The Medicare Hospice Benefit: A Beginner's Guide

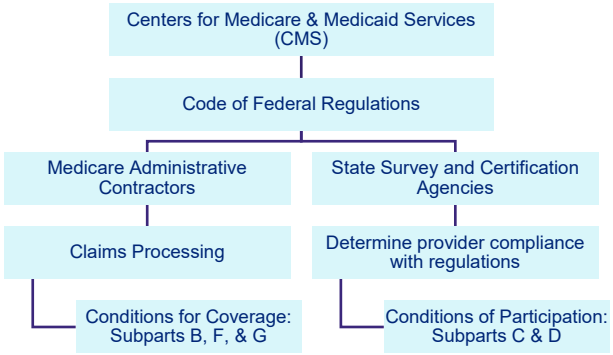
WHAT IS THE MEDICARE HOSPICE BENEFIT?

The Medicare Hospice Benefit was established with the goal of providing high-quality hospice care to Medicare beneficiaries. Although the hospice benefit is now offered through multiple outlets, most hospice services are reimbursed or paid for by the Medicare Hospice Benefit. All hospices who wish to receive payment for services through the Medicare Hospice Benefit must demonstrate compliance with Medicare regulations provided by The Centers for Medicare & Medicaid Services (CMS) and found within the Code of Federal Regulations, Title §42, Chapter 4, Part §418. The Code of Federal Regulations, Title §42, Chapter 4, Part §418 is divided into Subparts A through H:

- **Subpart A – General Provisions and Definitions:** Establishes the statutory basis and scope in addition to defining terms used throughout.
- **Subpart B – Eligibility, Election and Duration of Benefits:** Provides eligibility and election requirements and specifies benefit periods.
- **Subpart C – Conditions of Participation: Patient Care:** Covers the regulations that guide the delivery of patient care by all members of the interdisciplinary group.
- **Subpart D – Conditions of Participation: Organizational Environment:** Covers the regulations that guide hospice operations.
- **Subpart F – Covered Services:** Lists covered services and the requirements for payment.
- **Subpart G – Payment for Hospice Care:** Discusses basic rules and procedures for hospice payment.
- **Subpart H – Coinsurance:** Details an individual's liability for payment of services.

ADMINISTERING THE CODE OF FEDERAL REGULATIONS

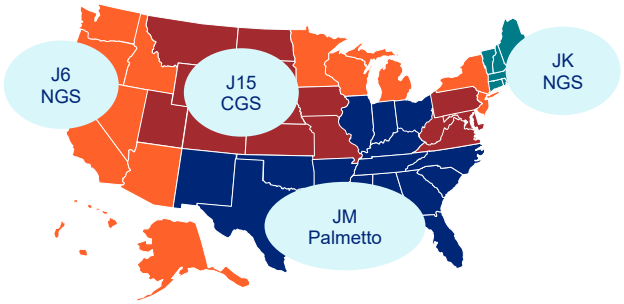
- Two entities are responsible for administering the Code of Federal Regulations:



Medicare Administrative Contractors

- Private insurer awarded a jurisdiction to process hospice claims, conduct medical reviews, ensure appropriate billing/payment, and handle appeals
- Follow the regulations for hospice eligibility, certification of terminal illness, and election and duration of benefits
- Provide *guidelines* to determine terminality called Local Coverage Determinations (LCDs)
  - General clinical indicators consistent with a limited prognosis
  - Guidelines for most common hospice diagnoses – disease-specific indicators of a terminal prognosis
  - Vary by MAC: divided into four jurisdictions

Four MAC Jurisdictions



State Surveyors & Accreditation Agencies

- Determine compliance with the Conditions of Participation (CoPs)
  - Compliance surveys every 3 years
- 22 CoPs - critical components required to participate in the Medicare and Medicaid hospice program
  - Apply to all hospice patients
  - May differ from state hospice licensure regulations – meet the higher standard
  - CoPs and standards are detailed in the State Operations Manual Appendix M – Guidance to Surveyors: Hospice
    - Organized in the following manner: Condition of Participation → Standards → L tags

HOSPICE ELIGIBILITY, ELECTION, DURATION OF BENEFITS

§418.20 Eligibility Requirements

- Entitled to Medicare Part A
- Certified as being terminally ill as specified in §418.22

§418.21 Duration of hospice care coverage – Election periods

- Initial 90-day period
- Subsequent 90-day period
- Unlimited number of subsequent 60-day periods

