



# Hospice 101: The Basics for New Staff

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Directed by The Hospice & Home Care Webinar Network

# Today's Presenter: Kathy Ahearn, RN, BSN, PHN



Kathy Ahearn has a Bachelor's in both Nursing and Social Work, and owns Ahearn Advisement Partners. With over 30 years working and serving the healthcare community the combination of nursing and social work has served her well in obtaining her OCN. She has worked in a variety of post-acute care settings with an emphasis on home health and hospice, home infusion, and homecare and skilled nursing as a PICC and compliance expert.

Kathy helped develop pain scales to standardize assessment with the American Pain Society and the Joint Commission, which led to identifying pain as the 5<sup>th</sup> vital sign. She was a trailblazer in the retail pharmacy world introducing the Joint Commission to the retail setting for disease state accreditation and reimbursement. In addition to developing manuals and policies, Kathy expanded into medical device as a Managed Care Director developing one of the first real-time cloud-based disease specific software programs to assist patients, clinicians, and managed care organizations improve outcomes and collect data.

Kathy began healthcare work due to a disabled parent and later a child with chronic disease state. She has experienced healthcare professionally and personally and has dedicated her life to it.

# Hospice 101 Benefit Outline

- Review Medicare (Medicaid) hospice benefit
- What is hospice?
- Why hospice?
- Conditions of Participation (CoPs)
- Eligibility (certification and recertification)
- Documentation
- Data and reporting
- Regulatory
- Questions?

# The Medicare Hospice Benefit

- Established 1983.
- Considered the “Model” for quality care for people with life limiting illnesses.
- Provided Medicare Beneficiaries with access to high quality end of life care.
- Patient Centered, Cost Effective Philosophy of Care.
- Utilizes an Interdisciplinary Team of Professionals.
- Provides compassionate and expert medical care, pain management, emotional and spiritual support tailored to the patients needs and wishes.  
(value)

# Hospice Values

Hospice represents many values within its philosophy. Here are but a few examples of values critical to the Hospice Philosophy:

- Service – Identifying patient needs, responding and identifying service failures.
- Compassion – Capacity to care, to have empathy, active listening.
- Dignity – Culture, spiritual beliefs and practices.
- Excellence – Quality
- Patient and Family Choice – Understands the importance of patient and family choice in the decision making process .
- Teamwork – Creative problem solving.
- Integrity – Confidentiality, accountability

NHPCO has a Hospice Competency Values Grid I have provided for Training Purposes.

# Medicare Hospice Beneficiary Considerations

- Growth and increase Medicare hospice benefit utilization related to more patient's with non-cancer terminal diagnosis (heart disease, COPD, Alzheimer's).
- Medicare costs for hospice patients is less than non-hospice Medicare beneficiaries with similar diagnosis and profiles (approx. \$2,300 less per year)
- Hospice enrollment is associated with fewer 30 day readmissions and in-patient deaths.
- Hospice enrollment is associated with significantly fewer hospital and ICU days.



# Provider Considerations Related to the Hospice Benefit

- Provider Post-Acute Care Networks - Care Transitions.
- Care Continuum – meeting a need along the continuum.
- Right care, right time, right place.
- Patient and family centered.
- Outcomes (quality of care, patient satisfaction).
- Payer penalties (CMS Cardiac APM's 2017).
- High risk patients that are frequent hospital readmissions, ER visits
- End of life

