MEDICARE INPATIENT BENEFIT

- There are two types of inpatient care under Medicare:
  - *General Inpatient Care is for pain control and symptom management*
  - *Respite is for of the patient's caregivers*
- Each type is provided under contract
- For 2008, Medicare Reimbursement is
  - GIP - $647.45
  - Respite - $148.89
- So, you can see why it's very important that we understand the differences between the two and have air-tight documentation for back-up!

1

MERRIMACK VALLEY HOSPICE

- GENERAL INPATIENT LEVEL OF CARE(GIP):
  - Level of difficulty on a scale of 1-10.....11!
  - Some of the most complex patients, with multiple diagnoses, refractory symptoms
  - Complicated, convoluted and confounding family situations

2

SETTINGS FOR GIP

- **Short-term inpatient care maybe provided in a participating:**
  - **Hospice Inpatient Unit**
  - **Skilled Nursing Facility**
  - **Nursing Facility***

  ***Must meet the special hospice standards regarding patient and staffing areas.**

3

GIP BASIC REQUIREMENTS

- 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. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.

4

GIP FOR PAIN MANAGEMENT

- Pain requiring:
  - Complicated technical delivery of medication requiring RN for calibration, tubing changes, or site care;
  - Frequent evaluation by physician/nurse;
  - Aggressive treatment to control pain;
  - Frequent medication adjustment.

5

GIP FOR SYMPTOM MANAGEMENT

- Symptom changes such as:
  - Sudden deterioration requiring intensive nursing intervention;
  - Uncontrolled nausea and vomiting;
  - Pathologic fractures;
  - Respiratory distress which becomes unmanageable;
  - Open lesions requiring frequent skilled care;
  - Traction and frequent repositioning requiring more than one staff member;
  - Complex wound care requiring complex dressing changes;
  - Severe agitated delirium or acute anxiety or depression secondary to the end-stage disease process requiring extensive intervention.
  - Imminent death:
    - Requiring skilled nursing care for pain or symptom management. Note: imminent death without a need for aggressive symptom management is not a reason for GIP.

6

UNDER OR OVER THE RADAR?

- Right now, we know that GIP is on the Medicare radar
- GIP has seen explosive growth, especially in the LTC setting by for-profit hospices
- GIP cases will probably be identified for audit by NGS (fiscal intermediary) in the near future
  - Auditors may or may not have hospice experience – could be a nurse with OB experience 20 years ago – so we need to spell things out!

7

WHERE WE CAN IMPROVE

- For patients admitted to GIP for symptom management we need to:
  - Identify the target symptom(s) clearly
  - Make sure all members of IDT know what the target symptoms are
  - Reference the target symptoms in all notes
  - Focus on symptoms the patient has – don't shine the light on things that are NOT present

8

GIP BASICS

- If the patient revokes to access the SNF benefit and has been on GIP ***in the hospital*** for 3 days or more, the 3-day stay qualifies the patient for the SNF benefit.
- If the patient needs NH placement, the search should be wide, should not decide on just one facility and wait until there is a bed, unless one will be available quickly.

9

DOCUMENTATION DOs & DON'Ts

DON'T

- Patient is well-palliated
  - This is a red-flag for a reviewer. Reviewer sees this as a stable patient no longer needing GIP

DO

- Patient reports pain as 4/10, down from 9/10 yesterday. Goal is 48 hours of stable pain relief before considering discharge home.

10

DOCUMENTATION DOs & DON'Ts

- Roxanol given with excellent relief

- 3:00 PM – Pain score = 8, Roxanol administered
- 3:30 PM – Pain score = 3

11

DOCUMENTATION DOs & DON'Ts

DON'T

- Family would like patient to be admitted for GIP – they cannot afford room and board
  - Although the family may be the catalyst for the request, GIP must be used based on IDT assessment

- DO
  - Family reports patient cannot be kept in bed, is wandering, combative and unable to take po medications. Pt. screams with pain, but does not allow family near.

12

DOCUMENTATION DOs & DON'Ts

DON'T

- Patient appropriate for inpatient level of care.
  - Why? Need to explain what the skilled needs are and what symptoms require intensive management.

DO

- Patient was admitted to ABC Hospital last week with ES COPD and pneumonia. Unable to tolerate Bi-Pap d/t dementia. Family wishes to stop IV antibiotics. Appropriate for GIP for management of terminal respiratory symptoms.

13

DOCUMENTATION DOs & DON'Ts

- DON'T
- decrease in cognitive function, increase lethargy, poor ability to concentrate and focus, increase in periods of apnea, increase ascites, unsteady ambulating and unable to stand by himself. **Pain well managed at present. No dyspnea. No n/v,** poor po intake-sips of fluids and soft solids, **no tremors, seizures or agitation**.

- DO
- decrease in cognitive function, increase lethargy, poor ability to concentrate and focus, increase in periods of apnea, increase ascites, unsteady ambulating and unable to stand by himself. Poor po intake-sips of fluids and soft solids.

14

DOCUMENTATION DOs & DON'Ts

- Words to avoid:
  - Comfortable
  - Well-managed
  - No complaints
  - Stable
  - Patient resting
  - Patient sleeping soundly (sleeping will do!)

15

DOCUMENTATION DOs & DON'Ts

- Avoid references to EOL care – EOL care can be delivered at a lower level of care – its symptom management that is key for GIP
- Imminent death is not a reason for GIP – patients die at home every day -

16

DOCUMENTATION DOs & DON'Ts - NARRATIVES

- Use only when you are unable to document important information that can't be covered under one of the formatted tabs
- Avoid extraneous comments such as:
  - Asked for a cup of decaffeinated coffee
  - Walked to the kitchen to get an Italian Ice
  - Had a nice visit with his dog

17

GIP GENERAL TIDBITS

- GIP is for pain/symptom management or ***skilled nursing care*** for a patient whose home support has broken down
- GIP contracted facilities must have 24-hour registered nursing services.
  - Tip - Nursing services should be "hands-on". It is not sufficient for the facility to have only a supervisory registered nurse who does not provide direct patient care.

18

GIP PAIN/SYMPTOM MANAGEMENT TIDBITS

- Examples of GIP for pain/symptom management:
  - At the end of a hospital stay, patient elects hospice benefit and remains in need of pain/symptom management that cannot be provided in another setting.
  - EXAMPLE: Patient is experiencing terminal restlessness/agitation and needs frequent assessment and medication adjustment. The patient is a large man, and the primary caregiver, his wife, is a petite woman who cannot physically assist him when he is agitated.

19

GIP PAIN/SYMPTOM MANAGEMENT TIDBITS

- Interventions in the home have not effectively managed the symptom
  - EXAMPLE: In spite of increased visits by the nurse, medication adjustments and frequent communication with the attending physician, the patient's respiratory distress is causing her severe anxiety, and her children are frightened.

20

GIP PAIN/SYMPTOM MANAGEMENT TIDBITS

- Complicated technical interventions are required
  - EXAMPLE: Patient is on a CADD pump for pain control and needs complex dressing changes for multiple necrotic pressure ulcers requiring pre-procedure medication
- Frequent assessment and medication adjustment by a nurse is necessary
  - Patient and her caregiver have previous issues of substance abuse and patient has been taking excessive amounts of pain medication to the point of near over-dose – needs skilled assessment for pain every 4 hours around the clock

21

GIP PAIN/SYMPTOM MANAGEMENT TIDBITS

- Open lesions requiring frequent skilled care and/or complicated dressings
- Patient/family teaching for complex medications or treatments
- Imminent death requiring skilled nursing care
- Stabilizing treatment such as psycho-social monitoring (e.g., patient may have suicidal ideation, agitation requiring 1:1, exacerbation of pre-existing mental illness)

22

GIP CARE-GIVER BREAKDOWN TIDBITS

- Behavioral issues such as dementia or confusion that require 24-hour supervision do not qualify for GIP unless ongoing skilled assessment and intervention is being attempted – goal to return patient home or to routine care nursing facility when stabilized.
  - *Tip – include recommendation that facility staff observe patient's response to various environmental factors/stimulation such as meals, music, visitors etc. Identify suspected "triggers" and recommend that they be avoided. Make sure medication/other interventions are linked to the skilled assessment!*

23

EXAMPLES OF CARE THAT IS NOT GIP

- Care-giver, and not patient need precipitated the GIP admission and no skilled needs are documented – *"family requests GIP"*
- Hospice admission following acute hospital stay where symptoms are managed and no new interventions are recommended by hospice
  - *Tip – make sure hospice recommendations are clear – may be as much or more about discontinuing meds, vital signs or other interventions as adding them!*

24

GIP "HOUSEKEEPING" DETAILS

- Any admission or change in GIP is a "Status Change".
- Any change in GIP is communicated to the attending physician and medical director.
- All patients on GIP level of care are discussed at IDT & the discussion is documented.
- IDT is in daily communication with facility staff regarding discharge planning – and documented in medical record.

25

RESPITE

- Respite is for "R&R" for caregivers – including "caregiver breakdown"
- Respite cannot be used for "caregiver breakdown" if there is no caregiver
  - Per Medicare, a "caregiver" is family, friends or other individuals
  - A "caregiver" is not a facility

26

RESPITE CARE TIDBITS

- Respite care can be provided for no more than 5 consecutive days on an "occasional" basis.
- Respite care is provided in a facility with which the hospice has a *contract for respite care.*
- Examples of respite care:
  - Caregiver needs a "break" for a short time and plans to resume care again
  - Caregiver unavailable due to personal illness (patient without skilled needs)
  - Caregiver needs to go out of town overnight

27

IN A NUTSHELL

- We want to provide the services needed by our patients and families
- We need to ensure that we are paid for providing those services, so that we can continue to expand our services to others who are in need
- By understanding the rules and regulations and making sure our practices and documentation are "tight" we can continue to thrive!

