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

57th Annual Meeting

Thursday, September 3, 2026
Crockett CD Room
1:30pm-2:30pm

5b. Defensible Documentation: A Hospice Leader's Playbook to Eligibility, Compliance, and Audit Survival

Presented by:

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DEFENSIBLE DOCUMENTATION

A Hospice Leader's Playbook to Eligibility, Compliance, and Audit Survival

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SESSION OVERVIEW

What We'll Cover Today

01 The Moratorium & Enforcement Climate
What CMS has implemented — and what it means for your organization right now

02 Claim Denial Trends
What auditors are finding and the real cost of a denial

03 Source of Truth + LCD Alignment
Connecting your documentation to Local Coverage Determinations

04 What Medical Review Reveals
Organizational risk patterns that invite denials

05 IDG Team Strategies
Aligning every discipline around eligibility documentation

06 The Leadership Playbook
Specific, actionable tools to drive defensible documentation culture

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BREAKING — MAY 2026

CMS Nationwide Moratorium & Mass Revocations

CMS has imposed a six-month nationwide halt on new hospice Medicare enrollment and has already revoked or suspended hundreds of providers — the most significant enforcement action against the hospice sector in recent memory, and the pressure is not going away.

If your documentation must be medical review ready.

Source: CMS Press Release & Federal Register, May 2026

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MORATORIUM & ENFORCEMENT

The Numbers Behind the Crackdown

800+	181	22%	$600M
Hospices subject to medical review as of June 2025	Hospices revoked from Medicare during PPEO initiative	Revocation rate	Estimated Medicare fraud in LA area alone

WHAT CMS HAS DONE — AND IS DOING NOW

- ~800 hospices & 23 HHAs suspended in one LA-area action — $600M+ in suspected fraud
- Nationwide site visits to verify operations and flag suspicious activity
- New public scoring system flags troubling utilization, quality, or compliance patterns
- Expanding pre/post-payment review in high-fraud states: AZ, CA, GA, NV, OH, TX

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MORATORIUM & ENFORCEMENT

What the Moratorium Means for Legitimate Providers

You are not the target — but you are in the same environment.

Scrutiny Has No Zip Code

CMS's data analytics flag outlier patterns nationally — compliant providers in high-fraud states face higher audit odds from regional concentration alone.

PPEO & EPR Expansion Is Real

Oversight is expanding. Reviewed hospices saw a 40% denial rate, and selected providers can have 100% of claims held pending review.

SSVI Scoring System Is Public

The new scoring system is visible to referral partners, families, and competitors.

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THE LEADERSHIP IMPERATIVE

Don't wait for an ADR to discover documentation gaps

The window to act is before scrutiny arrives — not after.

- Your MAC has access to the same scoring data CMS publishes
- Revocation does not require fraud — pattern-based billing anomalies are enough
- A single audit cycle can consume months of staff time and destabilize cash flow
- Leaders who act now spend weeks on improvement; leaders who wait spend months on appeals

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SECTION 02

Claim Denial Trends

Understanding denial patterns is a clinical leadership responsibility — not a billing function.

52.3%	Not Hospice Appropriate
30%	Requested Records not Submitted
4.6%	Face to Face Encounter Requirements Not Met
1%	Physician Narrative Not present or Not Valid

Source: Palmetto Jan-Mar 2026 Hospice Medical Review Top Denial Reason Codes

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5CF36, 5FF36: Not Hospice Appropriate

Published 05/10/2022

A- A+

The claim has been fully or partially denied because the documentation submitted for review did not support prognosis of six months or less.

