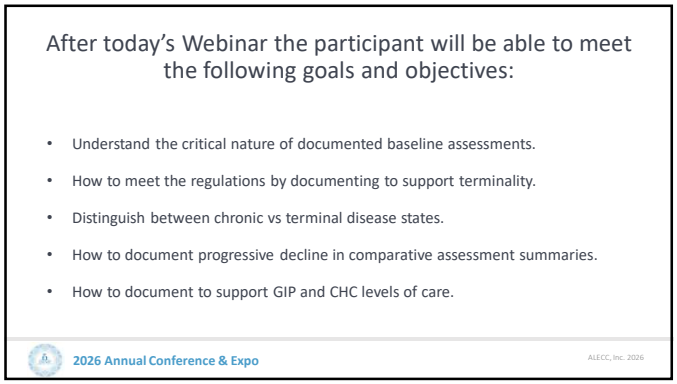
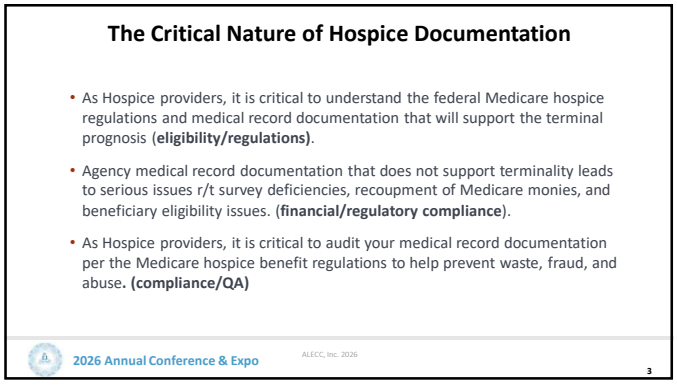

2026 ANNUAL
CONFERENCE & EXPO
Celebrating 60 Years
Then. Now. Next.
How To Document to Support Terminality
Kathy Ahearn, RN, BSN, PHN
www.ALECC.com
kathy@alecc.com
Tuesday, June 23, 2026, 1:45 pm - 3:15 pm
2026 Annual Conference & Expo

1


After today's Webinar the participant will be able to meet the following goals and objectives:
Understand the critical nature of documented baseline assessments.
How to meet the regulations by documenting to support terminality.
Distinguish between chronic vs terminal disease states.
How to document progressive decline in comparative assessment summaries.
How to document to support GIP and CHC levels of care.
2026 Annual Conference & Expo
ALECC, Inc. 2026

2


The Critical Nature of Hospice Documentation
As Hospice providers, it is critical to understand the federal Medicare hospice regulations and medical record documentation that will support the terminal prognosis (eligibility/regulations).
Agency medical record documentation that does not support terminality leads to serious issues r/t survey deficiencies, recoupment of Medicare monies, and beneficiary eligibility issues. (financial/regulatory compliance).
As Hospice providers, it is critical to audit your medical record documentation per the Medicare hospice benefit regulations to help prevent waste, fraud, and abuse. (compliance/QA)
2026 Annual Conference & Expo
ALECC, Inc. 2026
3

3

Top Hospice Denial Reasons for Payment Recoupment

- Election of Benefits does not meet statutory/regulatory requirements, it is invalid.
- The Physician Narrative Statement was not present or valid.
- Information provided does not support a terminal prognosis of six months or less (medically ineligible).
- The Face-to-Face encounter requirements are not met.
- The Hospice Plan of Care does not meet regulatory requirements.

4

Top Hospice Denial Reasons – General Inpatient (GIP)

- Election of Benefits does not meet statutory/regulatory requirements, it is invalid.
- Information provided does not support a terminal prognosis of six months or less (medically ineligible).
- The Physician Narrative Statement was not present or valid.
  The Face-to-Face encounter requirements are not met.
- ***General Inpatient level of care was not reasonable and necessary; therefore, the payment will be adjusted to routine homecare. Face-to-Face encounter requirements not met.***
- The Hospice Plan of Care does not meet regulatory requirements.

5

Hospice Medical Review Denials

Hospice Medical Review Denials

Top MR Denials

This table shows the top Medical Review (MR) denial data for a calendar quarter. See the MR Denial Reason Codes table for resources to help you avoid future claim denials.

Rank	Reason Code	Description	# of Claims Denied	% of Claims Denied
1	5PM01	According to Medicare hospice requirements, the information provided doesn't support a terminal prognosis of six months or less.	1061	53%
2	5PX06	The notice of election is invalid because it doesn't meet statutory or regulatory requirements.	649	33%
3	5PC08	Face-to-face encounter requirements aren't met.	66	3%
4	56900	Medical records weren't received timely.	50	3%
5	5PC01	A physician narrative is missing or invalid.	41	2%

https://www.cgsmedicare.com/hhh/medreview/hos_drc.html

6

Reason Code 5PM01 – 53% Denial

5PM01	According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less.

Resources:

- CMS Medicare Benefit Policy Manual (Pub. 100-02), Chapter 9, section 10 PDF
- SE1628: Documentation Requirements for the Hospice Physician Certification/Recertification PDF
- Hospice Denial Fact Sheet: Reason Code 5PM01 PDF
- LCDs & Medical Policies (see L34538: Hospice Determining Terminal Status)
- Suggestions for Improved Documentation to Support Medicare Hospice Services PDF
- Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patients PDF

https://www.cgsmedicare.com/hhh/medreview/hos_drc.html

7

5PM01 Denial "Cheat Sheet"

What should be documented to clearly support the six-month terminal prognosis?

