NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

A CLINICAL GUIDE TO HOSPICE GENERAL INPATIENT CARE (GIP)

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National Hospice and Palliative Care Organization

Introduction to General Inpatient Care

The National Hospice and Palliative Care Organization (NHPCO) is pleased to provide this resource on the use of and documentation for General Inpatient Care (GIP). NHPCO gratefully acknowledges the work of the GIP Workgroup, composed of members of the NHPCO Regulatory Committee and the NHPCO Quality and Standards Committee, whose case examples, content suggestions, and helpful references have all made this clinical guide more complete and an easy reference for hospice providers.

General inpatient (GIP) care is one of the four levels of hospice care that the federal Medicare hospice regulations require a hospice to provide as a condition of their Medicare certification. If a hospice does not have its own free standing inpatient facility or unit where it can provide GIP care directly, it must contract with a participating Medicare or Medicaid hospital, skilled nursing facility (SNF) or another hospice inpatient facility to provide GIP care.

The federal hospice guidance states that GIP may be required in order to manage acute pain and other symptoms that cannot be managed in any other setting.[1] It is initiated when other efforts to control symptoms are ineffective. There is no specified disease, condition, or symptom that qualifies a patient to receive GIP. Each patient and his or her symptoms will differ; GIP may be helpful to one patient and not to another with the same disease. GIP care carries specific requirements regarding where the services may be provided, as well as types and levels of staffing.

> **Note:** GIP is intended to be a **short-term intervention** (similar to the duration of an acute hospital stay).

[1] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, Section 40.1.5 Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Where can GIP be Provided?

GIP can be provided through contracting with a hospital or skilled nursing facility, or in a hospice-owned inpatient facility. The requirements for both are below:

Requirements for Contracting for GIP:
If GIP is contracted, the federal Medicare hospice Conditions of Participation (CoPs) at §418.108, require that GIP must be provided in a participating Medicare-certified facility as follows:

- A **Medicare-certified hospice** that meets the conditions of participation for providing inpatient care directly, as specified in §418.110.
- A **Medicare-certified hospital or skilled nursing facility** that also meets the standards specified in §418.110(b) and (f) regarding 24-hour nursing services and patient areas.[2]

It is important to note that when GIP is contracted from an allowable facility, providers must be compliant with the requirements for 24-hour nursing services and patient areas. (See requirements below)

§418.110(b) Standard: Twenty-four hour nursing services (CMS, 2008)

(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then **each shift must include a registered nurse who provides direct patient care**.

§418.110(f) Standard: Patient areas (CMS, 2008)

The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

(1) The hospice must provide —

(i) Physical space for private patient and family visiting;

(ii) Accommodations for family members to remain with the patient throughout the night; and

(iii) Physical space for family privacy after a patient's death.

(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

[2] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

GIP care **cannot** be provided in the home, in an assisted living facility, a hospice residential facility, or in a long-term care nursing facility (NF). These environments are not equipped to provide skilled nursing and medical care to manage an acute symptom crisis.

The hospice provider is the manager of the patient's care when GIP is contracted. This means that the hospice retains administrative and financial management responsibility, and oversight of staff and services provided under contractual arrangement. The hospice must ensure that patient care is provided in a safe and effective manner by qualified personnel and delivered in agreement with the patient's plan of care.[3]

Requirements for GIP in A Hospice Owned Inpatient Unit:

Providers who own an inpatient facility may provide the GIP level of care in accordance with the federal Medicare hospice regulations at §418.110 (Hospices that provide inpatient care directly)[4]. These regulations describe how the inpatient unit should be staffed with RNs, the physical environment for patient care, safety management, meal and linen service, infection control, and restraint and seclusion. The entirety of the regulatory requirements when GIP is provided in a hospice-owned inpatient unit are not reprinted in this document, but can be found here.