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The Hospice General Inpatient Level of Care

Criteria, Service Guidelines, Reimbursement and Contracting

A Report of
the General Inpatient Task Force
Hospice & Palliative Care Federation of MA
2008

Hospice General Inpatient Level of Care Task Force

Chair: JoAnne Nowak, MD, Medical Director, Partners Hospice

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Deborah Dolaway, LICSW, Hospice Administrator, Cranberry Hospice
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This document is intended to provide general guidance and not as legal authority.

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Mary H. Michael, JD and Matthew K. McManus, JD, Reinhardt Boerner Van Deuren, Madison, Wisconsin
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This report was reviewed by:
James W. Cope, MD, Medical Director, Part A, National Government Services, Inc.
(This review does not necessarily serve as an endorsement by National Government Services or the Centers for Medicare and Medicaid Services)

GENERAL INPATIENT LEVEL OF CARE (GIP)

A REPORT OF THE HOSPICE & PALLIATIVE CARE FEDERATION'S GENERAL INPATIENT TASK FORCE

I. Background

In Fall, 2007, the Federation's Board of Directors charged JoAnne Nowak, MD, Partners Hospice with chairing a task force to review, revise and update a Best Practice report on the General Inpatient Level of Care published in 2004.

This report summarizes the recommendations of the Task Force assigned to develop the Best Practice paper on the General Inpatient Level of Care.

Members:

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Nancy Muse, Director, All Care Hospice

In the course of its work, the GIP Task Force reviewed applicable regulations from the Medicare Conditions of Participation, the MA Department of Public Health; Standards of The Joint Commission (TJC) formerly the Joint Commission on the Accreditation of Health Care (JCAHO) and Community Health Accreditation Program (CHAP) and the National Hospice and Palliative Care Organization's (NHPCO): 2006 Standards of Practice for Hospice Programs; Hospice Operations (2005) and Service Guidelines.

On June 5, 2008, the Center for Medicare and Medicaid Services (CMS) published a new Final Rule: Medicare Hospice Conditions of Participation (CoPs). Hospices have been given a 180 day implementation deadline of December 2, 2008. Conditions and standards of the General Inpatient Level of Care have been substantially revised. The GIP Task Force will revise this report again to reflect the new CoPs but interested individuals can access them now at ***http://edocket.access.cpo.gov/2008/pdf/08-1305.pdf.***

This report was accepted by the Federation's Board of Directors on June 25, 2008.

II. DEFINITION

Inpatient care or services means short-term, general inpatient care provided either through a contract arrangement with an appropriately licensed and Medicare-certified hospital or long term care facility or directly by a hospice program in its hospice inpatient facility to provide pain control and symptom management that cannot be accomplished in another setting.
The home is defined as the patient's residence which may be a nursing home, group home, assisted living facility or personal residence.

III. REGULATIONS AND STANDARDS REGARDING THE GENERAL INPATIENT LEVEL OF CARE

***Medicare Conditions of Participation* 42 CFR Part 418**

418.98 **Short term inpatient care**

Inpatient care must be available for pain control, symptom management and respite purposes and must be provided in a participating Medicare or Medicaid facility.

(a) *Standard: Inpatient care for symptom control.* Inpatient care for pain control and symptom management must be provided in one of the following:

(1) A hospice that meets the condition of participation for providing inpatient care directly as specified in Sec. 418.100

(2) A hospital or a SNF that also meets the standards specified in Sec. 418.100 (a) and (e) regarding 24-hour nursing service and patient areas

***MA Licensure Regulations* (revised 9/03) 105 CMR**

141.020 Definitions

Inpatient care or services means short-term, general inpatient care either through a contract arrangement in a hospital or long term care facility or directly by a hospice program in its hospice inpatient facility to provide pain control and symptom management that cannot be accomplished in home or community.

141.204 Required Patient Care Services

(H) Inpatient Care

(1) The hospice shall provide or arrange for short-term inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting.

(2) Inpatient care shall be provided in hospitals licensed pursuant to M.G.L c.111. 51 or long term care facilities licensed pursuant to M.G.L. c. 111. 71 with whom the hospice has entered into a written contract, or hospice inpatient facilities directly owned and operated by a hospice program licensed pursuant to M.G.L. c.111.57D.

NHPCO Standards of Practice for Hospice Programs (2006) Appendix I-Hospice Inpatient Facility

(HIF) Hospices that operate an owned or leased inpatient facility will comply with applicable federal, state, and local health and safety laws, regulations and codes unless specific

waivers have been granted by the appropriate regulatory authorities. The inpatient facility and its staff will be appropriately licensed and, as applicable, certified to provide inpatient care.

