



Texas Association for
Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting
Wednesday, September 2, 2026
Crockett CD Room
2:45pm-3:45pm

3b. Hospice Eligibility & Prognosis: Getting It Right from Day One

Presented by:

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Thank you to our Partners:



Hospice Eligibility & Prognosis: Getting It Right from Day One

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Learning Objectives

At the completion of this educational activity, the learner will be able to :

- Describe technical denials seen in industry review trends
- Describe clinical documentation denials seen in industry review trends
- Discuss required elements of documenting hospice eligibility
- Describe best practices related to documentation of hospice eligibility
- Discuss structure and elements that should be addressed when ensuring compliant documentation

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This presentation will look at the processes of reviewers by reverse-engineering. The intention is to dissect exactly how audit contractors look at patient charts, where front-end processes fail under metadata mining, and how to hard-code compliance into documentation from the time a referral enters our agency database. The primary goal as executive leaders is to survive extended length-of-stay and all over types of oversight reviews by moving away from generic templates and mastering the art of the active clinical narrative.

- We are all becoming more and more used to the current environment - no longer one of simple, occasional retrospective audits. Instead, a matrix of overlapping contractors, each with a different focus.
- **Unified Program Integrity Contractors, or UPICs**, are looking for programmatic fraud, waste, and abuse, driven entirely by data-mining anomalies and time metadata.
- **Supplemental Medical Review Contractors, known as SMRCs**, are tasked by CMS to run large-scale medical necessity look-backs on specific billing codes or continuous home care utilization.
- **Recovery Audit Contractors, or RACs**, operate on automated contingency algorithms designed to identify long lengths of stay, specifically targeting non-cancer diagnoses that surpass the 180-day threshold without an explicit, multi-point trajectory of decline.
- **Palmetto, CMS and the CERT** program also perform ongoing audits, including PPEO and TPE initiatives that will be ongoing for the foreseeable future

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The Contractor Audit Matrix: Targets & Timelines

Inside the Reviewer's Playbook: How UPICs, SMRCs, RACs, and MACs Evaluate Charts

SMRCs & MAC TPE: Medical Necessity & Narrative Integrity

AUDITOR TRIGGER: MAC Targeted Probe & Educate (TPE) reviews are sequential rounds of 20-40 charts.

If technical documentation failures (late signatures, weak recertification narratives, unaligned IDG notes) exceed an acceptable percentage, the agency drops into succeeding restrictive review rounds.

Supplemental Medical Review Contractors (SMRC): Tasked by CMS to perform large-scale, focused look-backs at specific operational patterns (e.g., continuous home care billing, specific local MAC exceptions).

SMRCs aggressively target medical necessity, checking if the plan of care matches real-time charting. They have a baseline 45-day calendar response window.

UPICs & RACs: Fraud Interception & Automated Scrutiny

Unified Program Integrity Contractors (UPIC): Focus strictly on pre-payment and post-payment reviews driven by data-mining anomalies. Their timeline is highly compressed: providers have a strict 30-day response deadline under active program integrity regulations. Failure to produce a complete record results in immediate automatic claim invalidation and corporate extrapolation risk.

Recovery Audit Contractors (RAC): Utilize automated algorithms to scan claims database history looking for programmatic structural vulnerabilities. Their primary target is long length-of-stay (LOS) beneficiaries, specifically looking for non-cancer diagnoses (dementia, debility) that have crossed the 180-day threshold without a clear, objective shift in their terminal trajectory.

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How Data Mining Prevents "Routine" ADRs

- The reason that agencies describe less debilitated patients sliding through without getting hit with an ADR comes down to **how Palmetto GBA selects charts for audit**. [\[1\]](#)
- As clarified in the **Palmetto GBA Hospice Coalition Q&As**, the MAC does not have the staff to manually read every progress note. Instead, they use automated data analysis to compare your agency's billing patterns against your state peers. [\[1\]](#)
- If your agency's **average length of stay (LOS), live discharge rates, and continuous home care volumes** sit within normal statistical averages, your agency's risk score remains low.
- Because your data patterns do not trigger the data-mining filters, your less severe charts are never pulled for review in the first place. They bypass scrutiny because the system has no reason to generate an ADR. [\[1, 2\]](#)
- If your agency gets placed on a **Targeted Probe and Educate (TPE)** loop or hits a **UPIC prepayment filter**, data mining stops and manual human review begins. When a human auditor opens a chart for a patient who was ambulatory and eating fairly well at admission, they will immediately check the record against the strict language of LCD L34547. [\[1, 2, 3, 4\]](#)
- If the chart relies on a generic checklist, the auditor will issue a swift denial using *"Documentation fails to support a terminal prognosis because basic motor and bulbar functions remain intact."* [\[1\]](#)



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How Reviewers Execute the Technical Drop

- Contractors use computerized algorithms to flag data outliers. When an agency drops into a UPIC prepayment audit, reviewers are not assessing clinical symptoms initially; they are screening for procedural alignment
- **AUDITOR TRIGGER:** UPIC prepayment reviews weaponize minute timing and technical defects. If an election statement signature timestamp deviates from the core clinical assessment timeline, the entire billing sequence is systematically invalidated. Through data mining – reviewers look for discrepancies between signature on consent/election (must be first) and signatures on initial assessments (must come after)

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One of the primary front-end traps flagged by UPIC prepayment review teams is the "Continuity Gap." This technical vulnerability occurs when there is an unmediated contradiction between an external acute care discharge summary and the internal hospice admission note.

