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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Top Hospice Medical Review
Most Frequent Denial Reasons

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5PM01</td>
<td>70% Information provided does not support a terminal prognosis of six months or less.</td>
</tr>
<tr>
<td>5PX06</td>
<td>8% Notice of Election is invalid because it does not meet statutory/regulatory requirements.</td>
</tr>
<tr>
<td>5PC01</td>
<td>5% Physician narrative statement not present or not valid.</td>
</tr>
<tr>
<td>56900</td>
<td>5% Requested documentation not received/received untimely.</td>
</tr>
<tr>
<td>5MP07</td>
<td>5% Physician services were not reasonable and necessary or were administrative in nature.</td>
</tr>
</tbody>
</table>

https://www.cgsmedicare.com/hhh/medreview/hos_denial_reasons.html
Effective Documentation of Terminal Status

Decisions are reliant upon documentation

Results in a full denial for the submission

Documentation must be legible

Medical necessity is always based on the patient’s condition

- Is it the patient or the documentation?
- Make the reviewer see the patient
  - The reviewer isn’t allowed to read between the lines

Effective Documentation of Terminal Status

Documentation is expected to show significant changes in the beneficiary’s condition and plan of care

- Always include admission assessment
- Decline must be evident in documentation
- Chart or graph may be helpful
**Weight – Very Important**

- Document patient’s weight at least monthly and more often if possible
- Take weights in consistent fashion
  - Time of day
  - Clothing
  - Consistency in relation to meal time
- Show prior and current weights
  - Don’t - “loss of 4 pounds in since last weighing”
  - Do – Patient went from 132 pounds on January 17, 2019 to 128 pounds on February 20, 2019, showing a loss of 4 pounds (3%) in 34 days.

**Measurements**

- Upper arm/girth/leg measurements starting at admission
  - Even if able to weigh patient
  - Shows trend if suddenly unable to weigh
- Include policy in documentation that shows how and where measurements are taken
  - Be consistent!
Pain – Major Indicator Show Progression

- **Level** of pain
  - 0-10 scale is preferable, but may not be workable
  - Consistent method of pain measurement is key
- Expressed in the way **patient/caregiver** understands
  - Colors
  - Small, Medium, Big
  - Wong-Baker FACES Pain Rating Scale

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Pain

- Type of pain
- Body language!!!
- What does pain mean to the patient
- What else does pain effect
- Document any **extenuating** circumstances
  - Examples: Wound care just completed, ready for pain meds, etc.
Responsiveness

- Does the patient react to your presence?
- Is the patient frightened of you?
- Does the patient remember you from last visit?
- Does the patient remember why you’re there?
- Unresponsive
  - Respond to touch? Smell? Light?
  - Fades in and out of alertness?

ADLs

Levels of Activities of Daily Living (ADL) dependence

- What can they do SAFELY?
  - Examples – getting in/out of shower, ambulate while carrying food
- Are they impulsive?
- How does independence change?
- What is patient’s reaction to loss of independence?
Vital Signs

- Respiration rate, blood pressure, pulse, temperature
- **Graph** easily shows change
- Does patient have a response to the procedure?
- What are specific vital signs for your patient?

Strength

- Ask the patient to squeeze your hands
  - Is there a difference from last visit?
  - Can the patient raise their hands to yours?
- Is the patient able to stand?
  - Assisted or unassisted
  - How **long**?
  - Safely?
- What are they no longer able to do because of loss of strength?
Lucidity

- Can the patient carry on a **lucid** conversation?
  - If you change the subject abruptly can they still follow along?
- Can the patient make decisions?
  - Simple or complex
- Current events
  - Inside or outside their world
  - Does it frustrate your patient?

I’s and O’s

**Intake**

- Make sure the serving size is **appropriate** and **consistent**
- Check for dehydration
- Is the patient offered food that they like and is appropriate for them?
- Appetite persistent or changing?
- Have their tastes changed?
- Do they lose interest in food?
- Does increased weakness make it difficult to finish a meal?
I’s and O’s

**Output**

– Patient requests a catheter or incontinence protection
  » Too tired/weak to get up to the bathroom?
– Is there an odor in the home?
– Is there a system in place to measure output that is **workable** for the patient/family?
– Is your patient no longer embarrassed to ask for help?

**Fatigue**

- Meet you at the door?
- Too tired to get out of chair?
- Recurrent?
- Too tired for self grooming?
- Too tired to prepare food or eat?
- No longer does favorite tasks?
Agitation

- Variable levels
- Unable to participate in conversation
- New?
- Increased?
- How easily is the patient agitated?
- Frustrated by what is happening to them?
- Does caregiver indicate frustration?