CES 8.4

Care provided by the hospice in a contracted facility adhere to the same:

1. Standards of care
2. Intensity
3. Mix of service as that provided to patients in their own place of residence.

HIF IA I

Access to hospice general inpatient care is made available to all hospice patients who are in need of inpatient pain control or symptom management which cannot be provided in other settings and who meet the general admission criteria for admission to a hospice program.

HIF IA 1.1

The hospice patient has a right to participate in the decision-making process regarding where the inpatient level of care is to be delivered.

HIF IA 1.2

Access to hospice general inpatient care allows for options other than the hospice inpatient facility.

NHPCO Service Guidelines

II. V. Facility Based Services

Hospices providing care in all facility-based settings must:

- Ensure that the level of intensity and mix of hospice services meet the patient's needs and that service levels and visits are congruent across care sites.

CHAP

HII.9 Short-term inpatient care is available for pain control, symptom management and/or respite purposes and must be provided in a participating Medicare or Medicaid facility, 42 CFR 418.98 (a,b), (L-220, L-221)

HII.9a Inpatient care for pain control and symptom management is provided in one of the following settings:

1) A hospice facility that meets the Conditions of Participation for providing inpatient care directly as specified in 42 CFR.100 (L-222)

2) A hospital or SNF that also meets the standards specified in 42 CFR.100 (a) and (e) regarding 24 hour nursing service and patient areas (L-223)

IV. SERVICE LEVELS

***Medicare Conditions of Participation* 42 CMR Part 418**

418.100 Hospices that provide inpatient care directly

(a) Standard: Twenty-four hour nursing services

(1) The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient's plan of care. Each patient receives treatments, medication, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) Each shift must include a registered nurse who provides direct patient care.

(f) Standard: The Medical Director or his/her physician designee shall conduct regular onsite visits to the inpatient facility, including daily visits if necessary, to assess patient conditions and reevaluate medical orders of unstable patients.

***MA Licensure Regulations* CMR 105**

141.204 Required Patient Care Services

(H) Inpatient Care.

(4) Unless, pursuant to 105 CMR 141.099 (B), the Commissioner waives the applicability of a particular hospice of one or more of the requirements imposed herein, the hospice, with respect to the hospice inpatient facility directly owned and operated by the hospice program, shall:

(c) provide nursing services directly and meet the following additional nursing staffing requirements:

(i) A registered nurse shall be designated as director of nursing (or equivalent title). He/she shall be a qualified registered nurse who has administrative authority, responsibility and accountability for the functions, activities and training of nursing services staff.

(ii) A registered nurse shall be on duty in the hospice inpatient facility to supervise nursing care and nursing personnel 24 hours a day.

(iii) One registered nurse may serve as both director of nursing and day shift nursing supervisor if he/she can carry out adequately the responsibilities of both positions.

(iv) Additional licensed nursing and other staff shall be provided to meet each patient's total care needs 24 hours a day.

(4)(e) (iii)(a) All therapeutic diets shall be planned, prepared and served with consultation by a dietician.

NHPCO Service Guidelines

II. Levels of Care

2. General Inpatient Care

Policies should define that a minimum of one interdisciplinary team member contact per day (primarily visits), supplemented with volunteer visits as indicated is expected while the patient is on General Inpatient status at a contracted facility.

Committee Recommendation

The Committee endorses this voluntary NHPCO Service Guideline and recommends a daily visit, generally by a nurse, due to the ***medical acuity*** of GIP care.

NHPCO Standards of Practice for Hospice Programs (2000)
NHPCO Appendix I - Hospice Inpatient Facility

HIF PFC 1
Nursing services are available on-site twenty four hours a day, seven days a week, to meet the patient's nursing needs in accordance with the hospice plan of care.

HIF PFC 1.1 A registered nurse experienced in providing direct care to hospice patients is available on-site at all times

HIF PFC 1.2 Other nursing staff including registered nurses (RN), licensed practical nurses (LPN) or licensed vocational nurses (LVN) or hospice aides (titles as defined by applicable law) are available to ensure that each patient's medical needs are met in a timely, compassionate and professional manner.

Committee Recommendation

The Committee endorses voluntary NHPCO Standards HIF PFC 1, 1.1, and 1.2 as they are consistent with the Medicare Hospice Conditions of Participation. Massachusetts state hospice regulations (and the Conditions of Participation) require that a RN provide direct care to the patient on all shifts whether the setting is a freestanding GIP unit owned and managed by a hospice program or in a contracted facility.

HIF PFC 2 Psychosocial and spiritual care is available 24-hours a day, 7 days a week, to meet the needs of each patient and family receiving hospice general inpatient care.

Committee Recommendation

The Committee supports this voluntary standard and encourages hospices to evaluate their processes as to how to meet this goal. It is recommended that the interdisciplinary team anticipates and plans for the needs of patients who may require social work services and/or pastoral care during off-hours. Hospices should have crisis intervention policies in effect that clarify how the IDT and community resources are to be utilized. For example, hospices may supplement their pastoral care staff with community clergy to provide 24-hour spiritual care to patients.