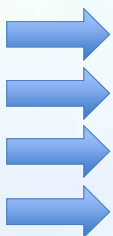
For example, if a hospital discharge planner notes that a patient is "stable at discharge", "returning home with managed symptoms", and the hospice admitting nurse documents "rapid terminal decline", bedbound with advanced renal failure" within 24 hours, automated data filters flag the file.

Reviewers exploit this continuity gap to claim that the hospice fabricated the terminal velocity to force an admission. To survive this filter, the intake team must force the clinical record to explicitly bridge the gap.

The chart must clearly explain the biological or pharmaceutical reason for the acute change—such as recent significant decline, onset of a new and significant terminal conditions, the determination that aggressive therapies have been ineffective, or the withdrawal of active aggressive measures—to justify the immediate shift from hospital stability to hospice eligibility.

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Every Medicare hospice claim rests on a foundation governed strictly by [42 CFR Part 418](#). To withstand federal scrutiny, clinical leadership must audit charts for the simultaneous presence of the four core regulatory pillars:



1. a valid physician certification of a terminal prognosis of six months or less,
2. a fully executed and compliant benefit election statement,
3. an individualized plan of care developed by the Interdisciplinary Group, and
4. a comprehensive assessment of the patient's holistic needs.

Reviewers look at these pillars as a conditional package for payment. If any of these contain a technical flaw—such as a missing date or an unsigned order—there can be reason for technical denial.

Contractors will invalidate the entire claim sequence under Medicare Part A, resulting in total recoupment without ever determining whether appropriate care was given. (next slide most recent Palmetto GBA audit results)

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Percent of Total Denials	Denial Code	Denial Description	Number of Occurrences
22%	5FF36, 5CF36	Documentation Submitted Does Not Support Prognosis of Six Months or Less	6
11%	5FFH9, 5CFH9	Physician Narrative Statement Not Present or Not Valid	3
7%	5FFH3, 5CFH3	No Certification for Dates Billed	2
7%	5FFH6, 5CFH6	Initial Certification Not Signed Timely	2

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WRITTEN CTI/RE-CTI

PHYSICIAN NARRATIVE STATEMENT OR NOT VALID/NO CERTIFICATION FOR DATES BILLED

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5FFH9, 5CFH9 —

Physician Narrative Statement Not Present or Not Valid (RELATED TO THE NARRATIVE STATEMENT REQUIRED ON THE WRITTEN CTI/RE-CTI)**Reason for Denial**

The claim has been denied as the physician narrative statement is not present or not valid.

• **How to Avoid This Denial - technical denial reasons:**

- The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms
- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature
- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum
- The narrative shall include a statement directly above the physician's signature attesting that, by signing, the physician confirms that the narrative was composed based on his or her review of the patient's medical record or, if applicable, his or her examination of the patient
- The narrative must reflect the patient's individual circumstances and cannot contain check boxes or standard language used for all patients

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Common Hospice Certification Errors (according to CGS (Palmetto's cousin))

- Medicare cannot make appropriate payment without correct dates, signatures and identifying roles of the physician(s). The following list identifies the common types of missing and inadequate information:
 - Predating physician(s) certification signatures
 - Not having both the hospice medical director and attending physician (if applicable) sign the initial certification as required
 - The physician narrative is missing
 - The physician's narrative does not include a statement attesting that it was composed by the physician
 - The attestation statement is missing
 - Not having verbal certifications by both the medical director and attending physician (if applicable)
 - No physician(s) signatures
 - Illegible physician signatures
 - Physician did not date his/her signature
 - Not clearly stating the dates the certification period encompasses
- (See samples next slides)

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Scenario A: Initial CTI or 2nd Benefit Period Recertification

Place this narrative directly above the physician's signature line on the certification form, or at the end of a dedicated addendum.

