The Hospice benefit is provided to beneficiaries with clinical evidence and descriptive notes to show the beneficiary is terminally ill and progressing in a manner that a physician would reasonably conclude that the beneficiary’s life expectancy is months or less.

**Importance of Descriptive Narratives in Clinical Records**

Descriptive information completes the picture started with check-based assessments. Comparative information establishes longitudinal decline and may indicate decline suggestive of terminal status.

Each Clinical Note must be able to stand alone and show how the patient remains terminally ill or it may appear the patient has stabilized, become chronically ill and requires discharge planning to occur. Failure to document a distinct different will result in payment denial for a month, certification period or even an entire admission.

Surveyors appear to be focusing on severe, unremitting symptoms as a basis for terminal status/medical necessity. Examples include: dyspnea at rest in patients with COPD or heart failure; and dysphagia with aspiration pneumonia in patients with dementia. Inconsistency decreases the clinical record’s credibility in the eyes of reviewers and makes it harder for those trying to identify the patient’s true clinical status and to defend your claims. Examples of inconsistency include:

- PPS assessments not supported by other assessment data in the clinical record
- Incorrectly applied FAST assessments and/or scores not supported by other assessment data
- Disparity between physician narratives and clinical information in the clinical record
- Lack of consistency in recording weights, anthropomorphic measurements, other objective data
- Absent or inconsistent data for a specific LCD has the appearance of disregard for or lack of awareness of the LCD which can also send up red flags.

Decline is inherent to the dying process in most diseases and most hospice staff are attuned to documenting the slightest signs. But decline is also associated with chronic conditions and advanced age. In denial statements, reviewers often state there is evidence of decline, but deny the claim because terminal status is not established.

Nursing narratives repeated verbatim across Clinical Notes, IDG Notes, and Plans of Care can have the effect of reducing credibility of documented assessments and narratives. This also may contribute to a clinical picture of stability for the patient. Documentation must support the patient’s decline. Each Clinical Note must show evidence of signs and symptoms of decline despite optimal care.

Document using International Classification of Functioning: impairments in function, activity limitations, participation limitations, and communication impairment. Include in narrative documentation information about how co-morbid conditions and secondary conditions affect the patient’s decline. Consider ways to document which systems of the body are in a terminal condition.

Allow documentation to describe changes in a patient’s health status. Compare historical assessment data with current assessment data and changes in the patient’s functional status from the past to the most current assessment.

Clinical Notes from all disciplines should demonstrate a consistent picture of terminal. Avoid vague statements such as: “slow decline,” “disease progressing.” The more objective the documentation, the better! Remember: Hospice is for those needing true “skilled palliation of end of life symptomology”.

Gentiva Health Services, Inc., 2015
Identify areas of need through interdisciplinary assessment. Include objective measurement, assessment scale information, and pt/family goals. Be sure that the Plan of Care addresses interventions needed to reach these goals. At each visit, document the plan of care area of need being addressed, intervention(s) provided and pt/family outcomes.

Each billed claim (calendar month) must “stand alone.” Associated documentation must provide sufficient support of the ongoing medical necessity of the services being provided. All interventions must be in direct response to the comprehensive assessment and the plan of care. Continual reassessment of patient/family/caregiver needs and goals throughout course of care must be completed no > every 15 days.

If a patient’s course of decline remains temporarily unchanged, it should still remain clear that the patient has a 6 mo prognosis in the medical record. If your documentation doesn’t reflect a 6-month or less prognosis (usually evidenced by clinical decline and medical necessity) you are at risk for payment denial!

Document measurable objectives such as: Weight/BMI, Abdominal girth, Mid Arm Circumference, Labs (albumin, electrolytes, renal/liver function), food and fluid intake, percent of meals completed, and the patient’s signs and symptoms and how it has changed over time.

<table>
<thead>
<tr>
<th>DO THIS</th>
<th>DON’T DO THIS</th>
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<tbody>
<tr>
<td>“Ate ½ cup oatmeal for breakfast and is refusing Ensure between meals.” (estimate calories; progressive decline in intake; increased time-to-task completion; etc.)</td>
<td>“Ate 50% of his breakfast”</td>
</tr>
<tr>
<td>“Lost 5 lbs. last month and 4 lbs. the month before” (BMI, MAC since admission)</td>
<td>“Appears to be losing weight”</td>
</tr>
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Within the narrative summary state how you drew your conclusions such as:
- Increasing dyspnea *as evidenced by* increased use of accessory muscles on inspiration and greater use of nebulizer, pursed-lip breathing, use of accessory muscles and use of medication to reduce the symptoms
- Lack of appetite and associated weight loss *as evidenced by* 1 inch decrease in Mid Arm Circumference and ill-fitting clothes
- Patient growing weaker over past 3 days *as evidenced by* now spending most of her time in bed (# of hrs per 24 spent in bed/sleeping)

For weight loss, document: ill-fitting dentures, eye glasses, or jewelry; clothing size; sunken cheeks; prominent bones; skeletal appearance; and poor intake. Every IDG member can, and should, describe the patient’s physical appearance and how it’s changing over time!

To reflect skin changes, document: skin changes, visible wounds, bruising, poor circulation, swelling, and mottling.

Make sure your narrative documentation clearly notes increased service utilization such:
- Need for more frequent or longer visits or greater involvement by members of IDG
- Changes in signs/symptoms
- Number of symptoms & degree of severity
- Medication changes to include the addition / discontinuation / titration / or route

Reference: Hospice Education Network - Disease-Specific Hospice Eligibility & Documentation Series - Documenting Clinical Eligibility and Recertification in Hospice