How to Prevent This Denial

- Ensure a legible signature is present on all documentation necessary to support six-month prognosis
- Submit documentation for review to provide clear evidence the beneficiary has a six-month or less prognoses which supports hospice appropriateness at the time the benefit is elected, and continues to be hospice appropriate for the dates of service billed
- Palmetto GBA has a Local Coverage Determination (LCD) for some non-cancer diagnoses. Submit documentation which supports the coverage criteria outlined in the policy. LCDs may be viewed on the Palmetto GBA Web site at www.PalmettoGBA.com/HHH. If documenting weight loss to demonstrate a decline in condition, include how much weight was lost over what period of time, past and current nutritional status, current weight and any related interventions.
- Document any co-morbidity, which may further support the terminal condition of the beneficiary and the continuing appropriateness of hospice care

Palmetto GBA - Jurisdiction M Home Health and Hospice - 5CF36, 5FF36: Not Hospice Appropriate

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SECTION 03

Anchor in Your Source of Truth

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SOURCE OF TRUTH

Medical Review ≠ Survey: Two Different Rulebooks

Survey and payment are graded differently — medical review checks conditions of payment, not participation.

Conditions of Participation (Survey)	Conditions of Payment (Medical Review)
Governs whether you can operate as a Medicare-certified hospice under 42 CFR Part 418. Ensures safe, quality care.	Governs whether a specific claim meets reimbursement criteria — the Benefit Policy Manual, Claims Processing Manual, and LCDs.
Enforced through state survey and accreditation, on a recurring cycle.	Enforced through medical review — ADRs, TPE, prepayment and post-payment audits — claim by claim.
Non-compliance produces survey deficiencies, a corrective action plan, CMS oversight/fines.	Non-compliance produces claim denial and recoupment — even at a fully certified, survey-compliant hospice.
Answers: Is this a legitimate, properly operated hospice? Do they provide safe, quality care?	Answers: Does this record prove the patient was eligible? Were billing requirements met?

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SOURCE OF TRUTH | REGULATORY REFERENCE

Your Source of Truth

Know These Regulatory Foundations— governs every hospice eligibility decision.

CMS FEDERAL AUTHORITY

Medicare Benefit Policy Manual — Ch. 9

The federal foundation — defines terminal illness as a 6-month prognosis and sets certification, recertification, F2F, and benefit-period rules.

Medicare Claims Processing Manual — Ch. 11

Governs how eligibility must be documented to support a payable claim, including certification narrative requirements.

Hospice Conditions of Participation — SOM Appendix M

Defines the standards hospices must meet to stay Medicare-enrolled; non-compliance risks deficiencies, corrective action, or exclusion.

THE 4 HH+H MACs THAT PROCESS CLAIMS

- **Palmetto GBA — JM HH+H**
  Largest by hospice count
  AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN, TX
- **NGS — J6 HH+H**
  Largest by beneficiary volume
  AK, AZ, CA, GU, HI, ID, MI, MN, NJ, NV, NY, OR, PR, VI, WA, WI
- **CGS Administrators — J15 HH+H**
  15.7% of HH+H workload
  CO, DC, DE, IA, KS, MD, MO, MT, NE, ND, PA, SD, UT, VA, WV, WY
- **NGS — JK HH+H**
  4.2% of HH+H workload
  CT, MA, ME, NH, RI, VT

Source: CMS.gov — Pub. 100-02 Ch. 9, Pub. 100-04 Ch. 11, 42 CFR Part 418 | LCD LOOKUP: cms.gov/medicare-coverage-database

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SOURCE OF TRUTH | MAC VARIATION

Not All MACs Review Hospice Eligibility the Same Way

Regardless of framework, the documentation goal is the same: support a prognosis of six months or less.

MOST MACs: THE "LCDs"

Most MACs rely heavily on the Hospice Determining Terminal Status LCD — commonly called the "Unipolicy" — as their primary framework for reviewing eligibility.

OTHER MACs: DISEASE-SPECIFIC CRITERIA

Others place greater emphasis on disease-specific criteria — the FAST, PPS, and diagnosis-based indicators.

TWO THINGS TO REMEMBER

1. Establish a solid baseline at admission. Your admission nurse's documentation anchors every recertification that follows.
2. **Age is not terminal.** A prognosis must be clinically supported — never assumed from advanced age alone.

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■ SOURCE OF TRUTH | LCD DEFINED

What Is a Local Coverage Determination (LCD)?

The rulebook that turns a diagnosis into a defensible eligibility case.