Documentation is essential in "painting the picture", especially for patients that:

- Have remained on the hospice benefit for a long period of time; or
- Have chronic illnesses with a more general decline.

Documentation to support the terminal prognosis at the time of the hospice admission may include:

- Changes in condition to initiate the hospice referral
- Diagnostic documentation to support terminal illness
- Physician assessments and documentation
- A date of diagnosis
- A course of the illness
- The patient's desire for palliative, curative care
- Records that show a trajectory of decline

Documentation to support the terminal prognosis throughout the hospice election:

- Changes in the patient's weight
- Diagnostic lab results
- Changes in pain (type, location, frequency)
- Changes in responsiveness
- Skin condition (turgor)
- Changes in the level of dependence for ADLs
- Changes in anthropomorphic measurements (abdominal girth, upper arm measurements)
- Changes in vital signs (RR, BP, pulse)
- Changes in strength
- Changes in lucidity
- Changes in intake/output
- Increasing ER visits or hospitalizations

Things to remember:

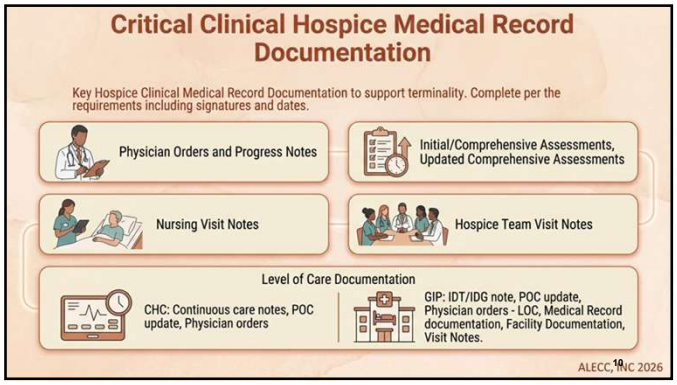
- Documentation to support terminal prognosis should be objective and include quantifiable values/measures (ex. Pounds, 4 on a scale of 1-5, inches, etc.)
- Documentation must "paint a picture" of the patient, their conditions and symptoms which support a life expectancy of 6 months or less.
- Avoid the use of vague statements such as: "disease progressing" or "slow decline"

8

Key Focus Areas Re: Hospice Documentation

- Hospice Election Statement – are you using a correct Election Statement?
- Patient Notification of Hospice Non-Covered Items, Services, and Drugs (Patient Addendum)
- Initial Physician Certification for the Medicare Hospice Benefit (CTI)
- Subsequent Physician Certification for the Medicare Hospice Benefit
- Physician Narrative – does the narrative support the terminal dx??
- Face-to-Face Encounter
- Plan of Care (POC)
- Comprehensive Assessment/Updated Comprehensive Assessment
- IDG/IDT Notes

9



10

Common Hospice Documentation Issues

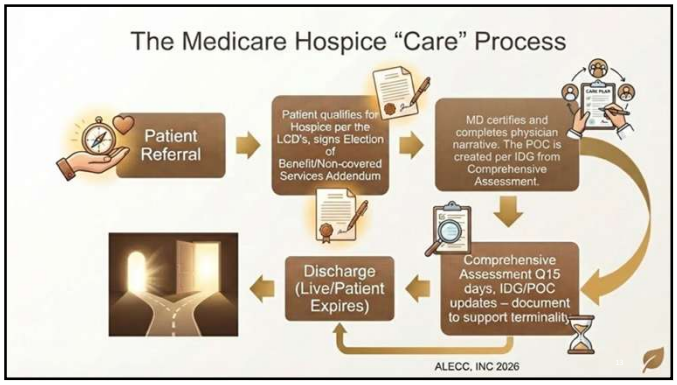
1. IDG/IDT Notes:
   - Do not address terminal illness/status or plan.
   - Contradicts F2F or visit notes (incongruent documentation).
   - Documentation does not reflect LCD guidelines/supporting terminality.
   - Cut/copy/paste of a visit note vs an update to the POC, what is working, any changes to the POC, patient condition changes, new meds, etc.
2. Physician Narrative
   - Narrative does not reflect clinical s/s (LCD guidelines) to support primary terminal diagnosis.
   - Should reflect a summary of notes, assessments, guidelines, physician judgment. Narratives should have comparatives of progressive decline between recertifications.

11

Common Hospice Documentation Issues

3. Notes: Includes Physician Narrative, Visit Notes, F2F, Comprehensive Assessments, re-assessments.
   - Documentation does not reflect LCD guidelines – documenting progressive decline per the guidelines.
   - Visit notes incongruent between disciplines including F2F.
   - ***Devoid of comparative summary documenting decline from baseline assessment moving forward.***
   - ***Lack of baseline data to provide comparisons for progressive decline in summaries in Physician Narratives, F2F, Comprehensive Assessments.***
4. Plan of Care
   - Not individualized, reviewed or updated routinely.
   - Visits do not match orders, care coordination off, scope/frequency (survey and TPE).

12



13

Why Hospice – Why Now???

What triggered the hospice referral now?

Key documentation required to support the hospice admission and recertifications!!

- Hospitalization – frequent hospital readmissions, ER visits is there an H&P?
- Symptom exacerbation – pain, SOB
- Changes in condition – LOC
- Need for additional care – ADLs
- Multiple MD visits for hospice-eligible diagnosis with poor prognosis?

