

# Hospice Regulations, Conditions of Participation (CoPs) and Conditions of Payment

Jennifer Kennedy, EdD, MA, BSN, RN, CHC  
National Hospice and Palliative Care Organization

December 5, 2019



## Learning Objectives

- Describe the hierarchy of federal hospice regulatory requirements
  - What are they?
  - Who enforces them?
  - What is the "penalty" for non-compliance?
- Explain how to navigate compliance and advise your organization when non-compliance occurs in the "real world".

# Hospice Regulations-Subparts

Subpart A	<ul style="list-style-type: none"><li>• Statutory basis</li><li>• Definitions</li></ul>
Subpart B	<ul style="list-style-type: none"><li>• Subpart B - Eligibility, Election and Duration of Benefits</li><li>• (Compliance assessed via MAC, federal, or state based audit)</li></ul>
Subparts C & D (CoPs)	<ul style="list-style-type: none"><li>• Patient Care</li><li>• Organizational Environment</li><li>• (Compliance assessed during an initial and recertification survey by state or accreditation organization)</li></ul>

## Subpart B - Eligibility, Election and Duration of Benefits

## Subpart B: Eligibility, Election and Duration of Benefits

### §§418.20 Eligibility requirements

An individual must be:

- (a) Entitled to Part A of Medicare and
- (b) Certified as being terminally ill

- “*Terminally ill* means that the individual has a medical **prognosis** that his or her life expectancy is 6 months or less if the illness runs its normal course.” (§§418.3 Definitions)

5



### § §418.22 Certification of Terminal Illness – First 90-day Benefit Period

	1 <sup>st</sup> 90-day period
<b>Verbal certification</b>	<input checked="" type="checkbox"/> If written certification is not obtained within 2 days of the start of care date <input checked="" type="checkbox"/> No physician signature required
<b>Written certification form</b>	<input checked="" type="checkbox"/> Signed by attending physician and hospice medical director/ hospice physician <input checked="" type="checkbox"/> Physician signature and date required
<b>Physician narrative statement and attestation statement</b>	<input checked="" type="checkbox"/> Narrative statement <input checked="" type="checkbox"/> Attestation statement <input checked="" type="checkbox"/> Physician signature required below attestation

6



## § §418.22 Certification of Terminal Illness – Second 90-day Benefit Period

2 <sup>nd</sup> 90-day period	
<b>Verbal certification</b>	<input checked="" type="checkbox"/> If written certification is not obtained within 2 days of the start of care date <input checked="" type="checkbox"/> No physician signature required
<b>Written certification form</b>	<input checked="" type="checkbox"/> Signed by hospice medical director or hospice physician <input checked="" type="checkbox"/> Physician signature and date required
<b>Physician narrative statement and attestation statement</b>	<input checked="" type="checkbox"/> Narrative statement <input checked="" type="checkbox"/> Attestation statement <input checked="" type="checkbox"/> Physician signature required below attestation

7



## § §418.22 Certification of Terminal Illness – First 60-day and Subsequent Benefit Periods

1 <sup>st</sup> 60-day & subsequent periods	
<b>Verbal certification</b>	<input checked="" type="checkbox"/> If written certification is not obtained within 2 days of the start of care date <input checked="" type="checkbox"/> No physician signature required
<b>Written certification form</b>	<input checked="" type="checkbox"/> Signed by hospice medical director or hospice physician <input checked="" type="checkbox"/> Physician signature and date required
<b>Face-to-face encounter attestation statement</b>	<input checked="" type="checkbox"/> Face-to-face encounter attestation statement <input checked="" type="checkbox"/> Physician/ NP signature and date required below attestation
<b>Physician narrative statement and attestation statement</b>	<input checked="" type="checkbox"/> Narrative statement <input checked="" type="checkbox"/> Attestation statement <input checked="" type="checkbox"/> Physician signature required below attestation

8



# Certification and Recertification of Hospice Terminal Illness

Process Maps to Guide Hospice Providers with Admissions

Version 4.0, January 2016

Available for purchase in the  
NHPCO Marketplace

<https://www.nhpco.org/marketplace/>



National Hospice and Palliative Care  
Organization



 NHPCO

## §§418.24 Election of Hospice Care

- Patient waives all rights to traditional Medicare payments under part A
- Hospices will have a **maximum of 5 days** to have the NOE submitted and accepted by their Medicare contractor
- The penalty for not filing the NOE timely is “provider liable” days where the hospice is responsible for providing care and services to the patient from effective date of election until the date the NOE is filed

## §§418.24 Election of Hospice Care

- Requires documentation of the patient’s chosen attending physician (if any) on the hospice election statement (effective 10/1/2014).
- Information required about attending physician should provide enough detail so that it is clear which physician, Nurse Practitioner (NP), or Physician Assistant (PA) was designated as the attending physician.
- Includes, but is not limited to...
  - the attending physician’s full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.
- The individual’s acknowledgment that the designated attending physician was the individual’s or representative’s choice.