1st Benefit Period	2nd Benefit Period	Subsequent Benefit Periods
• Duration: 90 days • Hospice physician/medical director and attending physician certify terminal illness	• Duration: 90 days • Only hospice physician/medical director certifies terminal illness	• Duration: unlimited 60-day periods • Only hospice physician/medical director certifies terminal illness • Face-to-face encounters required

§418.22 Certification of Terminal Illness

- Timing: written physician certification of terminal illness for each benefit period within 2 calendar days after the benefit period begins
  - Exceptions: If written certification cannot be obtained within 2 calendar days after the benefit period begins, obtain oral certification in that timeframe and written certification before submitting a claim; make an entry in the patient's medical record as soon as the oral certification is received
  - Certifications cannot be obtained more than 15 days prior to the effective date of election or start of next benefit period
- Content: prognosis of 6 months or less if terminal illness runs normal course with clinical information to support this prognosis
- Face-to-Face Encounter: complete no more than 30 calendar days prior to the 3rd and every subsequent benefit period

§418.24 Election of Hospice Care

- The hospice must file a Notice of Election with its Medicare contractor within 5 calendar days after the effective date of the election statement.
- Beginning October 1, 2020, the hospice must provide an election statement addendum if requested by patient, patient representative, non-hospice payer, or Medicare contractor.
  - Provides a written explanation of the services, supplies, durable medical equipment, and medications that would not be covered by hospice
  - If requested on start of care date, the hospice must provide this information in writing within 5 calendar days from the date of hospice election. If requested during any other period of hospice stay, the hospice must provide the information in writing withing 3 calendars of the request

Documentation to Support Hospice Eligibility and Terminality

- Event that triggered the hospice referral, such as a hospitalization, exacerbation of symptoms, significant change in condition, or an increased need for additional care
- History and progression of illness, including recent changes and current status
  - Provide a clinical picture of the patient 3-6 months ago versus today
  - Use appropriate scales to describe the extent of symptom severity over time
- Objective measures, such as weights, food, and fluid intake, and laboratory or radiological studies to support terminal illness
  - Don't document: Patient lost weight.
  - Do document: Patient has had a 25-pound weight loss over the last 6 months as evidenced by a change in weight from 150 pounds to 125 pounds.
- Disease specific eligibility guidelines or evidence of general decline in clinical status as provided in the Local coverage determinations (LCDs)

LOCAL COVERAGE DETERMINATIONS (LCDs)

- Medicare Administrative Contractors (MACs), follow *guidelines* to determine if an individual is eligible for hospice services called Local Coverage Determinations (LCDs).
- LCDs vary by MAC jurisdiction; however, they are generally divided into two categories – guidelines for general decline in clinical status and disease specific guidelines
  - Use Guidelines for General Decline in Clinical Status when terminal diagnosis does not have Disease Specific Guidelines
  - Disease Specific Guides: Use then when primary hospice diagnosis is ALS, cancer, dementia due to Alzheimer's disease, heart disease, HIV, liver disease, pulmonary disease, renal disease, or stoke/coma

GUIDELINES FOR GENERAL DECLINE IN CLINICAL STATUS

Worsening Clinical Status	Worsening Signs or Symptoms	Worsening Laboratory Values	Other Areas of Documentation
☐ Recurrent/intractable infections ☐ Progressive inanition ☐ Irreversible ↓ weight, ↓ mid-arm circumference or ↓ abdominal girth ☐ ↓ serum albumin or cholesterol ☐ Dysphagia causing recurrent aspiration and documented inadequate oral intake	☐ Dyspnea with ↑ respiratory rate ☐ Intractable cough, nausea/vomiting, or diarrhea ☐ Pain requiring frequent, increasing doses of analgesics ☐ Systolic blood pressure <90 or progressive postural hypotension ☐ Ascites; pleural/pericardial effusion ☐ Venous, arterial or lymphatic obstruction; edema ☐ Weakness ☐ Change in level of consciousness	☐ ↑ pCO2, ↓ pO2 or SaO2 ☐ ↑ calcium, creatinine, or liver function ☐ ↑ tumor markers ☐ Progressively ↑ serum potassium ☐ Progressively ↑ or ↓ serum sodium	☐ KPS/PPS <70% ☐ ↑ ER visits, hospitalizations, or physician visits related to primary hospice diagnosis ☐ Progressive decline in FAST score (from ≥7A on the FAST) ☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing ☐ Progressive stage 3-4 pressure injuries despite optimal care

