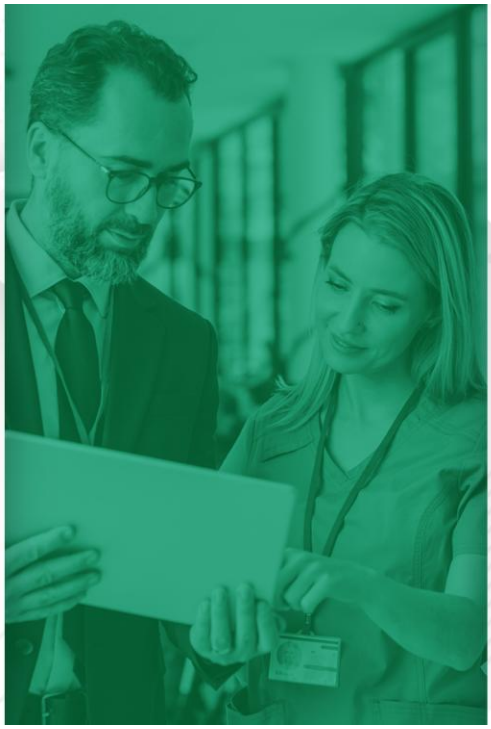
Hospice: Back to the Basics and Key Concepts



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Tammy Stewart is a registered nurse who joined Healthcare Provider Solutions, Inc. (HPS) as a clinical consultant in August 2021. Tammy's commitment to service and compassionate nursing care started over 30 years ago when she began as a home health nurse. She has also worked as a hospice nurse providing care to patients in their home and in general inpatient (GIP) settings. Tammy is a member of the National Association for Healthcare Quality obtaining a Certified Professional in Healthcare Quality (CPHQ). She is also a certified consultant for Community Health Accreditation Partner (CHAP) and Accreditation Commission for Health Care (ACHC). In addition, she is a Certified OASIS Specialist (COS-C).

As a part of the HPS clinical consulting team, Tammy provides support and solutions to home health and hospice agencies nationwide to achieve regulatory compliance. Her experience includes developing and implementing quality assurance and performance improvement programs (QAPI) for home health and hospice agencies in addition to data analysis, clinical chart reviews, onsite billing audit reviews, assisting with medical review ADRs and appeals, and provider education.

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Objectives

- Discuss the importance of determining eligibility at time of hospice admission and supporting continued eligibility throughout the hospice election.
- Discuss the required elements to support a valid hospice election, certification and recertifications.
- Discuss the 4 levels of care covered under the Medicare hospice benefit.
- Understand the role of the hospice IDG from referral to discharge.

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Hospice Eligibility

- To be eligible to elect hospice care under Medicare, an individual must be entitled to Medicare Part A and be certified as terminally ill.
- An individual is considered terminally ill if the medical prognosis is that the life expectancy is 6 months or less if the terminal illness runs its normal course.
- The hospice medical director or physician member of the IDG must make a clinical judgement and consider the following in determining certification
  - Diagnosis of the terminal condition of the patient
  - Other health conditions, whether related or unrelated to the terminal condition
  - Current clinically relevant information supporting all diagnoses
  - NPs/PAs cannot certify patients for hospice.

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Hospice Referral

- Referrals may be obtained from any of the following:
  - Physicians, NPs, PAs
  - Patients (Self-Referral)
  - Families
  - Caregivers
  - Social Workers
  - Long-term care facilities
  - Assisted Living Facilities
- A specific referral order is not required from a physician prior to hospice evaluation and assessment.

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Hospice Information Visits

- May be necessary prior to election to provide patient and/or family additional education regarding hospice eligibility requirements.
- During the visit it is important to discuss:
  - Medicare eligibility requirements
  - Certification of Terminal Illness
  - Hospice services
  - Plan of Care Development
  - Medical history in the previous 6-12 months
  - Patient and family perception of hospice care

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Hospice Information Visits

- During the visit it is important to assess:
  - Patient's current condition including functional and cognitive abilities.
  - Home environment including safety and availably of caregiver
  - Dynamics between patient and family
  - Why hospice? Why now?
- The patient's or family's desire not to return to the hospital does not automatically qualify the patient for hospice.
- General decline and debility over time without a terminal diagnosis does not support hospice eligibility.
  - Patient more forgetful, needing more assistance with ADLs