## §§418.28 Revoking the election of hospice care

- **Patient or representative may revoke** election of hospice care any time during an election period (**patient right and decision**)
- Revocation may not be “backdated”
- No verbal revocations are allowable
- Patient may at any time again elect coverage for hospice election periods for which patient is eligible

## §§418.30 Change of the Designated Hospice

- One transfer allowable in each election period
- Such change does not constitute a revocation
- Patient remains in the same benefit period during a transfer of provider
- **Obtain copy of face-to-face encounter from transferring hospice if transfer in the 3<sup>rd</sup> of later benefit period**
- Both programs can bill on date of transfer

13



## §§418.30 Change of the Designated Hospice

To change hospice providers the patient/representative must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:

- the name of the hospice from which the individual has received care
- the name of the hospice from which they plan to receive care
- the date the change is to be effective.

14



## §§418.26 - Discharge From Hospice Care

- Patient moves out of hospice service area (could be for a vacation), transfers to another hospice, or enters a non-contracted facility
- Patient is no longer terminally ill
- Discharge for cause: Patient's behavior (or others in home) is disruptive, abusive, or uncooperative to the extent that delivery of care or ability of hospice to operate effectively is seriously impaired
  - **Discharge for cause is a last resort**

## Examples of Patient Leaving Service Area

- When a hospice patient moves to another part of the country.
- When a hospice patient leaves the area for a vacation (optional... not required).
- When a hospice patient is admitted to a hospital or SNF that does not have a contractual arrangement with the hospice.



## ABN or NOMNC?

- Neither the Advance Beneficiary Notice (ABN) or the Notice of Medicare Non Coverage forms are issued for the patient leaving the service area

## Discharge – No Longer Terminally Ill

- If a hospice physician determines that the patient no longer meets Medicare eligibility requirements, the patient must be discharged.
  - Should never be a last minute event for patient and hospice.
  - Consistent evaluative lead up to determination to discharge for this reason should have been over a period of time.
  - Discussion of disease plateau should have been discussed with patient and family prior to notice of discharge.

## Discharge Notice

- **The Notification:**
  - A two-day minimum notice of discharge provided to patient / family.
    - If state regulations require more than two (2) days discharge notice, then the hospice follows the more stringent requirement.

## Notice of Medicare Non-Coverage

- Hospice issues the UPDATED Notice of Medicare Non-Coverage form (NOMNC) *Form CMS-10123*
  - This notice informs the patient that Medicare probably will not pay for hospice because they no longer meet hospice criteria
  - Form must be verbally reviewed with beneficiary/ representative and signed by such
  - Applicable forms:
    - [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED\\_NOMNC\\_Eng-Sp-.zip](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED_NOMNC_Eng-Sp-.zip)
    - [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED\\_InstructionsforNOMNC.pdf](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED_InstructionsforNOMNC.pdf)

## Notice of Medicare Provider Non-coverage - Detailed

- **The UPDATED Detailed Explanation of Non-coverage form -- Form CMS-10124**
  - Provided to the beneficiary/representative by the hospice when the family has appealed to the state's Quality Improvement Organization (QIO)
  - Form must verbally reviewed with beneficiary/ representative
  - The decision from the QIO is binding
  - Form and instructions are available at:
    - [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED\\_DENC\\_Eng-Sp-.zip](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED_DENC_Eng-Sp-.zip)
    - [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED\\_InstructionsforDENC.pdf](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/UPDATED_InstructionsforDENC.pdf)

## Expedited review

- The QIO is responsible for immediately contacting the provider if a beneficiary requests an expedited review and then making a decision no later than 72 hours after receipt of the beneficiary's request.
- The provider is responsible for providing the QIO with a detailed explanation of why coverage is ending.
- The provider may need to present additional information to the QIO for the QIO to use in making a decision.

## QIO Decision – Patient is Still Eligible

- Hospice physician could confer with QIO Medical Director regarding differing medical judgment.
- A QIO's decision cannot force a hospice to continue care if in the hospice physician's medical judgement is that the patient does not meet Medicare hospice eligibility.
- CMS, Chapter 30, 260.6.2:
  - In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders.
  - The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider.

