided by either an RN, an LPN, or an LVN.
- This means that at least 50% of the hours of care are provided by an RN, LPN, or LVN.
- Homemaker or hospice aide services may be provided to supplement the nursing care.
- Medical social workers, counselors, pastoral care, and bereavement counseling by any staff member certainly may be appropriate and valuable in the home during a crisis; however, those hours may not be counted in the continuous care hours.
- NOTE: When fewer than 8 hours of care are required, the services are covered as RHC rather than CHC.
- When the aide hours exceed the nursing hours, CHC would be denied and routine payment will be made.

When to Use Continuous Home Care

- The following circumstances may establish need for CHC.
 1. Frequent medication adjustment to control symptoms/collapse of family support system
 2. Symptom management/rapid deterioration/imminent death

- Continuous home care is only furnished during brief periods of crisis and covered only as necessary to maintain the terminally ill individual at home.

GIP, IRC, CHC Compliance Reminders

- Only use GIP or CHC level of care when the NEED for it is established
- Use guidelines and checklists to ensure that charting captures the specifics to support current and continued GIP level of care
- When the GIP or CHC level of care instability is no longer present, transition the patient back to most appropriate level of care (usually routine)
- Communication with facility and among staff is important to managing GIP level of care service
- Collaborate with facility staff to ensure their charting is correctly identifying patient needs and is consistent with GIP level of need
- Ensure level of care status is communicated with the facility to maintain accurate billing of service for GIP
- Hospice GIP/CHC level of care is an ACTIVE condition: monitoring patient status without clear need, changes to the plan of care for any uncontrolled symptoms, and keeping patients on GIP/CHC service without changes in condition DO NOT QUALIFY for these levels of care

References and Resources

- 42 CFR 418
- Medicare Benefit Policy Manual (MBPM), IOM Pub. 100-02, Chapter 9:
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf>
- Palmetto GBA GIP audit tool:
[https://www.palmettogba.com/palmetto/providers.nsf/files/Hospice_GIP_Audit_Tool.pdf/\\$FILE/Hospice_GIP_Audit_Tool.pdf](https://www.palmettogba.com/palmetto/providers.nsf/files/Hospice_GIP_Audit_Tool.pdf/$FILE/Hospice_GIP_Audit_Tool.pdf)
- CGS Administrators levels of care:
https://cgsmedicare.com/hhh/coverage/coverage_guidelines/levels_of_care.html
- NGS GIP Level of Care: <https://www.ngsmedicare.com/web/ngs/hospice-documentation?selectedArticleId=433233&lob=93618&state=97210&rgion=93624>
- NGS CHC Level of Care: <https://www.ngsmedicare.com/web/ngs/hospice-documentation?selectedArticleId=916402&lob=93618&state=97210&rgion=93624>

Conclusion

- Only use GIP or CHC level of care when the NEED for it is established
- Train staff on what prompts need for the higher level of care
- Provide facility staff guidance and material to assist their charting compliance
- Use checklists for each GIP/CHC condition for key items to document
- Track GIP/CHC usage
- Only continue use of GIP or CHC level of care when CURRENT NEED is shown

- THANK YOU FOR THE PRIVILEGE OF YOUR TIME



EDUCATIONAL RESOURCES

Thank you

Joe.Osentoski@gatewayhhc.com

(248) 230-9588

gatewayhhc.com

 HOME HEALTH



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



MASTER CLASS SERIES



UNLOCK HOSPICE BILLING SECRETS

REGISTER NOW FOR
LIVE VIRTUAL CLASSES

MAY 2024