Social Status

- Change in social support
- Relationships
- Quit going to church, favorite functions?
Effective Documentation of Terminal Status

Pitfalls in terminal prognosis documentation:

- Paradigm shift for medical professionals
  - Have been trained to show improvement – not decline

- Amount and detail dependent upon situation
  - Chronic, deteriorating condition vs. rapid progression
  - Chronic, deteriorating condition may depend upon small details
  - Rapid progression may be focused on only one symptom

Effective Documentation of Terminal Status

Failing to show “big picture”

- Send in relevant documentation outside of period requested
  - Always send in admission assessments

- Remember the reviewer can’t see the person
  - Chart the obvious
  - Decrease in appetite may mean the patient’s dentures no longer fit or they don’t like what is being served

- Should be able to identify person from the documentation without seeing the name
Effective Documentation of Terminal Status

Obtain history and physical information
- May come from more than one source
  - Different sources may have different focus
  - Dietician, emergency room staff
- Recent hospital stay?
- Lives or lived at facility?
- What does caregiver notice?

Effective Documentation of Terminal Status

Use functional scale, as appropriate and always
tell what changed to make change in status
- Karnofsky Performance Scale (KPS)
  - 30%, 40%, 50%, etc.
  - Don’t average numbers
- Palliative Performance Scale (PPS)
  - 30%, 40%, 50%, etc.
  - Don’t average numbers
Effective Documentation of Terminal Status

Use functional scale, as appropriate and always tell what changed to make change in status

- Functional Assessment Staging (FAST)
- New York Heart Association (NYHA)
  - Should be determined by physician

Don’t forget documentation from the interdisciplinary group (IDG) meetings

- Information from other staff members
  - May have different perspectives
  - Different staff members see patient at different times and in different circumstances
  - Example – nurse compared with social worker or chaplain
  - Aides have valuable information. See patient at most vulnerable.
  - Visits at different times of day
Effective Documentation of Terminal Status

- Refer to Local Coverage Determination (LCD) for guidance
- Use numbers
- Use observations and data, not conclusions
- Clinical indicators of decline
  - Weight loss, infections, changes in mobility, etc.
- Review terminal admitting diagnosis – still appropriate?
- Reassessment is ongoing
- Remember quality versus quantity

Common errors include:

- **No significant decline**
  - Documentation by various disciplines do not show same level of decline without explanation
  - No measurable signs/symptoms presented for comparison
  - Documentation does not support terminal status
  - Documentation shows hospice benefit being utilized as long-term care benefit

Results in partial or full denial
Weights and Measurements

8% weight loss in 180 days

- 200 pounds = 16 pounds in 180 days to 194 pounds
- 150 pounds = 12 pounds in 180 days to 138 pounds
- 100 pounds = 8 pounds in 180 days to 92 pounds
- 90 pounds = 7 pounds in 180 days to 83 pounds
Weights and Measurements

November 2019 she weighed 180 pounds.  MAC 12.8 inches
March 23, 2018 she weighed 174.5 pounds.  MAC 12.5 inches
“She has lost the majority of her body fat”

Is there significant edema?
If commenting on the fit of clothing, make sure it's the patient’s clothing and not someone else's. Be specific.

Weights and Measurements

- June 2019: 112.2 pounds
- July 2019: 116.8 pounds
- Aug 2019: 117.1 pounds
- Sept 2019: 120.9 pounds
- Oct 2019: 101.6 pounds
- Nov 2019: 98.8 pounds
- Dec 2019: 104.8 pounds

No mention of edema in charting
Weights and Measurements

- 5’3” female
- 121 pounds
- “Clothes hanging on body; wasting; cachexic”
  - Who reported this?
- BMI 21.4 (Normal is 18.5 – 24.9)

Weights and Measurements

Admitted to hospice September 5, 2017

October 1, 2017  105 pounds
March 20, 2018  114.5 pounds
July 10, 2018   122 pounds
February 29, 2019  127 pounds

Should have noticed change and addressed (edema?) or discharged.
Nurse Documentation

Fast 7F
PPS 20

Lying in bed, no eye contact or movement with occasional grunt and drooling. Doesn't respond to touch or voice.

Very thin, no edema. Falls asleep while feeding.
Nurse Documentation

Pulse 87  Respiration 16
Pulmonary: Diminished LS (change from norm?)