"This 76-year-old male with Stage IV Non-Small Cell Lung Cancer presents with rapid functional decline following the cessation of palliative chemotherapy three weeks ago. Over the last month, his Palliative Performance Scale (PPS) dropped from 60% to 40%. He is now primarily bed-to-chair bound and requires maximum assistance for transfers and activities of daily living (ADLs). He has experienced a documented, unintentional weight loss of 14 pounds over the past 45 days due to worsening anorexia. Recent imaging confirms new osteolytic bone metastases in the lumbar spine, causing severe, escalating pain that requires increasingly frequent opioid titration. He exhibits structural dyspnea at rest, requiring an increase in supplemental oxygen from 2L to 4L/min. His objective physical deterioration, progressive tumor burden, and lack of further oncological treatment options indicate a terminal trajectory. It is my clinical judgment that this patient's life expectancy is 6 months or less if his illness runs its normal course."

Physician Attestation:

By signing below, I confirm that I composed this narrative based on my review of the patient's medical record.

Physician Signature: _____ **Date:** _____

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Scenario B: 3rd Benefit Period or Subsequent Recertification (Includes Face-to-Face)

This option satisfies the additional regulatory requirement to explicitly integrate face-to-face (F2F) encounter findings.

"I conducted a face-to-face examination of this 76-year-old male with Stage IV Non-Small Cell Lung Cancer on [Insert Date]. This clinical encounter confirms a continued, measurable decline since his last recertification 90 days ago. During my examination, the patient demonstrated significant muscle wasting (cachexia) and was unable to sit up on the edge of the bed unassisted, reflecting a current PPS of 30%. His wife confirms he now sleeps more than 20 hours per day, a marked increase from his baseline three months ago. My physical assessment revealed decreased breath sounds bilaterally with significant retractions and audible wheezing, even while using 4L/min of supplemental oxygen. His oral intake has declined to minimal sips of liquids and occasional bites of soft food. He now displays signs of mild, intermittent delirium, characterized by confusion and picking at his bedsheets. These face-to-face clinical findings demonstrate a progressive, multi-system failure directly resulting from his advanced malignancy. These indicators confirm that he continues to meet hospice eligibility criteria with a life expectancy of 6 months or less if his disease runs its normal course."

Physician Attestation:

By signing below, I confirm that I composed this narrative based on my review of the patient's medical record and my examination of the patient.

Physician Signature: _____ **Date:** _____

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Why These Narratives Meet the Regulatory Criteria

Specific Prognosis: Both narratives explicitly state a life expectancy of "6 months or less if the illness runs its normal course" (Requirement 1).

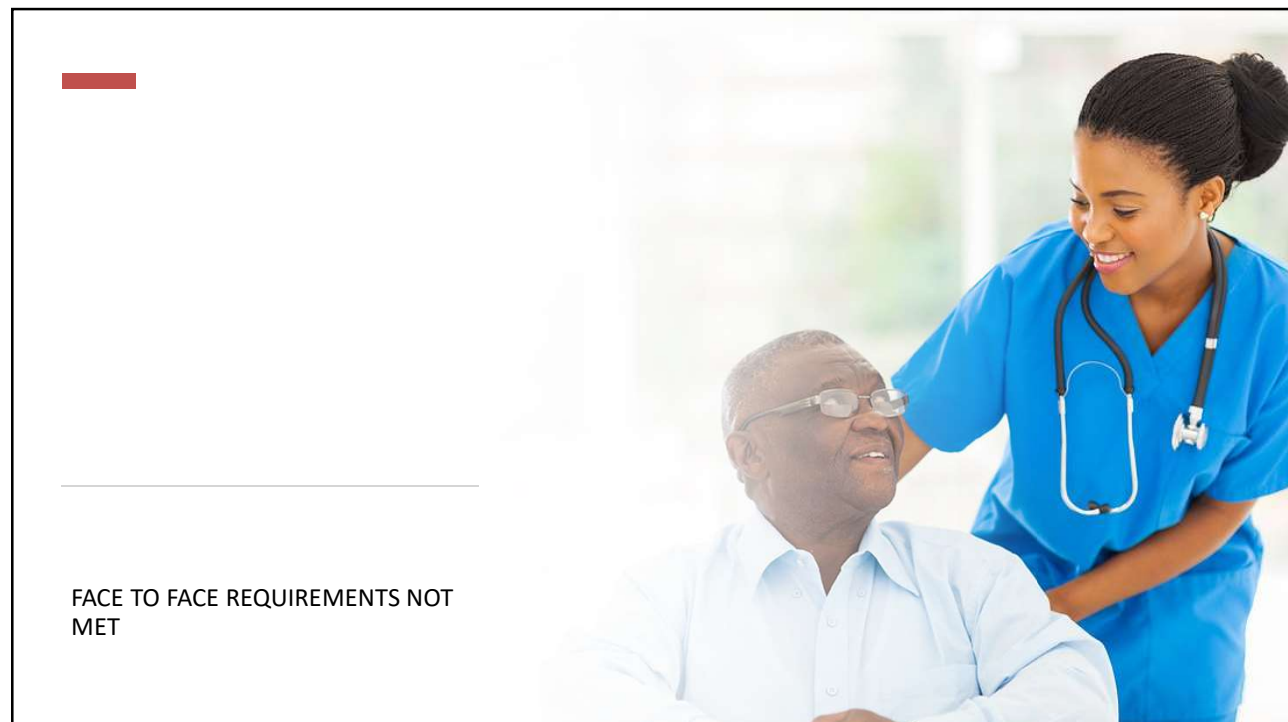
Clinical Documentation: They cite specific, measurable data points like PPS scores, weight loss, and physical changes (Requirement 2).

