GIP: Getting It Right
August 2016
Subscriber Webinar

The Plan for This Session

1. Identify the regulatory requirements for general inpatient level of care
2. Describe patients who are eligible for and can benefit from higher level of care
3. Documentation principles to support the general inpatient level of care and the connection with care planning

Levels of Care (LOC)

Medicare pays the hospice a per diem rate based on one of four levels of care

- Routine Home Care
- Inpatient Respite Care
- General Inpatient Care
- Continuous Home Care

Level of care determination

- Made by the hospice interdisciplinary team (IDG)
- Reevaluated by the IDG on a regular basis to assure appropriateness
- Requires a change to the plan of care (POC)

Hospices Not Providing All Levels of Care

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<th>No CHC</th>
<th>No Respite</th>
<th>No GIP or CHC</th>
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<td>All Hospices</td>
<td>28%</td>
<td>58%</td>
<td>25%</td>
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<td>By total # of Medicare Pts in 2013</td>
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MedPAC Report to the Congress: Medicare Payment Policy March 2015
OIG Interest in GIP March 2016 Report

Inappropriate GIP stays, 2012

- 20% - did not need GIP at all
- 10% - did not need GIP for part of stay
- 1% - no evidence of EOB or terminal illness

OIG March 2016 Report On GIP

- Hospices did not meet care planning requirements for 85 percent of GIP stays
- 72 percent of GIP stays, the hospice care plan was missing at least one key element
- In about half the stays, the hospice care plan was not developed by all the required parties

OIG Recommendations to CMS

1. Increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries;
2. Ensure that a physician is involved in the decision to use GIP;
3. Conduct prepayment reviews for lengthy GIP stays;
4. Increase surveyor efforts to ensure that hospices meet care planning requirements;
5. Establish additional enforcement remedies for poor hospice performance; and
6. Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.

CMS concurred with all six recommendations.

Ongoing GIP Issues Identified by CMS

- Documentation does not support the higher level of care
- Long stays
- Inappropriate use
- No plan initiated for discharge from GIP level of care
- Use of GIP for caregiver breakdown when medical symptoms do not support GIP
- Quality of care issues
Compliance Challenges of Higher Level of Care

- Ensuring care is provided in accordance with the plan of care and meets professional management responsibilities
- Documenting the rationale for moving to/from higher level of care
- Documenting to support higher level of care
- Increased scrutiny

A View of the Regulations

General Inpatient Care (GIP)

- A day in which a patient receives hospice inpatient care for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings
- Where
  - Contracted hospital (Medicare-certified)
  - Contracted skilled nursing facility (Medicare-certified)
  - Hospice inpatient facility – a hospice’s own or contract (Medicare-certified)
- Facility must have RN 24 hours/day who provides direct care

Medicare Hospice Conditions of Participation

General Inpatient Clarification

- Final Rule CMS-1539 effective August 2007
- Clarified
  - GIP should only be used based on the patient condition
  - When an individual’s pain and symptoms must be closely monitored or the intensity of interventions that are required cannot be provided in any other settings
  - GIP can not be used due to caregiver breakdown
  - Advised respite should be used in these circumstances (respite cannot be used for residents of a nursing facility)
General Inpatient Care

- The decision to change a patient’s care to the general inpatient (GIP) level is based on the clinical condition of the individual.
- General inpatient care requires the documentation of an acute change in the patient’s condition, requiring aggressive, intensive treatment for the management of symptoms.
- Why was the hospice unable to manage the symptoms at the current level of care?

General Inpatient Care

Intensity of care directed towards pain control and symptom management that cannot be managed in any other setting

- Close monitoring of pain and symptoms
- Level of care needed to manage pain and symptoms is the basis for the GIP level of care
  - “procedures necessary for pain control or acute or chronic symptom management” §418.202(e)

General Inpatient Care

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit

- A brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay
- Patient continues to need pain control or symptom management
- Cannot feasibly provide in other settings while the patient prepares to receive home care

GIP Level of Care in a Contracted Facility

- Hospice maintains professional management of the patient
  - Documentation by hospice staff should reflect that management
  - Should illustrate the coordination of care between the hospice and the contracted facility providing GIP level of care
- On discharge – need either a discharge summary or copy of the facility clinical record
- Includes residents of NF
Discharge Criteria from GIP

- Medical reasons for admission have stabilized
- Re-established family support system

Discharge planning starts on admission and is reviewed daily

  - What is Plan A?
  - What is Plan B?

