Hospice Eligibility Documentation Tips and Strategies

Hospice Documentation Requirements

The hospice clinical record must support the plan of care and frequencies of visits along with the findings of the comprehensive assessment and updates to the assessment. Documentation found in the clinical records must also be specific to changes in the patient/family’s status and show evidence that all the members of the interdisciplinary group participated in each patient specific written plan of care.

Documentation must clearly communicate observations and the reporting of patient status and the care or services furnished as well as the patient’s response.

Documentation to Support Hospice Admission

Patient record must support documentation in technical elements consistent with a terminal prognosis of 6 months or less. Documentation to support patient’s eligibility for the hospice benefit must include clear representation in the clinical record of:

- Worsening clinical status to initiate the hospice referral
- Decline in clinical status
- Diagnostic findings, Laboratory testing to support terminal illness
- Functional status decline
- Co-morbidities
- Date of diagnosis and course of illness
- Patient has desire for palliative, non-curative treatment
- Recurrent or intractable infections such as pneumonia, sepsis, or upper urinary tract infection
- Progressive quantifiable decline as documented by weight loss not due to reversible causes (depression, diuretics), decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes (depression, diuretics), decreasing serum albumin or cholesterol, dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreased food portion consumption

Documentation to Support Continued Eligibility (Documenting Decline)

We are responsible for assessing for all body systems and treating the whole patient, not just the symptoms related to the terminal illness. We may not be required to pay for medications, and/or treatments considered not related to the terminal illness, but we are still required to care for and assess the whole patient and acknowledge how unrelated issues are being addressed.

Negative charting demonstrates that we are noticing and treating those symptoms that are present at the terminal phase of one’s life. We know they are there: seek them out, collaborate with your fellow team members about them; document their presence, and their persistence. Finally, make sure your documentation clearly shows your patient was: assessed by a professional, cared for by a capable and competent clinician, the patient’s response to each of your interventions is clearly visible in your
documentation and the clinical record shows collaboration amongst members of the interdisciplinary group.

**Instead of “Non-ambulatory”:**
- Slumped over in chair
- Head resting on shoulder, chest
- Extremities are flaccid
- Only out of bed for meal(s)
- Leans to one side
- Requires lap buddy

**Instead of “Wheelchair bound”:**
- Total lift to wheelchair, pivot, Hoyer lift (explain how the patient got to the wheelchair)
- Describe activity of patient while in the wheelchair (motionless, slumped, propels with feet)

**Instead of “Ambulatory”:**
- Ambulatory with 2 person assist
- Utilizes cane or walker to ambulate
- Ambulates feet with a recovery time of minutes
- Noncompliance with use of cane/walker
- History of falls
- Shuffles feet when walks
- Increased fatigue with activity as evidenced by ____
- Decreased endurance / SOB with ambulation as evidenced by ____
- Unsteady gait
- Steadies self when ambulating by holding onto wall/furniture

**Instead of “Bedbound”:**
- Lying in bed motionless
- Time spent in bed is (increasing, decreasing)
- / 24 hours spent in bed
- No spontaneous movement
- Contracted
- Does not tolerate sitting in Geri chair or wheelchair as evidenced by ____
- Turned every hours with # of people required to turn patient with pillows utilized for positioning
- Length of time patient is out of bed
- Activities tolerated while out of bed (meals, shower)
- Sits in chair motionless

**Instead of “Disoriented”:**
- Chart specific questions asked to patient. (focus on what the patient cannot do/inappropriate answers)
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- Does the patient recognize his or her name
- Does the patient recognize family members, friends or caregivers
- Can the patient explain what they ate at their most recent meal
- Does the patient provide any of their own ADLs appropriately

**Instead of “Unresponsive / non-verbal”:**
- Does not track visually
- Drooling
- Shows no response to loud voice, squeezing of hand, calling of name
- Has flat affect / blank stare
- Keeps eyes closed at all times
- Behavior consistent or differs from the usual state of the patient as evidenced by ______
- change in behavior from previous behavior

**Instead of “Thin”:**
- Shoulder blades protruding
- Skin sagging from bones
- Protruding cheek bones
- Eyes are hollow or sunken
- Loose clothes
- Muscle wasting
- Temporal wasting

**Instead of “x% diet taken”:**
- Patient feeds self or requires assist of others (amount of assistance required)
- Amount of time it take to feed patient
- Type of diet (50% of cup of soup or 50% steak)
- Swallowing or chewing difficulties
- Pocketing food
- Change in diet taken (from % taken in the past X months /average consumption % of diet X months ago, now % of diet)
- Difficulty swallowing
- Episodes of choking since last visit
- Supplements consumed (frequency, type, calories, tolerated)
- Reason for change in diet (loss of appetite, refusing food)
- Takes only sips of fluid

**Instead of “Pale skin”:**
- Pasty, Dusky
- Gray circles around eyes
- Purple blue lips
- Transparent
- Tears easily
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- Skin Turgor __
- Capillary Refill  seconds
- Cold Extremities
- Cyanosis (location)
- Swelling (location, level)
- Rash
- Bruising

How to “Paint the Picture” of the Patient:

Remember, if we can paint a picture of the patient with our documentation, we will be ok. How do we “paint a picture” with words? Describe what you see, hear, smell, touch, measure and identify as deviant from normal. Compare a patient today with his/her assessment results at the start of care, last week, or last recertification and document that comparison (noting his/her prior assessment and how they present now). Use the patient and caregiver’s own words to describe changes in sleeping, eating, and activities of daily living.