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Medical Records

- Medical Records are **crucial** in making the determination for hospice eligibility prior to election.
- Obtain medical records from any ER and/or hospitalizations within the past 12 months of election. Also, it is important to obtain specialist's progress notes for patients with cardiac, pulmonary or renal diseases.
- The hospice physician and the admitting RN should review the medical records prior to the to the hospice admission to ensure:
  - The patient has been diagnosed with a terminal illness **prior** to hospice election.
  - Documentation supporting continued disease progression despite ER visits, hospitalizations, specialist's visits and/or other treatments.
  - If no medical records are available, then the physician/NP may need to assess the patient prior to certification.

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Medical Records – Hospice Admission

- **CTI** – Patient admitted with terminal diagnosis of Atherosclerotic Heart Disease with CAD, CKD, heart failure and Alzheimer's Disease. Increased weakness, increased confusion, agitation, having more difficulty with ambulation and 10lb weight loss.
- **RN SOC** – past 6-8 weeks with significant increase in weakness, lethargy, and needs with ADLs, was transferring independently, now needs assistance, increased confusion, agitation, pain. History of bleeding from prostate that continues, goes to adult daycare twice a week. Eat 2 meals a days, starting to refuse, daughter feels patient has lost 10lbs in six months.
  - Assessment – PPS 40%, FAST 6E, 5/6 ADLs, Pulmonary: never SOB, clear lung sounds, 96% O2 sat on room air; Cardiac: NYHA II, 2 + pedal pulses
- This patient died 12 days later after a sudden change of condition. Time between first routine SN visit and change in condition was 8 days.

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Medical Records – Hospice Admission

- What was **missing from the certification and SOC note** that was in the medical records?
  - Ejection Fraction of 27% which had decreased from 45% 1 ½ years ago.
  - History of 100% occlusion of right coronary artery and 90% of left anterior descending artery leading to stents as the patient refused cardiac bypass surgery less than 2 years ago.
  - Moderate to severe aortic stenosis
  - Diagnosed with UTI 2 months prior to admission requiring oral antibiotics
  - Recent ER visit for upper extremity pain/swelling
  - Contributing diagnoses
    - Iron Deficiency Anemia requiring transfusions every 2 weeks
    - History of Prostate Cancer now with active bleeding/hematuria. Was receiving Lupron every 3 months.

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Hospice Election

- Individuals who meet the eligibility requirements may file an election statement with their chosen hospice. If physically or mentally incapacitated, his/her representative may file an election statement.
- The election statement is a condition of payment and must be completed accurately to avoid claim denials under medical review.
- All sections must be completed prior to signing by the patient or representative.
- Common Problems- Missing effective date of election
  - Must not be left blank!
  - Cannot be written in after the election statement is signed.
  - Date must be legible.
  - Must be the first day of hospice care or a later date but may be no earlier than the date of election. An individual may not designate an effective date that is retroactive.

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Hospice Election

- Missing credentials or address/NPI number of attending physician
  - Information identifying the attending physician should provide enough detail so that is it's clear which MD, DO, NP or PA was designated.
  - Information should include but is not limited to the provider's full name with credentials, office address, NPI number or other detailed information.
- Missing signature and date by patient or representative
  - Ensure if signed by the representative, the reason the patient did not sign is documented.
  - Witness signature by the hospice representative is not required but is best practice to ensure validity of patient/representative signature if it is questioned under medical review.

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Hospice Election/Addendum

- Common problems: Election Statement Addendum (Patient Notification of Hospice Non-covered Items, Services and Drugs)
  - Lack of agency name and patient medical record number
  - Not furnished within the required timeframe after request.
    - 5 calendar days if requested at admission
    - 3 calendar days if requested at any time during the hospice election
  - Not signed by the patient/representative.
  - Reason why the addendum was not signed either by refusal or not returned was not documented on the addendum itself.