There are very specific requirements surrounding the use of restraint and seclusion for a patient in a hospice inpatient unit which are outlined in the federal Medicare hospice regulations at §418.110(n) Standard: Restraint or seclusion.[5] Restraint or seclusion staff training requirements are spelled out in §418.110(o) and include the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including periodic recertification.[6] A hospice may determine that their inpatient unit is "restraint and seclusion free" which means they do not use these methods with their patients during GIP care. If this is the case, the provider ought to possess a policy that states they do not use restraint and seclusion for a patient, and the process for a patient that requires either measure during their care.

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[3] Centers for Medicare and Medicaid Services. (2015, Oct 9). State Operations Manual Appendix M - Guidance to Surveyors: Hospice: §418.100(e) Standard: Professional Management Responsibility. Retrieved on 7/30/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

[4] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[5] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[6] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

Federal Regulations for GIP Care:

The CoPs that relate primarily to GIP are found in the federal Medicare hospice regulations at:

- §418.108 (Short-term inpatient care)
- §418.110 (Hospices that provide inpatient care directly)
- §418.202 (e) (Covered Services)
- §418.304 (Payment - General Inpatient Care)[7]

For more insight into the proper use of the GIP level of care, providers should also look closely at the corresponding Interpretive Guidelines and the preamble comments in the federal hospice 2008 Conditions of Participation.[8] There is also useful information in the Hospice Medicare Claims Processing Manual (section 30.1; 80.1)[9] and the Hospice Medicare Policy Manual (section 40.1.5)[10]. In addition, providers should check their state's hospice licensure laws and regulations for specific requirements, such as Certificate of Need (CON) for hospice facility beds and/or state licensure for a hospice inpatient facility. If the state requires CON and licensure, or licensure for a facility, the hospice must comply. Beyond the items specific to GIP, all other expectations for quality hospice care remain in effect.

It is the expectation that this level of care is to be provided to the patient when appropriate. That includes ensuring that there is at least one contract in place for General Inpatient Care in the hospice's service area. While there *is* current federal scrutiny by the Centers for Medicaid and Medicare Services (CMS) and the Office of the Inspector General (OIG) on the provision of hospice GIP and billing, this should not discourage hospice providers from providing this level of care when needed. Rather, the information provided in this document should be used to guide the hospice in documenting the justification of the higher level of care. An outline of the federal scrutiny is located in NHPCO's *Scrutiny about Hospice General Inpatient Care* resource and on the NHPCO website.

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[7] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[8] Centers for Medicare and Medicaid Services. (2008). Medicare and Medicaid Programs: Hospice Conditions of Participation; Retrieved on 7/30/2018: https://www.gpo.gov/fdsys/pkg/FR-2008-06-05/pdf/08-1305.pdf

[9] Centers for Medicare and Medicaid Services. (2016) Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims. (Sections 30.1 and 80.1) Retrieved on 7/30/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

[10] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Section 40.1.5). Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Resources:

GIP FAQs – common questions and answers about hospice GIP (April 2017)

Scrutiny about Hospice General Inpatient Care (April 2017)

When GIP Is Appropriate and Not Appropriate

Appropriate for GIP

The interdisciplinary group (IDG), composed of a physician, nurse, social worker and counselor, is required to approve general inpatient care (GIP) and document this approval in the medical record, per 42 C.F.R. §48.56.[11],[12] The IDG determines that the patient's pain or other symptoms cannot be effectively managed in another setting, including the patient's home or other residential setting. This may occur suddenly after a period of gradual decline, with a sudden change in symptoms or condition, or when Continuous Home Care (CHC) has failed to relieve the problems.

When the IDG assesses that the patient requires a higher level of care to achieve effective symptom management, a change to the GIP level of care should be considered to manage the patient's acute symptom crisis.