HIF PFC 2.1 Psychosocial and spiritual care is provided by members of the hospice interdisciplinary team and/or counselors or social workers directly assigned to the hospice inpatient facility.

Committee Recommendation

The Committee endorses this voluntary NHPCO standard.

CHAP

HII.8aThe inpatient hospice facility provides 24-hour nursing services that are: (L-224, L-302)
1) Sufficient to meet the patients' total nursing needs
2) In accordance with the patient's plan of care for treatments, medications and diet as prescribed

3) Focused on insuring that the patient is kept comfortable, clean, well-groomed and protected from accident, injury and infection

HII.8b Each shift at the facility must include a registered nurse who provides direct patient care. (L-303)

V. CRITERIA FOR ADMISSION TO THE GIP LEVEL OF CARE *(See also Sample Policy included in Appendix A)*

Committee Recommendation

The Committee recommends the following criteria as guidelines for admission to the GIP level of care. The recommendations were drawn after a review of the 2008 Federal Wage Index NRPM (1), Cahaba GBA coverage guidelines (2), and United Government Services "Hospice Determining Terminal Status." (3)

(1) FY 2008 Wage Index NRPM. Fed Reg vol 72 no 83, May 1, 2007: 24119-24120

(2) Coverage Guideline for Hospice Agencies, Cahaba Government Benefit Administrators (r) (BGA), LLC. June 2006

(3) Hospice-Determining Terminal Status - UGS ***http://ugsmedicare.com/providers/lmrp/lmrp_home.asp last accessed October 4, 2007.***

(4) Medical Benefit Policy Manual, Chapter 9, Coverage of Hospice Services Under Hospital Insurance 40.1.5. Short-term inpatient care

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) believes the patient needs pain control or symptom management that *cannot feasibly be 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" should not be billed as GIP regardless of where services are provided unless the intensity-of-skilled care requirement is met.*

The hospice may provide GIP care or contract with a participating hospital, skilled nursing facility or hospice inpatient unit that provides 24-hour nursing care. The hospice maintains professional responsibility for its patient and works with the facility in the development of the patient's Plan of Care. The length of stay for a short-term general inpatient level of care is based on the patient's condition and acute need, not any specific number of days. In determining whether an inpatient stay is needed, focus is on the acute needs of the patient and the event or events that initiated the admission. A patient appropriate for the GIP benefit may present with one or more of, but not limited to, the following:

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
- Frequent medication adjustment

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

Imminent Death

(As evidenced by mottling, respiratory status, and level of consciousness).

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

VI. CRITERIA FOR CONTINUED STAY AT THE GENERAL INPATIENT LEVEL OF CARE

- Hospice is aggressively working to develop and provide a plan for safe discharge
- Pain continues to require active treatment and frequent assessment
- 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
- 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

VII. CRITERIA FOR DISCHARGE FROM THE INPATIENT LEVEL OF CARE

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

VIII. DOCUMENTATION TIPS

Document when the change in level of care happened and the reason why: (e.g., vomiting uncontrolled and caregiver unable to manage care at home; dyspnea requiring intermittent IV morphine unable to be provided at home or SNF if patient is in the acute care hospital setting). A reviewer should be able to easily identify the dates and times of changes in levels of care and the reason for the change.

DO

- 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").
- 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.
- Document care that patient 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 provide skilled care in the home.
- 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 SNF".
- 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 GIP.
- Create a "snapshot" note that paints a picture of who the patient is and what the care entails.

DON'T

- 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).
- Document resolution of the precipitating event that led to GIP status without also documenting further criteria that maintains GIP status.

IX. CLINICAL RECORDS

***Massachusetts Hospice Licensure Regulations* 105 CMR**
141.209 When a hospice patient is admitted to a hospice inpatient facility, a copy of the patient's plan of care and sufficient relevant supporting documentation to ensure coordination of care shall be transmitted to the inpatient facility. When the patient is discharged from the hospice inpatient facility, a medical record and discharge summary shall be transmitted to the hospice administrative office to be included in the patient's clinical record.
(Note: This regulation applies to contracted faculties as well as freestanding GIP units.)

X. REIMBURSEMENT

***Medicare Conditions of Participation* 42 CMR Section 418**
418.302 **Payment procedures**

(A)(4) General Inpatient Care Day. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

418. 302(e)(5) The inpatient rate is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the beneficiary is discharged deceased, the inpatient rate is paid for the discharge day.

418.98 **Short term inpatient care**

(C) *Standard:* Inpatient care limitation. The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in any 12 month period preceding a certification survey in a particular hospice may not exceed 20 percent of the total number of hospice days for this group of beneficiaries.