Exact Signature Placement: The mandatory attestation statements are positioned directly above the signature line (Requirement 3, i-iv).

No Boilerplate Text: The language isolates unique clinical features (oxygen needs, specific metastasis sites) rather than generic phrases (Requirement 3, iv).

F2F Integration: Scenario B directly connects the physical exam observations to the terminal 6-month prognosis (Requirement 3, v).

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FACE TO FACE REQUIREMENTS NOT
MET

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- Next to the CTI, the Face-to-Face encounter is the single most heavily scrutinized document in those charts that fall into the 3rd benefit period and beyond, which is a requirement implemented under the Affordable Care Act.

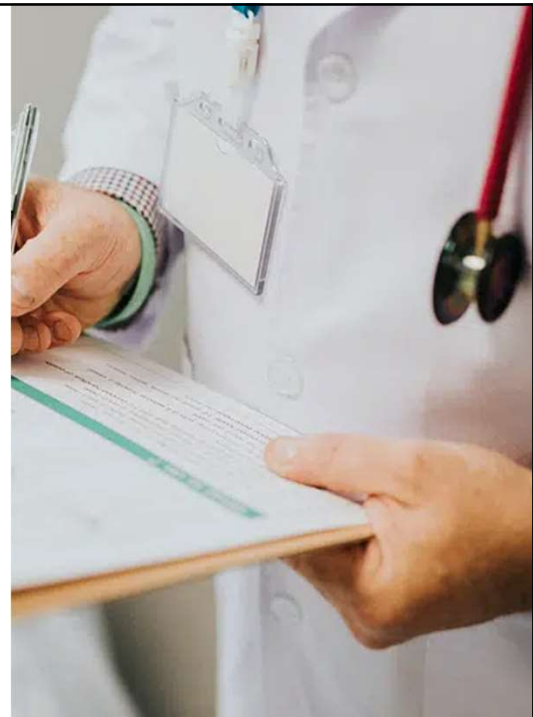
-

- Revised standards under **42 CFR § 418.22(b)(4)** allow a clinical note to serve as the official attestation, provided it contains:

- the explicit date of the visit
- the precise clinical findings
- the signature of the physician or authorized Nurse Practitioner, and
- the date of that signature.

- If an addendum or separate attestation sheet is used instead of a combined clinical note, it *must* include the explicit statement verifying that the visit findings were provided to the certifying physician for use in determining continued eligibility.

- Missing this attestation language is an automatic technical failure that completely invalidates the subsequent billing cycle.



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When it comes to improving F2F narratives, the Palliative Care Network of Wisconsin (see resources for link) suggests the following strategies:

Involve the Caregiver: A patient's caregiver usually spends more time with the patient than anyone else. They often provide valuable evidence for ongoing hospice eligibility, especially when clinicians counsel them on what to watch for. For example, a caregiver might notice that the patient is eating less or taking longer to eat the same amount of food compared to two months ago.

FTFE assessment: Consider the following domains in a FTFE (not comprehensive) (8). Only use diagnostic testing such as labs (e.g., serum albumin for nutrition, creatinine for renal function) or imaging if the benefits in prognostic formulation significantly outweigh the burden.

- **Nutrition: Quantitative (Quant):** appetite (# meals/day, % of meals eaten), weight, body mass index, mid-arm or mid-thigh circumference; **Qualitative (Qual):** dietary consistency (was on chopped diet now pureed; was on thin liquids now thickened), physical signs of wasting (well-fitted clothes in past now loose fitting, temporal wasting, prominent clavicles, concaved abdomen).
- **Function: Quant:** Activities of Daily Living (ADLs), Palliative Performance Scale, Karnofsky Performance Scale (10), number of falls, time to task (e.g. time to eat one meal), ability to swallow (# throat clearing, coughs, or choking episodes per meal), angle of contracted extremities; **Qual:** assistive devices (e.g. used cane and now wheelchair bound), feeding (1:1 feedings, feeding refusal, pocketing, was spoon-fed and now syringe fed), presence of fecal or urinary incontinence.
- **Cognition: Quant:** # hours asleep per 24 hours, mini mental status, speech and communication (# words/sentence), confusion (# hours lucid vs. confused); **Qual:** ability to verbalize (slurred speech, whispered speech), failure to recognize familiar people, decline in complexity of daily activities (e.g. played chess, then only watched TV, now falls asleep during meals).
- **Disease-specific:** e.g., Alzheimer's (FAST score), congestive heart failure (NYHA class, diuretic or O2 adjustments, edema, # exacerbations), renal failure (volume overload, signs of uremia, urine output).
- **Non-specific:** Recurrent infections, wounds (e.g. pressure ulcers with stage), skin appearance, vital signs, uncontrolled symptoms (e.g. pain, dyspnea), comfort medication titration, emergent events, ascites, aspiration events, prognostic indices: e.g., Mitchell Index (for nonspecific advanced dementia), Porock Index (11,12)