14

Required Documentation

	Initial Certification		Recertification(s)
	Benefit Period 1	**Benefit Period 2**	**Benefit Periods 3+**
Number of Days	First 90 Days	Second 90 Days	Unlimited, subsequent 60-Day Periods
Signatures	1. Hospice Medical Director or Physician Member of the hospice IDG 2. Attending Physician, if the patient has one	Hospice Medical Director or Physician Member of hospice IDG	Hospice Medical Director or Physician Member of hospice IDG
Face-to-Face Encounter with Hospice Physician or Nurse Practitioner	Not required for benefit period 1	Not required for benefit period 2	Required before benefit period 3 and before each subsequent benefit period
When should hospices receive an oral or written CTI?	Up to 15 days before each benefit period or by the end of the third day of **each benefit period.** A written certification must be on file in the hospice record **prior to** the submission of a claim to the Medicare contractor.		

If the signed certification is more than two days after admission (without a verbal), the billing date starts the day the certification is signed, and earlier days are lost.

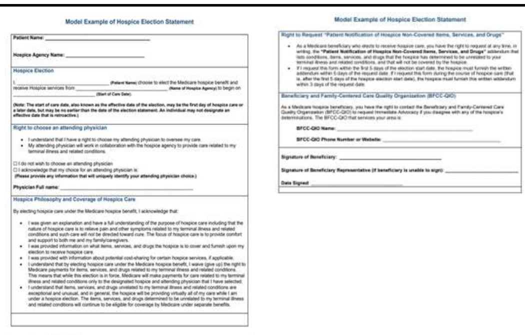
15

§418.24 Election of Hospice Care
Election Statement Requirements

- All election statements must include the following information:
  - Identification of the particular hospice which will provide care
  - Acknowledgement the individual/representative has a full understanding of hospice, particularly the palliative vs. curative nature of treatment
  - Acknowledgement that certain Medicare services are waived by the election
  - Effective date of the election
  - Individual's designated attending physician (if any)
  - Individual's acknowledgement the designated attending physician is their choice
  - Information on cost sharing/notification of the right to receive an election statement addendum/information on the BFCC-QIO, including the right to immediate advocacy and a phone number
  - Signature of the individual/representative

2026 Annual Conference & Expo ALECC, Inc. 2026 16

16



Model Example of Hospice Election Statement

Patient Name: ____________________

Hospice Agency Name: ____________________

Hospice Election

I, ____________________ **(Patient Name)** choose to elect the Medicare hospice benefit and receive Hospice services from ____________________ **(Name of Hospice Agency)** to begin on ____________________ **(Start of Care Date)**.

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: ____________________

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

Last updated: March 2024

Model Example of Hospice Election Statement

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- If I request this form within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If I request this form during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: ____________________

BFCC-QIO Phone Number or Website: ____________________

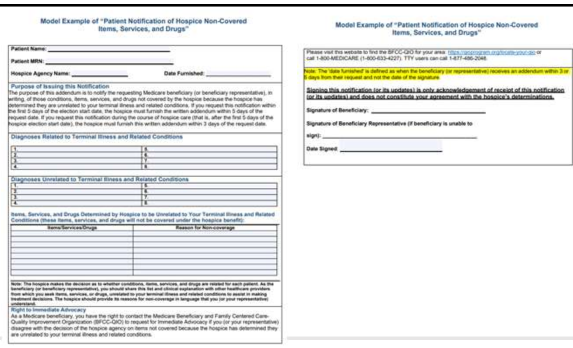
Signature of Beneficiary: ____________________

Signature of Beneficiary Representative (if beneficiary is unable to sign): ____________________

Date Signed: ____________________

2026 Annual Conference & Expo ALECC, Inc. 2026

17



Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Patient Name: ____________________

Patient MRN: ____________________

Hospice Agency Name: ____________________ **Date Furnished:** ____________________

Purpose of Issuing this Notification

The purpose of this addendum is to notify the requesting Medicare beneficiary (or beneficiary representative), in writing, of those conditions, items, services, and drugs not covered by the hospice because the hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If you request this notification during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

Diagnoses Related to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Diagnoses Unrelated to Terminal Illness and Related Conditions

1.	5.
2.	6.
3.	7.
4.	8.

Items, Services, and Drugs Determined by Hospice to be Unrelated to Your Terminal Illness and Related Conditions (these items, services, and drugs will not be covered under the hospice benefit):

Items/Services/Drugs	Reason for Non-coverage

Note: The hospice makes the decision as to whether conditions, items, services, and drugs are related for each patient. As the beneficiary (or beneficiary representative), you should share this list and clinical explanation with other healthcare providers from which you seek items, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions. The hospice should provide its reasons for non-coverage in language that you (or your representative) understand.

Right to Immediate Advocacy

As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions.

Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Please visit this website to find the BFCC-QIO for your area: https://qioprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The 'date furnished' is defined as when the beneficiary (or representative) receives an addendum within 3 or 5 days from their request and not the date of the signature.

Signing this notification (or its updates) is only acknowledgement of receipt of this notification (or its updates) and does not constitute your agreement with the hospice's determinations.

Signature of Beneficiary: ____________________

Signature of Beneficiary Representative (if beneficiary is unable to sign): ____________________

Date Signed: ____________________

2026 Annual Conference & Expo ALECC, Inc. 2026

18

Certification of Terminal Illness (CTI)

Critical to obtain a CTI within two calendar days. (no later than 3rd). Always recommend that the RN get a verbal after the initial assessment to cover the admission.

If a Provider cannot obtain a written CTI within the required timeframe, obtain a verbal certification!

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 two days after admission (without a verbal), the billing date starts the day the certification is signed, and earlier days are lost.