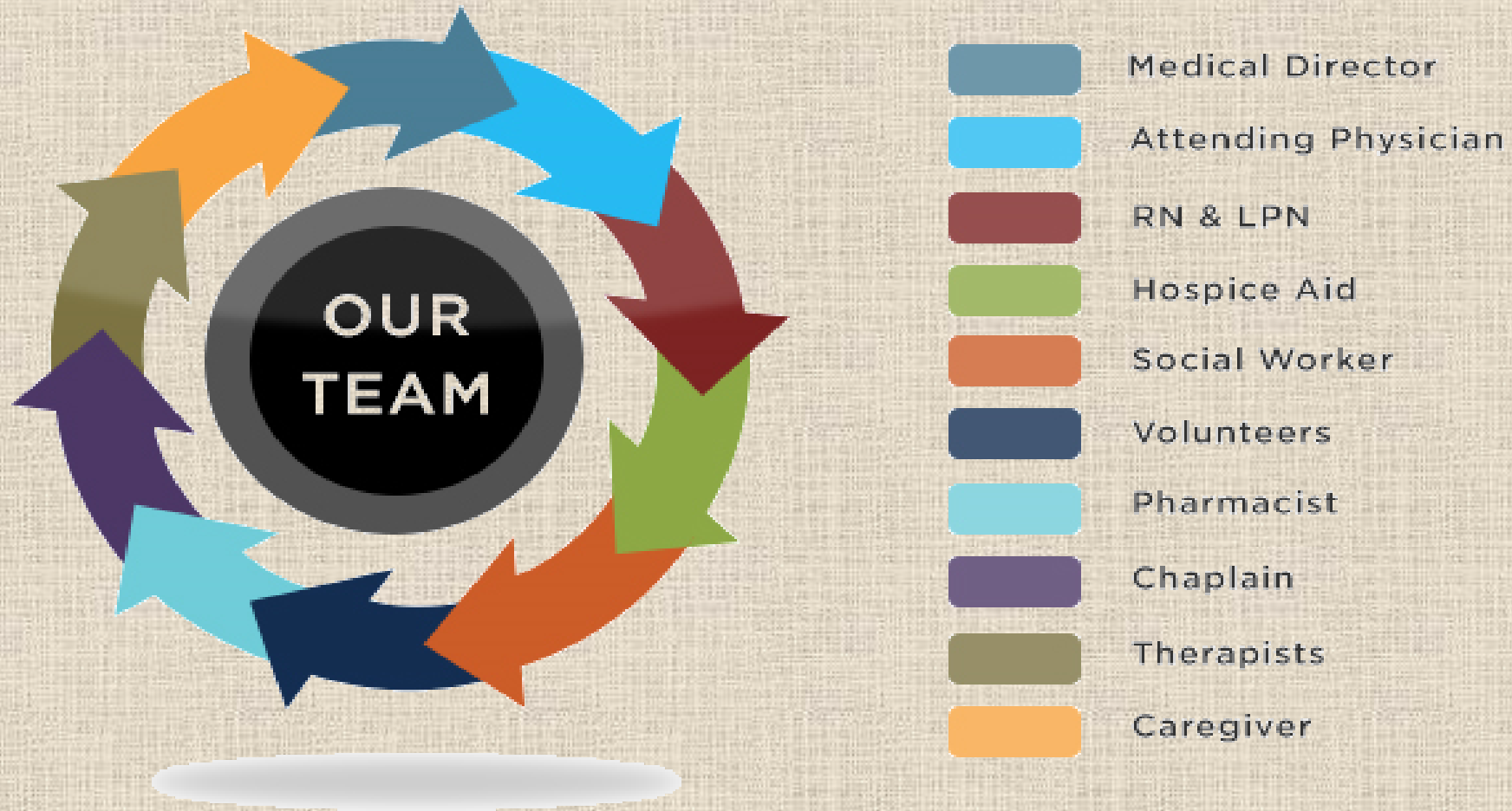
# Core Aspects of Hospice Care

- Patient/family focused
- Interdisciplinary care team of Professionals
  - **Handout Provided “NHPCO Hospice Interdisciplinary Team Competency Grid for Training”**
- Provides a range of services (core):
  - Interdisciplinary case management
  - Pharmaceuticals
  - Durable medical equipment
  - Supplies
  - Volunteers
  - Grief support

# Additional Services Hospice Offers

- Hospices offer additional services, including:
- Hospice residential care (facility)
- Inpatient hospice care
- Palliative care
- Complementary therapies
- Specialized pediatric team
- Caregiver training
- Community bereavement services

