

SUGGESTIONS FOR IMPROVED DOCUMENTATION to Support Medicare Hospice Services

The following list is a guide for hospice providers and their staff to improve documentation of Medicare covered hospice services by including complete and accurate documentation. This list is intended only as a guide, and is not inclusive, nor does it ensure payment. Remember, the documentation must present a visual picture of the patient, their condition and symptoms to support the terminal prognosis.

Documentation to Support Hospice Admission

- Change in or deterioration of condition to initiate hospice referral
- Diagnostic documentation to support anticipated life expectancy of six months or less
- Physician assessment and documentation
- Patient or their representative must elect hospice care (signed election statement)

Documentation to Support Hospice Services

- Change in patient's weight (pounds, kilograms)
- Worsening lab results
- Change in pain
 - Type (ache, throb, sharp)
 - Intensity (Level 0-10)
 - Location (upper, lower)
 - Frequency (constantly, hourly, daily)
 - Medication usage (dosage, frequency, effectiveness)
- Change in responsiveness (alert, less responsive, unresponsive)
- Skin integrity (fragile, intact, tears easily, broken wounds)
- Dependence on assistance with Activities of Daily Living (ADLs)
 - Dress (assisted, unassisted)
 - Bathe (assisted, unassisted)
 - Ambulate safety and ability (assisted, unassisted)
 - Ambulation distance (feet, steps)
- Change in anthropomorphic measures
 - Mid arm circumference (MAC) or thigh circumference measurement (inches, centimeters)
 - Abdominal girth (inches, centimeters)
- Change in signs and symptoms
 - Respiratory rate (increased, decreased)
 - Dyspnea
 - Oxygen flow rate (liters per minute)
 - Hyper/hypotension
 - Radial/apical pulse (tachycardic, bradycardiac, regular, irregular)
 - Edema (level 1-4, pitting, non-pitting)
 - Turgor (slow, normal)

- Incontinence (frequency)
- Change in strength/weakness
- Change in lucidity (oriented, confused)
- Change in intake/output
 - Amount (cups, liters, ounces, teaspoons, mgs, ml, cc)
 - Frequency

Documentation to Support Higher Level of Care

- Requirements to support GIP or CHC levels of care
 - Uncontrolled signs/symptoms
 - Ineffective intervention(s) at routine level of care prior to GIP or CHC
- Caregiver need for relief to qualify for respite care
- Continued higher level of care is reasonable and medically necessary
- Time of initiation of and discharge from high level of care
- Services consistent with plan of care

Prior to Claim Submission Ensure the Following

- Election statement was signed and dated prior to start of care according to Medicare regulations
- Certification/recertification was signed and dated according to Medicare regulations
- IDG Plan of Care (POC) with updates completed by IDG every 15 days

Additional Quantifiable Values may include:

- Size (inches, centimeters)
- Timeframe (hours, days, weeks, months)
- Saturation (percent)
- Frequency (hourly, daily, weekly)
- Speech pattern (repetition, word count, word salad)

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