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

One of the Following (either 1 or 2)

1. Critically impaired breathing
   - ☐ Vital capacity (VC) <30% (if available)
   - ☐ Dyspnea at rest
   - ☐ Declines mechanical ventilation
2. Rapid progression of ALS and either critical nutritional impairment or life-threatening complications:
   - ☐ Rapid progression of ALS
     - ☐ Ambulatory → wheelchair or bed bound
     - ☐ Normal → barely or unintelligible speech
     - ☐ Normal → pureed diet
     - ☐ Independent → dependent in ADLs
   - ☐ Critical nutritional impairment
     - ☐ Oral intake insufficient to sustain life; continued weight loss; dehydration; hypovolemia; absence of artificial nutrition
   - ☐ Life-threatening complications
     - ☐ Recurrent aspiration pneumonia
     - ☐ Infection: upper urinary tract or fever after antibiotic therapy
     - ☐ Stage 3 or 4 pressure injury

DEMENTIA DUE TO ALZHEIMER'S DISEASE

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

All of the Following

☐ Stage 7 or beyond on the Functional Assessment Staging Tool (FAST)
☐ Dependent for ambulation, dressing, and bathing
☐ Urinary and/or fecal incontinence
☐ Speech limited to 6 or fewer intelligible words

One of the Following in the Past 12 Months

☐ Aspiration pneumonia
☐ Pyelonephritis
☐ Pressure injuries, multiple, stage 3-4
☐ Septicemia; fever despite antibiotics
☐ 10% weight loss in the last six months or serum albumin <2.5 g/dL

STROKE

Baseline Guidelines

☐ KPS/PPS <40%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

One of the Following

☐ Inability to maintain hydration and caloric intake with one of the following
   - ☐ Weight loss >10% in past 6 months or >7.5% in past 3 months
   - ☐ Serum albumin <2.5 g/dL
   - ☐ Aspiration unresponsive to SLP interventions
   - ☐ Sequential calorie counts reflect inadequate intake
   - ☐ Dysphagia inhibiting adequate intake, artificial nutrition and hydration refused

Supporting Documentation

☐ Aspiration pneumonia; upper urinary tract infection
☐ Sepsis; fever despite antibiotics
☐ Refractory stage 3-4 pressure injuries

CANCER

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

One of the following (either 1 or 2)

1. Distant metastases at presentation
2. Progression to metastatic disease with either
   - ☐ Continued decline despite treatment
   - ☐ Patient declines treatment

HEART DISEASE

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

All of the Following

☐ Optimally treated for heart disease or have declined/are not candidates for transplant
☐ Patients with CHF or angina should meet the criteria for NYHA Class IV

Supporting Documentation

☐ Treatment-resistant, symptomatic arrhythmias
☐ Cardiac arrest/resuscitation
☐ Unexplained syncope
☐ Brain embolism of cardiac origin
☐ HIV disease
☐ For CHF, ejection fraction less than 20%

PULMONARY DISEASE

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

All of the Following

☐ Dyspnea at rest poorly/unresponsive to bronchodilators
☐ ↑ ER visits or hospital admissions for pulmonary infections/respiratory failure, ↑ physician home visits
☐ Hypoxemia at rest (pO2 ≤55 mmHg) or O2 saturation ≤88% or hypercapnia (pCO2 ≥50 mmHg)

Supporting Documentation

☐ Right heart failure secondary to pulmonary disease (cor pulmonale)
☐ Weight loss >10% over preceding 6 months
☐ Resting tachycardia >100 bpm

CHRONIC RENAL FAILURE

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

One of the Following (either 1, 2, or 3)

1. Declines dialysis, transplant; stopped dialysis
2. Creatinine clearance <10 mL/min (diabetes: <15 mL/min)
3. SCr >8 mg/dL (diabetes: >6 mg/dL)

Supporting Documentation

☐ Uremia; uremic pericarditis
☐ Oliguria; refractory fluid overload
☐ Refractory hyperkalemia (>7 mEq/L)
☐ Hepatorenal syndrome

COMA

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

Three of the Following on Day 3 of Coma

☐ Abnormal brain stem response
☐ Absent verbal response
☐ Absent withdrawal response to pain
☐ Serum creatinine >1.5 mg/dL