CHAP

HI.2b The Hospice Organization applies the Medicare Conditions of Participation to ALL patients of the hospice - both Medicare and non-Medicare (L-101)

HI.2b2The Medicare COP Continuation of Care Requirement (418.60) and the 80-20 Inpatient Care Limitation (418.98c) apply ONLY to Medicare beneficiaries, not to non-Medicare patients. (L-226)

HII.7 The total number of inpatient days, used by Medicare beneficiaries, who elected hospice coverage in any 12 month period preceding a certification survey, is reviewed to insure the total does not exceed 20 percent of the total number of hospice days for this group of beneficiaries (L-226) and (42 CFR 418.98c)

Hospice Operations, National Hospice & Palliative Care Organization, 2005
Issues Related to the Payment Under the Medicare Hospice Benefits

Inpatient rates are paid from the date of admission and all subsequent days, with the exception of the date of discharge, which is billed at the level of care to which the patient is moved that day (i.e., routine home care or continuous care).If the patient dies while in an inpatient setting then the date of discharge is billed as an inpatient day (revenue code 656). If the beneficiary revokes the benefit or is discharged, the last day of GIP is billed at the routine home care rate.

The total aggregate inpatient days of the hospice's Medicare enrollees may not exceed 20% of the total aggregate hospice days. If the hospice exceeds the 20% limitation on total inpatient days, then the hospice must refund the difference between the Routine Home Care rate and the Hospice Inpatient rate to Medicare.

NOTE: The hospice attending physician continues to bill Medicare Part B directly using a GV or GW modifier. All physicians who are not the attending physician or the hospice medical director must have a contract with the hospice in order to be paid for services related to the terminal illness. Check the CPT manuals for details.

Resource:
Chapter 11 Processing Medicare Hospice Claims *www.cms.hhs.gov/manuals*

XI. CONTRACTS *(See also Sample Contract included in Appendix)*

418.56 ***Medicare Conditions of Participation 42 CMR*** -- Professional Management
(NOTE: On June 5, 2008, the Centers for Medicare and Medicaid Services (CMS) published new Medicare Hospice Conditions of Participation (CoPs) with an implementation deadline of December 2, 2008. Standards relating to contracts have been substantially revised. Readers may review the new Condition of Participation: Short-term inpatient care 418.08 in Appendix J . The new CoPs are available online at ***http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf.***

(E) Inpatient care

The hospice ensures that inpatient care is furnished only in a facility which meets the requirements in Sec. 418.98 and its arrangement for inpatient care is described in a legally binding written agreement that meet the requirements of paragraph (b) and that also specifies at a minimum --

(1) That the hospice furnishes to the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;

(2) That the inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient care protocols established by the hospice for its patients;

(3) That the medical record includes a record of all inpatient services and events and that a copy of the discharge summary, and, if requested, a copy of the medical record are provided to the hospice;

(4) The party responsible for the implementation of the provisions of the agreement and

(5) That the hospice retains responsibility for appropriate hospice care training of the personnel who provide the care under the agreement.
(6) That a way to verify that requirements in paragraphs (c)(1) through (c)(5) of this section have been met and established.

***MA Hospice Licensure Regulations* 105 CMR**
141.204 Required Patient Care Services
(H) Inpatient Care.
(3) Contracts for inpatient care shall, in addition to the provisions of 105 CMR 141.212 include, at a minimum, the following mutually agreed upon terms:
(a) that the inpatient provider has established policies consistent with those of the hospice program and that the inpatient facility agrees to abide by the patient care plan and protocol established by the hospice program;
(b) that the hospital or long term care facility will provide the hospice with a copy of the discharge summary and, if requested, a copy of the entire medical record; and
(c) that the hospice program shall make available appropriate hospice care training of hospital or long term care facility personnel who provide care under the agreement, including staff orientation.

NHPCO Standards of Practice for Hospice Programs (2006)
CES 8.3 When services are not provided directly by the hospice, written agreements exist to define the services provided by both the hospice and the contracted provider. These agreements define care delivery to assure that contracted services are consistent with hospice standards and care is provided in accordance with the hospice plan of care.
CES 8.5 Hospice contracts for inpatient care specify:
1. That the hospice provides a copy of the patient's plan of care and specifies the inpatient services to be provided.
2. That the inpatient provider has policies consistent with those of the hospice and agrees to abide by the hospice's patient care protocols
3. That the clinical record includes a record of all patient services and events
4. That a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice
5. The party responsible for the implementation of the provisions in the agreement
6. That the hospice provides appropriate training for personnel who provide care under the agreement.
7. That the hospice assumes overall management for the terminal illness in coordination with all other providers.

CHAP
HIII.2a The hospice program has established a mechanism for all levels of care provided, including written agreements/contracts where appropriate.
HIII.2b The agreement includes elements 1-7 of CIII.2b plus HIII.2b and HIII.2c.