# Hospice Interdisciplinary Team/Group (IDT/IDG)



# The Role of the Hospice Team – Why You Are There.

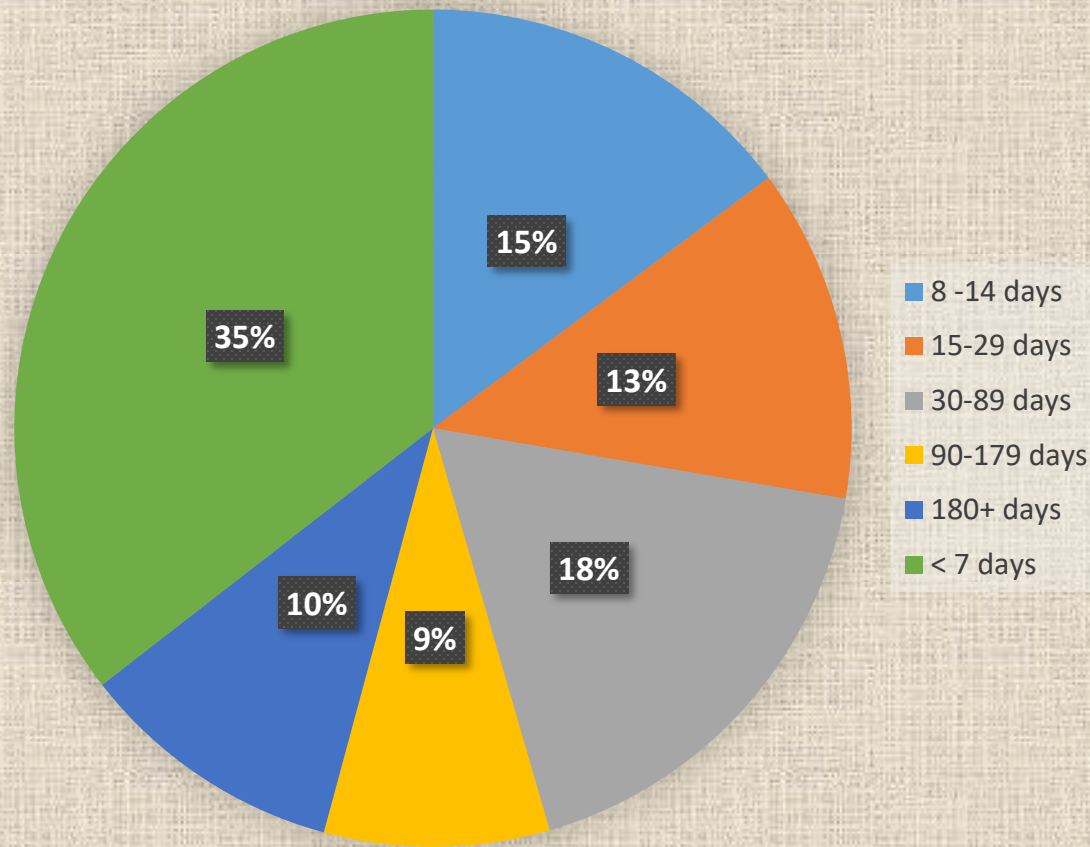
- Develops the plan of care
- Manages pain and symptoms
- Attends to the emotional, psychosocial and spiritual aspects of dying and caregiving
- Teaches the family how to provide care
- Advocates for the patient and family
- Provides bereavement care and counseling
- Part of the “continuum of care”

# Where is Hospice Care Provided?

- Home – the patient's or loved one's home
- Nursing Facility
- Assisted Living Facility
- Hospital
- Hospice residence or unit
- Correctional setting, homeless shelter – wherever the person is located



# Hospice Length of Service 2014



Length of Service relates to how long the patient is on service.

Average Length of Service (LOS) = 72.6 Days

Median LOS = 17.4 Days

# Level of Care (LOC)

- The four Levels of Care are:
  - Routine Home Care (RHC)
  - General Inpatient Care (GIP)
  - Continuous Care
  - Respite Care

It is **CRITICAL** to date and fully document a Change in Level of Care with supportive data related to a change in patient status and care requirements.