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Hospice Admission

Initial Assessment

- Must be performed by an RN within 48 hours of election to identify the immediate care and support needs of the patient.
- Must take place in the location where hospice services are being delivered.
- Not a “meet and greet” visit.
- Assesses the immediate physical, psychosocial, emotional and spiritual needs related to the terminal illness and related conditions.
- The RN consults with other IDG members with information gathered from the initial assessment to develop the initial plan of care. The IDG determines who should visit the patient/family during the 1st 5 days of hospice care. This must be documented in the record.
- Collaborate with the attending physician (if any) via fax, emails, messaging, etc.

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Hospice Admission

Comprehensive Assessment

- The hospice IDG, in consultation with the patient's attending physician (if any) must complete the comprehensive assessment no later than 5 calendar days after the hospice election.
- All members of the IDG must be involved.
- May be competed at the same time as the initial assessment is completed.
- All components must be assessed regardless of the patient's refusal of psychosocial or spiritual services.
  - Most often defaults to admitting RN.
  - Document clearly in the record for patient refusal of hospice psychosocial or spiritual care services.

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Hospice Admission

Comprehensive Assessment includes:

- Pain and non-pain symptoms, patient/family's goals for pain management
- Physical exam and current medical conditions
- Current medications and drug regimen review
- Nature and condition causing admission
- Complications and risk factors that may affect care planning
- Functional status, patient's ability to understand/participate in his/her own care
- Imminence of death (commonly missed in documented)
- Severity of symptoms
- Bereavement (commonly missed if MSW or Chaplain is refused)
- Need for referrals

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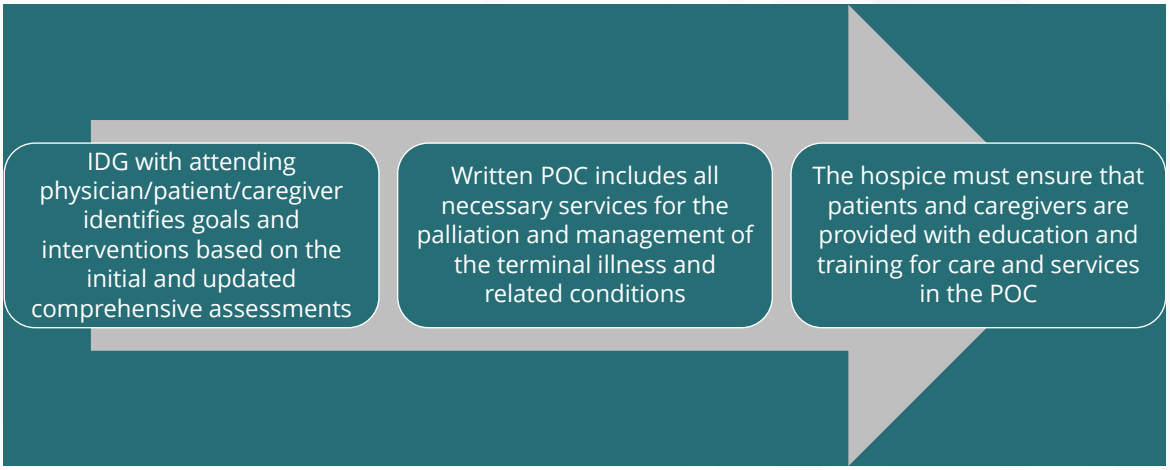
Hospice Plan of Care



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Hospice Plan of Care

- Clinical findings identified in the comprehensive assessment are used to develop the initial plan of care.
  - Not every patient problem or diagnosis has to be care planned.
  - Problems, interventions and goals should be based on clinical findings significantly impacting the patient's terminal illness and related conditions.
  - Does the patient have pain, nausea, constipation, worsening confusion, agitation, frequent falls, dysphagia, lack of mobility, wounds, etc. that impacts their overall condition?
    - <u>If yes, then care plan it!</u> If not, these areas would continue to be routinely assessed during routine visits.

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Hospice Plan of Care

Medicare requires the POC to include:

- Interventions to manage pain and symptoms
- Scope and frequency of services
- Measurable outcomes expected from implementing and coordinating the POC
- Drugs and treatments necessary to meet patient needs
- Medical supplies and appliances
- IDG documentation of the patient/representative's level of understanding, involvement and agreement with the POC.