1. An LCD outlines criteria required to support hospice eligibility for specific terminal illnesses.
2. LCDs translate the 6-month prognosis standard into measurable indicators — FAST/PPS staging, weight loss, comorbidities, etc.
3. Reviewers score documentation against the LCD in effect for your jurisdiction — no alignment, no basis to pay.

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■ LCD ALIGNMENT | SECTION 03

Translating LCD Criteria Into Defensible Documentation

If your documentation doesn't mirror the LCD language, your claim is vulnerable.

LCD Clinical Indicator	✕ Weak Documentation	✓ Defensible Documentation
Functional decline (FAST / PPS)	*"Patient continues to decline."*	"PPS 40% → 30% over 60 days. Dependent for all ADLs. Patient now unable to ambulate without max assist."
Weight loss / nutritional failure	*"Poor appetite noted."*	"7.2 lb loss in 30 days (9% body weight). Refuses all oral intake. No response to appetite stimulant."
Dyspnea / respiratory decline	*"Dyspnea at rest."*	"Dyspnea at rest, 4L O2 continuously. O2 sat 86% on RA. MMRC Grade 4. Morphine q4h for comfort."
Altered mental status / dementia decline	*"Confusion present."*	"FAST Stage decreased from 7A to 7C. Non-verbal, bedbound. No family recognition. Full assist for positioning and oral care."

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■ LCD IN PRACTICE | DOCUMENTATION EXAMPLE

LCD in Practice: Alzheimer's Disease & Related Disorders

LCD REQUIRES (Palmetto GBA, L34567): FAST Stage 7 or > + at least ONE comorbid or secondary condition

The LCD does not name specific diagnoses or thresholds. It requires the condition's structural/functional impairments and activity limitations be described — sufficient, combined with the AD, to support a 6-month prognosis.

✕ NOT SUPPORTIVE — NO IMPAIRMENT DETAIL

RN VISIT NOTE

Patient with dementia continues to progress. Confused, not eating well. Family reports no changes. Fast 6e. Will continue to monitor.

PHYSICIAN F2F NARRATIVE

Patient has advanced dementia and is appropriate for hospice. Prognosis is 6 months or less. Fast 7a.

SOCIAL WORK NOTE

Family meeting held. Family coping with patient's condition. Emotional support provided. Will follow up next visit.

✓ DEFENSIBLE — MIRRORS THE LCD LANGUAGE

FAST 7c confirmed: non-ambulatory, requires two-person assist to reposition. Oral intake <25% of meals x 14 days, coughing/choking with thin liquids (aspiration risk) — a secondary condition directly tied to AD-related dysphagia.

FAST 7c Alzheimer's disease: bedbound, non-verbal, total dependence for all ADLs. Secondary condition — Stage 3 pressure ulcer, sacrum, 4cm, not healing despite offloading — reflects impaired mobility and skin integrity from the AD itself. Supports a 6-month or less prognosis if the disease runs its natural course.

Patient non-verbal throughout visit, made no response to name or daughter's voice — daughter reports this is a new change from 3 weeks ago when patient still tracked her movement across the room. Daughter tearful, describing grief over 'losing him a little more each visit.'

Note: LCD criteria vary by MAC. Always verify against the current LCD for your specific MAC jurisdiction. This slide reflects Palmetto GBA LCD L34567, revised 02/29/2024.

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■ LCD IN PRACTICE | DOCUMENTATION EXAMPLE

LCD in Practice: End-Stage Liver Disease

LCD REQUIRES (L34544 — Palmetto): PT >5 sec over control (or INR >1.5) AND serum albumin <2.5 g/dL

PLUS, at least ONE: Refractory ascites | Spontaneous bacterial peritonitis | Hepatorenal syndrome | Refractory hepatic encephalopathy | Recurrent variceal bleeding despite intensive therapy

Supporting (not independently sufficient): progressive malnutrition, muscle wasting, active alcoholism >80g ethanol/day, hepatocellular carcinoma, HBsAg positivity, interferon-refractory Hepatitis C.

✕ WEAK — DOES NOT SUPPORT THE CLAIM

RN VISIT NOTE

Patient with liver disease continues on hospice. Abdomen appears distended. Family reports doing okay. Will continue to monitor.