19

Certification/Recertification of Terminal Illness

For a patient to be eligible for the Medicare hospice benefit, the patient must be certified as being terminally ill. The certification/recertification is a critical piece of documentation necessary to ensure Medicare payment for the hospice services you provide. The written certification/re-cert must include:

- The statement that the patient's medical **prognosis** is that their life expectancy is six months or less if the terminal illness runs its normal course.
- A brief narrative, written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of six months or less.

20

Physician Narrative

Purpose and must include:

- Explains the rationale used by the physician to determine that the patient has a terminal prognosis. Content is matter of eligibility (**technical requirement**).
- Focuses on prognosis, including prognostic indicators and explanation of the ***patient-specific clinical findings*** that support a terminal prognosis.
- Addresses the terminal condition and related conditions.
- Must include an attestation that the physician composed the narrative based on the review of the medical record and/or examination of the patient.
- The physician's signature must follow the narrative.

21

Physician Narrative

- If the condition is not related or in support of eligibility, do not put it into the narrative.
- Information in the narrative should be available and able to access in the patient record. It is important that all information is consistent.
- When the patient diagnosis and supporting factors do not meet the LCD, say it and why you consider the patient hospice eligible.
  - Ex: In my experience…other patients with such diagnosis…
- The physician's signature must follow the narrative.
- Must include an attestation that the physician composed the narrative based on the review of the medical record and/or examination of the patient.

22

Where to Document Physician Narrative

Document this under:

- Physician Narrative/Sign and date – imperative to do!
- Always, when re-certifying, do a comparative from the previous benefit period. Use the LCD guidelines.
- Critical to remember that this is a technical requirement.
- If the attending provides a CTI for the initial certification, it is recommended the Hospice Medical Director provide the physician narrative with their certification.
- Physician narrative must include an explanation of how the clinical findings from the F2F encounter support the primary terminal diagnosis and life expectancy of six months or less.

23

What to Document (Both Narrative and F2F)

- Patient's end-stage disease trajectory (six months or less).
- Any comorbid or secondary diagnosis that could impact the terminal diagnosis.
- Relevant findings with tests, lab values, etc.
  - Albumin, CHO, NYHA Classification, O2 Sats.
- Decline in functional, performance – be as descriptive as possible.
  - ADL assistance (critical to document).
  - Time required to perform functions.
  - Transfers, feeding, continence, bathing, ambulation.
- Nutritional decline:
  - Weights, MACs, diet (type), intake percent.

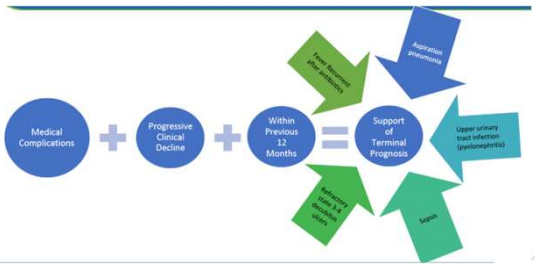
24

Critical Tips for Documenting (PN/F2F)

- Are there general indicators of decline and increasing needs?
- Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- General physical decline and increasing need for support
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further active treatment
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <2.5

25

Documentation to Support Terminality



26

Physician Narrative Documentation Audit

ALECC

Physician Narrative		
Documented under Physician Narrative?	☐	
Documentation in narrative reflects clinical findings that support the terminal diagnosis/prognosis identified in the CTI. • Clinical justification – were LCD guidelines used?	☐	
Re-certification, was a comparative done from previous benefit period with clinical findings to support terminality?	☐	
Attestation statement included?	☐	
Signed and dated?	☐	

ALECC recommends... The Physician Narrative is just that, a clinical narrative that supports the terminal diagnosis. This is not a generalization, a cut, copy, paste section but rather clinical specifics including hospitalizations, ER visits, physical, functional, and cognitive changes. Make sure to use the LCD guidelines and all supporting documentation to build that narrative. This technical requirement is frequently denied in audits if not completed correctly.

27

F2F Encounter & Attestation

Timeframe for completion (pay attention to hospice transfers!):

- No more than 30 calendar days before the 3rd benefit period and each subsequent recertification (may occur on the first day of the benefit period)

Who qualifies to complete the F2F:

- Hospice physician/hospice NP

Attestation:

- The hospice physician/NP who performs the encounter must attest in writing that they had the F2F encounter
- The attestation requirement may be fulfilled by not only a clearly titled section of or an addendum to the recertification form, but also by a clearly signed and dated clinical note within the medical record that indicates clear documentation that the face-to-face encounter did occur including dates of the visit, signature of the practitioner conducting the face-to-face and the date of the signature.
- When the hospice NP/non-certifying physician performs the F2F, the attestation must also state the clinical findings were provided to the certifying physician for use in determining continued eligibility for hospice care.

28

Certification CTI with Physician Narrative

Terminal Diagnosis
G30. 9 Alzheimer's disease unspecified

I certify that this patient is terminally ill with a life expectancy of six months or less if the disease follows its normal course.

Brief narrative statement (Review the individual's clinical circumstances and synthesize the medical information to provide justification for admission to hospice services):

Ms. [redacted] is an 85-year-old male who has been admitted to [redacted] Healthcare with a terminal hospice diagnosis of Alzheimer's disease. Related diagnoses include major neurocognitive disorder and dementia. Comorbidities include left femur fracture 8/9 ORIF in October 2024 due to a fall, pneumonia, aortic valve replacement, type 2 diabetes, hyperlipidemia, and hypertension.

