HOSPICE DENIAL FACT SHEET

Denial Reason 5PM02: Reduced Level of Care (Medical Necessity)

Denial Reason 5PX03: Reduced Level of Care (Technical)

What are the "levels of care" under the Medicare hospice benefit?

The level of care under the Medicare hospice benefit is determined based on the **intensity of care** provided to the beneficiary; NOT the location where services are provided.

There are four levels of hospice care:

- **Routine Home Care** is the default level of care, when no other level of care is appropriate. It is typically provided to the beneficiary in their home, according to their needs.
- **Continuous Home Care (CHC)** is provided only during periods of crisis to maintain the beneficiary in their home. A minimum of eight hours of nursing, aide and homemaker services must be provided in a 24-hour period (midnight to midnight), and at least 50% of the total care provided must be provided by a nurse. Care does not need to be continuous (ex. Nursing care from 6:00 a.m. -10:00 a.m., and 7:00 p.m. – 11:00 p.m. would meet the eight hour requirement).
  - Care plan, documentation and supervision of aides cannot be counted in the skilled nursing hours
  - Overlapping hours, when medically necessary, are counted separately
  - All hours must be counted (aide and homemaker hours cannot be discounted to achieve 50%)
- **Inpatient Respite** is short term inpatient care to relieve the beneficiary's family or caregiver. Respite care is provided on an occasional basis.
  - Up to five consecutive respite days may be reimbursed
  - Multiple respite stays are allowed during a hospice benefit period
  - The day of discharge from respite care is billed as routine home care
- **General Inpatient (GIP)** is short term inpatient care due to the patient's need for pain control or symptom management, which cannot be provided in any other setting. GIP CANNOT be used to provide caregiver relief.
  - Must follow the plan of care
  - May be required for pain control that requires:
    - The skills of a nurse (including teaching)
    - Frequent evaluation
    - Frequent medication adjustment
    - Aggressive treatment to control pain
    - Transfusions
  - May be required for symptom changes, such as:
    - Sudden deterioration
    - Uncontrolled nausea and/or vomiting
    - Pathological fractures
    - Unmanageable respiratory distress
    - Frequent, skilled wound care
    - New or increased delirium and/or agitation
  - Other reasons:
    - Medication adjustment
    - Observation
    - Stabilizing treatment
    - Psycho-social monitoring
    - Family unwilling to provide the needed care in the home (intensity of care must still be met)

Most hospice care is considered "routine home care." Routine home care is billed when the other levels of care are not appropriate. When a beneficiary's condition requires a higher level of care, it should be clearly documented what precipitated the change, and any attempts to maintain the beneficiary under routine home care.

What documentation is required to support the level of care provided?

Continuous Home Care (CHC) documentation requirements:

- Description of the crisis
- Description of the interventions to alleviate the current crisis
- Documentation to support the required number of hours and disciplines to support CHC level of care
- Hourly documentation (recommended) of the following (when applicable):
  - Symptoms
  - Symptom management methods/ treatments, consistent with the POC
  - Medication management
  - Collapse of family support
  - Unwilling or unable caregiver for current crisis
  - Rapid deterioration
  - Imminent death

Example: "Patient in severe pain, caregiver unable to manage. Continuous home care began 1/1/YYYY at 8 a.m., Sue Nurse, RN" later entry- "Patient pain is well controlled at this time, teaching for the caregiver completed and she is able to manage the pain at this time, routine care to begin 1/3/YYYY at 10 a.m., Sue Nurse, RN"

Inpatient Respite Care documentation requirements:

- Reason that precipitated the respite services
- Date and time of change to respite care

Example: "Patient transferred to inpatient facility for respite services. Caregiver requested respite care due to patients needs keeping her up all night and she would like to sleep. Respite care initiated 10/10/YYYY at 6 a.m., Sue Nurse, RN" later entry- "Caregiver states respite care has allowed for her to sleep and she is able to now care for the patient at home. Transfer beneficiary to routine home care at home 10/14/YYYY at 8 a.m., Sue Nurse, RN"

General Inpatient (GIP) documentation requirements:

- A precipitating crisis
- The interventions tried at home that were unsuccessful in managing the crisis
- Supportive data that the crisis is ongoing
- Interventions to resolve the crisis
- The patient's response
- Quantitative data
  - Weight, vital signs, meal % eaten, calories counts, intake/output, pain ratings and quotes from the patient and/or family

Example: "Patient continues to rate pain at a 10 and vomiting 200 ml per hour of clear fluids. Pain medications and anti-nausea medication has been given and patient has been NPO for 6 hours with no relief. Patient will be transferred to GIP on 10/12/YYYY at 10 a.m., Sue Nurse, RN" note while patient is in GIP- "Patient continues to rate pain at an 8, with a desired pain level of a 4 or below. IV Morphine and Phenergan initiated 2 hours ago (see medication flow sheet). Patient has vomited 50 ml clear liquids since Phenergan was given and no oral intake. Nurse will continuously monitor pain and vomiting and continue to manage medications to alleviate these symptoms."

Where do I find more information?

- **CGS's Hospice Levels of Care Web page:** http://www.cgsmedicare.com/hhh/coverage/Coverage_Guidelines/Levels_of_Care.html
- **Medicare Benefit Policy Manual (CMS Pub. 100-02) Ch. 9 § 40.1.5, 40.2.1 and 40.2.2:** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- **Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 11 §30.1:** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf