Hospice Discharges

Legacy Hospice
Live Discharges

• Once a Medicare beneficiary elects the hospice benefit, hospice may not automatically or routinely d/c the beneficiary at it’s discretion, even if the care is costly or inconvenient.

• Hospice discharge can only be initiated by the hospice provider for the regulated allowable reasons.

• Some discharges are patient’s choice and should not be impeded by the hospice.
Upon Discharge:

- No longer covered under the Medicare Hospice Benefit and loses the remaining days in the benefit period.

- Resumes Medicare coverage

- May re-elect hospice coverage for any other hospice election period that he/she is eligible
## Discharge Types

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Discharge: Revocations

Patient choice discharge
Points to Remember

• Patient or designated caregiver may choose to revoke the hospice benefit at any time.

• Hospice staff may never “revoke a patient from hospice”

• Revocation must be in writing, verbal revocations not allowed

• The beneficiary does not have to provide a reason for revocation
Points to Remember

• Individuals may not designate an effective date earlier than the date the revocation is made

• The patient is free to reelect the hospice benefit at any time

• Documentation should include circumstances around the revocation
Revocation Documentation

- Legacy Hospice Revocation Form, signed and dated by patient or caregiver
- Discipline Narrative and IDT note
- Discharge summary
- Discharge checklist
Common Reasons for Revocation

- Seeking aggressive treatment
- No longer wish to remain in the Medicare Hospice Benefit
- Nursing facility and/or patient choose skilled bed
- Exacerbation of symptoms and family takes patient to hospital for symptom control
- Poor understanding of Medicare Hospice Benefit
When a beneficiary enrolls in hospice, he/she is instructed to coordinate all of their care through the hospice agency or else it might not be covered by Medicare. Hospice providers are not required to pay for emergency or non-emergency services not coordinated by hospice. Patients going to the hospital for reasons related to their diagnosis do not automatically equal revocation.
Revocation Prevention

- Educate pt/cg at initial visit and each visit thereafter: CALL HOSPICE FIRST

- Explain consequences of going to hospital without first coordinating care with hospice

- Help the pt/cg identify their expectations about hospice care

- Help the pt/cg identify their wishes as the patient declines
Revocation Prevention

• Educate the cg about the disease process

• Provide cg with interventions he/she can provide during symptom exacerbation or times of emotional insecurity

• Utilize other disciplines in providing emotional support to pt/cg who are overly anxious or having difficulty accepting the disease process
Revocation Prevention

- Promote importance to staff of “being available” to pt/cg
- Instill confidence to pt/cg of our ability to provide a higher quality of life and keep their symptoms managed at end of life
Discharge: Transfers

Patient Choice Discharge
Points to Remember

• A patient may elect, **once** in his/her election period, to change their hospice provider

• Transfer is **not** considered a revocation, except for when a patient wishes to change hospices more than once in a benefit period

• When electing a transfer, the patient must sign a statement with the following:
  ▫ Name of hospice from which patient has received care
  ▫ Name of hospice from which they plan to receive care
  ▫ Date the change will be effective
## Transfer Documentation

### Receiving a Transfer
- Change of Provider form
- New Notice of Election (patient stays in current benefit periods.)
- Face to Face if patient in 3rd or later benefit period (must be able to prove face to face was completed)
- Plan of care
- Med list
- Legacy Documentation-Treat as New Admit

### Sending a Transfer
- Change of Provider form
- Face to Face
- Plan of care
- Med list
- Discharge Checklist-Legacy Record
- Discharge Summary-LR
- Nursing Narrative detailing circumstances surrounding transfer-LR
Discharge: No longer terminally ill

Hospice Discharge
Points to Remember

• Hospice must consider possibility of patients stabilizing and/or improving

• Patients should be consistently evaluated for stabilization or consistent improvement

• “No longer terminally ill discharges” are NEVER a last minute decision

• As improvement/stabilization is noted, the patient and caregiver should be notified of the possibility of discharge if the plateau continues
Points to Remember

• Discussion of potential discharge and discharge planning with the patient/caregiver must be documented in the discipline narratives as well as the IDT notes.

• Once the decision to discharge is made with the IDT, the patient/caregiver must be notified of the decision, along with their right to appeal.

• Once the IDT agrees to discharge, discharge planning begins and the patient/caregiver is notified.
Discharge Planning:

- Obtain Physician’s Order to discharge

- Deliver Notice of Medicare Non-coverage form (NOMNC) (no later than 48 hours prior to d/c)

- If pt/cg choose to appeal give them Detailed Explanation of Non-Coverage (DENC)

- Referral to outside agencies
  - Attending Physician
  - Home Health
  - Outpatient Therapy
  - Counseling services
Discharge Planning continued:

- Educate patient/caregiver
  - Medication, treatments, and supplies, etc.
  - Follow up with referrals and attending physician
  - Reelection of hospice services in the future
Digging Deeper: Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)
Notice of Medicare Non-Coverage

• NOMNC informs patient/caregiver that Medicare will probably cease to pay for hospice services due to patient no longer meeting hospice criteria

• Must be given no later than 2 days prior to end of coverage. End date must be listed on form.
  ▫ Some states have stricter guidelines. More stringent guideline must be followed.