The patient demonstrates hospice appropriateness with significant functional decline secondary to Alzheimer's disease and post-surgical complications. Clinical indicators include an ADL score of 5/6 with complete dependence except for assisted self-feeding, bed/chair confinement with mobility limited to 2-3 hours daily wheelchair sitting, and orientation restricted to a person only. Nutritional parameters show compromised intake (<50% of two daily meals plus 4 Ensure supplements). The patient exhibits increased somnolence (18 hours/day), behavioral changes including agitation and verbal aggression, and diminished social engagement. Stage 2 sacral pressure ulcer confirms skin integrity compromise. This combination of functional deterioration, cognitive impairment, nutritional decline, behavioral changes, and integumentary breakdown supports terminal trajectory and hospice eligibility. Given his progressive decline and current functional state, the patient and family has chosen to forgo curative treatments, opting instead for a focus on comfort care to prioritize his quality of life.

29

Re-certification CTI with Physician Narrative

Terminal Diagnosis
G30. 9 Alzheimer's disease unspecified

I recertify that this patient is terminally ill with a life expectancy of six months or less if the disease follows its normal course.

Brief narrative statement (Review the individual's clinical circumstances and synthesize the medical information to provide justification for admission to hospice services):

Ms. [redacted] is an 85-year-old female who has been admitted to [redacted] Healthcare with a terminal hospice diagnosis of Alzheimer's disease. Related diagnoses include major neurocognitive disorder and dementia. Comorbidities include left femur fracture status post ORIF, pneumonia, aortic valve replacement, type 2 diabetes, hyperlipidemia, and hypertension.

Narrative:

Ms. [redacted] continues to show progressive decline consistent with end-stage Alzheimer's disease. She has deteriorated from requiring partial assistance with ADLs to total dependence (ADLs declined from 5/6 to 6/6). She is now bedbound, with worsening cachexia as indicated by a reduction in LMAC from 20.5 cm to 19 cm. Nutritional intake has declined; currently eating <50% of two meals daily and tolerating only 3-4 bottles of Ensure per day. Somnolence has increased from 18 to 19 hours per day. Cognitive status remains severely impaired with worsening agitation requiring pharmacologic intervention. A stage 2 sacral pressure ulcer persists, reflecting progressive immobility and skin breakdown. These clinical markers-decline in functional ability, nutrition, cognition, and skin integrity-collectively confirm terminal trajectory. The patient and family continue to opt for hospice care to focus on comfort and quality of life.

30

Re-certification of Terminal Illness (CTI) Ex. Of what not to do

Senile degeneration of brain, not elsewhere classified (G31.1)
Upon assessment and evaluation patient significantly deteriorating. Patient meets LCD Medical Guidelines to receive hospice service, for recertification period 3, Effective: 9/27/2024 To 11/25/2024. Patient is recertified for hospice and is appropriate to continue hospice care with a terminal prognosis of 6 months or less if disease process follows its normal course.

31

Documenting Assessments

The Initial Assessment (§418.54(a)) (L522):

- The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care unless the MD, patient, or representative requests that the assessment be completed sooner.
- Purpose – to gather critical information necessary to meet the patient/family's immediate needs and to begin the Plan of Care.

The Comprehensive Assessment (§418.54(b)) (L522):

- The IDG, in consultation with the attending and/or MD, must complete no later than five calendar days after the election of the hospice benefit.
- Identify the physical, psychosocial, emotional, and spiritual needs r/t the terminal illness that must be addressed to promote the patient's well-being, comfort, and dignity throughout the dying process.
- Assess for the imminence of death.

32

Comprehensive Assessment - Considerations

- The nature and condition causing admission – terminal diagnosis.
- Complications and risk factors that affect care planning.
- Functional status, including the patient's ability to understand and participate in his or her own care.
- Psychosocial Assessment (§418.64(c)) (L594)
- Severity of symptoms
  - Changes in cognition, LOC, MAC/weight/appearance, appetite.
  - Ascites/edema/dyspnea
- Medication profile, ***both prescriptive and non-prescriptive*** is part of the patient-specific comprehensive assessment (§418.54(c)(6)(i-v)) (L530). COP's expect Nursing to maintain and update med profile and discuss in IDG with team.
  - Pain meds/effectiveness.
  - Oxygen

33

End of Life Symptoms Frequently Seen

- Pain
- Nausea / Vomiting
- Anxiety and Depression
- Constipation and Diarrhea
- Insomnia
- Agitation, Psychosis, Delirium
- Fluid Retention
- Appetite Loss
- Infections
- Oral / Pharyngeal Secretions
- Fatigue
- Dyspnea
- Wounds & Decubitus Ulcers
- Dyspepsia

34

HOPE Admission Timepoint
Required Sections to Complete

Section A – Administrative Information
Section F – Preferences
Section I – Active Diagnosis
Principal Diagnosis list has expanded from three to ten.
Comorbidities and coexisting conditions have been added.
Section J – Health Conditions
Several new items have been added – helps when updating the POC!!
Section M - Skin Conditions
Section N – Medications
Section Z – Record Administration

35

Section I – Active Diagnosis

Section I	Active Diagnoses

I0010. Principal Diagnosis

Enter Code	
02	01. Cancer 02. Dementia (including Alzheimer's disease) 03. Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS)) 04. Stroke 05. Chronic Obstructive Pulmonary Disease (COPD) 06. Cardiovascular (excluding heart failure) 07. Heart Failure 08. Liver Disease 09. Renal Disease 99. None of the above