1. The hospice assures the continuity of patient/family care in home, outpatient and inpatient settings (L-116).
2. Identification of services to be provided (L-118).
3. A stipulation that services be provided with the express authorization of the hospice (L-119).
4. The manner in which the contracted services are coordinated, supervised and evaluated by the hospice (L-120).
5. The delineation of the role(s) of the hospice and the contractor in the admission process, patient family assessment, and the IDG care conferences (L-121).
6. Requirements for documenting that services are provided in accordance with the agreement (L-122).
7. The qualification of the personnel providing the services (L-123).
8. The hospice retains professional responsibilities for the services provided under the arrangement (L-124).
9. The hospice retains responsibility for the payment of services (L-125).
10. The hospice retains exclusive authority to admit and discharge patients (L-119).

HIII2c When inpatient care is provided under arrangement, the written agreement includes elements in CIII.2b (see below) AND HIII.2b (see above).

HIII.2c1The hospice insures that inpatient care is furnished only in a facility that meets all applicable local, state, federal laws, and regulations (L-126,L-222, L-223, L224, l-225).

HIII.2c2The inpatient provider is furnished a copy of the patient's plan of care that specifies the inpatient services to be furnished (L-127).

HIII.2c3 The inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient care protocols established by the hospice for its patients (L-128).

HIII.2c4 The medical record includes documentation of all inpatient services and events and a discharge summary (L-129).

HIII.2c5A copy of the medical record is provided to the hospice on request (L-129).

HIII.2c6The parties responsible for the implementation of the provisions of the agreement (L-130).

HIII.2c7The hospice retains responsibility for appropriate hospice care training of the personnel who provide the care under the agreement (L-131).

HIII2c8 Inpatient provider agrees to abide by the hospice program's post-mortem procedures (L-139).

CIII.2bThe executed document stipulates the terms of the contract including:

1. The specific services/products to be provided
2. Contractor is required to adhere to applicable primary organization's policies and procedures
3. Assurance by contractor of the education, training, qualification and identification of personnel designated to provide care, services and products

4. Mechanisms for the contractor parties to participate in Performance Improvement activities
5. Procedures for the documentation and submission of documented notes that verify the provision of services/products in accordance with written agreement
6. Procedures for the submission of bills and related information and reimbursement for care, services, and products provided
7. Effective dates of the contract including terms of renewal and/or termination

The Joint Commission (TJC)

RI.7 The hospice patient has a right to unlimited contact with visitors and others.

Committee Recommendation

Based on the standards and guidelines listed above, the Committee recommends that the following language be included in the contract between the hospice and the facility:

- The facility has policies consistent with the hospice program.
- The facility agrees to abide by the hospice Plan of Care.
- The facility agrees to provide a copy of the discharge summary and medical record upon request.
- The hospice retains responsibility for education and training to the facility staff.
- The defined services and responsibilities as agreed upon by the facility and the hospice.
- The clinical record including all services and events while the patient is in the facility.
- The hospice retains overall management of the care of the patient in coordination with other providers.
- The facility meets all federal, state and local regulations.
- The hospice patient has the right to unlimited visitors while in the facility.
- The facility notifies the hospice upon the death of the patient.
- A copy of the HIPAA Business Associates contract.
- An annual addendum that includes the rate of reimbursement, including the treatment of the nursing home user fee.

XIII. FREQUENTLY ASKED QUESTIONS ABOUT REGULATORY COMPLIANCE

Q. Can a hospice contract with any extended care facility for inpatient care?

A. According to the Medicare Hospice Conditions of Participation, the nursing facility must provide 24 hour nursing services in order for hospice to contract with them for inpatient care. Each shift must include a registered nurse who provides direct patient care. (CoPs 418.100 and 418.98)

Q. Does the hospice have responsibility for assuring that there is an RN on every shift?

A. Yes. Medicare Hospice Conditions of Participation 418.56 requires that the hospice retain professional management responsibility for all contracts, including the provision of General Inpatient Care in a facility or hospital and so the hospice must assure compliance with

Condition of Participation 418.100.a2: "each shift must include a RN who provides direct patient care."

Q. What happens if a nursing home resident on the hospice benefit changes from routine hospice to the general inpatient level of care and there is no contract for GIP?
A. If the hospice can ensure compliance with the requirement for 24 hour RN care, it can sign a contract with the facility for general inpatient care. If there is no 24 hour RN care, the patient can be transferred to another facility where the hospice program has a contract for general inpatient care or the hospice can provide continuous care in the facility.

Q. Can a hospital require hospice nurses to go through its credentialing process prior to allowing them to provide inpatient care?
A. Yes. The hospice must abide by hospital policy and provide the hospital with the information requested. The Federation board recommended that good practice would be for the contract between Hospice and Hospital to lay out credentialing requirements for both sides.

Q. Is the hospice responsible for the oversight of the nursing home's documentation when it is providing a setting for GIP care?
A. Yes. The documentation of the hospice and the nursing home should both reflect and support the Plan of Care and the eligibility of the patient for GIP level of care.

Q. Can a hospital refer an acute care patient to hospice for the general inpatient level of care?
A. Yes, if the patient meets the criteria for the general inpatient level of care. Only the hospice can determine whether or not the patient is eligible.