23



## Discharge for Cause

- **Before discharging a patient for cause, the hospice must:**
  - ✓ Advise the patient that a discharge for cause is being considered.
  - ✓ Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation.
  - ✓ Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.
- **Discharge for cause can never be for:**
  - Financial issues (i.e.: costs for care are high).
  - Because the hospice does not like the patient or family.

24



## Discharge for Cause (cont'd)

- Each hospice must formulate its own discharge policy and apply it equally to all patients.
- A hospice has to determine what does *“patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired”* mean.
- Providers required to report patients discharged for cause to:
  - State survey agency

25



## Examples of Discharge for Cause

- Cases where patients consistently refuse to permit the hospice to visit or deliver care.
- It is dangerous for staff to visit the home even with a security escort.
- Patient repeatedly leaves the service area without letting the hospice know.

26



## ABN or NOMNC?

- Neither the Advance Beneficiary Notice (ABN) or the Notice of Medicare Non Coverage forms are issued for this discharge for cause.

27



## §§418.26 - Discharge From Hospice Care

### Discharge order

- Consult attending physician before discharge; include his/her review and decision in discharge note
- Obtain written physician's discharge order from the hospice medical director prior to discharge

### Discharge planning

- Hospice must have a discharge planning process
- Process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill

28



## Notice of Termination/Revocation (NOTR)

- Hospices will have a **maximum of 5 days** to have the NOE submitted and accepted by their Medicare contractor
- No penalty for late filing of the NOTR

29

 NHPCO

### Hospice Discharge, Revocation, and Change of Designated Hospice

Process Maps to Guide Hospice Providers

Version 2.1, January 2016



National Hospice and Palliative Care  
Organization



Available for purchase in the  
**NHPCO Marketplace**  
<https://www.nhpc.org/marketplace/>

30

 NHPCO

# Conditions of Participation (CoPs) Subparts C&D

31



## 2008 CoP Foundations

- The 2008 CoPs focus on a patient-centered, outcome-oriented, and transparent process that promotes quality patient care for every patient, every time.
- Contain a core requirements for hospice services that encompass patient rights, comprehensive assessment, patient care planning and coordination by a hospice interdisciplinary group (IDG).
- Encompass the core requirements of quality assessment and performance improvement program which focus on the hospice provider's own quality management system being key to improved patient care performance.

32





## 2008 CoPs

CMS's objective in the CoPs is to achieve a balanced regulatory approach by ensuring that a hospice furnishes health care that meets essential health and quality standards, while ensuring that it monitors and improves its own performance.



## Subpart C: Condition of Participation - Patient Care

- §418.52 Condition of participation: Patient's rights.
- §418.54 Condition of participation: Initial and comprehensive assessment of the patient.
- §418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.
- §418.58 Condition of participation: Quality assessment and performance improvement.
- §418.64 Condition of Participation: Core Services
- §418.76 Condition of Participation: Hospice Aide and Homemaker Services
- §418.78 Condition of participation: Volunteers

## §418.52 Patient's rights

- Informed about rights and responsibilities verbally and in writing.
  - Patient/representative signs a statement
- Translation – must provide all information in a language and manner that the patient/ representative/family can understand.
- Advance directives
  - Hospice must provide advance directive information as needed/ per patient request
  - Cannot refuse service based on advance directive content
  - Hospice must provide a statement of limitation if advance directive cannot be honored on the basis of conscience
    - Policy

35



## §418.52 Patient's rights

- Exercise of rights and respect for property and person
  - Surveyors will look at documented complaints for last 12 months and outcomes of the complaint
  - 5 working days from becoming aware of complaint to investigate
    - If verified, report to state/local bodies within those 5 days
  - All alleged and real violations reported to hospice administrator
  - Surveyors will look at documented complaints for last 12 months and outcomes of the complaint
  - 5 working days from becoming aware of complaint to investigate
  - If verified, report to state/local bodies within those 5 days
  - **Pay attention to alleged and real reports or observations of abuse or neglect.**

36



## §418.52 Patient's rights

- Pain management & symptom control
  - Hospice response to patient's request for pain management 24/7
- Patient/ family involvement in developing plan of care
  - How do they participate?
  - How does hospice staff facilitate?
- Refusal of service is a right
  - Are there trends?
  - How do you introduce services?