36

Section I – Active Diagnosis

Comorbidities and Co-existing Conditions	
↓ Check all that apply	
	Cancer
☐	I0100. Cancer
	Heart/Circulation
X	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
X	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	I0950. Cardiovascular (excluding heart failure)
	Gastrointestinal
☐	I1101. Liver disease (e.g., cirrhosis)
	Genitourinary
☐	I1510. Renal disease
	Infections
X	I2102. Sepsis
	Metabolic
X	I2900. Diabetes Mellitus (DM)
X	I2910. Neuropathy
	Neurological
X	I4501. Stroke
☐	I4801. Dementia (including Alzheimer's disease)
☐	I5150. Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)
	I5401. Seizure Disorder
	Pulmonary
☐	I6202. Chronic Obstructive Pulmonary Disease (COPD)
	Other
☐	I8005. Other Medical Condition

37

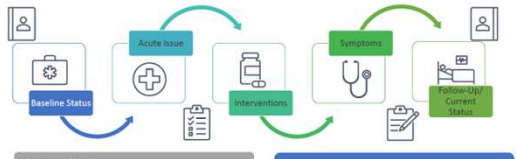
Comprehensive Assessment

The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires but no less frequently than every 15 days. (418.54(d) (L533)

- The comprehensive assessment must be updated at least every 15 days.
- It includes information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care.
- The hospice must also document if there were no changes in the patient's condition or needs.
  - Do not keep documenting "no change" and keep the patient on service! Are they truly eligible for hospice services? Do they meet the criteria? LCD guidelines?
  - Documentation should be descriptive. MAC's, wound changes, scales used (KPS, PPS – measure and document weekly).

38

Chronic Illness vs Terminal



Chronically Ill
- Slowly declining disease process
- May require assistance with activities of daily living
- Can live several years as their body fails

Terminally Ill
- Disease progression significantly declining
- Trajectory of progression provides prognosis of a life expectancy of less than six months

39

Comprehensive Reassessment Narrative Needs to include

- Terminal Dx
- Comorbidities
- Assessment to support terminal LCD
- Decline in status
- Changes in medication
- MAC and meal %
- KPS, PPS, FAST, NYHA
- Any interventions provided during visit

40

Recertification – Considerations in Documentation

Chronic vs Terminal

Clinical Status:

- BMI (persistent/change)
- Food Consumption
- Functional status (ADL change)
- Social Status (Relationship change)
- Recurrent aspiration
- Infections

Symptoms:

- Coughing
- Dyspnea
- Nausea and/or vomiting
- Dysphagia and/or aspirating
- Pain (new medications)
- CNS activity (seizure related to disease)

ALECC, INC 2026

41

Recertification – Considerations in Documentation

Chronic vs Terminal

Physiological Indicators

- Edema
- Heart Rate/BP changes (< Systolic BP)
- Ascites
- LOC
- Change in KPS/PPS/FAST
- Wounds/Skin/Pressure ulcers

Functional & Care Changes

- Behavioral Changes (agitation – new, persistent, increased)
- Weakness/Fatigue/Increased sleep (changes, increased)
- Medication changes
- PRN visits for breakthrough symptoms
- Respite/GIP/CHC

ALECC, iNC 2026

42

Words Play a Critical Role in Documentations

Use:
- Cachexic
- Anorexic
- Dyspneic on rest/minimal exertion
- Frail or as "evidenced by"

Do Not Use:
- Stable
- No change
- No issues noted
- Eating well

43

LCD Part 1 – Decline in Clinical Status Guidelines

Progression of disease as documented by worsening clinical status, symptoms, signs, and laboratory results.

A. **Clinical Status**

1) Recurrent or intractable infections such as pneumonia, sepsis, or upper urinary tract.

2) Progressive inanition as documented by:

a. Weight loss is not due to reversible causes such as depression or the use of diuretics.

b. Decreasing anthropomorphic measurements.

- Mid-arm circumference and abdominal girth not due to reversible causes such as depression or use of diuretics.

c. Decreasing serum albumin or cholesterol.

3) Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

44

LCD Part 1 – Decline in Clinical Status Guidelines

Symptoms

- Dyspnea with increasing respiratory rate
- Cough, intractable
- Nausea/vomiting poorly responsive to treatment
- Diarrhea, intractable
- Pain requiring increasing doses of major analgesics more than briefly

Signs

- Decline in systolic blood pressure to below 90 or progressive postural hypotension
- Ascites
- Venous, arterial, or lymphatic obstruction due to local progression or metastatic disease
- Edema

45

LCD Part 1 – Decline in Clinical Status Guidelines

Signs continued...

- Pleural/pericardial effusion
- Weakness
- Change in level of consciousness

Laboratory – When available, lab testing is not required to establish hospice eligibility however recommended for LLOS!

- Increasing pCO2 or decreasing pO2 or decreasing SaO2
- Increasing calcium, creatinine, or liver function studies
- Increasing tumor markers (e.g., CEA, PSA)
- Progressively decreasing or increasing serum sodium or increasing serum potassium

46

Part II Non-Disease Specific Baseline Guidelines

1) Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
2) Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis.
3) Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST).
4) Progression to dependence on assistance with additional activities of daily living (See Part II, Section 2).
5) Progressive stage three to four pressure ulcers in spite of optimal care.

47

Medicare Hospice Local Coverage Determination

Part II: Non-disease specific baseline guidelines (both should be met).

1) Physiologic impairment of functional status as demonstrated by:

   Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%. Note that two of the disease specific guidelines (HIV Disease, Stroke, and Coma) establish a lower qualifying KPS or PPS.