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Hospice Plan of Care

- Problems, interventions and goals should be revised and/or resolved as appropriate.
  - Don't forget orders/interventions for wound care, catheter changes, ostomy care, etc.
- Goals should be individualized and measurable to ensure interventions are effective in meeting the patient's needs.
  - Avoid EMR templates for goals!!
  - Timeframes for achievement must be realistic.
    - If goal target date is 0-24 hours, then the goal should be resolved or the targe date revised if not met within the original timeframe. Red flag to surveyors when goals are not updated throughout hospice care.
    - Avoid target dates of by death or discharge. Red flag to surveyors when all goals have the same target date of death/discharge and is never updated throughout the patient's hospice care.

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Hospice Plan of Care- Development

Patient has a primary hospice diagnosis of pulmonary fibrosis. In the last three weeks the patient has gone from **ambulatory to bed bound** resulting from **disabling dyspnea**. Also now has **a foley** to decrease symptoms related to patient transferring to the commode to urinate as it requires 5-10 minutes of recuperation to catch his breath after transfers. Has developed a **new stage 2 wound** to the coccyx. Has intermittently been **choking on pills**. Patient's **cognitive status also seemed to be declining** as evidenced by not knowing if he was holding the remote control or his phone.

Care Plan Problems:

- Skin integrity including interventions for skin breakdown
- GU – foley management
- Infection Control measures
- Dysphagia
- Confusion/safety
- Dyspnea

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Hospice IDG

- The hospice IDG works together to provide comfort and dignity to the patient and family based on their needs and goals of care.
- Supports the physical, medical, psychosocial, emotional and spiritual needs.
- Collaborates to develop the initial POC
- Continuously updates the POC and comprehensive assessment during the hospice election.
- IDG meetings must occur no later than every 15 days.
  - Documentation must support that the POC, and comprehensive assessment was reviewed/updated during the meeting.
  - Documentation must include changes in the patient's clinical condition since the last IDG and/or admission/recert to support eligibility and progress towards goals to ensure interventions are effective in managing patient symptoms.

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Ongoing Eligibility Documentation

- Eligibility resources include provider encounter notes, H & Ps, hospital, ED records, labs, x-rays, tumor markers, facility notes.
- LCD-Ensure you are using the MAC specific LCDs. If an LCD checklist is included in the EMR, does the patient data meet the disease specific LCD guidelines?
- Documentation should be cumulative and ongoing in the IDG visit and meeting notes. Example: The patient exhibited signs of progressive weight loss from 114 pounds 3 months prior to 97 pounds during today's visit which reflects a 15% weight loss.
- Information may come from clinical assessment, patient/caregiver interview, facility staff, other members of the IDG.

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Common Documentation Pitfalls

- Missing documentation of medical complications deriving from comorbidities, infections, wounds, and weight loss.
- Clinicians fail to document frequency, severity, response to treatment and relationship to the terminal prognosis. It is important to document the recurrence patterns or impact on the patient's functional and cognitive condition.
  - Example – Patient was treated for Pneumonia six months ago.
  - Example – This was the patient's 3rd UTI within 6 months requiring antibiotics.
  - Example – 2-3+ edema persists despite 40mg of Lasix daily and elevating extremities
  - Include patterns of decline in recert and IDG notes. Don't just compare to the last benefit period!

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Common Documentation Pitfalls

Copy and Paste is a Problem!!

- Involves physicians, NP, nurses, MSW, Chaplains
- Auditors often identify when documentation is copied and pasted from previous documentation in visit notes, IDG notes and/or certification.
- Raises a red flag about whether the certifying physician evaluated the patient's continued eligibility.
- Every visit note must answer **"Why hospice now?"** Don't rely on just documentation at recertification to support the terminal illness and its progression.