In hospice we need to spend most of our time focusing on the problems (actual and/or probable) the patient/family is having. With each assessment we need to look for and identify problems. Our job is to do what we can to manage identified problem(s). Be it medical, psychosocial or spiritual, the process is the same.

Some insurance payor sources provide reimbursement by what is identified as patient decline or worsening of patient condition and will pay or deny payment based on the words we use in our documentation. Documentation must be objective. We are to document what we: see, hear, smell, touch, measure and identify as deviant from normal. Insurance payors may reject payment and may force us to discontinue care for those who need our care, if visible decline or deterioration of health is not visible in our documentation.

Each visit note must be able to stand alone and reinforce the patient is appropriate / eligible for hospice EVERY time you chart on EVERY note, find the time and place to use the following words and phrases. In other words, find what is wrong and Document It!

Use descriptive words such as the following which can be medical, psychosocial and/or spiritual in nature and therefore are not discipline specific: requires, throbbing, unrelenting, uncontrolled, hurting, suffer, severe, pain, endure, needs, persistent, intolerable, agony, constant, excruciating, distress, irregular, unbearable, piercing, unequal, gasping, soreness, breathless, fatigue, tender, incapable, immovable, and exhausted.
Further clarify the patient’s decline by focusing negative aspects of the patient’s condition.

<table>
<thead>
<tr>
<th>INSTEAD OF USING THESE</th>
<th>USE NEGATIVE CHARTING OPTIONS</th>
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<tbody>
<tr>
<td>“Stable”</td>
<td>“Comfortable,” “Well-managed”</td>
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<tr>
<td>“Skin intact”</td>
<td>“Tenting,” “Dehydrated,” “Dry”</td>
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<td>“No new changes”</td>
<td>“Continues to require…” “Max assist with ADLs, Lasix”</td>
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<tr>
<td>“Breath Sounds CTA”</td>
<td>“Still requires oxygen,” “Only walks six steps before SOB”</td>
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<td>“Eats 100% / Good PO Intake”</td>
<td>“Food must be pureed,” “Requires assistance with feeding”</td>
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<td>“BM daily”</td>
<td>“Requires 200 mg bid of DSS and 4 tabs of Senna daily”</td>
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<tr>
<td>“Ambulates”</td>
<td>“Requires max assist,” “Requires use of walker”</td>
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<tr>
<td>“Urine clear”</td>
<td>“Requires a Foley,” “Urinates four times nightly,” “Antibiotics”</td>
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<tr>
<td>“AAOx4”</td>
<td>“Frequent episodes of forgetfulness,” “Periods of lucidity”</td>
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<tr>
<td>“Sleeps well”</td>
<td>“Requires 30 mg of Temazepam for sleep,” “Must use Ambien”</td>
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<td>“Heart sounds normal”</td>
<td>“Requires Lasix, Procardia ...”</td>
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<tr>
<td>“No weight loss”</td>
<td>“Requires appetite stimulant,” “No weight gain”</td>
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Document Evidence of Decline for Related Diagnoses:

Documentation must communicate evidence of decline by focusing on problems the patient/caregiver is having.

- Assess all body systems and treat the patient holistically
- Document toward decline
- Negative charting demonstrates that we are noticing and treating those symptoms that are present at the terminal phase of life
- Negative charting also allows the clinician to focus on strategies to reduce suffering and provide quality end of life care
- Negative charting supports reimbursement for care provided

Disease Specific Documentation Examples:

**Alzheimer’s Disease:**

- “Patient/family requests no further hospitalizations”
- “Decline in Functional Assessment Staging (FAST) now 7 from 7C on (date).”
- “Dependence in bathing/dressing/feeding”
- “Speech is limited to approx 6 or fewer words-or no meaningful verbal communication”
- “Cannot ambulate alone without assistance of walker/cane/person assist”
- “Cannot sit up without assist”, “Loss of ability to smile”, “Flat affect”
- “Cannot hold head independently”, “Unable to change position without assist”
- Bed bound -- “Bed to chair transfer only”, “Geri-chair”
- “Progressive weight loss. Wt is lbs which is down from lbs on (date)”
- “Decreasing measurements of mid-arm cir or abd girth-decreased to cm on date”
- “Review of mealtime log shows pt eats 3-4 bites of Jello & ¼ cup soup at mealtime”
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- “Serum album gm/dl on (date) (<2.5) Pre-albumin (18)”
- “Taking only sips of fluids” – “drooling”, “swallowing difficulty”, “chokes easily”
- “Incontinent of urine & feces”, “contractures”, “decubitus ulcer stage 3 or 4”
- “Episodes of fever & or recurrent after antibiotic tx” “UTI on (date)”, “Septicemia on (date)”
- “Episodes of aspiration or aspiration pneumonia on (date)”, “Requires 02 at l/min”
- “Co-morbidities include_ _” “pneumonia on (date)”, “decubitus ulcer stage 3 or 4”