# Increased Level of Care Eligibility Requirements

## **GIP or Continuous Care**

Present justification of need for elevated level of care:

- IDG/IDT along with attending and Hospice Medical Director determine symptoms cannot be managed at home.
- Medical crisis required (Pain Control or Acute/Chronic Symptom Management).
- Must have symptom that cannot be controlled at RHC level of care.
- Must have a need for professional nursing management to control symptoms (cannot be purely custodial care).
- Identify what has been tried to resolve medical crisis at RHC that has not worked

# Increased Level of Care Eligibility Requirements

## **GIP or Continuous Care**

- Focus on the interventions needed to manage symptoms
- Use appropriate tools to document symptoms.
- Need for elevated level of care must be related to terminal diagnosis
- Document, document, document continuously – symptoms out of control, response to treatments, all interventions including times/doses.
- Include plan for return to routine home care from the beginning of the elevated level of care
  - GIP and Continuous Care are meant to be short term

# Medicare Conditions of Participation (CoPs)



**KEEP  
CALM  
&  
FOLLOW  
THE RULES**

# CMS Title 42 Chapter IV Part 418 Hospice Care CoPs

- SubPart A – General Provision and Definitions
- SubPart B – Eligibility Election and Duration of Benefits
  - 418.20 – Eligibility Requirements
  - 418.21 – Duration of Hospice Care Coverage – Election periods
  - 418.22 – Certification of Terminal Illness
- SubPart C – CoP: Patient Care
  - 418.54 – Initial and Comprehensive assessment of the patient
  - 418.56 – IDT/IDG, Care Planning and the Coordination of Services
  - Core Services
  - Non- Core Services

[http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418\\_170](http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_170)

# CMS Title 42 Chapter IV Part 418 Hospice Care CoPs

- SubPart D – CoP: Organizational Environment
  - 418.102 – Medical Director
  - 418.104 – Clinical Records
  - 418.113 – Emergency Preparedness
  - 418.114 – Personnel Qualifications
- SubPart F – Covered Services
- SubPart G – Payment for Services
  - 418.309 – Hospice Aggregate Cap
    - Cap – Adj. Cap Amount X Patient days of # of Medicare Beneficiaries on service
  - 418.310 – Reporting and Record Keeping
- SubPart H - Coinsurance

# Reimbursement

- Medicare
- Medicaid
- Insurance and HMOs (Part D)
- Private pay
- Sometimes a combination



## 2 Tiered Payment Model under CMS and Routine HC

- 1<sup>st</sup> 60 days reimbursed \$183.17/day.
- 61 days and greater reimbursed \$143.94/day.

# Eligibility

## **What triggered the hospice referral at this particular time?**

Document...

- Hospitalization – frequent hospital readmissions, ER visits
- Symptom exacerbation – pain, SOB
- Changes in condition – LOC
- Need for additional care – ADL's
- Multiple MD visits for Hospice Eligible Diagnosis with poor prognosis?

# Election of the Hospice Benefit – Determining Eligibility Considerations

- Claims initially denied can be eventually paid during an extensive appeal process and is an inefficient and expensive way to get reimbursed for Hospice Services.
- We have an ethical obligation to admit patients who are terminally ill, whether or not they strictly meet LCD criteria. (LCD = Local Coverage Determinations)
- Determining prognosis through the use of best available tools and determining hospice eligibility are related however not identical activities
- Neither is an exact science
  - Patient and disease variability
  - Inadequate prognostic tools make prognosis as much an art as a science



# Local Coverage Determinations (LCDs)

- Guidelines established by CMS and the MACs to facilitate medical review of hospice admissions and ongoing service
- Originally based on NHO Guidelines meant to increase access to hospice care
- Useful for the hospice to utilize as a “screening tool” in the eligibility decision making process
- Link provided below is for Palmetto/TX/CMS – LCD’s Hospice.
- [https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx?s=51&DocType=Active&Ctrctr=227&name=Palmetto+GBA+\(11004%2c+HHH+MAC\)&ContrVer=1&CtrctrSelected=227\\*1&bc=AggAAAAAAAAAAAA%3d%3d&#ResultsAnchor](https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx?s=51&DocType=Active&Ctrctr=227&name=Palmetto+GBA+(11004%2c+HHH+MAC)&ContrVer=1&CtrctrSelected=227*1&bc=AggAAAAAAAAAAAA%3d%3d&#ResultsAnchor)

# Hospice Eligibility Considerations

- Why is it important to be familiar with the LCDs and appropriate documentation?
- Why focus on the LCDs to determine hospice eligibility?
- Medicare auditors are trained to use the LCD criteria to make payment decisions – MEDPAC has made recommendations for an increase on hospice program oversight that were incorporated in to the ACA, pay attention to your LOS and supportive documentation.
- It provides the best chance of reimbursement at the first level of medical review – it is always good to focus on passing the first level of review!