Q. What documentation is required when a patient in an acute care hospital is admitted to hospice?
A. In the medical record, there should be a discharge summary and order from the hospital. A complete admission record with orders is then required from the hospice. Documentation should focus on when the change in level of care happened and the reasons why (i.e., uncontrolled vomiting and caregiver unable to manage care at home, new agitated delirium, dyspnea requiring intermittent IV morphine unable to be provided at home or skilled nursing facility.)

Q. Does the hospice need to maintain a separate record for the time a patient is on the general inpatient level of care in a facility?
A. Yes. There will be a gap in the record if the hospice utilizes the skilled nursing facility or hospital record exclusively.

Q. When contracting with a hospital or long term care facility for GIP, is the hospice required to have a copy of the complete medical record from the facility.
A. No. The hospice is only required to maintain a copy of the discharge summary. However, IF REQUESTED, a complete copy of the medical record, documenting that services were provided

in accordance with the plan of care and the written agreement between the facility and the hospice, must be provided to the hospice. If the Fiscal Intermediary requests the record, the entire record must be submitted.

Q. If a hospice patient is transferred to a contracted hospital for a condition related to the terminal illness without notifying the hospice, is the hospice responsible for the cost of care?

A. The hospice is responsible for all costs and the general inpatient rate to the contracted facility but can only bill for routine care until the plan of care has been revised. Until the revised plan of care is in place, the hospice should bill the insurer at the routine home hospice rate but pay the hospital for the general inpatient rate.

Q. Can payment to the facility be denied because the hospitalization was not in the hospice plan of care?

A. The plan of care is the patients' plan of care, not the hospice's. It is the responsibility of the hospice to have clear discussions with the facility and/or patient and family around the issue of hospitalization. If the hospitalization is related to the terminal illness, the hospice is responsible for payment to the hospital.

Q. If a patient is transferred to a non-contracted hospital for a condition related to the terminal illness, is admitted, and meets GIP criteria, what is the obligation of the hospice?

A. Documentation should demonstrate patient and family education regarding contracted facilities and the hospice's role in professionally managing care. The hospice should attempt to obtain a one-time contract for this admission only. The hospice can assist in transferring the patient to a contracted facility if the condition of the patient allows, or it can have the patient/family be given an Advance Beneficiary Notice (ABN) or the patient has the option of revoking the hospice benefit. The hospital is responsible for issuing a Hospital Notice of Non-Coverage to the beneficiary

If the hospital is outside the service area and the hospice can not meet its obligation to manage the plan of care in a distant facility, the hospice should not attempt to negotiate a one-time contract with the facility and may discharge the patient.

Q. If a patient is hospitalized in a local, non-contracted hospital for a condition related to the terminal illness and the hospice chooses not to make a one-time GIP contract, can the hospice encourage the family to revoke the hospice benefit?

A. No. A hospice is required to have inpatient care available for pain control and symptom management. By regulation, having a patient revoke the hospice benefit as a means of cost control for the hospice is not allowable.

Q. What is the hospice role if a patient is admitted to the hospital for a condition not related to the terminal illness?

A. The hospice continues to manage the terminal diagnosis and bills for routine home care.

Q. Does a three day stay on the hospice general inpatient level of care in an acute care hospital qualify a patient for the 100-day Skilled Nursing Benefit?
A. Yes. If a hospice patient receives general inpatient care for 3 days or more, he/she would be covered for SNF services but only if the GIP services were provided in a hospital, not a SNF or free-standing hospice facility.

Q. Is a physician's order required for transfer to the general inpatient level of care?
A. A physician's order is required for a change in the level of care as well as changes in the frequency of services.

Q. Is it the hospice's responsibility to ensure that the hospital or long term care facility complies with all federal and state regulatory requirements related to general inpatient care (e.g., 24-hour nursing services with a registered nurse who provides direct care, accommodations for family members to remain with the patient through the night)?
A. Yes. In accordance with Medicare Hospice Conditions of Participation (CoP) 42 CFR 418-98-100, the hospice retains professional management responsibility for the patient and must ensure that all applicable Conditions of Participation are met in the facility contracted to provide care for the hospice patient.

Q. Can a long term care facility require a guarantee that a certain number or percentage of days be provided at the GIP level of care?
A. No. This would be construed as remuneration to induce or reward referrals of services payable by a Federal health care program. A hospice qualifies a patient for the general inpatient level of care based solely on meeting the specific eligibility criteria for the GIP level of care.

Q. Can a hospice pay a hospital or long term care facility more than the payor's reimbursement for the general inpatient level of care?
A. The reimbursement must stand up to regulatory scrutiny that charges are based on fair market value such that it can not be construed as remuneration to induce referrals.

Q. In addition to the daily GIP rate, can the long term care facility or hospital require the hospice to pay separately for medications, durable medical equipment and/or therapies related to the terminal illness?
A. Yes, if that is negotiated in the terms of the contract between the hospice and the facility or hospital.