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IDG AND PLAN OF CARE
DOCUMENTATION



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While MACs and RACs evaluate our charts for medical necessity and payment metrics, we must also look at documentation through the lens of state surveyors via the [CMS State Operations Manual \(SOM\) Appendix M](#).

Surveyors focus on Conditions of Participation rather than strict billing codes, but their documentation expectations are deeply connected.

Under recent Appendix M revisions, surveyors are directed to perform an enhanced pre-survey task.

They actively mine public media, Care Compare metrics, IQIES reports, and prior complaint investigations before setting foot in your office.

When they review records, they are tracking the actual quality of care delivery, focusing heavily on how interdisciplinary team updates the individualized plan of care every 15 days to reflect real-time patient status changes. A chart that fails to show dynamic updates to the plan of care during a period of physical decline signals a total systemic failure to surveyors.

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Alzheimer's Disease & related conditions - LCD L34567

The Strict Multi-Layered Functional Baseline

When establishing or defending eligibility for advanced cognitive decline within our region, clinical records should align precisely with Palmetto GBA's standalone policy, [LCD L34567: Hospice Alzheimer's Disease & Related Disorders](#).

While other regional Medicare contractors use more flexible entry standards, Palmetto enforces a strict, concurrent cluster of functional losses that reviewers audit aggressively.

To support an initial admission or subsequent recertification, the medical record must systematically prove that the patient has reached a functional baseline of FAST Scale Stage 7 or beyond, documentation cannot simply check a box; it must explicitly demonstrate total dependence across a mandatory cluster of personal care thresholds. The chart must verify that the patient is entirely unable to ambulate without physical assistance, completely unable to dress or bathe without maximum caregiver intervention, and exhibits total or intermittent double incontinence.

Satisfying the FAST Stage 7 functional cluster meets only the first half of Palmetto GBA's strict LCD mandate. To build a survival-proof chart, documentation must include a profound loss of verbal communication, confirming that the beneficiary is restricted strictly to automatic, stereotypical phrases or speaks six or fewer intelligible words throughout a standard 24-hour observation cycle.

Most critically, Palmetto requires that this severe cognitive and functional baseline be directly paired with at least one secondary structural complication manifesting within the preceding 12 months. The clinical narrative must trend and isolate specific, severe secondary events: a verified medical history of recurrent aspiration pneumonia, severe pyelonephritis, systemic sepsis, or multiple stage 3 to 4 decubitus ulcers that resist aggressive pressure-relief protocols. Alternatively, clinicians can anchor eligibility by proving an active, severe nutritional collapse, logging an objective, documented 10% weight loss over the previous six months or a visceral protein collapse showing serum albumin below 2.5 g/dL.

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Neurological Conditions (Non-Alzheimer's) Under Palmetto GBA LCD L34547 Advanced Neurological Collapse & Progressive Disease Trajectories

For all non-cognitive end-stage neurological diagnoses—including Amyotrophic Lateral Sclerosis (ALS), Parkinson's disease, Huntington's chorea, and acute post-stroke chronic states—Palmetto GBA explicitly separates review criteria from dementia rules, governing these claims under [Palmetto GBA LCD L34547: Hospice Neurological Conditions](#). To insulate these charts from long length-of-stay recoupments by RAC and UPIC contractors, the clinical narrative must document a clear, multi-point trajectory of rapid physical decline paired with a severe loss of functional reserve.

For ALS, the LCD focuses heavily on respiratory destruction, requiring documentation of a Forced Vital Capacity (FVC) below 30% predicted, a steep downward trajectory in voluntary ventilation, or a documented, formal patient refusal of invasive mechanical ventilation. [1]

Auditors heavily scrutinize these structural files to isolate a documented shift from a chronic, managed state to an active terminal trajectory. The medical record must anchor baseline eligibility by verifying a structural functional breakdown, proving that the beneficiary has reached a Palliative Performance Scale (PPS) score strictly at or below 40%, leaving them completely disabled, bedbound or chairbound, and dependent on maximum caregiver assistance for all basic tasks.

For rapid-progression conditions like ALS, the clinical narrative must trend critical pulmonary and nutritional markers over the preceding 12 months, logging an objective vital capacity dropping strictly below 30% of predicted values or proving significant dyspnea at rest without supplemental oxygen support. [1, 2]

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Non-ALS Neurological Regression & Progressive Disability Baselines

For non-ALS neurodegenerative conditions—specifically advanced Parkinson's Disease, Multiple Sclerosis, and Huntington's Chorea—clinical charting must systematically prove that the beneficiary has transitioned from a chronic, managed phase into an unremitting terminal downward spiral.