# ADR Audit Considerations

- MAC audits for billing compliance (ADR Audits)
- Three areas of focus under “requirements”:

## **Technical Requirements:**

1. Valid election of Medicare Hospice Benefit
2. Valid attending and Medical Director certifications which include physician narratives and face-to-face encounters (for all 60-day periods)

## **Eligibility Requirement:**

3. Evidence of 6 month or less prognosis

# ADR Audit Considerations

- Eligibility – Initial and continuing
- Dementia, debility, pulmonary and cardiac diagnoses
- Extended length of stay (especially non-cancer dx, > 180 days)
- Level of care: general inpatient care and continuous care at home
- Increased activity
- Various state and federal government audit contractors:
  - Recovery Audit Contractors (RACs)
  - Zone Program Integrity Contractors (ZPICs)
  - Medicaid Integrity Contractors (MICs)
- Post payment reviews for hospice eligibility

# Technical Requirements for Eligibility: Medicare Benefit Election

- Must be signed by patient or representative (if not the patient, document why)
- Election date documented before services can begin
- Effective date cannot be earlier than the first day of hospice care (may be a later date)

At the time of admission, the patient must be certified as being terminally ill with a prognosis of 6 months or less if the illness runs its normal course

- By the attending physician
- By the hospice medical director

# Attending Physician

The attending physician:

- Is chosen by the patient
- Has the most significant role in the determination and delivery of the individual's medical care
- Choice of attending physician is a patient right according to the Conditions of Participation (hospice may make a recommendation, but cannot coerce the decision)
- Is considered part of the Hospice Team including the Plan of Care especially if Levels of Care changes occur.

# Certification of Terminal Illness – Physician

On Admission (and re-certification):

- Must have a verbal or written certification within 2 calendar days of admission
- May be obtained up to 15 days prior to election
- Written certification must be present before submitting a claim
- If the signed certification is more than 2 days after admission (without a verbal), the billing date starts the day the certification is signed and earlier days are lost

# Certification of Terminal Illness – Physician

- Physician required to date his/her own signature
  - No pre-dating by staff
  - No post-dating by staff
  - Stamped dates no longer acceptable
- Certifications cannot be completed by a nurse practitioner
- Regulation specifically requires the physician's certification determination must be:
  - Based on clinical information and other documentation
  - Documented in the medical record
  - Included as part of the hospice's eligibility assessment



# Certification of Terminal Illness – Physician

- Regulation specifically requires the physician's certification determination must be:
  - Based on clinical information and other supportive documentation
  - Documented in the medical record
  - Included as part of the hospice's eligibility assessment
    - Critical at the initial IDT/IDG meeting that verification occur of all required documents and supportive documentation of the he Physician and agency are in place.
- **Statement of Certification**
  - Statement that the patient has a prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course
  - Dates of the certification period

# Face-to-Face Considerations

- More administrative than a clinical visit to determine continued hospice eligibility
- Required for all 60-day periods (3rd period and beyond)
- May not occur earlier than 30 days prior to the beginning of the period
- May be completed by a hospice physician or NP (not PA)
- Document pertinent diagnostic data
  - (albumin, BNP, EF, BUN/creatinine, oxygen saturation)
- Review status for diagnosis-specific LCD criteria
  - Don't skip any criteria. If not met, explain why patient still considered appropriate.
- Use interview assessment techniques
  - Go beyond "point in time" assessment by asking questions about symptoms and response to interventions since last F2F visit
  - Describe changes over last few weeks or months

# Face-to-Face Attestation

- Signed and dated by person performing F2F encounter
- Clearly titled addendum or separate section of certification
- Must attest in writing that he or she performed the encounter, including the date of the encounter
- The nurse practitioner or physician other than the medical director signing the certification must also attest that the clinical findings were provided to the certifying physician

