HOSPICE Documentation Checklist Tool

Election Statement	
Does the Election Statement include the following information: • Identification of the hospice that will provide care • Acknowledgement the beneficiary has been given a full understanding of hospice care, **palliative versus curative treatment** • Acknowledgement certain Medicare services are waived by the election of hospice • Effective date of the election - May be the first day of hospice care or a later date, but cannot designate a retroactive effective date • Designated attending physician information (if any) including, but not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician • Beneficiary's acknowledgement the designated attending physician was their choice.	☐
Is the Election Statement signed by the beneficiary or authorized representative?	☐

Certification Of Terminal Illness	
Certification/Recertification	
Is the certification statement signed and dated by the hospice medical director or a hospice physician member of the IDG no later than 2 calendar days after hospice care is initiated (that is, by the end of the third day), but no earlier than 15 days before hospice care is elected? • **If initial certification, must also be signed by the beneficiary's attending physician (if any).**	☐
If written certification was not obtained within 2 calendar days, is a verbal certification obtained and documented within 2 calendar days including? • Identification of the physician providing oral certification • A statement that the patient is terminally ill with a 6 month or less medical prognosis • Hospice staff signed and dated entry in the patient's medical record of oral certification receipt.	☐
Does the certification include: • A statement that the patient is terminally ill with a 6 months or less medical prognosis • A narrative written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of 6 months or less - Narrative shall include a statement, located directly above the physician's signature and date, that attests to the fact that by signing the form, the physician confirms that he/she **composed** the narrative based on his/her review of the patient's medical record or his/her examination of the patient - Narrative must be located immediately above the physician's signature • Benefit period dates (from and thru date) • Physician signature and date • Effective for recertifications on/after January 1, 2011, narratives associated with the third benefit period and subsequent benefit periods must explain why the clinical findings of the face-to-face encounter support a life expectancy of six months or less. Documentation must include the date of the encounter, an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary. If the encounter was performed by a nurse practitioner or a non-certifying physician, he/she must attest that clinical findings were provided to the certifying physician.	☐

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Face-to-Face (if applicable) *On or after January 1, 2011 a face-to-face is required for all beneficiaries entering their third or later benefit period*	
Did the face-to-face encounter occur no more than 30 days before the third benefit period recertification and each subsequent recertification? • A face-to-face encounter may occur on the first day of the benefit period and still be considered timely.	☐
Did the hospice physician or nurse practitioner who performed the encounter attest in writing that he/she had a face-to-face encounter with the patient, including the date of the encounter? • The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled • If the face-to-face is a separate addendum, the certification period dates (from and thru) must appear on the addendum • **Only the individual who performs the face-to-face encounter may attest to the completion of the visit.**	☐
If a nurse practitioner or non-certifying hospice physician performed the face-to-face encounter, did they attest the clinical findings were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less?	☐
Is the attestation signed and dated by the physician or nurse practitioner who performed the encounter?	☐

Plan of Care (POC)	
Does the Plan of Care identify treatment goals and coordination of services to meet patient needs?	☐
Was the POC established by the interdisciplinary group (IDG) and a physician(s)?	☐
Did the IDG review the POC as the patient's condition requires but no less frequently than every 15 days?	☐
Is a POC review submitted that covers all dates of service under review? • Reminder, the 15 day POC update may have been performed in the prior month.	☐

Terminal Prognosis		
Does the documentation "paint 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.		☐
Does the documentation support the six-month terminal prognosis?		
Documentation at the time of 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, not curative care • Records that show a trajectory of decline • Increasing ER visits or hospitalizations	Documentation throughout the hospice election may include: • Changes in: - Patient's weight - Pain (type, location, frequency) - Responsiveness - Level of dependence for ADLs - Anthropomorphic measurements (abdominal girth, upper arm measurements) - Vital signs (RR, BP, pulse) - Strength - Lucidity - Intake/output • Skin condition (turgor) • Diagnostic lab results (when available)	☐

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Terminal Prognosis	
Is the documentation objective and include quantifiable values/measures (ex. Pounds, 4 on a scale of 1-5, inches, etc.)?	☐
Does the documentation avoid the use of vague statements such as: “disease progressing” or “slow decline”?	☐

Level of Care (LOC)	
Does the documentation support the level of care billed? • When and why the LOC was changed.	☐
If Continuous Home Care (CHC) is billed, is a minimum of 8 hours of nursing, hospice aide, and/or homemaker care provided during a 24-hour day (begins and ends at midnight) and at least 50% or greater of the total care provided is nursing delivered by an RN/LPN/LVN?	☐
If Respite Care is billed does the beneficiary reside in their home and not a facility (such as a long term care facility)?	☐
If General Inpatient Care is billed does documentation show the beneficiary requires care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings? • Medication adjustment • Observation • Psycho-social monitoring • Other stabilizing treatments	☐

Resources
Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

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