Cardiac: 4+ BLE edema, irregular HR, impaired circulation
  Has edema been addressed?
  Irregular heart rate reported to physician?
  How is circulation impaired?

Secondary symptoms: cardiovascular compromise, breathing issues
  Addressed above – how are they secondary symptoms?
Skin: fragile, warm/dry, bruising, hx skin tears, pale
  Any current broken or torn skin?

November 14, 2019

Nurse Documentation

Client's appetite is fair.

*********************************************************************
She typically has something quick to fix for breakfast such as a frozen waffle or previously prepared hard boiled egg, eats leftovers from prior evening meal for her lunch, and her daughter brings her supper.

Are there always leftovers available? Do they need reheated?
Does dinner mean noon or evening?

November 14, 2019
Nurse Documentation

She was sleeping longer hours. On admission she was sleeping 8 hours and by this review she is sleeping 10 hours per day. She dozed off during conversations or assessments.

8/10 out of 24 hours or 8 hours during the day?

Nurse Documentation

04/22/17 (Admit)
Intake 50%; Incontinent B/B, SOB with minimal exertion, requires assist with 6/6 ADLs
PPS 30% 96 pounds

04/02/19
Intake less than 50% at meals. Incontinent of bowel and bladder at times. SOA with minimal exertion including eating and talking
FAST 6E PPS 30% 95 pounds
Nurse Documentation

Patient is sitting in her w/c or lying in her bed 90% of the day. She tries to get up by herself and is too weak and unsteady which is leading to falls. Max assist with two to get from bed to wheelchair. Patient will ambulate behind w/c on occasion.

Where does she live?

Is there always someone available to help?

Nurse Documentation

Recently patient sleeps more and doesn’t talk as much.
Nurse Documentation

Patient seems to be getting worse per visitor

Who reported?
How often do they see patient?
More details.

Nurse Documentation

86 y/o patient with Alzheimer's. Patient frail with sunken temples, hollow cheeks, muscle wasting. Very sleepy during visit – rouses to voice and returns immediately to sleep. Staff reports patient sleeps 18-20 hours per 24 hours. Patient is completely dependent for 6/6 ADLs. Bed to chair existence with assist of 2 to pivot from chair to bed. Patient continues to lose weight – down 13 pounds in past 5 months.

Intake?
Able to speak?
Nurse Documentation

ES Cardiac
Heart rhythm: irregular without pattern
Pitting Edema 2+ RLE

○
Exp Wheezes
B Diminished
SOB

Nurse Documentation

Feeds self, but uses utensils inappropriately
Had two infections in past 3 months. Treated with antibiotics.

Were infections resolved? UTI?

*************************************************************************

Unable to feed self – who reported?
Nurse Documentation

Patient sleeps 8 to 10 hours per day. He is able to feed himself, but does better with finger foods. His appetite is fair. He has had a 6 pound weight loss over the past 3 months. He also had a 2cm decrease in the measure of his right upper arm from October to December. Episodes of low blood pressure. Increased pain meds. Ambulation unsteady.

Staff Documentation
Staff Documentation

Social Work Assessment

Summary: 85 y/o Caucasian female dcd from SNF 5/22 then returned to hospital on 5/25. Pt had begun decline with confusion and memory loss, many falls and constant UTI’s. Ps was dx’d with significant resp failure d/t asp pna. Dgtr/mpoa chose hospice for comfort care only. Family very supportive of patient and each other. Patient’s spiritual needs have been met and faith is family’s strength.

November 14, 2019

Staff Documentation

Spiritual notes

Patient appears to be in discomfort
Appetite looks very good
Refused usual scripture reading

November 14, 2019
Staff Documentation

Has new shower chair due to increased weakness. Requires assistance with showers, where 6 months ago patient was able to get into a regular shower/tub combination without assistance. Showers shortened to 5 minutes, where patient used to enjoy being in the warm water.

Staff Documentation

SW Notes:
Patient is unsteady, uses walker and dependent on O2. Wheezing noticed prior to O2 being supplied by staff.

O2 not mentioned anywhere else in chart.

New to patient?
Did it belong to patient?
Contact physician
Staff Documentation

Chaplain notes:

Chaplain visited patient on date. He did not get up to open the door which is unusual for him. He appears thinner than at last visit, and more pale. He has to rest frequently when speaking because he becomes short of breath. Several times in the course of the conversation, he attempted to subtract numbers in order to figure out the years various events took place. Each time he became confused and gave up.

On April 27, patient had increased SOB to a self reported level of 10. He required a bed bath saying he was “too wiped out for a shower”. On April 28th he again had SOB with difficulty speaking having to stop every few words to take a breath. He was diaphoretic. His telephone was moved closer to his bed to minimize exertion.