# Physician Narrative at Admission

- Describe patient's status related to each LCD criteria for hospice diagnosis
- Physician's signature must follow narrative
- Must include an attestation that the physician composed the narrative based on review of the medical record and/or examination of the patient
- If using justification for a 6 month or less prognosis other than the LCDs:
  - Explain justification in narrative
  - Be specific
  - Provide citations of information for the chart

# Requirements

- A F2F encounter is required prior to certification
- Physician narrative also required
- Requirements may be waived for exceptional circumstances
  - Meant to address "11<sup>th</sup> hour" admissions, weekend admissions or other exceptional circumstances
    - CMS data on previous admission was not available so hospice was unaware of patient's previous hospice service
    - Emergency weekend admission - impossible for physician/NP to see patient until the following Monday
- If a patient dies within 2 days of admission without a F2F encounter, the encounter deemed complete

# Why is Documentation so Critical?

- Supports eligibility for Medicare Hospice (all payer sources)
- Determines proper reimbursement (levels of care, service industry add-ons)
- Impacts treatment and related decisions
- Confirms that hospice is needed
- Communicates important information to members of the care team
- Confirms compliance with Medicare regulations

# LCD Documentation Guidelines – Determining Terminal Status

- Documentation certifying terminal status must contain enough information to support terminal status upon review.
- Re-certifications require same Clinical Standards are met as certification.
- Documentation must paint a picture of why the patient is appropriate for Hospice and the level of care provided.
- Records should include both observations and data!!!
- Always include supporting events such as any changes in level of ADL's, recent hospitalizations or ER visits.

# LCD Documentation Guidelines – Determining Terminal Status

- Documentation must always have the initial assessment, all IDT/IDG discussions and any evaluations.
- Any records showing patient progression of disease should be included.
- Documentation should easily identify both the date and time a change in the patient's Level of Care occurred and all supportive documentation for the new Level of Care.
- Karnofsky Performance Status (KPS), Palliative Performance Score (PPS) and Functional Assessment Staging (FAST) tools available.



# Clinical Status Documentation Guidelines (LCD)

## Decline in Clinical Status Guidelines:

- A. Recurrent or intractable serious infection (pneumonia, sepsis)
- B. Progressive inanition (quality/state of being empty) as documented by:
  - 10% body weight loss in the prior 6 months not due to reversible causes.
  - Decreasing anthropomorphic measurements (arm, abdomen)
  - Loose skin turgor, ill fitting clothing.
  - Decrease serum album, CHO
  - Dysphagia leading to recurrent aspiration

**Symptoms Include:** Ascites, decline in systolic BP or progressive postural hypotension, edema, pleural/pericardial effusion, change in LOC, weakness

# Clinical Status Documentation Guidelines

- Progression to ADL Assistance
- Decline in KPS or PPS assessment scores due to disease progression
- Increased ER Visits, hospitalizations or MD visits related to Primary Diagnosis (diagnosis was the main reason for the referral to Hospice).
- Laboratory Changes
  - Increase PCO<sub>2</sub>, decreased O<sub>2</sub> and SaO<sub>2</sub>
  - Calcium, creatinine or liver function



# Significant Secondary & Comorbid Diagnosis

- Secondary diagnoses are those medical conditions that arise secondary to the primary hospice diagnosis.
  - Example: a patient with dementia and dysphagia d/t this develops aspiration pneumonia. The aspiration pneumonia would be a secondary diagnosis.
  - Example: a patient with end-stage cardiac disease and atrial fibrillation develops an embolic CVA. The CVA would be a secondary diagnosis.
- Significant comorbid diagnoses are those illnesses unrelated to the primary hospice diagnosis, but that are of significant severity to negatively impact life-expectancy of the patient, especially in combination with the primary diagnosis.
  - Example: the patient with end-stage dementia also has congestive heart failure and is NYHA Class III. The CHF would be a comorbid diagnosis.
  - Example: the patient with end-stage COPD has dementia, FAST Stage 6D. The dementia would be a comorbid diagnosis.

