SUGGESTIONS FOR IMPROVED DOCUMENTATION
to Support Medicare Hospice Services

The following list is a guide for hospice providers and their staff to improve documentation of Medicare covered hospice services by including basic documentation. This list is intended only as a guide, and is not inclusive, nor ensures payment. Remember, the documentation must present a visual picture of the patient, their conditions and symptoms to support the terminal prognosis.

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 crisis for GIP or CHC, and caregiver need or crisis for Respite) which support higher level of care
- Interventions which were not effective at routine level of care prior to GIP or CHC care
- Continued higher level of care reasonable and medically necessary
- Start/stop time of higher level of care
- Services consistent with plan of care

Documentation to Support Hospice Services with Examples of Possible Quantifiable Values/Measures

Documentation need only include that information that is specific to the patient being assessed.

Examples may include:

- Change in patient's weight (pounds, kilograms)
- Worsening diagnostic lab results (increase, decrease)
- Change in pain
  - Type (ache, throb, sharp)
  - Intensity (Level 0-10)
  - Location (upper, lower)
  - Frequency (hourly, daily)
  - Medication usage (dosage, frequency)
- Change in responsiveness (fading, alert, unresponsive)
- Skin thickness/condition (fragile, intact, tears easily)
- Dependence on ADLs
  - Occurrences of incontinence
  - Dress (assisted, unassisted)
  - Bathe (assisted, unassisted)
  - Ambulation ability (assisted, unassisted)
  - Ambulation distance (feet, steps)
- Change in anthropomorphic measures
  - Upper arm measurement (inches, centimeters)
  - Abdominal girth (inches, centimeters)
- Change in signs
  - Respiratory rate (increased, decreased)
  - Oxygen flow rate (liters)
  - Hyper/hypotension
  - Radial/apical pulse (tachycardic, bradycardiac, regular, irregular)
  - Edema (level 1-4, pitting, non-pitting)
  - Turgor (slow, normal)
- Change in strenght/weakness (level 0-5)
- Change in lucidity (oriented, confused)
- Measurement/change in intake/output
  - Amount (cups, liters, ounces, teaspoons, mgs, ml, cc)
  - Frequency

Documentation to Support Hospice Physician Services

- Physician is medical director, employee, volunteer, or consultant of hospice
- Services were provided
- Services were reasonable and medically necessary

Prior to Claim Submission Ensure the Following

- Election statement was signed and dated at start of care
- Certification/recertification was signed and dated according to Medicare regulations
- Plan of Care (POC) signed and dated according to Medicare regulations
- The number of days/time and visits for each level of care is identified

Additional Quantifiable Values may include:

- Size (inches, centimeters)
- Timeframe (hours, days, weeks, months)
- Saturation (percent)
- Frequency (hourly, daily, weekly)
- Head elevation (number of pillow(s), degrees)
- Speech pattern (repetition, word count)

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