PHYSICIAN F2F NARRATIVE

Patient has cirrhosis and is appropriate for hospice. Prognosis is 6 months or less.

SOCIAL WORK NOTE

Family meeting held. Family coping with patient's condition. Emotional support provided. Will follow up next visit.

✓ DEFENSIBLE — MIRRORS LCD LANGUAGE

Labs reviewed: INR 1.9, albumin 2.1 g/dL. Ascites refractory to max diuretics (spironolactone 400mg/furosemide 160mg) — large-volume paracentesis performed x2 in past month, 6L removed most recent. Abdominal girth increased 4 inches since last visit.

End-stage liver disease: INR 2.1, albumin 1.8 g/dL. Hepatic encephalopathy grade 2 (disorientation, asterixis) refractory despite lactulose/rifaximin compliance per caregiver report. Ascites requiring paracentesis every 2 weeks despite maximal diuretic therapy. Supports prognosis of 6 months or less if disease runs its natural course.

Patient noted to be intermittently confused during visit, unable to state day or year, drowsy but arousable — consistent with reported hepatic encephalopathy per RN. Spouse confirms patient continuing to drink (~6 beers daily) despite repeated education on impact; assessed readiness for change — patient states 'doesn't matter now,'

Note: LCD criteria vary by MAC. Always verify against the current LCD for your specific MAC jurisdiction. This slide reflects LCD L34544, revised 08/01/2024.

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■ LCD IN PRACTICE | DOCUMENTATION EXAMPLE

LCD in Practice: Adult Failure to Thrive Syndrome

LCD REQUIRES (L34558 — Palmetto): BMI <22 kg/m² + Karnofsky/PPS ≤40%

Both must be present — nutritional impairment alone or disability alone does not qualify. BMI reflects decline/non-response despite adequate caloric intake, not simply a low number; reversible causes must already be excluded.

Both measurements must be dated within 6 months (180 days) of the certification/recertification. If enteral/parenteral support is in place, measure at initial certification and each recertification.

✕ WEAK — DOES NOT SUPPORT THE CLAIM	✓ DEFENSIBLE — MIRRORS LCD LANGUAGE
RN VISIT NOTE *Patient continues to lose weight and is weak. Not eating well. Family reports doing okay. Will continue to monitor.*	Weight 98 lbs, height 5'4" — BMI 16.8 kg/m², down from 19.2 six weeks ago despite fortified shakes offered at every meal (adequate caloric intake attempted, no response). PPS 30% — in bed >50% of the day, requires total assistance with all ADLs, unable to do any work.
PHYSICIAN F2F NARRATIVE *Patient has failure to thrive and is appropriate for hospice. Prognosis is 6 months or less.*	Reversible causes of weight loss and functional decline excluded (no active infection, malignancy, or depression identified on workup). BMI 17.1 kg/m², declining despite trial of oral supplementation — no response to adequate caloric intake. Karnofsky 30%: unable to care for self, requires nursing care, disease progressing rapidly. Supports prognosis of 6 months or less if the syndrome runs its natural course.
SOCIAL WORK NOTE *Family meeting held. Family coping with patient's condition. Emotional support provided. Will follow up next visit.*	Patient observed in bed at 11am, unable to independently prepare or reach food left at bedside by caregiver 3 hours earlier — consistent with reported functional decline. Depression screening negative. Caregiver reports exhaustion managing patient's total care needs and having stopped attempts at oral intake due to patient's consistent refusal/lack of interest in food.

Note: LCD criteria vary by MAC. Always verify against the current LCD for your specific MAC jurisdiction. This slide reflects LCD L34558, revised 01/04/2024.

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THE CORE PRINCIPLE

You know your patient. The reviewer doesn't.

The documentation MUST paint the picture of 'why hospice, why now?'

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SECTION 04

What Medical Review Reveals About Your Risk

Auditors don't just review individual notes. They look for systemic patterns that reveal how an organization functions.