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Common Documentation Pitfalls

- Documentation must include how persistent and new symptoms of disease progression impacts the patient.
- Key is showing changes in the patient's condition over time through measurable, objective data points.
- Avoid these words/phrases in documentation
  - Still
  - Unchanged
  - No changes
  - Doing about the same
  - Remained the same, remains
  - Continued

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Hospice Documentation/Eligibility is not supported

- 80-year-old male admitted with Protein Calorie Malnutrition with comorbid diagnoses of Senile Degeneration of the Brain and CKD.
- The MSW documented the patient has a poor understanding of hospice services as well as his illness/prognosis.
  - The patient signed consent and election statement.
  - The patient lived alone
  - Only family is a sister that lives across the country in another state
- The Chaplain documented the patient was not happy that he is in hospice care and his sister asked him not to mention it.

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Hospice Documentation/Eligibility is not supported- Written CTI

Initial Certification - 80 y/o male with unspecified protein calorie malnutrition comorbidities of senile degeneration of the brain, CKD, he has weight loss, poor po intake, and had to graduate to a higher level of care. He is cachectic LMAC 20cm PPS 50%, 2/6 ADLS, he is a fall risk, ambulates with a walker. Forgetful with decreased cognitive capacity.

Key issues identified

- Weight loss is not defined.
- LMAC 20cm – no baseline or comparative measurement.
- Poor PO intake – subjective assessment and not quantifiable, no baseline or comparisons
- What is decreased functional capacity?
- Higher level of care is not defined.

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Hospice Documentation/Eligibility is not supported-Initial Comprehensive Assessment

Patient with a history of chronic wounds and recent weight loss, has been experiencing a decline in his health status. He has been losing weight, eating poorly, and his chronic wounds are not healing. Despite the need for a higher level of care, he has been resistant to moving to a care facility due to past negative experiences. His family and home health nurse have been involved in his care and are in agreement that he needs more care. The patient has been in and out of the emergency department due to confusion and paranoia and a recent urinary tract infection was identified. Patient cachectic in appearance. Poor nutrition intake likely due to increased cognitive impairment. Patient declined for RN to remove current dressing. dressing appears clean, dry and intact. Cardio/resp No SOB and distress oh. Lungs CTA. No edema. Denies chest pain. Diet: regular GI: abdomen soft and non-tender. **Able to go walk through the restroom with walker.** Functional status: PPS 50% able to ambulate with walker device. Wobbly gait. Able to feed self. Sister buying door dash/uber eats. **Patient is chair and bedbound** Nutrition: eating 2X per day in small amount. Appetite Poor Today's food consumption was equal to last week's food consumption by 40% **Why hospice. Keep patient home with family and managed symptoms. No more hospitalization.** LMAC 20.

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Certification of Terminal Illness

- A brief narrative explanation of **WHY** the clinical findings supports a life expectancy of six months or less as part of the certification and recertification forms.
- Physicians are required to compose the narrative based on an exam of the patient or review of medical records and the F2F encounter.
  - **Cannot be copied** exactly from the SN visit notes and/or F2F encounter note
  - Administrative and/or Nursing staff cannot document the written CTI for the physician to sign
- The narrative must reflect the comparable objective clinical findings with changes in their terminal condition and the timeframe of when the changes occurred. Clinical findings must be supported in the nursing documentation such as PPS/KPS scores, FAST, NYHA, etc.
  - A generalized current assessment of the patient's clinical condition **is not enough** to support hospice eligibility with a six month or less prognosis.

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Certification of Terminal Illness

- Medical Review Denial Decision – January 2026

The certifying physician's narrative **must not duplicate other medical documentation**. Instead, CMS stated: "…the physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative… This synthesis should not be a simple restatement of the medical record facts but instead sets out the physician's rationale as to how the facts justify the prognosis."

For the benefit period beginning February 6, 2023, neither the physician narrative, nor the clinical documentation supported the beneficiary met coverage criteria. **The physician narratives did not synthesize why the clinical findings support hospice services as reasonable and necessary. Neither the physician narrative**, nor the clinical documentation supported the beneficiary met coverage criteria.