Need for GIP

- Palliation / management of acute medical symptoms
- Observation and monitoring to control pain and other acute symptoms
- Require predominantly nursing care
- Actively dying? Must be a clinical need for services, such as pain control
- Caregiver breakdown? Must have a skilled nursing need going unmet because the caregiver is unwilling or unable to provide the skilled nursing care

Psychological and Social Problems

Questions to ask & responses to document

- What is the specific patient care need going unmet as a result of the caregiver crisis?
- Why can’t it be managed in the home?
- Does the patient need placement in a facility?

Does the documentation tell the story?

Cues for Need of GIP

- Increase calls to the office for help
- Difficulty managing symptoms with intermittent visits
- Increase in after hours calls
- Statements of wanting to go to the hospital or to call 911
- Caregiver’s anxieties and fears escalating to where no longer can provide skilled care
How Does GIP Work?

Setting Standards

- Determine need for higher level of care meets the requirements (changes in comprehensive assessment)
  - What happened that the patient needs and qualifies for a higher level of care
  - Why can’t the patient be managed at RHC?
  - What are the assessment findings?

Making it Happen

RN contacts the physician regarding the change in the patient’s condition and completes the following:
- Documents the discussion with the physician and any order changes
- Revises POC reflecting the level of care, new or exacerbation of problems necessitating the need for higher level of care, and any changes in interventions
- Involves all members of IDG in the changes to the plan of care
- Updates Hospice Aide assignment as applicable
- Assures the Medication/Patient Profile is updated and complete.

Making it Happen

- Change level of care
- Arrange for transfer
- Documentation should reflect what happened that the patient now needs and qualifies for GIP
  - Interventions attempted and response by patient
Involvement of the IDG

- GIP is primarily focused on skilled nursing needs to meet the unmet needs of the patient
- However ....
  - The services of SWs and chaplains should also increase during these periods of crisis
  - SW and chaplain continue to address the psychosocial/spiritual issues which may have escalated depending on the crisis

When the Symptoms Are Managed

- Comprehensive assessment drives changes in POC, i.e. crisis is resolved and symptoms now managed
- Change in plan of care with IDG involvement
  - How will the POC be different?
  - What goals were met?
- Obtain physician orders as appropriate for any new medications/interventions, change in level of care

So, How Does Documentation Fit In With All of This?

Steps to Successful Documentation

1. Identify the precipitating event(s) that led to need for higher level of care including any less than successful attempts to control symptoms that occurred prior to starting GIP
2. Identify specific symptoms that are being actively addressed
3. Document skilled care that patient requires and which cannot be managed without GIP
4. Describe the services provided
Documentation Prior to the Crisis
There must be a clinical need precipitated by a crisis for this level of care to be warranted
- What did the assessment show prior to initiation
- Clinical need such as services for pain control, must be clearly evident in the documentation
- Response to interventions tried

Admitting Documentation
- What is the clinical need precipitated by the crisis
- Document failed interventions in the other setting (home, NF, ALF, etc.)
- Reasons why new interventions can’t be provided in the other setting
- Why the family can no longer provide the care
- For patients in contract GIP in NF, how will the NF care be different? More intense?
- Involvement of IDG and attending physician in the decision to change to GIP
  Paint the picture why management in their current environment is not realistic

Documentation of GIP Should...
- Answer these questions
  - Why here?
  - What is happening that can’t be managed in the home or at current level in facility setting?
- Reflect a more intensive level of care – should not read the same as routine home care notes
- Expect to see
  - Changes to the plan of care and interventions
  - Medication adjustments or other stabilization treatments
  - Measures being taken to resolve the reason for admission or continued stay
  - Supporting documentation that the family / NF cannot provide needed care

Plan of Care
- Revise the plan of care
  - Problems, interventions and expected outcomes
- Ensure assessments drive the plan of care
- Document response to plan of care and progress / lack of progress towards goals
- If no progress towards goals, adjust Plan of care
Admitting Documentation

- Does this paint the picture why admitted?

Patient continues to have increased dyspnea, respiratory distress, and associated anxiety, despite increase in steroids and other medication changes over the past 2 days. Patient in need of inhalation treatments every 2 – 3 hours and IV medications every 4 - 6 hours

- Would it support GIP admission?

Daily Documentation

Should include
- What is the reason for level of care now (today)
- Assessment of signs and symptoms being managed
- Medication changes, titration, patient response
- Quantitative data
  - ADL needs and dependency
  - Vital signs
  - Intake and output
  - % of meals taken and quantity
  - Pain ratings
- Caregiver teaching
- Discharge planning

Paint the picture of the patient and patient needs as identified on the Plan of Care

Visit Notes Must...