2) Dependence on assistance for two or more activities of daily living (ADLs):

   A. Feeding.
   B. Ambulation.
   C. Continence.
   D. Transfer.
   E. Bathing.
   F. Dressing.

48

Part III: Co-Morbidities

Part III: Co-Morbidities

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Ischemic Heart Disease
- Diabetes Mellitus
- Neurologic Disease (CVA, ALS, MS, Parkinson's)
- Renal Failure
- Liver Disease
- Neoplasia
- Acquired Immune Deficiency Syndrome
- Dementia

49

Disease Specific Guidelines

Section I: Cancer Diagnoses

Section II: Non-Cancer Diagnoses

- Amyotrophic Lateral Sclerosis
- Dementia due to Alzheimer's Disease and Related Disorders
- Heart Disease
- HIV Disease
- Liver Disease
- Pulmonary Disease
- Renal Disease
- Stroke and Coma

50

Secondary Conditions Impact on Prognosis and Function

- Secondary conditions in hospice care refer to complications or related problems that arise because of primary illness or diagnosis for which the patient is receiving hospice care. These conditions can impact a patient's overall prognosis and functional status and influence the need for hospice care.
- Critical to document baseline secondary condition data on hospice admission from the clinical records and assessment. This will also help to support continued comparative summary of progressive decline each reassessment and recertification.
- Measure against baseline data and its impact on prognosis, function, and the need for hospice services.

51

Examples of Secondary Conditions in Hospice

- Protein-calorie malnutrition – decreased nutritional status due to primary illness.
- Behavioral or cognitive decline – changes in thinking, memory or behavior often associated with advanced stages of the certain diseases.
- Pneumonia – infections – frequent in neuro/respiratory patients.
- Septicemia – serious bloodstream infection, generally secondary to something else.
- Decubitus ulcers – (stage 3 and 4).
- Dysphagia – swallowing issues, choking, etc. (Now using thicken).
- Mobility Issues

52

Hospice Terminal Prognosis: Dementia Due to Alzheimer's Disease

Disease Specific Guidelines

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria. Patients with dementia should show all the following characteristics:

Note: These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines" described in Part II of the basic policy.

1. Stage seven or beyond according to the Functional Assessment Staging Scale;
2. Unable to ambulate without assistance;
3. Unable to dress without assistance;
4. Unable to bathe without assistance;
5. Urinary and fecal incontinence, intermittent or constant;
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

53

Hospice Terminal Prognosis: Dementia Due to Alzheimer's Disease

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia;
2. Pyelonephritis or other upper urinary tract infection;
3. Septicemia;
4. Decubitus ulcers, multiple, stage 3-4;
5. Fever, recurrent after antibiotics;
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl.

Note: This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia.

Part II. Non-Disease Specific Baseline Guidelines (both of these should be met)

1. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%.
2. Dependence on assistance for two or more activities of daily living (ADLs)

A. Feeding	C. Continence	E. Bathing
B. Ambulation	D. Transfer	F. Dressing

54

Hospice Terminal Prognosis: Dementia Due to Alzheimer's Disease

Part III. Co-Morbidities

Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

A. Chronic obstructive pulmonary disease
B. Congestive heart failure
C. Ischemic heart disease
D. Diabetes mellitus
E. Neurologic disease (CVA, ALS, MS, Parkinson's)
F. Renal failure
G. Liver Disease
H. Neoplasia
I. Acquired immune deficiency syndrome
J. Dementia

55

RN Admission Narrative Example

Sample

Patient admitted to routine level of care with terminal diagnosis of Alzheimer's Dementia. Comorbidities include CHF, h/o UTI, h/o breast cancer Patient has lost 20 pounds in past six months. Weight loss of 15% body weight in six months. Current MAC 20cm. Family reporting decrease in ADL functioning – last year patient was confused but able to perform all ADLs and eating regular diet. Currently patient is dependent on 5/6 ADLs, incontinent of bowel and bladder, has had three falls in past month. FAST 7C only ambulates with support of caregiver. High risk for falls. KPS 40% PPS 40%. Patient hospitalized for UTI in 1/2021,4/2021. Patient is DNR and family requesting comfort care support and no hospitalization. Verbal CTI received from Dr Allen, attending and Dr Bobby, medical director. IDT team agrees with initial plan of care. Skilled nursing 2xweek, Hospice Aide 3xweek, Chaplain and SW to evaluate for needs.

56

RN Recertification Narrative Example

Sample:
Pt. admitted to hospice with a primary terminal dx of Alzheimer's dementia. Co-morbidities include CHF, h/o UTI's, h/o breast cancer. MAC at admission was 20cm, currently 19.5cm. Patient presents with sunken eye orbits, extremely loose-fitting clothing, skin tears, dentures are now loose fitting. Family states patient is now eating approximately 50% of her meals which is a decrease from 75% intake of meals prior. Meals take approximately 30 minutes with the patient in a chair surrounded by multiple pillows to prevent the patient from falling over. ADL's have progressed from 5/6 to 6/6. FAST 7D, KPS 40%, PPS 40%. Patient is now experiencing episodes of agitation and mild aggression in the evening, Trazadone ordered. Sleeping 16/24 hours per day. Family has hired a caregiver with the assistance of the MSW to help with the evenings since patient is declining and requiring more assistance. SN will continue 2x/wk, HHA 3x/wk, MSW 1x/mo. and prn, SC 1x/mo and prn. IDG and family in agreement with current POC.

57

LCD Documentation Guidelines – Supporting Primary 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! KPS, PPS, FAST.
- Always include supporting events such as any changes in the level of ADLs/functional, recent hospitalizations, or ER visits/antibiotics.