End Stage Cardiac Disease:
- “Inability to carry on any physical activity without discomfort”, “limited physical activities”
- “Discomfort is increased with any physical activity”, “orthopnea” (can’t breathe lying down)
- “Paroxysmal nocturnal dyspnea” (waking up during the night SOB)
- “Symptoms of heart failure even at rest”, “angina symptoms even at rest”, “refractory angina”
- “Dyspnea at rest” dyspnea on exertion” (describe) “chest pain” (describe) “gallop rhythm “S3 S4”
- “Diaphoresis”, “rales – wet crackles in lungs upon inspiration”, “weakness”
- “Syncope” (how often)
- “Edema” LE & pitting (where-how much-when) “nail bed dusky”, “ejection fraction of %(<=20)
- “Symptoms of CHF (specify) despite medical management with___” (diuretics & vasodilators)
- “Symptomatic arrhythmias that are resistant to antiarrhythmic therapy”
- “History of cardiac arrest & resuscitation”, “history of embolic CVA or cardiac origin”
- “Jugulovenous distention” (JVD), “neck vein distention above clavicle”, “liver enlargement”
- “Cachexia – profound weight loss” (document wts) “weight gain due to fluid retention”
- “Vital sign fluctuations (blood pressure/pulse rates) showing instability of heart function”
- “Med changes_____”

End Stage Neurological Disease:
- “Patient/family requests no further hospitalizations”
- “Decline in Functional Assessment Staging (FAST) now 7 from 7C on (date)”
- “Ability to speak is limited to words” (6 or less), “No meaningful communication”
- “Cannot ambulate alone with assistance of walker/cane/person assist”
- “Cannot sit up without assist”, “Loss of ability to smile”, “Flat affect”
- “Dependence in bathing/dressing/feeding”
- “Comatose”, “persistent vegetative state”, “periods of unconsciousness”
- “Absent verbal responses”, “post stroke dementia”, “absent withdrawal response to pain”
- “Declines artificial nutrition & hydration”, “dysphagia”, “takes only sips of fluids”
- “Weight is lb down from lbs on (date)” “progressive wt loss of % or lbs in past mos”
- “Muscle wasting”, “abdomen sunken”, “bones protruding (state which bones)”
- “Decreasing measurements of mid-arm circ or abd girth-decreased to cm on (date)”
- “Review of mealtime log shows that pt eats bites of_____at mealtimes”
- “Fever on (date)”, “Septicemia on (date)”, “UTI on (date)”
- “Serum creatinine” (>1.5) – “serum albumin” (<2.5) “pre-albumin” (<18)
End Stage Pulmonary Disease:

- “Unable to ambulate without assistance of _”, “Increased dyspnea after ___ ft of ambulation”
- “Needs to sit & rest after ambulating ___ ft to reduce dyspnea”
- “Housebound/chair bound or bed bound due to __”, “Unable to bathe or dress without assistance”
- “Dyspnea while talking, coming to a standing position, ambulating __ ft or ___ ft”
- “Disabling dyspnea with minimal exertion (describe activity)”, “disabling dyspnea at rest”
- “Bed to chair existence”, “fatigues easily”, “resting tachycardia of ___ >100”
- “Uses 02 of ___ l/min continuously”, “pulmonary hyperinflation – barrel-chested”
- “Pursed-lip breathing”, “respiratory retractions: supraclavicular”, “depressed diaphragm”
- “Increased expiratory phase: slowed forced expiration”, “wheezing” “diminished breath sounds”
- “Cyanosis of lips and fingertips”, “coughing (productive or non productive)”
- “Copious or purulent sputum”, “pulse oximetry of ___ %<or = 88% on supp oxygen”
- “Hypoxemia at rest on supplemental 02”, “No response to bronchodilators (name meds)”
- “Taking (___ RX) for respiratory infection”, “med changes (___ RX)”
- “Admitted to GIP level of care for exacerbation of resp condition & severe SOB on (date)”
- “Co-morbidities include__ __”, “pneumonia on (date)”, “decubitus ulcer stage 3 or 4”

Summary

Contained within the clinical record must be enough objective data and descriptive notes to show the patient’s illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary’s life expectancy is six months.