• Should be verbally reviewed with pt/cg

• If pt/cg agree with decision, services end on the day listed on the NOMNC
Detailed Explanation of Non-Coverage

- Given to patients/caregivers when they disagree with decision to discharge

- DENC provides QIO contact information to pt/cg

- Pt/cg contacts QIO requesting appeal of hospice decision

- QIO contacts hospice provider for records and makes decision within 72 hours
Detailed Explanation of Non-Coverage

• Hospice is required to continue care for patient until decision is delivered by QIO

• QIO will verbally notify hospice and will mail letter to hospice detailing decision

• Communication between hospice and QIO must be documented and filed in chart

• If QIO agree with hospice decision, hospice services end on the day hospice is notified

• If QIO disagree with hospice decision, hospice services continue
Documentation: Discharge-No longer terminally ill

- Physician’s Order
- Discharge Summary Order
- Discharge Checklist
- NOMNC and DENC (if appealed)
- Discipline Narratives and IDT updates with detailed information of circumstances surrounding discharge, education of pt/cg, and delivery of NOMNC/DENC
Discharge: Outside the Coverage Area

Hospice Choice
Reasons to Discharge: Outside the Coverage Area:

The patient:

- Moves out of the provider’s service area
- Is traveling
- Is admitted to a hospital, for a hospice related reason, that does not have a contractual relationship with the hospice
- Is admitted to a hospital, for an un-related hospice reason, but whose length of stay is expected to be lengthy
- Is admitted to a SNF that does not have a contractual relationship with the hospice
Discharge Planning

- Obtain Physician Order

- Referral to outside agencies
  - Attending Physician
  - Home Health
  - Outpatient Therapy
  - Counseling services

- Educate patient/caregiver
  - Medication, treatments, and supplies, etc..
  - Follow up with referrals and attending physician
  - Reelection of hospice services in the future
Documentation

• Physician’s Order

• Discharge Summary Order

• Discharge checklist

• Discipline Narratives and IDT updates with detailed information of circumstances surrounding discharge
Discharge: Discharge for Cause

Hospice Decision
The Rule:

When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the 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, the hospice can consider discharge for cause.
Points to remember

• Hospice must make **every** effort to resolve the problem satisfactorily before discharge for cause is an option

• Efforts to resolve the problem must be documented in detail in the EMR

• Social Workers need immediate involvement when discharge for cause is being considered

• Open conversations between hospice staff and pt/cg must take place prior to discharge
Steps Prior to Discharge

• Advise the patient discharge for cause is being considered

• Make a **serious** effort to resolve the problem

• Determine if there is an underlying reason for discharge due to the patient’s use of necessary hospice services

• Document the problem and efforts made to resolve the problem, in detail, in the EMR
Discharge Planning

• If interventions to resolve the problem have been unsuccessful, the patient may be discharged

• Obtain Physician Order

• Notify Medicare Contractor and State Surveyor Agency of pending discharge and circumstances

• Make referrals to other relevant state/community agencies (APS) as needed

• Notify designated Attending Physician
Documentation

- Physician’s Order
- Discharge Summary Order
- Discipline Narratives and IDT notes
- Discharge Checklist
Scenarios
Case study#1

Primary caregiver of a 78 year old COPD patient reports to hospice nurse on Monday morning prior to nursing visit, that patient has been in the hospital since Sunday night for SOB, anxiety, and chest pain. States they did not want to bother the nurse due to the time.

What should you do?

Offer option to revoke hospice services or option to remain on hospice services. Make certain cg is aware that Medicare may not pay for their hospital stay if the admission diagnosis is related to their hospice diagnosis. Make certain cg is aware that he/she will be responsible for hospital payment up to the time of revocation due to not notifying hospice staff.

If cg choses option to revoke, what date is listed on the revocation form?

• The date the cg choses to revoke hospice services, not the date they admitted to the hospital.
Case Study #2

Cg calls on-call nurse and reports he is going to take pt to ER because she fell. She has numerous bruises on her arms and legs. Cg denies patient lost consciousness and does not think she hit her head. Hospice diagnosis is CHF.

What should you do?

You tell the cg that you are on the way to the home to assess the patient. You explain that after your assessment, the two of you can decide if she needs to go to the hospital for evaluation. You reassure the cg that you will make certain she is okay and if you are not able to determine that, will send to ER for assessment. During visit, determine reason for patient’s fall.

If cg refuses visit:
Make contact with ER pt is being transported to. Inform them she is a hospice patient and reason she is coming to ER (fall). Do not make determination to offer revocation or other discharge option until patient has been evaluated and reason for fall is determined. If fall is related to dx or pt receives treatment for CHF while at ER, offer revocation
Case Study #3

76 year old hospice pt with CHF currently resides at an ALF. Her daughter is moving her out of the state to an ALF closer to her. Due to travel time involved in making the trip out of state, there is an anticipated break in service of 7-10 days. Travel time to her new ALF is approximately 3 days with overnight stays in other states.

What should you do?

Discharge for outside coverage area. Due to travel time and break in service, we can not guarantee care. A transfer to another hospice would not be ideal due to travel time before arriving at destination. A traveling contract would not be warranted as location change for patient is permanent.
Case Study #4

42 year old Cirrhosis of the liver patient. Pt frequently not at home for scheduled staff visits. Staff discussed concerns with pt about missed visits and visit schedules arranged with pt at his convenience. Attending physician also notified of missed visits and had conversation with pt of importance of allowing hospice providers to make scheduled visits. Pt continues to be absent from home at time of scheduled visits. Issue has been present for 2 months with periods of up to 2 weeks in which hospice staff was not able to provide care. Staff continue to notify Attending physician of issue and continue to try and schedule visits at patient’s convenience and have warned pt that this behavior can not continue or discharge may be considered.

What should you do?
Case Study #5

You arrive at a 46 year old cancer patient’s home to find them with intractable nausea, vomiting, and pain. Over the course of 2 hours, you administer multiple doses of anti-emetics and pain medication. There is no change in the patient’s condition. You try to arrange GIP but we do not have a contract with the patient’s local hospital and we are unable to arrange a 1 time contract for this patient.

What should you do?
Questions