1. Copy-forward / cloned documentation across visits
2. Stability language without disease trajectory context
3. Long stays with no documented functional decline
4. Discipline notes that contradict each other
5. Physician narratives that repeat without clinical detail

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HIGH-RISK PATTERNS

Documentation Patterns That Auditors Flag Immediately

Copy-Forward / Cloned Notes

Identical language across visits signals copying, not assessing. Auditors flag this to question the entire record.

Stability Language Without Context

"Patient stable" and "tolerating care well" imply improvement. Pair with disease-progression evidence.

Missing Decline Trajectory Over Time

A 6-month claim with no arc of decline is hard to defend. Each recertification must show deterioration over the last.

Contradictory Discipline Notes

RN documents bedbound/non-verbal; aide notes patient walked to bathroom. Auditors use contradictions to challenge the record.

Generic Physician Narratives

"Pt has CHF and is appropriate for hospice" is not sufficient. The F2F must describe findings that support a 6-month prognosis.

Social Work With No Eligibility Link

SW notes limited to coordination and emotional support miss an opportunity — decline observations are clinically relevant.

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SECTION 05

IDG Team Strategies

Aligning Every Discipline Around Eligibility Documentation

RN / Case Manager | Social Worker | Chaplain | Hospice Aide | Physician / NP

No single discipline owns eligibility. Every IDG member either strengthens or weakens the clinical picture.

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IDG TEAM STRATEGIES

Discipline-Specific Documentation Responsibilities

RN / Case Manager

- Trend decline with measurable data: PPS %, FAST stage, weight (lbs + % body wt), symptom frequency
- If possible, every visit note should answer: what is worse than last time? Be specific.
- Avoid copy-forward — document what you actually observed THIS visit

Social Worker

- Document caregiver burden reflecting disease severity, not just support provided
- Record patient/family understanding of prognosis and disease trajectory
- Note functional limitations affecting social/family roles — these support eligibility

Chaplain / Spiritual Care

- Describe specific observed changes: confusion, decreased engagement, shorter tolerance for visits
- Document patient's awareness of and response to illness severity — this is eligibility-relevant
- Avoid generic spiritual support language; describe what you saw

Physician / NP

- Face-to-face narrative must tell a clinical story — not just list diagnoses
- Explicitly state why prognosis is 6 months or less if the disease runs its natural course
- Review IDG notes before recertification

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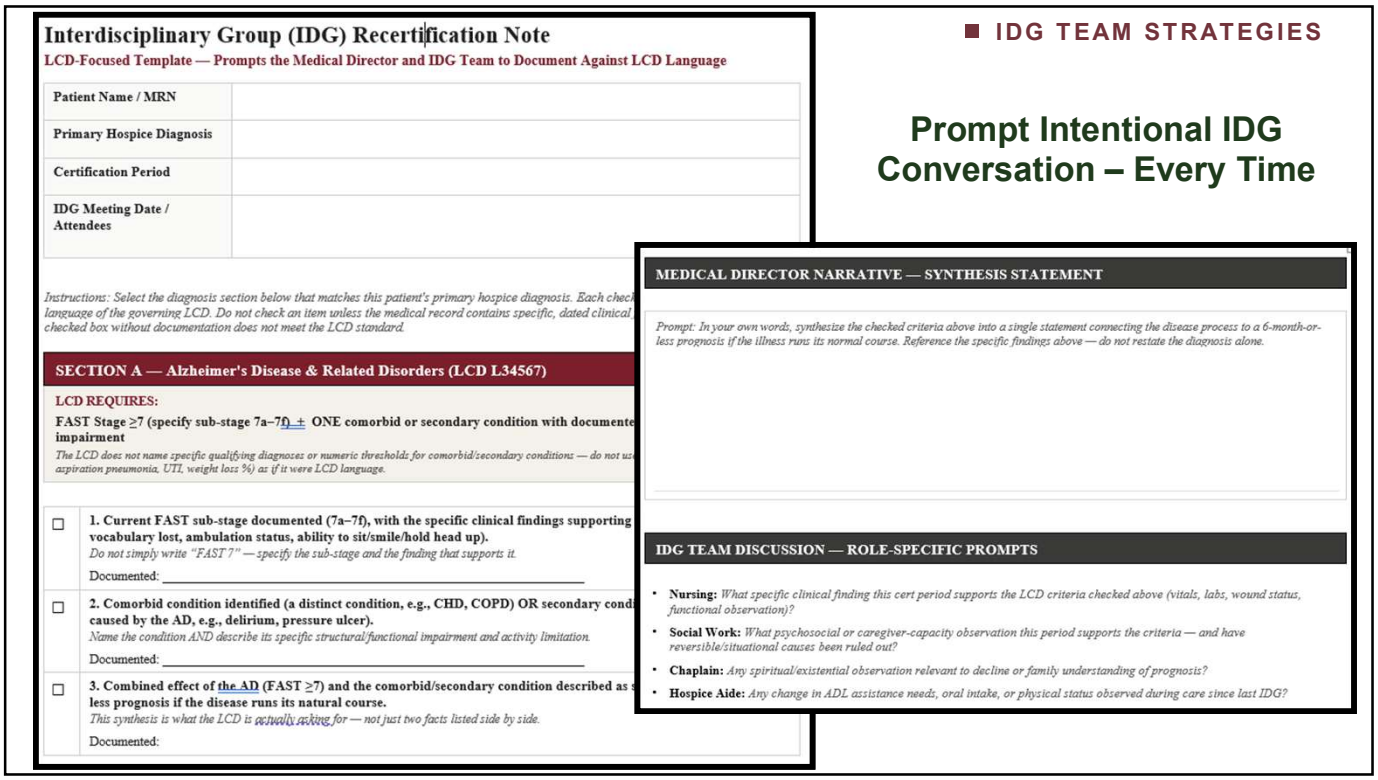