37



## §418.54 Initial & comprehensive assessment

### Initial assessment

- Completed by RN
- **48 hours** from the effective date of the notice of election
- Not a “meet and greet” visit
- Must be completed in the location where the hospice services are being delivered
- RN begins to develop the plan of care
- Focus is on meeting immediate needs of patient/ family

38



## §418.54 Initial & comprehensive assessment

### Comprehensive assessment

- **5 calendar days** after the effective date of the election of hospice care
- Plan of care is not formed by RN in a vacuum
  - IDG participation
  - Attending physician
- Guidelines:
  - Heavy focus on pain assessment
  - Medication review
    - Are current medications achieving the outcome wanted by the patient?

## §418.54 Initial & comprehensive assessment

### Initial bereavement assessment

- Initial assessment of bereavement services must be included in comprehensive assessment
  - Bereavement services can be offered prior to a patient's death
  - Patient plan of care must address bereavement issues

## §418.54 Initial & comprehensive assessment

### Update of the comprehensive assessment

- Minimally every **15 days** or as the patient's condition requires
- Assessment updates should be easily identified in the clinical record
- Required to document if there were no changes in the condition of the patient/family needs
- Evidence that IDG is actively involved in evaluating patient care

## §418.54 Initial & comprehensive assessment

### Patient outcome measures

- Must include data elements in assessment that would allow for the measurement of outcomes
- Suggested:
  - Pain
  - Dyspnea
  - Nausea
  - Vomiting
  - Constipation
  - Emotional distress
  - Spiritual needs

## §418.56 IDG, care planning, and coordination of services

### Approach to service delivery

- Documentation that verifies participation of all core IDG members in written plan of care
- Process for developing plan of care with IDG and attending physician
- Assessment – plan of care link
- Needs of patient unrelated to terminal illness
  - Document awareness of needs and who is addressing them

### RN coordinates plan of care

- How does the RN assure that IDG kept informed of patient/family status and coordination of care?

43



## §418.56 Care planning

### Plan of Care

- Individualized plan of care
- Development was collaborative
  - Signatures on plan of care not necessary, but documentation of collaboration must be evident
- Include complimentary/ alternative therapies if provided to patient/ family
- Medications
  - Proactive anticipation of side effects
  - Preventative measures implemented
  - Hospice response to patient needs for pain/ symptom management

44



## §418.56 Care planning

### Content of the plan of care

- Scope and frequency of services
  - Visit ranges acceptable
    - Small intervals (1-3/week)
  - PRN visits acceptable as an accompaniment to an established visit frequency
    - PRN may not be a standalone visit frequency
- Standing orders must be individualized and signed by patient's physician

## §418.56 Care planning

### Content of the plan of care

- Measurable outcomes
  - Outcomes should be a measurable result of the implementation of the plan of care
  - Data elements should be used as part of the plan of care to see if they are meeting the goals of care
  - Are outcomes documented and measurable?

## §418.56 Care planning

Review of the plan of care

- Minimally every **15 days** or as the patient's condition requires
- All IDG members participate whether actively providing care or not
- Communication with attending may be through phone calls, electronic methods, orders received, or other means
  - Define in policy

47



## §418.56 Coordination of services

Coordination of services

- What systems are in place to facilitate exchange of information and coordination of services between:
  - Hospice staff
  - Non-hospice staff
- Is there documentation in the clinical record of information sharing between:
  - Hospice staff
  - Non-hospice staff

48





## § 418.58 Quality assessment and performance improvement (QAPI)

- Organization self assessment
- QAPI plan – written
- Program scope
  - Adverse patient events
- Program data
- Program activities
- Performance improvement projects
- Governing body involvement

49



## § 418.58 QAPI

- Patient-focused and outcome (or results) oriented
- Goal
  - To monitor quality/performance
  - Find opportunities for improvement
  - To improve care
- Focus is on achieving patient/family desired outcomes or results
- Tied to other regulations

50



## FAQ's

- §418.52 Condition of participation: Patient's rights.
  - *What if a patient wishes to be a full code at the time of admission?*
- §418.54 Condition of participation: Initial and comprehensive assessment of the patient.
  - *What is the first day of the 5 calendar day count for the comprehensive assessment?*
  - *Can we start the patient's assessment while we are coordinating care before they are discharged from the hospital?*

## FAQ's

- §418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.
  - *Can an IDT member join the IDT meeting by phone?*
  - *What is the minimum number of visits/week for a nurse?*
  - *Do both physicians need to sign the plan of care?*
- §418.58 Condition of participation: Quality assessment and performance improvement
  - *How do QAPI and the HQR program connect?*

## Subpart C—Condition of Participation—Patient Care

- **CORE SERVICES**
- §418.64 Condition of participation: Core services.
- §418.66 Condition of participation: Nursing services waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.