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Certification of Terminal Illness- Terminal Diagnosis ***Not*** Supported

- 90-year-old female admitted to hospice services with DX CVA; PMH: Protein Calorie Malnutrition, Left Sided Hemiparesis, Hemiplegia, DM2, HTN, Hyperlipidemia, Depression, Anxiety, Occlusion. Incontinent, requires assist 5/6 ADLs. Patient continues to decline.
- 94-year-old male on hospice services for Parkinson's. comorbidities include hypothyroidism, hyperlipidemia and hypertension. PPS 40%, discussed with hospice team plan of care. Medications reviewed; symptoms managed appropriately. No issues identified.
- 87-year-old female with primary hospice diagnosis of Alzheimer's Disease secondary severe protein calorie malnutrition. FAST 7D was 7C, PPS 40%, MAC 19.1, Weights: Oct 110lbs, Sept 109lbs, August 116lbs.
- 96-year-old male with Alzheimer's Disease. PPS 40, MAC 25, FAST 7C from 7B. New stage 1 pressure injury to sacrum, decreased appetite, spitting out food.

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Certification of Terminal Illness- Terminal Diagnosis *Supported*

72-year-old female with advanced cognitive decline related to senile degeneration of the brain. Increasing behavioral fluctuations with becoming highly anxious and fearful with delusions threats that lead to increased agitation. Personal hygiene products removed from access as she was attempting to ingest shampoo, soap and lotion. Smears feces on face creating skin irritation and rashes. Nutritional intake has declined, previously consumed 50% of 3 meals daily, now eat between 25-50% depending on level of agitation. Weight loss from 124lbs to 118lbs over the benefit period. Fully dependent for all ADLS. Treated for a yeast infection, conjunctivitis and facial dermatitis during the benefit period. Her delusions and unsafe behaviors indicate progressive neurological decline despite periods of apparent lucidity.

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Face-to-Face Encounter

Needs to be completed:

- **PRIOR** to the third benefit period and with each subsequent recertification.
- Can be performed by hospice physician or nurse practitioner. If a nurse practitioner, he/she must be a hospice employee.
- Physician may be a hospice employee or contracted.

Must Occur:

- **No more than 30 days prior to the recertification date.**
- May occur on the first day of the benefit period.
- **Prior** to certifying physician's composition of written CTI narrative.
- Will be considered complete if the patient dies within 2 days of admission without a F2F encounter.

- **Must include** clinical findings with changes in the patient's condition supporting the certification and six month or less prognosis.

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Hospice Levels of Care

- Routine Home Care - May be provided in a private home, ALF, LTC or non-skilled NF (unskilled), SNF, inpatient hospital, inpatient hospice facility, LTCH, Inpatient psychiatric facility, place not otherwise specified, hospice residential facility.
- Respite Care
- General Inpatient Care
- Continuous Care

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Respite Care

- May be provided in a LTC or non-skilled facility, SNF, inpatient hospital, inpatient hospice facility, LTCH, Inpatient psychiatric facility, place not otherwise specified.
- Respite care is short-term inpatient care that is provided to individual only when needed to relieve family/caregivers who are providing care to the patient.
- May be reimbursed up to 5 consecutive days at a time.
- May not be provided on the date of discharge.
- More than one respite stay may be allowed during a single billing period.
- Respite is not appropriate when there is no identified caregiver, when the patient resides in a nursing facility or facility that providers 24/7 care.

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Respite Care (cont.)

- There is no clear reason for caregiver relief.
- While transitioning a patient from GIP to respite may occur. CMS guidance uses the example "if the usual caregiver has fallen ill". Medicare considers this to be a unique and likely rare occurrence. This should not be a standard practice.
- The total number of inpatient days, including GIP and respite may not exceed 20% of the total number of hospice days for which these patients have elected hospice care.
- Medical Review Denial January 2026:

  The claim for respite was denied due to the absence of documentation indicating caregiver burden and the appropriateness of a short-term inpatient level of care. Respite services must be supported by clinical rationale and evidence that the caregiver is unable to continue providing care without temporary relief. Without this information, the need for the respite stay billed cannot be verified.

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General Inpatient Care

- May be provided in a SNF, inpatient hospital, inpatient hospice facility, LTCH, Inpatient psychiatric facility, place not otherwise specified.
- Hospice may provide GIP directly in your hospice-owned facility or through a contractual agreement with another facility that can provide the GIP level of care.
- 24 Hour nursing services must be provided in the facility. If at least one patient in the hospice facility is receiving GIP, then each shift must include an RN who provides direct patient care.
- Is considered a short-term intervention and should be utilized only when symptoms cannot be managed in any other setting.
- Documentation should support the need for the level of care change and the interventions performed throughout the GIP stay to support the ongoing need until symptoms are managed.