- Continuously and consistently support the terminal prognosis and reason for GIP
- Reason for admission or continued stay to GIP level of care
- Measures being taken to resolve the reason for admission or continued stay
- Contain objective measures
  - Contain vital signs, weights, body mass measurements, lab data/values, meal percentages, other objective data
- Documents to problems, interventions and goals in POC
- Wounds – why is this complex care?
- Interventions such as suctioning, positioning, spiritual support

Discharge Planning

- Should begin before patient is admitted to GIP
- Document discharge planning daily
- Delays should be documented along with “Plan B” and attempts to resolve barriers for discharge
- If there is no documentation to support GIP level of care, should change to routine home care
**GIP Actual Documentation**

- Change in LOC order – GIP
  - Anasarca, decreased urine output
  - POC SN frequencies changed to 5xWeek
- Progress note – GIP
  - Continues to have weeping from edema of upper extremities, RR=20. Medicated with Ativan and Morphone. No anxiety at this time, afibrile. B/P 108/60. Will continue to monitor on GIP for any further decline
  
  Does this paint the picture of why GIP?

**GIP Documentation**

- Day 1 – admitted from hospital for dyspnea. Is O2 dependent. No pain on admit. Use of accessory muscles, cough, increase secretions, but no other descriptors. On sublingual MS and Ativan every 4 hours as needed.
- Day 3 – up in chair most of day. Always short of breath. MS 3 times in 24 hours and Ativan 2 times in 24 hours.

**GIP Documentation - continued**

- Day 4 – Fatigues with minimal exertion. Rales at bases; 2+ BLE edema. Feels good today with no SOB noted. MS x4 and Ativan x2 in past 24 hours. Cardiovascular assessment “improved”. Tentative schedule for discharge on Monday (2 days).
- Day 5 Feels well today. Using NC instead of mask.
- Day 6 – respiratory assessment – no abnormal findings. Lungs clear bilateral. O2 controls shortness of breath. Transferred to NH.

**GIP Documentation**

- Pain well controlled with current plan of care
- Continue to monitor for comfort
- Terminal care
- Comfortable with no chest pain, coughing, fever, or seizures

What do you think of this?
What It Should Say

- Pain controlled with use of a continuous drip of IV morphine. Uses IV Ativan 2 – 3 times per day to control the dyspnea at rest and gasping for air.
- Chest pain controlled with around the clock Morphine and breakthrough medication 3 – 4 times per day. After aspirating his coffee, now has a wet, non-productive cough and is unable to clear secretions, requiring oral suctioning every 2 – 3 hours. All oral medications have been discontinued.

Admitting Documentation

What about this?

Patient resides at home. Was taking oral pain medication and can no longer swallow. Patient reports pain at a level of between 8 – 9 for the past 24 hours and has not slept. Suppositories have been ineffective. Medications changed to IV with titrating dosing.

FAQs

Question

Is there a maximum number of days a patient can be under the GIP level of care?

- No. As long as the patient qualifies for palliation or management of acute medical symptoms that needs the skilled level of care, there is no limit.
- However be aware that a very long length of stay which generates a large claim may trigger a review of the stay by your MAC.
Question
The medication was effective in controlling the pain and the patient hasn’t had pain above an acceptable level for 12 hours, do I have to change the higher level of care to RHC?

• There is no hard rule on how long after a symptom is managed that a patient continues to qualify for a higher level of care. You need to look individually at each patient: how long did it take to get it controlled; how many adjustments did you have to make, what is the rest of the patient’s condition like; what might you expect the disease progression to look like next?

Question
Do the regulations require a physician’s order to change LOC to GIP?

• There is no regulation requiring a physician’s order to change the LOC. §418.56(d) addresses the need to “review, revise and document the individualized plan as frequently as the patient requires, but no less frequently than every 15 calendar days”

Question
Do the regulations required a daily visit from the hospice RN when a patient is in a contracted bed for GIP?

• No, there is no regulation. However it is a good practice, good care and will help support the need for the GIP level of care.

Monitoring & Auditing
Processes to Monitor

Review of clinical notes to support level of care
  – symptom management
  – Documentation supports ongoing need
  – IDG updates POC with changes to and from GIP

Review of any LOS exceeding 5 days

Summary – Key Concepts – GIP

• §418.108 – Short – term inpatient care
  – Meant to be short term
• Medicare Benefit Manual clearly states that care under GIP must be care that “cannot feasibly be provided in other settings”
• Documentation must demonstrate why care cannot be provided at “home”

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