SW – I put away his groceries I had obtained for him at the food bank because he was too short of breath to do it. He began to sweat as we talked. I encouraged him to slow down and take his time. April 28
Hospice Resources

Very Helpful

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 9)


Medicare Benefit Policy Manual
Chapter 9 - Coverage of Hospice Services Under Hospital Insurance
Six Months or Less Terminal Prognosis

http://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/hospice_documentation.html

Hospice Documentation

Hospice providers must establish and maintain a clinical record for every individual receiving care and services.
- The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.
- The record must include all services, whether furnished directly or under arrangements made by the hospice.
- Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary’s life expectancy is six months or less.
- Hospice benefit periods are unlimited as long as the above remains true and documentation of disease progression is evident.
- Generally, a beneficiary will show decline from one certification period to the next; however, this may not be the case for some beneficiaries whose condition may not run the normal course of decline and remain temporarily unchanged. However, documentation in the medical record should still show that the beneficiary has a six month prognosis.
- Documentation notes from multiple disciplines involved in the care of the beneficiary should demonstrate a picture of the beneficiary’s terminal progression. Avoid vague statement such as “slow decline” or “disease progressing” that do not clearly support the terminal progression requirements; the more objective the documentation, the better.
- When receiving a beneficiary as a transfer from another agency in the middle of a benefit period, obtain a copy of the signed certification for that benefit period from the transferring agency to complete that benefit period. Remember that the benefit period does not change due to a transfer.
- When a beneficiary’s level of care changes, the documentation should show when the change occurred and the reason for the change.

Additional Resources

*Suggestions for Improved Documentation to Support Medicare Hospice Services* quick resource tool

*Sedative Clinical Factors to Consider During Recertification of Medicare Hospice Patients* quick resource tool

Hospice Clinical Resources


SUGGESTIONS FOR IMPROVED DOCUMENTATION to Support Medicare Hospice Services

- Documentation to Support Hospice Admission
  - Change in condition to initiate hospice referral
  - Diagnostic documentation to support terminal illness
  - Physician assessment and documentation
  - Date of diagnosis and course of illness
  - Patient has desire for palliative, non-curative treatment (signed election statement)

- Documentation to Support Level of Care
  - Patient needs or event (symptom control via Opioid or non-Opioid medications)
  - Change in anthropomorphic measures
    - Upper arm measurement (inches, centimeters)
    - Abdominal girth (inches, centimeters)
  - Change in signs
    - Respiratory rate (increased, decreased)
    - Oxygen flow rate (liters)
    - Hypertension
    - Bradycardia
    - Edema
      - Level 1, 4, pitting, non-pitting
      - Tumor (size, location)}
Six Months or Less Terminal Prognosis


**APPROPRIATE CLINICAL FACTORS TO CONSIDER DURING RECERTIFICATION OF MEDICARE HOSPICE PATIENTS**

The following is a guide hospice providers and their staff can use during recertification of a hospice patient. This tool is intended only as a guide, and is not inclusive, nor ensures payment. The use of this tool is not required and is completely voluntary. Any new/persistent change in clinical factors exhibited by the patient should be documented in the medical record to support the appropriateness of the hospice services provided. Documentation should be in a quantitative form (pounds, 4 on a scale of 1-5, inches, etc.) (See Suggestions for Improved Documentation tool)

**CLINICAL STATUS**

- Appetite/food consumption
- 

**SYMPTOMS**

- Cough/persistent change

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**CGS HH&H Website: Educational Materials**