A study completed by the OIG in 2016 (Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care (OEI-02-10-00491)) stated that, "involving physicians in the decisions to start and continue GIP would help ensure that GIP is used appropriately". As stated by the OIG, "The hospice physician should be actively involved in the care of a patient, particularly if symptoms are acute enough to require a higher level of care."[13] In the CMS response to the OIG Portfolio Report on hospice in 2018, (Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio), CMS confirms that the "interdisciplinary group is required to approve GIP and document this approval in the medical record."[14]

GIP may also be provided at the end of an acute hospital stay if there is a need for pain control or symptom management which cannot be provided in the home setting at hospital discharge.[15] However, not every patient who reaches the end of an acute

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[11] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[12] Office of Inspector General. (2018, July). Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity, an OIG Portfolio (OEI-02-16-00570). Retrieved on August 1, 2018: https://www.oig.hhs.gov/oei/reports/oei-02-16-00570.asp

[13] Office of the Inspector General. (2016, March). Hospices inappropriately billed Medicare over $250 million for general inpatient care (oei-02-10-00491). Retrieved on 7/30/18: https://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf

[14] Office of Inspector General. (2018, July). Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity, an OIG Portfolio (OEI-02-16-00570). Retrieved on August 1, 2018: https://www.oig.hhs.gov/oei/reports/oei-02-16-00570.asp

[15] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Section 40.1.5). Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

hospital stay will qualify for GIP. Careful assessment of pain and other symptoms is required to determine GIP eligibility.

The following examples of patient status triggers may lead to a change to GIP level of care:

- Pain or symptom crisis not managed by changes in treatment in the current setting or that requires frequent medication adjustments and monitoring
- Intractable nausea/vomiting
- Advanced open wounds requiring changes in treatment and close monitoring
- Unmanageable respiratory distress
- Delirium with behavioral issues
- Sudden decline necessitating intensive nursing intervention
- Imminent death – **only** if pain or other symptoms are present and intensive nursing intervention is needed

Not Appropriate for GIP

- A patient who **does not have** acute pain or symptom management issues that cannot be resolved in another setting.
- GIP is **not** intended as a way to address unsafe living conditions in the patient's home.
- GIP is **not** intended for caregiver respite. If a patient has no caregiver or a caregiver is unable to help the patient adequately, other arrangements can or should be made.

> **NOTE:** CMS clarified in the FY 2008 Hospice Wage Index final rule that caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met.[16]

- GIP is **not** allowable when a patient's acute symptom crisis resolves and there is no further intensity of care need.
  - In this situation, the patient needs to transition back to routine home level of care (RHC).
- Patient/family refuses to leave inpatient care. If a patient or their family refuses to leave the inpatient setting of care, the hospice provider should issue an Advance Beneficiary Notice (ABN) form to the patient/family.
  - The ABN notifies the patient/family that the GIP level of care will not be paid by Medicare on a specific date and going forward and that the patient/family will be financially liable for the difference between the GIP

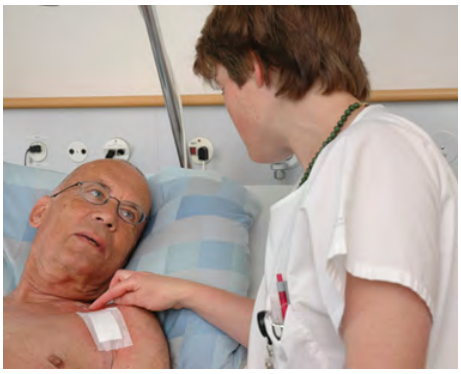
[16] Centers for Medicare and Medicaid Services. (2008). Medicare Program; Hospice Wage Index for Fiscal Year 2008. Retrieved on 5/31/18: https://www.gpo.gov/fdsys/pkg/FR-2007-08-31/pdf/07-4292.pdf

and RHC daily rate. Daily room and board charges would also apply as Medicare does not cover room and board for the RHC level of care.[17]