# Comorbid Conditions Documentation Guidelines

Documenting Comorbid conditions:

- LCD Worksheet?
- It's not the number of diagnosis you can list
  - Edema, Renal insufficiency, Rheumatoid Arthritis, DM, Liver Disease, Neurologic Disease, HIV
- How significant are they with impacting the patient's prognosis?
  - NYHA Class III CHF
  - Severe dysphagia
  - Ejection Fraction < 20%

# Medical Director Documentation Guidelines

- Visit notes must:
  - Continuously and consistently support the terminal prognosis
  - Include information using the LCD language, as appropriate
  - Contain objective data such as vital signs, weights, body mass measurements, meal percentages, lab values, pulse oximeter readings, and others, as appropriate
- Use “AEB” (as evidenced by)
  - Disease has progressed AEB...
  - Patient is hospice eligible as evidenced by...

# Determining Eligibility – Consider Everything

1. Does the patient meets all LCD criteria?
2. Does the patient meets most of the LCD criteria AND has documented rapid clinical decline suggesting a limited prognosis?
3. Does the patient meets most of the LCD criteria AND has significant comorbid conditions that impact the prognosis?

## **If the Patients who do not meet all LCDs does documentation:**

- Specifically show evidence of eligibility including the physician narrative?
- Describe how all conditions/comorbidities contributing to a poor prognosis
- Is it specific with dates, times, activity and supportive data?

# Request Supportive Reports & Data

- Discharge Summary
- History & Physical
- Transfer Summary
- Pertinent Diagnostic Tests
- Physician Clinic Notes (including those while patient in hospice)
- Reports from Specialists (ditto)
- Review clinical information to ensure
  - Not more than a year old, Addresses the hospice diagnosis or end-stage status
  - Addresses significant comorbidities
  - It is pertinent to supporting eligibility

# Nursing Home Supportive Reports & Data

- Nursing Home Documentation
  - Weight Records
  - Dietitian's Assessments from past 3 quarters
  - Quarterly Minimum Data Set (MDS) from past 3 quarters
  - Pertinent nursing progress notes supporting the precipitating event
  - DME utilization
  - O2 utilization
  - O2 Sat reports, PCO2, Blood Gas Reports
  - Laboratory, Liver and Kidney function tests
  - Cognitive Assessments



# Alzheimer's Diagnosis

- The LCD is specific for **Alzheimer's disease** and related disorders and is NOT appropriate for other types of dementia
- Patients with Alzheimer's dementia should show all the following characteristics:
  - FAST stage 7 or beyond (**must be at this stage to qualify**)
  - Unable to ambulate without personal assistance
  - Unable to dress without assistance (**ADL documentation critical**)
  - Urinary and fecal incontinence, intermittent or constant
  - No consistently meaningful verbal communication: stereotypical phrases only or speech is limited to six or fewer intelligible words (**be specific when documenting cognitive deficits**)
  - Presence of Comorbidities or secondary diagnosis is significant!

# Cardiac Conditions

- Intermediaries differ in LCDs for Cardiac and Pulmonary Conditions, so it is critical to follow the LCD's of your intermediary!
- Associated with specific structural/functional impairments and relevant activity limitations
- Health status changes associated with cardiopulmonary conditions characterized using categories contained in ICF domains related to cardiovascular and respiratory system, communication, mobility, and self-care. These should be documented in the patient's record.
- Document relevant secondary and/or comorbid conditions affecting prognosis and care needs

# Cardiac Conditions

Patients with CHF or angina should meet the criteria for **NYHA Class IV**

- Inability to carry out any physical activity without discomfort
- Discomfort can be chest/jaw/shoulder pain or respiratory distress
- Symptoms may occur even at rest
- Any physical activity increases the discomfort
- Patients usually require complete rest to avoid pain or dyspnea
- Also a documented ejection fraction of 20% or less will support a 6 month or less prognosis.