To satisfy Palmetto GBA's strict disease-specific criteria, the record must anchor initial or ongoing eligibility by verifying a severe, foundational neuro-functional deficit, documenting that the patient has reached a Palliative Performance Scale (PPS) score strictly at or below 40%.

This mandates that the patient is entirely bedbound or chairbound, completely disabled, and dependent on maximum caregiver assistance for all basic personal care thresholds, including transfers, dressing, and hygiene. To build an audit-proof defense layer, this baseline functional deficit must be directly paired with a documented trajectory of severe, progressive clinical erosion manifesting within the preceding 12 months.

The clinical narrative must isolate and trend sequential, objective clusters of decline: a verified history of recurrent, severe aspiration pneumonia secondary to advanced neurogenic dysphagia, systemic sepsis, or multiple Stage 3 to 4 decubitus ulcers that remain completely refractory to aggressive pressure-relief protocols. Alternatively, clinicians can anchor the terminal prognosis by proving an active, severe nutritional collapse. This requires tracking a voluntary refusal of artificial feeding mechanisms paired with a documented, involuntary weight loss exceeding 10% over the previous six months, or a visceral protein collapse showing serum albumin below 2.5 g/dL, confirming an irreversible systemic failure.

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Cardiopulmonary Deep-Dive: Metric-Driven Defense

Palmetto GBA LCD L34548 Compliance Matrix & ICD-10-CM Intersections

To withstand an aggressive Palmetto GBA medical necessity review for a cardiopulmonary diagnosis, documentation must move past generic diagnostic lists and structure itself around Palmetto's specific dual-impairment framework under **Palmetto GBA LCD L34548**.

Unlike other MACs that rely on flat diagnostic test thresholds, Palmetto evaluates the combined weight of primary physical limitations and structural disease markers.

For Congestive Heart Failure, charts must explicitly track a New York Heart Association (NYHA) Class IV designation—proving that the patient experiences severe dyspnea, fatigue, or anginal chest discomfort strictly at rest, making any physical activity impossible without escalating distress.

If a cardiac test is present in the electronic health record, an Ejection Fraction equal to or less than 20% serves as a critical biological baseline, which must be paired with proof that the disease remains entirely refractory despite a maximized trial of guideline-directed medical therapies or detailed medical contraindications. [\[1\]](#)

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Cardiopulmonary Deep-Dive: Metric-Driven Defense

Palmetto GBA LCD L34548 Compliance Matrix & ICD-10-CM Intersections

Chronic Obstructive Pulmonary Disease Thresholds

When defending an end-stage pulmonary claim under LCD L34548, Palmetto requires clear confirmation of a GOLD Stage IV designation.

This must be structurally supported by documenting a post-bronchodilator FEV1 under 30% predicted.

Clinicians must explicitly prove that the patient is entirely dependent on continuous supplemental home oxygen at rest, anchoring the severe hypoxemia with an objective oxygen saturation equal to or less than 88% on room air, or tracking hypercapnia via an active pCO2 greater than 50 mmHg.

SMRC and Palmetto auditors actively check nursing and therapist notes for ***internal contradictions***. A chart that lists a GOLD Stage IV or NYHA Class IV designation but casually describes the patient as safely ambulating or completing independent daily care activities without real-time, immediate respiratory distress creates a fatal flaw that triggers an automatic medical necessity claim denial

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End-Stage Renal Disease (ESRD) Under Palmetto GBA LCD

Advanced Renal Collapse & Clearance Sourcing Guidelines

When establishing or defending an audit-proof prognosis for end-stage renal disease for Palmetto, clinical records must move entirely past generic diagnostic staging. Medical reviewers scrutinize renal charts for concrete proof of systemic uremic collapse combined with a definitive breakdown in compensatory mechanisms.

To anchor eligibility under Palmetto GBA's disease-specific guidelines, the charting must explicitly document that the beneficiary is either not a candidate for dialysis/transplantation or has made a voluntary, informed choice to decline or discontinue renal replacement therapy. The baseline framework requires objective laboratory confirmation of advanced clearance failure, capturing a serum creatinine level strictly above 8.0 mg/dL (or above 6.0 mg/dL for patients with significant comorbid diabetes mellitus) alongside an estimated Glomerular Filtration Rate (eGFR) trending consistently below 10 mL/min.