### § 418.58 QAPI

- Patient-focused and outcome (or results) oriented
- Goal
  - To monitor quality/performance
  - Find opportunities for improvement
  - To improve care
- Focus is on achieving patient/family desired outcomes or results
- Tied to other regulations

## § 418.64 Core services

- Hospice must routinely provide **substantially all** core services directly by hospice employees
  - Nursing
  - Medical Social Services
  - Counseling
    - Bereavement
    - Spiritual
    - Dietary
- May use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances
  - Continuous home care may not be routinely contracted out

55



## § 418.76 Hospice Aide

- **Qualifications and competency requirements**
- **A registered nurse must make an on-site visit to the patient's home:**
  - No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs
  - The hospice aide does not have to be present during this visit
  - If state regulation is more stringent, follow it

56



## § 418.76 Hospice Aide

Hospice aide written instructions:

- Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group
- Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide
  - Written by the RN (RN is responsible for the supervision of the aide)
  - Must be patient specific and not generic

57



## § 418.78 Volunteers

**Role and activities:**

- Used in day to day administrative and/ or direct patient care roles
  - Office activities
  - Direct patient care services
  - Non-administrative patient care activities (may not use these hours for 5% level of activity)
- Direct patient care services must be evident in patient plan of care
- There should be documentation of time spent and the services provided by volunteers

58



## Subpart D: Conditions of Participation - Organizational Environment

- §418.100 Condition of participation: Organization and administration of services
- §418.102 Condition of participation: Medical director
- §418.104 Condition of participation: Clinical records
- §418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment
- §418.108 Condition of participation: Short-term inpatient care

59



## Subpart D: Organizational Environment

- §§418.108 Short-term inpatient care (contracted)
  - Respite
  - GIP
- §§418.110 Hospices that provide inpatient care directly
  - Environmental requirements
  - Restraint and seclusion
- §418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR
  - Coordination of care requirements with NF
  - Hospice and NF responsibilities
- §418.114 Personnel qualifications
  - Social worker qualifications
  - Criminal background check

60



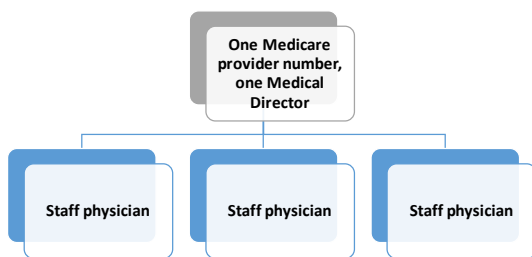
## § 418.100 Organization and administration of services

- Standard: Services: Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis 7 days a week.
- Standard: Professional management responsibility: A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care.
- Standard: Hospice multiple locations
- Standard: Training

61



## § 418.102 Medical Director



Read more info about hospice medical directors at [https://www.nhpc.org/wp-content/uploads/2019/05/Reg-Alert\\_Hospice-Med-Directors\\_Region-V.pdf](https://www.nhpc.org/wp-content/uploads/2019/05/Reg-Alert_Hospice-Med-Directors_Region-V.pdf)

- Each hospice provider certification number will have **ONE** medical director
- Responsible for medical component of the hospice's patient care program.
- The "physician designee" is a pre-selected physician that assumes the medical director's duties in his/her absence.
- All additional physicians report to the Medical Director
  - Additional physicians perform IDG duties
  - Medical director supervises staff physicians



## § 418.106 Drugs and biologicals, medical supplies, and durable medical equipment

### (a) Standard: Managing drugs and biologicals

- Ensure that IDG confers with individual with education and training in drug management to ensure that drugs and biologicals meet each patient's needs
  - Individuals may include:
    - Licensed pharmacist
    - Board certified physicians in palliative medicine
    - RN's certified in palliative care
    - Physicians, RN's, NP's who complete a specific hospice or palliative care drug management course

63



## § 418.106 Drugs and biologicals, medical supplies, and durable medical equipment

- §418.106(b) Standard: Ordering of Drugs
  - Only a physician or NP may order drugs.
- §418.106(d) Standard: Administration of drugs and biologicals
  - IDG must determine patient/family ability to safely administer drugs
  - Must be identified in patient plan of care
- (e) Standard: Labeling, disposing, and storing of drugs and biologicals
  - **Provide a copy of written policies and procedures** for managing and disposing of drugs in patient's home, and discuss with patient and family at the time when controlled drugs are first ordered, document discussion in clinical record.

64





## § 418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR

- June 27, 2013 - CMS published the [final rule](#) regarding requirements for long term care facilities when they enter into an agreement with a hospice to offer hospice services to residents of the facility.
  - Effective August 26, 2013
  - [Side-by-side comparison chart detailing regulatory roles and responsibilities for each provider type](#)
- Greater scrutiny on provision of care for a patient receiving hospice care in a nursing facility for both the hospice and the facility
  - Nursing facility surveyors have been instructed to select at least 1 hospice patient during a facility survey

## § 418.112 - Professional management

Professional management of the patient's terminal illness

- Professional management involves assessing, planning, monitoring, directing, and evaluating.
- Hospice duties:
  - Ongoing assessment of the patient's terminal illness
  - Care planning
  - Monitoring
  - Coordination and provision of hospice care by IDG
  - Coordination of care with facility staff

## § 418.112 Contractual agreement

### Agreement must include:

- Communication and documentation strategy
  - The hospice must document that communication has occurred.
- Provision for notifying hospice under certain circumstances
- Hospice responsibility for determining hospice care provided
- Both providers must comply with their applicable conditions/requirements for participation in Medicare/Medicaid

67



## § 418.112 Contractual agreement

### Agreement also includes:

- Hospice responsibility to provide services to same extent as serving a patient in a private home
- Delineation of hospice responsibilities
- Provision to use facility personnel to assist in implementing the plan of care only to the extent that a hospice would routinely use a patient's family
- Hospice reports to facility all patient rights violations unrelated to the hospice
- Bereavement services

68



## § 418.112 Nursing Facility Responsibilities

- Included in the contractual agreement
  - An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.

## § 418.112 Nursing Facility Responsibilities

The facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit

- Room and board services
- Care for conditions unrelated to diagnoses that contribute to the hospice prognosis
- Core hospice services may not be delegated to facility staff
- Hospice may offer bereavement services to facility staff or residents that fulfill the role of a hospice patient's family as identified in the plan of care

## § 418.112 Hospice Responsibilities

A delineation of the hospice's responsibilities, which include, but are not limited to the following:

- Providing medical direction and management of the patient's terminal illness.
- Nursing.
- Counseling, including spiritual, dietary and bereavement.
- Social work.
- Provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms.
- All other hospice services that are necessary for the care of the patient/resident's diagnoses that contribute to the hospice prognosis.

## § 418.112 Hospices plan of care

- Coordinated and guides both providers
- May be divided into two portions; separately maintained
- Hospice plan of care must identify the provider responsible for each function/ intervention in plan of care for the patient's terminal illness
- Both providers portion of plan of care should reflect identification of:
  - Common problem list
  - Palliative interventions and outcomes
  - Responsible discipline/ provider
  - Patient goals

## § 418.112 Coordination of Services

- Hospice designates IDG member to provide overall coordination of care
  - May or may not be the hospice RN; (physician, social worker or counselor member of the IDG)
  - Implementation of plan of care with facility representatives
  - Communicates with facility to implement hospice plan of care
- Surveyors will look for evidence of communication, system coordination, outcomes meeting patient goals in both the hospice and the facility charts
  - May talk to facility nursing aide

73



## § 418.112 Orientation and training

- Hospice assures orientation facility staff in:
  - Hospice philosophy
  - Policies and procedures
  - Pain control and symptom management methods
  - Patient rights
  - Forms
  - Record keeping
- Hospices can collaborate for general hospice philosophy and pain management training
- Specific training regarding forms, record keeping and coordination between each hospice and facility needs to be completed individually by the hospice

74



## § 418.114 Condition of participation: Personnel qualifications

- *Social worker.* A person who—
  - Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or
  - Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education;
  - or a baccalaureate degree in psychology, sociology, or other field related to social work and
  - Is supervised by an MSW if:
    - Baccalaureate degree in psychology, sociology, or other field
    - Has a BSW and was hired by hospice organization after December 2, 2008
  - Has 1 year of social work experience in a healthcare setting

## § 418.114 Criminal background check

- The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records.
- Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.



# QUESTIONS

77



## Contact us at NHPCO for Regulatory and Quality Assistance

NHPCO members enjoy unlimited access to Regulatory & Quality Assistance

Regulatory questions

Email us at: [regulatory@nhpco.org](mailto:regulatory@nhpco.org)

Quality questions

Email us at: [quality@nhpco.org](mailto:quality@nhpco.org)

78