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SECTION 06

The Leadership Playbook

Specific, Actionable Strategies to Drive Defensible Documentation Across Your Organization

Turning leadership intent into leadership action.

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LEADERSHIP PLAYBOOK

Four Pillars of a Defensible Documentation Organization

1 STANDARDS

- Create discipline-specific documentation guides aligned to your MAC's LCDs
- Define what 'evidence of decline' looks like for your top 5 diagnosis groups
- Set clear documentation expectations

2 OVERSIGHT

- Conduct pre-bill chart audits on high-risk patients: LOS >6 months, dementia, etc.
- Score charts against LCD criteria — not just for completeness
- Review your PEPPER Report for outliers

3 ALIGNMENT

- Redesign IDG meetings to include a 3-minute eligibility narrative review per patient
- Require physician narrative review before recertification signature
- Create shared accountability — everyone's note builds or weakens the claim

4 IMPROVEMENT

- Use your own denials or internal audit results as education case studies — anonymize and teach from them
- Coach managers monthly on documentation risk identification, not just productivity
- Measure and report documentation quality metrics alongside clinical quality metrics

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LEADERSHIP PLAYBOOK | TACTICAL TOOL

The Leader's Weekly Documentation Oversight Routine

What high-performing clinical leaders do — and when they do it.

Tuesday 20 min	**Audit 3 charts of patients with LOS > 6 months.** Ask: does this show a clear decline trajectory? Could I defend this claim today? If not, who owns the fix?
Wednesday IDG	**Run your IDG using an objective data template.** Capture PPS/FAST score, weight trend, symptom changes, and which disciplines documented decline. Templates drive consistency.
Thursday 10 min	**Review physician certifications before they are finalized.** Does the F2F narrative tell a clinical story and link findings to prognosis? Return any lacking clinical detail.
Friday 10 min	**Check one newly admitted patient's initial documentation.** Does intake documentation establish a strong baseline against the LCD? It anchors every recertification that follows.
Ongoing Tips	**Equip your team and invest in your infrastructure.** Give clinicians laminated LCD flip books for your top 5 diagnoses. Consider AI tools that flag high-risk patterns before claims submit. Optimize your EMR!

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■ LEADERSHIP PLAYBOOK | TACTICAL TOOL

The Leader's Monthly Documentation Oversight Routine

The step back from weekly spot-checks — trends, patterns, and systemic fixes.

WEEK 1 30 min	**Pull a full-census LOS trend report by diagnosis.** Which diagnoses are running long (e.g., dementia averaging 400+ days)? Flag any diagnosis-level pattern — not just individual charts — for deeper review.
WEEK 2 IDG	**Audit one chart per based on a trend noted in week 1.** Pick one active patient per top diagnosis and read the full chart — admission through today — against the governing LCD. Spot-checks catch typos; full-chart reviews catch drift.
WEEK 3 30 min	**Review live discharge and revocation reasons.** For every live discharge this month: did the chart support decline right up to the discharge date, or does it read like the patient stabilized weeks ago and no one noticed?
WEEK 4 30 min	**Run the compliance scorecard.** Trend internal audits. Recert denial rate, ADR turnaround and win rate, F2F completion timeliness, live discharge rate by diagnosis. Trend month over month — one bad month is noise, three is a pattern.
ONGOING Tips	**Close the loop with the team.** Bring one denied or auditor-flagged claim to a monthly case review — anonymized, blameless, specific. Update LCD flip books the same week a MAC revises a policy.

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■ LEADERSHIP PLAYBOOK | TACTICAL TOOL

The Leader's Quarterly QAPI Documentation Cycle

Turns the weekly and monthly habits into the data your QAPI program is required to run on.

STEP 1 Data	**Roll up the quarter's scorecards into QAPI-ready metrics.** Aggregate the monthly compliance numbers (internal audits AND/OR recert denial rate, ADR win rate, live discharge rate, F2F timeliness) by diagnosis. Compare to last quarter and to your own threshold.
STEP 2 Root Cause	**Drill into the 1–2 metrics that missed threshold.** Pull the underlying charts, not just the number. Is the gap a training issue, a workload/staffing issue, a form/template issue, or a specific diagnosis category where the LCD standard isn't landing? Name the root cause before naming a fix.
STEP 3 PIP	**Launch or update a Performance Improvement Project.** One metric, one owner, one measurable target, one timeline. Tie it directly to the root cause from Step 2 — a PIP without a clear owner and re-measurement date is a memo, not a QAPI project.
STEP 4 Governing Body	**Present the quarterly QAPI report and get sign-off.** Data, trend direction, active PIP status, and any new PIP proposal. This is also the record that shows your governing body is actually overseeing QAPI — not just receiving it.
ONGOING Tips	**Close the loop back into the weekly and monthly routines.** Retire PIPs that hit target; don't let them run on autopilot. Feed what you learned into the flip books, the IDG template, and next quarter's chart audit focus — QAPI should change what gets checked, not just get checked itself.

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CASE STUDY

Case Study: TPE Review → Turnaround

THE SITUATION

- Mid-size hospice, ~150 patients census
- MAC initiated Targeted Probe & Educate (TPE) review
- 35 claims selected; 18 denied on initial review (51%)
- Primary finding: terminal illness not supported
- Physician F2F narratives nearly identical across recertifications
- Physician narrative and RN assessment conflicting
- Social work notes contained zero eligibility-relevant content
- IDG meetings discussed care — but not prognosis or trajectory

WHAT LEADERSHIP CHANGED

- Implemented LCD-aligned nursing narrative guides by diagnosis
- Required F2F narrative review before physician signature
- Restructured IDG to include 3-min eligibility review per patient
- Trained social workers on eligibility-relevant language
- Monthly chart audits with manager-level accountability
- Denial case studies used in staff education (anonymized)

RESULT: Denial rate dropped from 51% → 11% over two TPE rounds

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KEY TAKEAWAYS

What Every Hospice Leader Should Leave With Today

1. The moratorium signals a new enforcement era — existing providers aren't exempt; they're the ones being reviewed now.
2. Your documentation must speak the language of LCDs. If it doesn't mirror the criteria, it cannot defend the claim.
3. Denial patterns are predictable and visible in your records before auditors find them. Look now.
4. Every IDG discipline either strengthens or weakens eligibility. Alignment is a leadership function.
5. Chart audits are prevention tools. Be proactive.
6. The gap between organizations that reduce denials and those that don't is follow-through.

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THE BOTTOM LINE

The documentation MUST paint the picture of 'why hospice, why now?'

Thank You

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