Meeting these hard laboratory thresholds fulfills only the baseline eligibility criteria. To ensure the clinical chart survives aggressive medical reviews, the narrative must actively link this clearance failure to a profound, multi-system functional decline manifesting within the preceding 12 months. Documentation must explicitly track and quantify uremic systemic symptoms that remain completely refractory to standard medical management. This mandates structural trending of advanced uremic pericarditis, severe and intractable fluid overload resistant to aggressive high-dose diuretic interventions, or an escalating frequency of uremic encephalopathy marked by progressive cognitive failure or organic delirium. Alternatively, the clinician can anchor the terminal trajectory by documenting severe nutritional collapse secondary to advanced uremia, logging a verified, involuntary weight loss exceeding 10% of total body mass over the previous 6 months, or chronic, severe hyperkalemia consistently exceeding 6.0 mEq/L despite regular administration of potassium-binding agents.

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Acute Liver Failure & End-Stage Hepatic Disease Under Palmetto GBA LCD

Hepatic Parenchymal Breakdown & Visceral Protein Collapse Metrics

Defending terminal eligibility for advanced cirrhosis or acute liver failure under Palmetto GBA's strict standalone criteria mandates a clinical narrative focused on structural parenchymal destruction and downstream vascular complications.

Medical records cannot merely label a patient as having end-stage liver disease; they must systematically prove a complete loss of hepatic reserve and metabolic functionality.

The chart must anchor baseline eligibility by logging objective, concurrent laboratory impairments that reveal severe coagulation and biliary excretion failure.

This requires documenting a baseline Prothrombin Time (PT) prolonged strictly greater than 5 seconds above control, or an International Normalized Ratio (INR) consistently exceeding 1.5, directly paired with a total serum bilirubin level trending strictly above 10 mg/dL, establishing an advanced hepatic breakdown.

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Acute Liver Failure Cont'd

To construct a survival-proof chart for medical review, this baseline functional deficit must be accompanied by a documented history of severe, progressive structural complications occurring within the past year.

The clinical record must explicitly chart the staging and trajectory of hepatic encephalopathy, proving progression to at least Stage 3 or 4 (characterized by profound somnolence, gross confusion, or coma) that exhibits a total lack of response to optimal lactulose and rifaximin therapies.

Clinicians must also provide a detailed narrative regarding advanced portal hypertension, capturing refractory ascites where therapeutic paracentesis loops are required at frequent intervals, or recurrent, life-threatening gastric or esophageal variceal bleeding events.

The defense is further fortified by logging severe nutritional cachexia, proving a progressive muscle wasting profile alongside an absolute visceral protein collapse evidenced by a serum albumin level strictly below 2.5 g/dL.

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Nutritional Status & Documenting Weight Loss Under Palmetto GBA LCD The Nutritional Collapse Framework & Objective Verification Thresholds

When anchoring terminal hospice eligibility on advanced nutritional collapse or cachexia within our contractor's region, clinical records must completely abandon vague, subjective approximations like "poor appetite" or "clothes fitting looser." Palmetto GBA enforces strict, quantitative baseline rules that mandate clear mathematical verification of progressive, involuntary weight loss to survive a MAC or UPIC medical review. To establish eligibility based primarily on nutritional collapse, the chart must systematically document an involuntary weight loss of at least 10% of total body mass within the preceding six months, or a rapid, acute loss of 5% within the trailing 30 days. This quantitative drop cannot rely on a single, isolated estimate; it must be backed by a clear trend of sequential weights obtained using consistent equipment and methods, or structurally supported by an absolute visceral protein collapse evidenced by a serum albumin level dropping strictly below 2.5 g/dL.

Satisfying the raw weight loss percentage fulfills only the baseline requirement of Palmetto GBA's strict nutritional mandate. To construct a survival-proof chart, field staff must explicitly pair these metrics with an exhaustive clinical narrative that documents the physiological inability of the patient to maintain metabolic equilibrium despite optimization. The chart must systematically track advanced dysphagia, severe structural feeding difficulties, chronic unremitting cachexia, or an absolute, documented refusal of artificial nutrition and hydration interventions like PEG tubes or TPN. Reviewers aggressively audit files for evidence that the weight loss is an unremitting, irreversible manifestation of the terminal disease process itself, rather than an underlying temporary condition. Therefore, the clinical record must explicitly rule out or document the failure of standard nutritional interventions, creating a continuous trajectory of progressive, down-trending systemic depletion that leaves an undeniable audit trail of terminal status.

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Operational Action Plan — Reverse-Engineering the Audit Baseline

Suggestions for Leaders:

- **Audit-Driven Intake Screenings:** Mandate intake teams work backward from standard contractor templates to isolate and verify the specific core diagnostic thresholds prior to scheduling formal admission appointments.
- **Individualized CTI Clinical Narratives:** Enforce a rigid pre-billing gatekeeping protocol requiring all Certifications of Terminal Illness (CTIs) contain a customized, data-driven narrative that replaces generic boilerplate text. Use editing cues as necessary to develop robust narratives, but ensure edit points are updated
- **Quantitative Baselines:** Require field clinicians to capture objective tracking metrics (consistent serial weights, mid-arm measurements, and complete FAST/PPS functional scales) on all assessments
- **Active Mechanics Documentation:** Transition nursing assessment protocols away from simple checkbox score inputs toward explicit written descriptions of the physical mechanics of a beneficiary's physical or cognitive regression.
- **Incremental Decline Tracking:** Force comprehensive charting of exact assistive ambulation details, precise cognitive verbal limitations (such as tracking intelligible word count metrics), and localized structural complication trends.
- **Targeted Recertification Review Loops:** Establish a mandatory peer-review audit routing loop for all active patient files entering a third or subsequent benefit period to verify continuous, measurable physiological decline – this could be an IDT exercise.