# Pulmonary Disease

Patients will be considered in terminal stages of pulmonary disease if they have the following:

- Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity
  - AEB Bed to chair existence, fatigue, and/or cough
  - FEV1 <30% of predicted after bronchodilator is supportive evidence

Progression of end stage pulmonary disease as evidenced by:

- Increasing visits to the ER for pulmonary infections
- Increasing hospitalizations for pulmonary infections or respiratory failure
- Increasing physician clinic visits
- Increasing physician home visits

# Pulmonary Disease

Hypoxemia at rest on room air as evidenced by one or more of the following:

- pO<sub>2</sub> less than or equal to 55 mmHG
- pCO<sub>2</sub> greater than or equal to 50 mmHG
- Oxygen saturation less than or equal to 88%
- Supportive evidence includes:
  - Right heart failure (RHF) secondary to pulmonary disease (Cor Pulmonale)
  - Unintentional progressive weight loss >10% of body weight over the past 6 months
  - Resting tachycardia >100 bpm
- If they almost meet criteria and have significant comorbid conditions, they may still be eligible

# Data Reporting & Questions

Data  
Reporting



# Reporting Requirements & Reimbursement

- Hospice Item Set (HIS) Standardized Reporting for all Patients admitted to Hospice.
  - Hospices must submit data on line on a rolling basis 30 days within each patients admit and discharge.
  - HIS includes a set of data elements CMS will utilize to calculate scores for the 7 NQF endorsed Quality Measures.
  - Hospices up and running in 2014 that failed to report received a 2% reduction in CMS reimbursement in 2016.
- NOE/NOTR Filing (Notice of Election/Notice of Termination/Revocation)
  - Max 5 days to submit and be accepted by your Medicare Contractor
  - Failure to submit holds you responsible to provide all care without reimbursement

# Hospice Item Set (HIS) Quality Measures

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html>
- NQF #1617 Patients Treated with An Opioid who are Given a Bowel Regimen
- NQF #1634 Pain Screening
- NQF # 1637 Pain Assessment
- NQF #1639 Dyspnea Screening
- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by the patient)
- Hospice Visits When Death is Imminent
- Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission



# Toolkit Resources

## TAKE-AWAY TOOLKIT – HANDOUT'S

- The Medicare Hospice Benefit
- CASPER Fact Sheet
- HIS Implementation/Best Practices
- Hospice Values Competency Grid (Novice, Proficient, Expert)
  - **Will review briefly during presentation**
- Questions about Hospice Care – a Caregivers guide to selecting a Hospice.
- NHPCO Hospice Interdisciplinary Team Competency Grid for training
  - **Will review briefly during presentation**
- Website links to: How Hospice Works – CMS, Hospice Code of Federal Regulations (electronic), Hospice and Respite Care.
  - **Links embedded within specific slides and also on Resource pages 58 and 59.**

# Resources

NHPCO's Facts and Figures: Pediatric Palliative and Hospice Care in America, 2015 Edition:

[http://www.nhpco.org/sites/default/files/public/Statistics Research/2015 Facts Figures.pdf](http://www.nhpco.org/sites/default/files/public/Statistics%20Research/2015%20Facts%20Figures.pdf)

Nation Hospice and Palliative Care Organization:

<http://www.nhpco.org>

CMS.gov Local Coverage Determinations (LCD's) by State Index Browser:

[https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx?s=51&DocType=Active&Ctrctr=227&name=Palmetto+GBA+\(11004%2c+HHH+MAC\)&ContrVer=1&CtrctrSelected=227\\*1&bc=AggAAAAAAAAAAAA%3d%3d&#ResultsAnchor](https://www.cms.gov/medicare-coverage-database/indexes/lcd-state-index.aspx?s=51&DocType=Active&Ctrctr=227&name=Palmetto+GBA+(11004%2c+HHH+MAC)&ContrVer=1&CtrctrSelected=227*1&bc=AggAAAAAAAAAAAA%3d%3d&#ResultsAnchor)

# Resources & Links

Medicare.gov Hospice and Respite Care:

<https://www.medicare.gov/coverage/hospice-and-respite-care.html>

CMS: Getting Started with Hospice CASPER Quality Measure Reports:  
December 2016:

[https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Fact-Sheet\\_CASPER-QM-Reports.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Fact-Sheet_CASPER-QM-Reports.pdf)

Electronic Code of Federal Regulations, December 31, 2016:

[http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418\\_170](http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5#se42.3.418_170)

Questions?

Thank You for Attending!

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