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General Inpatient Level of Care (GIP)

When may GIP Level of Care be Appropriate?

- Aggressive treatment to control pain
- Sudden deterioration requiring intensive nursing intervention.
- Uncontrolled nausea or vomiting.
- Pathological fractures
- Uncontrolled bleeding
- Frequent seizures
- Unmanageable respiratory distress
- Severe agitated delirium/anxiety/agitation related to end-stage disease process.

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General Inpatient Level of Care (GIP)

When GIP Level of Care is NOT Appropriate?

- General Decline
- End-of-life care
- Patient actively dying
- Caregiver breakdown
- No available caregiver in the home
- Fall risk and supervision needed

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Continuous Home Care (CHC)

- May be provided in a private home, ALF, LTC or non-skilled NF, place not otherwise specified or hospice residential facility.
- 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**. 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. Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by an RN, LPN, or LVN, are nursing services and are paid at the same continuous home care rate. This means that more than half 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.
- Hospices cannot write off aide or homemaker services that would cause the aide/homemaker care provided to exceed more care than the care provided by the hospice RN, LPN or LVN.

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Continuous Home Care

- When is Continuous Home Care Appropriate?
  - Continuous home care is only furnished during brief periods of crisis and covered only as necessary to maintain the terminally ill individual at home.
  - 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, then during the period of crisis, the skills of a nurse may be needed to replace services that had been provided by the caregiver.
  - Frequent medication adjustment to control symptoms/collapse of family support system
  - Symptom management/rapid deterioration/imminent death

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Continuous Home Care

- When is CHC not appropriate?
  - Imminently dying with no acute skilled pain or symptom management needs.
  - Caregiver breakdown with no acute skilled pain or symptom management needs.
  - CHC is not intended to be used as respite care.
  - For safety concerns such as falls, wandering in the absence of a need for skilled interventions.
  - As an alternative to paid caregivers or placement in another setting.

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Hospice Discharges

A patient is considered discharged from hospice when the patient is no longer receiving services for the hospice or there is an interruption in care/services related to one of the following reasons:

- ❑Death
- ❑Revocation
- ❑No longer terminally ill
- ❑Moved out of the service area
- ❑Transferred to another hospice
- ❑Discharged for cause

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Hospice Discharges

- A discharge/transfer summary is required to be completed at time of DC/transfer.
- A discharge order is required for all planned discharges.
- The DC summary must include:
  - A summary of the patient's stay including treatments, symptoms and pain management;
  - The patient's current plan of care;
  - The patient's latest physician orders; and
  - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

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Hospice Discharges

- If a patient chooses to transfer to another hospice provider, a transfer form should be signed by the patient/responsible party and retained by the transferring hospice. The receiving hospice may also request a copy and/or request a patient sign a transfer form to their agency.
- A revocation form must be signed if the patient revokes the hospice benefit. Revocations may not be verbal and must be initiated by the patient/caregiver.
  - Election of the hospice benefit is the beneficiary's choice rather than the hospice's choice, and the hospice cannot revoke the election. Neither should the hospice request or demand that the patient revoke his/her election.
  - Form must be signed on the day of revocation.

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Discharge Planning

- For planned live discharges, documentation should support discharge planning occurred following agency policy and State regulations as applicable.
  - Discharge planning should be a process with IDG collaboration that begins before the date of discharge.
  - Includes any planning necessary for family counseling, patient education, or other services before the patient is discharged.
- A NOMNC (Notice of Medicare Non-Coverage) is required to be signed by the patient/caregiver at least 2 calendar days before the discharge date or on the 2nd to the last day of service if care is not being provided daily.
  - NOMNC forms have expiration dates.
  - Ensure your agency is using the most current form published in January 2025.

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Resources/References

- Medicare Claims Processing Manual Chapter 11 – Processing Hospice Claims
  www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
- State Operations Manual Appendix M – Guidance to Surveyors: Hospice
  www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- Medicare Benefit Policy Manual Chapter 9

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

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QUESTIONS?

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Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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