http://www.cgsmedicare.com/hhh/education/materials/hospice_qrt.html

**Hospice Quick Resource Tools**

- Medical Review Additional Development Request (AR ADM) Tool [PDF]
- Hospice Face-To-Face (FTF) Encounters for Recertification [PDF]
- Hospice Reference [PDF]
- Medicare Hospice Benefit Facts [PDF]
- Summary of Hospital Records Requests [PDF]
- Hospice Prescription Drug Reporting Table [PDF]
- Hospice Prescriptions for New Patients [PDF]
- Hospice Reimbursement for New Patients [PDF]
- Hospice Reimbursement for New Providers [PDF]
- Submitting Hospice Notice of Election (HOBIS) [PDF]
- Submitting a Hospice Notice of Election via EDDI (HOE) – ECN [PDF]
- Submitting a Hospice Notice of Elections (EDDI) [PDF]
- Submitting a Hospice Notice of Change of Patient (EAD) [PDF]
- Submitting Hospice Notice of Change of Location (EDR) [PDF]
- Submitting Hospice Notice of Change of Sponsorship (EAD) [PDF]
- Submitting Hospice Notice of Transfer of Care (EDR) [PDF]
- Submitting Hospice Notice of Change of Sponsorship (EAD) [PDF]
- Submitting Hospice Notice of Transfer of Care (EDR) [PDF]
- 2019 Leap Year Hospice Face-To-Face Encounter Calendar [PDF]
- Hospice Face-To-Face Encounter Calendar [PDF]
- Hospice Reimbursement for New Patients [PDF]
- Hospice Reimbursement for New Providers [PDF]
- Hospice Reimbursement for New Clinicians [PDF]
- Signature Guidelines for Home Health & Hospice Medical Review [PDF]
- Suggestions for Improved Documentation to Support Medicare Hospice Services [PDF]
- Hospice Clinical System Sheets [PDF]
- Hospice Certification Recertification [PDF]
- Hospice NPI & NPIs [PDF]
- Hospice Enrollment Statement [PDF]
- SCPBS – Plan of Care [PDF]
- STRA2017/PP20 – Reduced Level of Care [PDF]
- STRA313 – Six Month Terminal Prognosis [PDF]
- STRA353 – Six Month Terminal Prognosis [PDF]

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CGS Frequently Asked Questions

http://www.cgsmedicare.com/hhh/education/faqs/index.html

Frequently Asked Questions (FAQs)
- Additional Development Request (ADR)/Medical Review
- Adjustments/Cancal
- Appeals
- Ask-the-Contractor Teleconference (ACT) Questions and Answers
- Beneficiary Eligibility Information
- Checking Claim Status
- Comprehensive Error Rate Testing (CERT) Program
- Cost Report
- Cost Report Reopening
- DME
- Home Health Billing
- Home Health Clinical – Medical Review
- Hospice Billing
  - Change Request 8358
  - Change Request 8877
  - Change Request 8877: Updates from CGS on Timely Filing of NOEs and Exception Requests Ask-the-Contractor Teleconference (ACT), February 18, 2015
  - Change Request 8877 Ask-the-Contractor Teleconference (ACT), September 24, 2014
- Hospice Clinical
- Hospice Face-to-Face (FTF) Encounters
- Hospice Physician Billing
- ICD-10-CM/PCS
- Payer/Contractor Policies and Procedures (PCPP)

Documentation Checklist


HOSPICE Documentation Checklist Tool

Selection Statement

Does the Election Statement include the following information:
- Identification of the hospice that will provide care
- Acknowledgement the beneficiary has been given a full understanding of hospice care, palliative versus curative treatment
- Acknowledgement certain Medicare services are waived by the election of hospice
- Effective date of the election
  - May be the first day of hospice care or a later date, but cannot designate a retroactive effective date
- Designated attention physician information if any, including, but not limited to, the
**Documentation Checklist**


### Terminal Prognosis

**Does the documentation “paint the picture,” especially for patients that:**

- Have remained on the hospice benefit for a long period of time; or
- Have chronic illnesses with a more general decline

**Does the documentation support the six-month terminal prognosis?**

Documentation at the time of hospice admission may include:

- Changes in condition to initiate the hospice referral
- Diagnostic documentation to support terminal illness
- Physician assessments and documentation
- A date of diagnosis
- A course of the illness
- The patient's desire for palliative, not curative care
- Records that show a trajectory of decline
- Increasing ER visits or hospitalizations

Documentation throughout the hospice election may include:

- Changes in:
  - Patient's weight
  - Pain (type, location, frequency)
  - Responsiveness
  - Level of dependence for ADLs
  - Anthropomorphic measurements (abdominal girth, upper arm measurements)
  - Vital signs (RR, BP, pulse)
  - Strength
  - Lucidity
  - Intake/output
  - Skin condition (turgor)
  - Diagnostic lab results (when available)

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**Terminal Prognosis**

**Is the documentation objective and include quantifiable values/measures (e.g., Pounds, 4 on a scale of 1-5, inches, etc.)?**

**Does the documentation avoid the use of vague statements such as “disease progressing” or “slow decline”?”**
Questions?

CGS Provider Contact Center:

**1.877.299.4500**

Option 1: Customer Service

Option 2: Electronic Data Interchange (EDI)

Option 3: Provider Enrollment

Option 4: Overpayment Recovery (OPR)

OR

**J15_HHH_EDUCATION@cgsadmin.com**