58

Hospice Plan of Care – IDG Team

The IDG Team:

- Supports and manages the physical, medical, psychosocial, emotional, and spiritual needs of hospice patients and families
- Sets up the POC at the time an individual chooses hospice
- Continuously updates the POC while the patient gets the hospice benefit
- Also, offer a bereavement POC and supportive services to the caregiver and family for 1 year after the death of the hospice patient

"…The IDG team work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement…"
42 CFR 418.56 (a)

59

Hospice Plan of Care

Principles of Quality Care Planning

Medicare requires the POC include:

- Interventions to manage pain and symptoms
- A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs
- Measurable outcomes expected from implementing and coordinating the POC
- Drugs and treatments necessary to meet patient needs
- Medical supplies and appliances necessary to meet patient needs
- IDG documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC

60

Hospice Plan of Care

Common Deficiencies Related to POC Implementation

We analyzed 2019 hospice survey deficiency data at the Condition of Participation (CoP) for Interdisciplinary Group, care planning, and coordination of services (42 CFR 418.56). Common survey deficiencies were related to POC implementation.

For example, we found that:

- POCs weren't individualized
- Hospice staff missed direct-care visits
- Documentation of visits didn't meet requirements (for example, wound care)
- POCs were incomplete (for example, not inclusive of all needed services)
- IDG meetings were inconsistent, with POCs not being updated

MLN9895410 April 2024

61

Importance of IDG/IDT

- IDG/IDT documentation should show evidence of continued support of terminality and patient's hospice eligibility. Document all team member interventions, updates, prn visits made, med changes, secondary condition changes noted, noted POC changes, visit changes to address decline.
  - **POC review required per COP's every 15 days or sooner depending on patient condition requires.**
- IDG/IDT documentation provides critical evidence to support terminality and patient hospice eligibility.
- IDG/IDT review and update the patient POC.
- LLOS (> 180 d– increased documentation and review of LCDs to support terminality should be noted within IDG/IDT documentation. Document how CMS audits (LCDs).
  - Is the patient with LLOS chronic vs terminal?

62

GIP OR CONTINUOUS CARE

JUSTIFICATION OF THE NEED FOR ELEVATED LEVEL OF CARE:

- IDG/IDT, attending, and hospice medical director determine symptoms cannot be managed at home.
- Medical crisis required (pain control, symptom management). Must have symptom(s) uncontrolled at RHC level.
- Need for professional nursing management to control symptoms (not purely custodial care).
- Identify what has been tried to resolve the medical crisis at RHC that has not worked.
- Include a plan for return to routine home care from the beginning.

KEY TAKEAWAYS

- GIP and continuous care are meant to be short term.
- Imminent death alone is not the criterion for the GIP level of care.

ALECC, INC 2026

63

GIP Documentation

GIP Initiation & Orders:

1. Identify precipitating circumstances/medical crisis along with prior unsuccessful interventions necessitating GIP level of care.
2. IDG/IDT determines and documents need for GIP LOC.
3. Physician order for GIP LOC.

Ongoing Documentation & Care:

4. POC is updated routinely/frequently with all interventions. Documentation supports response to interventions. (meds, treatments)
5. Facility staff communication (coordinate/collaborate) with evidence that documentation supports appropriate interventions and need for GIP LOC.
6. Documentation reflects GIP and all interventions, response to interventions. Follow guidelines to support GIP status/LOC.

Transitions & Limitations:

7, GIP care is short-term and as crisis begins to resolve, evidence of transition and discharge plan documented with appropriate interventions. POC updated as appropriate, MD orders for D/C.
8. Imminence for death, not a GIP reason.

64

CHC Documentation

CHC Initiation & Orders

1. Identify precipitating circumstances necessitating CHC level of care.
2. IDG/IDT documents need for CHC LOC.
3. Physician order for CHC LOC.

Ongoing Documentation & Care

4. Documentation reflects CHC and all interventions, VS, patient response. Frequent documentation noted with CHC.
5. POC is updated routinely with all interventions. Documentation supports response to interventions (meds, treatments).
6. CHC care is short-term and as crisis begins to resolve, what is the plan, interventions and updated POC.

Transition & Limitations

7. If facility is involved, communicate LOC.
8. Imminence for death, not a CHC reason.

ALECC, INC 2026

65

Best Practices to Support Optimal Documentation

Clinical staff is educated re: documenting per the LCD's and congruent documentation.	Establish baseline documentation on hospice patients using LCDs. Each CTI, F2F, updated comprehensive assessment and narrative, should trend from the baseline documentation to support ongoing terminality.	IDG/IDT documentation should reflect and support patient visits from previous IDG/IDT. Note any changes (per LCDs) that support terminality. Evidence of POC review and update during IDG/IDT.
Visit notes should not just be cut, copy and paste. They must address LCDs, progressive decline, any changes including POC updates, what to report in IDG/IDT.	LOC changes require specific documentation/process. Make certain the process is followed re: the triggering event, needs/interventions, documentation between agency/facility, orders and POC updates, discharge plans.	Audit your charts, educate your staff and use documentation challenges as QAPI opportunities. Look for patterns, trends to focus on.

66

Resources

Weblinks:

- https://www.cgsmedicare.com/hhh/medreview/hos_drc.html
- https://www.ngsmedicare.com/web/ngs/medicare-compliance?lob=93618&state=97162&rgion=93624
- https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/Hospice_GIP_Audit_Tool.pdf/$FILE/Hospice_GIP_Audit_Tool.pdf
- https://www.cgsmedicare.com/hhh/education/materials/hospice_qrt.html
- https://www.ngsmedicare.com/documents/20124/121641/1522_0522_Hospice+Documentation+Checklist_508.pdf/80da5d1e-912b-f188-8334-69db3de386f4?t=1652896126741

67

Thank You!

68