HIV

Baseline Guidelines

☐ KPS/PPS <50%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

All of the Following

☐ CD4 >100,000 copies/mL

One of the Following

☐ CNS or systemic lymphoma
☐ Refractory or untreated muscle wasting (loss of ≥10% lean body mass)
☐ Mycobacterium avium complex
☐ Multifocal leukoencephalopathy
☐ Visceral Kaposi's sarcoma
☐ Renal failure, no dialysis
☐ Cryptosporidium infection
☐ Toxoplasmosis

Supporting Documentation

☐ Chronic diarrhea >1 year
☐ Serum albumin <2.5 g/dL
☐ Active substance abuse
☐ Age >50 years
☐ Advanced AIDS dementia complex
☐ CHF, symptomatic at rest
☐ Advanced liver disease
☐ Absence of or resistance to HIV drug therapy

LIVER DISEASE

Baseline Guidelines

☐ KPS/PPS <70%
☐ Dependent for 2+ ADLs: feeding, ambulation, continence, transfers, bathing, dressing

All of the Following

☐ PT >5 seconds over control, INR >1.5, serum albumin <2.5 g/dL
☐ Evidence of end stage liver disease with one of the following
   - ☐ Refractory ascites
   - ☐ Spontaneous bacterial peritonitis
   - ☐ Hepatorenal syndrome (↑ BUN and creatinine with oliguria)
   - ☐ Refractory hepatic encephalopathy
   - ☐ Recurrent variceal bleeding

Supporting Documentation

☐ Progressive malnutrition
☐ Muscle wasting with reduced strength and endurance
☐ Active alcoholism (>80 g ethanol/day)
☐ Hepatocellular carcinoma
☐ + Hepatitis B; refractory Hepatitis C

HOSPICE COVERED SERVICES

- Hospice covers all costs of care for the terminal diagnosis and all other diagnoses that contribute to the *terminal prognosis*
  - Conditions contributing to the terminal prognosis are referred to as related
  - Identifying diagnoses that contribute to the terminal prognosis is commonly referred to as determining relatedness
    - Performed upon admission and with change in condition

Related to terminal *prognosis* and medically necessary?
- Hospice pays

Related to terminal *prognosis* but not medically necessary?
- Discontinue or patient pays

Unrelated to terminal *prognosis* but medically necessary?
- Part D pays

Unrelated to terminal *prognosis* and not medically necessary?
- Discontinue or patient pays

CARE PLANNING

§418.56 Care Planning
- The interdisciplinary team must develop a plan of care that is individualized to each patient as part of its initial comprehensive assessment – must have a plan of care for every identified problem.
  - Updated every 15 days
  - Includes measurable goals and the care, treatment, or services the hospice will provide to achieve those coals

REQUIRED ELEMENTS FOR THE PLAN OF CARE

- Interventions to manage pain and other symptoms
- Scope and frequency of services necessary to meet patient and family needs
- Specific and measurable outcomes from plan of care implementation
- Drugs, treatments, medical supplies, and durable medical equipment
- Documentation of patient's involvement in planning or implementation plan of care

INITIAL AND COMPREHENSIVE ASSESSMENT

§418.54 Initial and Comprehensive Assessment

Initial Assessment
- *Registered nurse* must complete within *48 hours* of admission
- Identifies immediate symptom management needs

Comprehensive Assessment
- *Hospice interdisciplinary team* must complete no later than *5 calendar days* after election of hospice
- Identifies the physical, psychosocial, emotional, and spiritual needs related to the terminal illness
- *Updated* as frequently as the condition of the patient requires, but no less frequently than *every 15 days*.

Key Components

- Nature of the terminal condition and severity of symptoms
- Complications and risk factors impacting care planning
- Functional status, including patient's ability to provide self-care
- Imminence of death
- Drug profile review: review all prescription, OTC, herbal, and other alternative medications that could impact drug therapy:
  - Effectiveness of drug therapy
  - Side effects; actual or potential drug interactions
  - Duplicate drug therapy
  - Drug therapy currently associated with laboratory monitoring
- Bereavement
- Need for referral or evaluation by an appropriate healthcare professional

Documentation Considerations

- Describe the patient's current physical, emotional, and spiritual status and any associated symptom burden using symptom and functional assessment scales when necessary.
  - Avoid general statements and descriptors not supported by evidence. For example, if documenting a general descriptor, such as cachectic, dyspneic, or weaker, always include objective evidence to justify the use of that terminology.
  - Include documentation of the services and interventions provided, as outlined in the plan of care, to achieve symptom control as well as patient and caregiver response to services and interventions.
- If symptom control is not achieved with current plan of care, document communication with members of the IDG and any associated changes to the plan of care.
- Describe the current status of the caregiver and any potential barriers to the plan of care.
- Describe the patient's environment and the impact the current environment has on implementing the plan of care.