GIP Patient Case Examples

1. Case example #1 – Acute, complicated pain management

56-year-old man with a principal hospice diagnosis of non-small cell lung cancer, now metastatic to his left kidney. Patient diagnosed four years ago. He has been on hospice routine home care, but his pain is now severe, despite team attempts to manage his pain at home. He rates his pain level at an 8/10, unless he lays perfectly still, with which it drops to a 4/10. He is using two fentanyl 100 mcg patches every 72 hours and is on a morphine CADD pump, with a basal rate of 11 mg/hour, with 1 mg bolus every 10 minutes prn pain. He has a history of chronic post-laminectomy pain, but also has generalized pain. He lives with his 10-year old daughter. He has an extreme narcissistic personality disorder, with a tendency to manage his medications as he pleases. He believes he knows best how to manage his opioids. He has a long history of opioid use. He can still swallow medications. His BMI is 17.3, he is sleeping 16-18 hours per day, and his PPS is 50%. He is admitted to GIP level of care at the hospice inpatient unit for conversion to methadone, skilled management of his conversion in a very controlled setting, and reassessment of adjuvant treatment options and other factors which could be contributing to his pain.



2. Case example #2 – Other acute symptom management

A 75-year-old female with ovarian cancer was admitted to hospice at home one month ago. She has had intermittent episodes of nausea that have generally been managed with Compazine. Over the past 48 hours she has been vomiting. The Compazine was scheduled yesterday and the vomiting has persisted. She has been unable to keep her pain medication down so her abdominal pain has been worse today. She was referred for admission to GIP level of care to manage her nausea and her pain.

[17] Centers for Medicare and Medicaid Services. Beneficiary Notices Initiative. Retrieved on 7/30/18: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

This 82-year-old male has a long history of chronic obstructive pulmonary disease (COPD) and last week was admitted to hospice after a recent diagnosis of lung cancer which was metastatic, and he had decided not to proceed with chemotherapy or radiation. Since admission he has developed worsening dyspnea. He has been using his inhalers, but these have not helped. He has not been hypoxic. His wife reports he took some morphine and then became lethargic. She is not clear how much he took. He is more awake now but reporting severe dyspnea. He was referred for admission to GIP level of care for management of dyspnea.

3. Case example #3 – Acute terminal restlessness

62-year-old male admitted to hospice services following aggressive treatment for liver cancer. He could no longer tolerate chemotherapy and he and his family opted for comfort care with the desire to remain in his own home. His wife was the primary caregiver and extended family was available for additional support. Palliative performance scale (PPS) score at admission was 60% and there were no identified symptoms to be managed.

The first night of service, the patient was restless and had difficulty sleeping. When assessed by the hospice nurse on her visit, the patient had only vague complaints of not being able to sleep and wanting to move around. The current Trazadone at sleep order was discontinued and Benadryl at sleep was initiated by the hospice physician. This was not effective and Seroquel at sleep was added. This addition was not helpful and the night-time restless continued with the addition of pacing and a sense of being unsettled both day and night.

By day 4, the patient began to exhibit irritability along with restlessness; refusing Lactulose and other medications and not eating or drinking well. The hospice nurse received orders to begin Haldol and Ativan prn. This combination did allow the patient to sleep a few hours. At this time his PPS scored was 50% due to increased need for supervision and assistance.

Hospice nursing visits continued daily in effort to determine the most effective medication regimen and assess the level of restlessness/agitation and now confusion and fatigue. Hospice social work visits identified that the patient was fearful of dying in his sleep and was “not ready to go”. Family members were now taking shifts to provide care and supervision. All family members wanted to honor

the patient's desire to remain in his own home. The family declined a GIP admission for symptom management.

During a hospice nurse visit, it became apparent that the medication regimen was not being followed consistently due to varying opinions of the multiple family members involved in his care. Also, the hospice team noted increased tensions and frustrations on the part of all the family members. Again, hospice offered a GIP admission but the family declined.

By day 7, the patient had declined further, his PPS was 40%. He had become increasing confused, weaker with an unsteady gait, and continued restlessness and agitation. Nursing noted an increased abdominal girth, bruising, and evidence of jaundice. Both hospice nursing and social work met with the family and provided end-of-life education and offered care planning. At this time the family accepted the offer of a GIP admission to further assess and manage the increasing symptoms.

Throughout his 4-day GIP stay, multiple adjustments to the medication regimen were made and he was seen by the hospice physician daily. It became clear that this was a terminal admission with continued restlessness, confusion, and lethargy. He became hypoxic with apnea; jaundice and ascites increased. With regular medication dosing he was able to rest quietly with family at the bedside. Hospice team members, including music therapy and chaplain, provided support for the family and the patient died quietly on day 4 of GIP admission.

4. Case example #4 – Acute behavioral symptoms

83-year-old female with Alzheimer's dementia with psychosis and moderate protein calorie malnutrition. The patient had exhibited significant agitation and paranoia behaviors for a year prior to being admitted to hospice. She lost 25% of her body weight at the time of hospice admission. She lived in an assisted living facility (ALF).

The hospice team held regular conferences with the family and staff at the ALF to address the patient's care plan. During her second benefit period, the patient's agitation and psychosis escalated significantly, as the patient refused to take all medications, including her antipsychotics. The team switched to liquid dosing, but during her periods of heightened agitation, she would refuse PRN (as needed) doses.

With the consent of the family, the Hospice Medical Director ordered injectable medications. The patient was given subcutaneous injections through a subcutaneous (SubQ) button of morphine (1

mg) and Midazolam (1 mg) initially, and dosages for each drug were titrated to 2 mg. Unable to achieve the desired medication effect, the hospice nurse remained in the ALF with the patient for several hours, dosing the patient per physician orders. Morphine 2 mg was given at 11:53 with patient continuing to be notable for agitation, although it was less than prior to administration. A second dose of Morphine 2 mg was administered at 12:45. As of 13:15, patient still showed notable agitation. A dose of Midazolam 2 mg given at 13:17. Patient continued to be agitated and refused cares. The next dose of Midazolam 2 mg was administered at 14:15. Despite some sedation, the patient still exhibited hitting and biting whenever care was attempted and was unable to tolerate any touch. It took four people to change the patient's briefs or to bathe her.

The hospice team was also concerned that the patient may have underlying pain, but the patient's inability to communicate or cooperate with any assessment limited investigating any further. During a conference with hospice medical director and patient's husband and daughter, the family expressed wishes that the patient be comfortable, even if the trade-off was increased sedation. The patient was admitted to a local hospital under GIP status, as her level of agitation and restlessness were a risk for her safety and the safety of others.

At the time of GIP admission, the patient was initially started on a continuous morphine drip at 1 mg/hour, which was eventually titrated up to 3 mg/hour over the first day; Midazolam drip also administered at 1 mg/hr. Nursing assessments around the clock were required over a several day period while medications were adjusted, as even though the combativeness had decreased, the patient showed signs of tension during initial dosing. On the third GIP day, plans were initiated to transfer the patient to a skilled nursing facility. However, on day four, the patient's breathing became labored and nursing assessments were required in anticipation of possible increases in morphine dosing. The patient also received IV Robinul for secretions. The patient passed away on day five of the GIP stay.

5. Case example #5 – Acute wound care

Mr. M. is a 35-year-old man with a diagnosis of necrotizing fasciitis of the right leg admitted to a hospice facility from an acute care hospital. While hospitalized, multiple IV antibiotics were used along with debridement and intense wound care in an effort to control the condition. Mr. M. declined an above the knee amputation offered in an effort to save his life. While hospitalized, a plan of care meeting was held, and Mr. M. consented to a transfer to a hospice facility for

further management of symptoms including pain, extensive wound care, and continued antibiotic therapy.

Pain was both physical and emotional. Medications needed to be titrated prior to dressing changes to assure comfort and to decrease anxiety.

Wound care involved astute daily skin assessment and documentation in order determine the progression of the condition as a means to care plan future care needs

Dressing changes initially involved 4 staff and took over one hour.

With intervention from all team members after a period of 7 days at GIP level of care, dressing changes took 2 people less than 30 minutes and an established plan for supplies and medication needs for the dressing changes was established. Anxiety and generalized somatic pain were also addressed. Team members were actively involved in this man's physical and emotional suffering.

Change in Level of Care, But Not Location of Care

Routine home care (RHC) level of care in a hospital

There are several considerations related to caring for a RHC patient in a hospital setting. Unless the "hospice unit" in the hospital is licensed and certified to the hospice (not the hospital) and the patient is billed for "room and board", there can be regulatory concerns associated with regularly billing RHC when a patient is in an inpatient setting, and not at a GIP level of care. This approach is not something that is advisable to do on a regular basis for the following reasons:

- The hospice benefit does not cover "room and board" in a residence unless it is part of a GIP or respite level of care. Therefore, it would be expected that the hospice provider would charge for the "room and board" to avoid Medicare beneficiary inducement concerns.
- When a patient receives RHC, the federal Medicare hospice Conditions of Participation at §418.64 require that **all core services, including nursing, social work and counseling, be provided by employees of the hospice.**[18] This means that hospice nurses, not hospital nurses, would need to provide the nursing care, which would be expected to be intermittent on RHC (i.e., several times a week for a couple of hours).

GIP to Respite Level of Care

In 2014, CMS revised the respite guidance in Chapter 9, section 40.1.5 of the Medicare Benefit Policy to include specific examples of when respite may be appropriate, one of which includes transitioning a patient directly from GIP to respite level of care. The guidance states respite may be provided for "a few days immediately following a GIP stay if the usual caregiver has fallen ill."[19] While this guidance appears to allow respite in instances where the patient is not currently residing at home, the qualifying language is important and signals an expectation that these transitions will not be the norm. Therefore, hospices should be cautious when making such transitions and ensure they have supportive documentation consistent with the guidance to justify the level of care change.

[18] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[19] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Section 40.1.5). Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Resources:

- Palmetto GBA GIP Video about Eligibility
- Palmetto GBA Script for GIP video.

Hospice Responsibility for Professional Management of Care

Professional Management and Oversight

Regardless of care setting, the hospice IDG is responsible for the professional management of the patient's care in accordance with the hospice plan of care as set by the IDG. Guidance in the federal Conditions of Participation at §418.100(e) states that contracts with appropriate facilities for GIP services should be clear regarding the IDG oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement. The written agreements may also clarify payment rates and procedures.[20]

Care Collaboration

When a patient transitions from RHC to GIP level of care, the home hospice team continues to have a role in the patient's care. While the frequency of IDG visits to a patient receiving GIP level of care is not specified in the federal regulations, a good standard of practice is a daily visit from an IDG member to assure professional management, coordination of the plan of care, communication with the patient, family, and hospital or SNF staff, continuity of care and evaluation of continued eligibility for this level of care. The IDG needs to ensure that the focus is palliative and based on the plan of care. If the patient decides to shift to a more aggressive course, then a plan of care conversation should occur.

It is also essential that there is coordination and communication with the physician overseeing inpatient care, the attending physician, and the hospice physician. Professional care management is essential during the inpatient stay and during the decision-making process for transitions from GIP to a lower level of care. The IDG should also continue services provided by social workers and chaplains as needed and continue support and communication to the family and caregivers during a GIP inpatient stay.

Transition Planning

Consideration of transitioning the patient from GIP back to RHC requires planning and should occur the moment the patient moves to the GIP level of care. The hospice (not the hospital staff when the facility is a hospital) is responsible for managing the transition back to RHC or any other level of care. Documentation should show that the IDG is

[20] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

assessing the situation on a daily basis and planning for the transition to another setting or level of care.

> **NOTE:** GIP under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate.[21]

Resources:

- Hospice General Inpatient Care Fact Sheet for Hospitals – teaching tool to use with hospital partners about hospice GIP (April 2017). This is a word document that can be customized to add a hospice provider's logo and contact information.

- Hospice General Inpatient Care Fact Sheet for Skilled Nursing Facilities – teaching tool to use with SNF partners about hospice GIP (April 2017). This is a word document that can be customized to add a hospice provider's logo and contact information.

[21] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Section 40.1.5). Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

Documenting GIP Care

Transitioning to GIP Level of Care

- The precipitating event (onset of uncontrolled symptoms or pain) which prompted the need to change to GIP level of care should be evident in the comprehensive assessment documentation.
    - Ensure that a detailed description of the acute symptoms is documented in the clinical record.
- The nurse should document pain and symptom management interventions that were implemented in the home (or wherever they reside) prior to initiating GIP level of care and the patient's response.

- Documentation should describe the patient's needs (i.e., for around-the-clock medication adjustments, observation, or stabilizing treatments such as assessment of acute unstable symptoms).
    - Example: "Attempts to manage the patient's escalating pain levels in the home setting over the past two days have failed to achieve the desired level of comfort. Patient will require frequent RN/NP/MD assessment and titration of medications in an inpatient setting to control pain."
- The hospice should arrange to transport the patient to the appropriate inpatient setting that can meet the patient's needs. Per CoP at §418.56(e)(4), the hospice staff must share information among all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.[22]

> **Note:** Hospice providers are not responsible for covering transportation cost prior to the initial assessment and therefore prior to the plan of care's development. Ambulance transports of a hospice patient, which are related to the terminal illness and which occur after the effective date of election, are the responsibility of the hospice.[23]

- When transitioning a patient to GIP level of care, documentation should minimally include:
    - A summary of the patient's current status for the inpatient staff

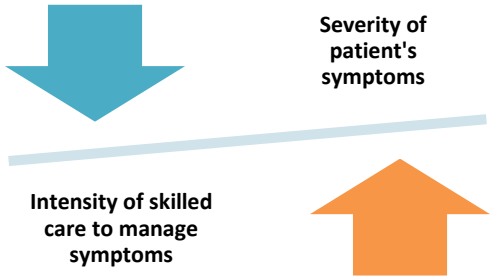
[22] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

[23] Centers for Medicare and Medicaid Services. (2015). Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Section 40.1.5). Retrieved on 5/31/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

        - Include interventions implemented prior to change in level of care
    - A copy of the patient's current plan of care
    - A copy of current physician orders
        - Industry best practice recommends that the hospice provider obtain a physician's order to change the level of care even though it is not expressly required in the federal hospice regulatory text. A surveyor/auditor will also most likely expect this physician's order for a change to GIP care.
    - A copy of the patient's advance care directives and MOLST/POLST form (as applicable).
    - A copy of the patient's current medication profile.

Documentation During the GIP Stay

Documentation during GIP level of care must be thorough and reflect the severity of the symptoms and the intensity of skilled care to manage the crisis.



- Implementation of the plan of care must be directed towards stabilizing acute symptoms, obtaining a positive palliative outcome (documenting whether the care made a difference), and moving the patient to a lower level of care at the appropriate time.
- When a hospice provider contracts with a hospital or SNF for GIP care, the facility staff needs to be educated related to documentation content.
- Physicians and nurses need to address symptom management, observations, medications initiated and changes in medications, other changes in treatment, etc. Other IDG members need to document what they see in terms of symptom management, patient and family coping, discharge planning discussions, options for returning to the routine home care or another level of care, etc.
- All IDG members should document to paint a complete picture of the patient, including the pain and symptoms not adequately managed and why GIP is necessary **each day** the patient receives this level of care.
- Documentation should be clear prospectively, not just retrospectively. Many times during a retrospective medical review of a clinical record, the care provided during

part of the GIP stay may not appear to be "skilled." Each day of care must reflect the intensity of skilled care and the severity of the patient's symptoms.

> **NOTE:** When documentation in the clinical record states that the patient's acute symptoms are stabilized, then GIP care must end. If a patient's symptom stability is being evaluated for its long-term effect, then the documentation should state that fact, particularly if medication is being titrated or tried to determine whether it will stabilize the crisis.

- Documentation should integrate the specific Medicare Administrative Contractor's (MAC) Local Coverage Determination (LCDs), as applicable.
- Policies, procedures and the patient's status should dictate visit and documentation frequencies. Keep in mind that a higher level of care demands that documentation and visits are more frequent.
- Documentation of transition planning should also appear in the clinical record throughout the GIP stay.
- Documentation content – suggestions for GIP documentation are contained in The Carolinas *Center Resource Guide for General Inpatient (GIP) Level of Care: Utilization, Coordination, & Documentation*

Resources:

- *The* Carolinas Center Resource Guide For General Inpatient (GIP) Level of Care: Utilization, Coordination, & Documentation (Jan 2016)
- Medicare Administrative Contractor guidance
  - CGS General Inpatient Care (Jul 2012)
  - NGS GIP Job Aid (Feb 2015)
  - Palmetto Hospice GIP Audit Tool (August 2017)
  - Palmetto Hospice GIP Video (February 2015)

- Centers for Medicare and Medicaid Guidance related to GIP
  - Medicare Benefit Policy Manual, Hospice - Chapter 9 - 40.1.5 - Short-Term Inpatient Care
  - Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims.

Quality & Compliance Considerations

Quality Assurance & Performance Improvement (QAPI)

GIP is a challenging level of care to manage, and providers should self-assess their GIP processes, performance, and any compliance issues or reports to determine if it is an area needing improvement. The goal for the hospice provider is to not only provide acute symptom relief for the patient but to also facilitate a smooth transition to the GIP level of care for the patient, family, the hospice IDG, and facility staff as applicable.

Hospice providers should consider evaluating internal processes and policies related to assessing patient needs, providing and/or monitoring care, transition planning and frequent problems that arise with GIP care such as unnecessary testing and procedures that are not palliative in nature and may add burden to the patient. Identified issues should be added to the provider's QAPI plan for targeted improvement per the guidance in the federal Medicare CoPs at §418.58 Quality Assessment Performance Improvement.[24]

Hospice Quality Reporting

The Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey outcomes can be used as data for performance improvement. CAHPS survey topic areas include:

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Care Training
- Rating of Hospice
- Willingness to Recommend

The CAHPS survey is designed to capture outcomes including the decedent's last location/setting of care (e.g., home, assisted living facility, nursing home, acute care hospital, freestanding hospice inpatient unit). Hospice providers can work with their CAHPS survey vendor to determine which survey responses encompass inpatient care.

Audit Readiness

Clinical records are subject to review during an audit by a Medicare Administrative Contractor (MAC) and/or other oversight agencies. Providers should train their staff on

[24] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/30/2018: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

standard practice and documentation standards and periodically conduct internal audits to ensure documentation supports the GIP level of care. Palmetto GBA developed a Hospice GIP Audit Tool to assist hospice providers in evaluating documentation for GIP criteria.

There is current federal scrutiny on hospice GIP provision and billing by the Centers for Medicaid and Medicare Services (CMS) and the Health and Human Services Office of the Inspector General (OIG). An outline of the scrutiny is located in NHPCO's *Scrutiny about Hospice General Inpatient Care* resource and on the NHPCO website.

Resources:

- Palmetto Hospice GIP Audit Tool
- NHPCO's Scrutiny about Hospice General Inpatient Care (April 2017)

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