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The Anatomy of a Referral: Front-End Risk Mitigation

Building the Pre-Admission Narrative to Survival-Proof the Chart

The First 48 Hours: Intake & Interception Strategy

Referral Source Auditing: Do not accept a standalone phrase 'eligible for hospice' as an intake trigger. H&P documents – sometimes from several recent visits/admissions are no longer an option, they are a must – ensure that the documentation paints not only a clear picture of the patient's decline and appropriateness for hospice, but also that it is supported as the primary diagnosis/terminal diagnosis for hospice

The Continuity Gap: Audit teams from UPICs frequently flag claims where a hospital discharge summary notes 'stable at discharge' but the hospice admits the patient 24 hours later under 'rapid terminal decline' without reconciling the narrative shift. (Qlarant)

Pre-Election Review: Establish a mandatory executive gatekeeper layer. An experienced clinical auditor or QA nurse must review the gathered external baseline data *prior* to scheduling the formal election encounter. This person should be dynamic, self-directed and persistent, especially with collecting documentation from community and other facility sources.

Structural Data Extraction: Systematically isolate historic biometric markers: trends in serial metabolic panels, therapeutic failures in specialist notes (Cardiology/Oncology), and historic diagnostic imaging reports.

Legal & Regulatory Gatekeeping (42 CFR Part 418)

CTI Validation Mechanics: The Certification of Terminal Illness (CTI) must contain a tailored, highly specific narrative text block. Checkboxes, electronic dropdown macros, and automated templates trigger automated structural text-deficiency denials.

Admission Referral Authority: Per recent CMS regulatory clarifications, while the hospice medical director or an IDG-associated physician has clear statutory authority to confirm admission conditions, the narrative must show strict individualization.

F2F Attestation Standards: For patients entering their 3rd or subsequent benefit period, the Face-to-Face encounter note is an absolute compliance anchor. It must explicitly state:

- the practitioner's name,
- signature,
- date, and
- standalone assessment data.

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The Blueprint for Defensible Charting

Operationalizing the 'Clinical Story' to Survive Extended Length-of-Stay Audits

Eradicating Internal Chart Inconsistencies & Structuring the Clinical Narrative

The Multi-Discipline Contradiction Trap: This is the number one cause of ADR and TPE losses. A nurse documents a patient as 'completely bedbound, max assist for positioning due to total neurological loss,' while the hospice aide note from the same week states 'assisted patient with ambulation to the bathroom, tolerated well.' Reviewers use the aide note to invalidate the entire eligibility claim. Nursing and aide charting must be systematically reconciled before a bill is submitted.

The Fallacy of 'Hospice-Induced Stability': Auditors frequently write: 'Patient has stabilized on hospice, therefore is no longer terminal.' To defeat this, your clinical team must learn to chart the biological cost of stability. The narrative must read: 'The patient's lack of acute hospitalization is due to daily skilled nursing adjustments of loop diuretics and airway positioning. In the absence of this highly intensive palliative intervention, immediate pulmonary collapse is expected within days.'

Constructing a Compliant Progress Note Structure: Every single discipline note must establish a clear structural progression: (1) Historical Baseline: Where was the patient 90 days ago? (2) Real-Time Kinetic Trajectory: What objective, measurable decline occurred this week? (3) Symptom Management: Detail the escalating dosage of major analgesics or increasing reliance on supplemental oxygen to demonstrate the physiological work required to manage the terminal state.

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Resources

Centers for Medicare & Medicaid Services. (2024). *Local coverage determination: Hospice - liver disease (L34544)*. U.S. Department of Health and Human Services. Medicare Coverage Database [1, 2]

Centers for Medicare & Medicaid Services. (2024). *Local coverage determination: Hospice - neurological conditions (L34547)*. U.S. Department of Health and Human Services. Medicare Coverage Database [2, 3]

Centers for Medicare & Medicaid Services. (2025). *Local coverage determination: Hospice Alzheimer's disease & related disorders (L34567)*. U.S. Department of Health and Human Services. Medicare Coverage Database [4, 5, 6]

Palmetto GBA. (2026). *Billing and coding: Hospice Alzheimer's disease & related disorders (A56639)*. Palmetto GBA Medicare Advisory portal [5]

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