INTERDISCIPLINARY GROUP

§418.56 Interdisciplinary Group
- Required members:
  - Hospice physician
  - Registered nurse
  - Social worker
  - Pastoral or spiritual counselor

Other members of the team can attend!

INTERDISCIPLINARY GROUP MEETINGS

Key topics of Interdisciplinary group meetings:
- Patient eligibility and recertification
- Updates to the plan of care
- Unmanaged symptoms
- Social or spiritual needs
- Discharges and deaths

Patient plateaus and other recertification concerns should NOT be a surprise!

VISIT FREQUENCY & DOCUMENTATION

§418.76 Visit Frequency
- No less frequently than every 14 days
  - Ensure that services ordered by the hospice interdisciplinary group meet the patient's needs
  - Assess the quality of care and services provided by the hospice aide
- Annually: on-site visit to the location where a patient is receiving care to observe and assess each aide while he or she is performing care

VISIT FREQUENCY AND DOCUMENTATION BY LEVEL OF SERVICE

Level of Service	Visit Frequency	Documentation
Routine Home Care (RHC)	• No less frequently than every 14 days • Varies based on patient need or preference	• Comprehensive assessment every 15 days • Patient needs met or unmet by plan of care • Last 7 days of life: document visit to obtain service intensity add on payment
Continuous Home Care (CHC)	• Minimum of 8 hours of care per day - at least 50% of care provided by a nurse (RN, LPN) remaining care provided by an aide	• Precipitating crisis and time at which the crisis started • All ineffective interventions • Desire to remain in the home setting • Communication with the physician or other members of the IDG. • When providing CHC, document symptom frequency and severity, communication with IDG members, any interventions to palliate the symptoms, and the patient's response to these interventions
Inpatient Respite	• Varies based on patient need or preference	• Start and stop date and time • Reason for changing level of care • Care coordination with accepting facility
General Inpatient Care (GIC)	• If in hospice IPU: document per policy • If in other setting: daily visits	• Describe the frequency and severity of the unmanaged symptom(s), all ineffective interventions trialed prior to seeking a higher level of care, the reason(s) why the current symptoms cannot be managed in the home or facility at RHC level of care, and communication with the physician or other members of the IDG. • Once GIC is decided, the nurse should also document any arrangements for patient transportation and conversations to coordinate care with the facility providing GIC

PATIENT RIGHTS

§418.52 Patient Rights

- Effective pain management and symptom control
- Involved in developing the hospice plan of care
- Refuse care or treatment
- Choose attending physician
- Have a confidential clinical record
- Receive information about the services covered under the hospice benefit
- Receive information about the scope of services that the hospice will provide and specific limitations on those services
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of property

PROVIDING CARE TO NURSING HOME RESIDENTS

§418.112 Providing Hospice Care to Nursing Home Residents

- Clear delineation of the hospice's responsibilities
  - Hospice assumes care of the patient
    - Hospice must provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IID resident were in his or her own home, i.e., provide durable medical equipment, medications, and supplies as you would in the home
- Collaboration between nursing home staff and hospice for the plan of care
  - Hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care
- Immediate notification from nursing home staff of patient change in condition
- Reimbursement for room and board only if patient is also a Medicaid recipient

Required Documents for Nursing Home Residents

Provide the nursing facility with the following documents for each patient:

- Hospice election form and any advance directives specific to each patient
- Physician certification and recertification of the terminal illness
- Names and contact information for hospice personnel involved in hospice care of each patient
- Instructions on how to access the hospice's 24-hour on-call system
- Hospice medication information specific to each patient
- Hospice physician/attending physician orders specific to each patient
- Hospice plan of care with evidence of collaboration between the hospice and nursing facility

ABUSE & NEGLECT

§418.52 Abuse and Neglect

- Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish
- Patients have the right to be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property

TYPES OF ABUSE AND NEGLECT

Verbal abuse
- Disparaging or derogatory oral, written or gestured language that willfully to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability

Mental abuse
- Humiliation, harassment, and threats of punishment or deprivation

Sexual abuse
- Sexual harassment, sexual coercion, or sexual assault

Physical abuse
- Hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment

Neglect
- Failure to provide goods and services necessary to avoid physical harm or mental anguish

Misappropriation of patient property
- Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent

Injuries of unknown source
- Suspicious injury where the source of the injury was not observed or the source of the injury could not be explained by the patient

Reporting Abuse and Neglect

- "All patient complaints and alleged or real violations included in this standard must be reported ***immediately*** to the hospice administrator and should be investigated, resolved and documented."
- "Immediately" is defined as "as soon as possible," but not to exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement.

HOSPICE DISCHARGE

§418.26 Hospice Discharge

- A hospice can discharge a patient from service only upon death or in other limited situations. Documentation is critical to demonstrating that a discharge was appropriate.

DOCUMENTING HOSPICE DISCHARGE

Discharge Reason	Documentation
Patient Moves Out of Service Area **Patient Transfers to Another Hospice**	• Objective findings supporting discharge for this reason • Communication with members of the IDG • Any interventions trialed to resolve the problem(s) necessitating discharge and the patient's response • Interventions completed for discharge planning • Any efforts to coordinate care with the accepting hospice, facility, home health care, or other health care provider

Patient is No Longer Terminally Ill	• Objective findings supporting discharge for this reason
	• Communication with members of the IDG
	• Any interventions trialed to resolve the problem(s) necessitating discharge and the patient's response
	  ○ Determine if the plateau or improvement is due to the care provided by the hospice
	  ▪ What strategies have prevented repeated hospitalization?
	  ▪ What interventions have been put in place to achieve symptom management?
	  ○ Identify instances where the documentation is not painting an accurate clinical picture
	  ▪ Example: A nurse documents that a patient's weight has been stable for the past three months. However, during IDG, the nurse notes that the patient only weighs 86 pounds. Further weight loss would be unexpected.
	  ○ Does a review of LCDs indicate the patient is still terminal?
	  ▪ Symptoms and condition may have stabilized with hospice care, but LCDs still indicate patient is terminally ill
	• Interventions completed for discharge planning, including discussions with the accepting hospice, facility, or other health care provider

Discharge for Cause	• The patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired; provide objective findings supporting discharge for this reason
	• Prior to discharging a patient for cause, you must:
	  ○ Advise the patient that a discharge for cause is being considered
	  ○ Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation
	  ○ Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services
	  ○ Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records
	• Also, document Interventions completed for discharge planning, including efforts to coordinate care with the accepting provider

Optum

References

1. Davis FA. Medicare hospice benefit: early program experiences. *Health Care Financing Review*. 1988;9(4): 99-111. https://www.cms.gov/research-statistics-data-and-systems/research/healthcarefinancingreview/downloads/cms1192048dl.pdf
2. Centers for Medicare & Medicaid Services (CMS). Medicare and Medicaid Programs: Hospice Conditions of Participation; Final Rule. *Fed Regist.* 2008;73(109):32088-32220. Codified at 42 CFR 418. https://ecfr.io/Title-42/pt42.3.418#se42.3.418_12
3. Centers for Medicare & Medicaid Services (CMS). 2019. What is a MAC. https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.
4. Centers for Medicare & Medicaid Services (CMS). Local Coverage Determinations (LCDs) by contractor index. 2021. https://www.cms.gov/medicare-coverage-database/indexes/lcd-contractor-index.aspx?bc=AQAAAAAAAAAA&
5. CGS Medicare. Suggestions for Improved Documentation to Support Medicare Hospice Services. 2016. https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_documentation_tool_h-021-01_07-2011.pdf
6. Hospice Payment System. CMS Medicare Learning Network. 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf
7. Hospice Services Payment System. MEDPAC. 2016. http://www.medpac.gov/doc s/default-source/payment-basics/medpac_payment_basics_16_hospice_final.pdf
8. National Hospice and Palliative Care Organization. Determining Terminal Prognosis. 2020. https://www.nhpco.org/regulatory-and-quality/regulatory/determining-terminal-prognosis/
9. National Hospice and Palliative Care Organization. NHPCO Relatedness Process Flow. 2020. https://www.nhpco.org/rg-new/rg-conditions-medications-drugs-and-services/
10. Optum Hospice Pharmacy Services. Dementia medication talking points for health care providers. Contact druginformation@optum.com for more information.
11. Kennedy J. Hospice documentation: the big picture. *Home Healthcare Nurse*. 2009;27(9): 547-554.
12. Centers for Medicare & Medicaid Services (CMS). State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Rev. 211, 02-03-23. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf