Federal Regulations

• **General Inpatient Care provided under contract**
  - 42 C.F.R. Section 418.108
    - Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

• **General Inpatient Care provided by hospice directly**
  - 42 C.F.R. Section 418.110
    - A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the standards in this regulation.

Federal Regulations

• **Covered Services**
  - 42 C.F.R. Section 418.202 (e)
    - Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or SNF, that additionally meets the standards in §418.202 (a) and (e) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management.

• **Payment Procedures for Hospice Care**
  - 42 C.F.R. Section 418.302 (b)(4)
    - A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.
Percentage of Days for GIP by Location of Care

Focus on General Inpatient Care

- March 2016 OIG Report
- Supplemental Medical Review Contractor (SMRC) audit of GIP stay records
- February 2017 research on physician and nurse practitioner visits during a GIP stay
- Review of hospices who provided NO GIP in a 12 month period

OIG Report on Hospice General Inpatient Care

- Among the findings published March 31, 2016 the OIG found that “hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012
- Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms
- Study based on 565 GIP stays in FY2012
General Inpatient Data – FY 2012

- 69% of GIP stays were inappropriate ($754 million).
- 31% of GIP stays were appropriate ($268 million).
- 20% of beneficiaries did not need GIP at all during the stay.
- 10% of beneficiaries did not need GIP for part of the stay.
- 1% of beneficiaries had no evidence that they elected hospice or had terminal illness.

Reasons for Inappropriate Billing

<table>
<thead>
<tr>
<th>Reason for inappropriate GIP billing</th>
<th>% of inappropriate GIP stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary did not have uncontrolled pain or unmanaged symptoms, or the beneficiary received care that could have been provided at home</td>
<td>89%</td>
</tr>
<tr>
<td>Caregiver issues</td>
<td>15%</td>
</tr>
</tbody>
</table>

What Should Your Hospice Do?

- Review GIP documentation
  - Details on the reasons for the change in level of care
  - Documentation daily
  - Physician or NP visit documented and billed daily
  - Documentation is consistent regardless of location of GIP
    - Physician or NP visits standard practice EVERY DAY of GIP
- Review billing practices
  - Billing consistently for physician and NP visits at GIP level of care
  - On hospice claim or in Part B
- Set up Performance Improvement Plan (PIP) as appropriate
Medicare Administrative Contractors (MACs)

- Conducting claims review and possible ADR for GIP stays
- Some review for GIP stays > 5 days
- Some provider-specific review

Supplemental Medical Review Contractor (SMRC)

- At the direction of CMS Center for Program Integrity
- Contractor: Strategic Health Solutions
- Post-payment review of GIP claims for CY 2015 to identify claims for GIP care that may have been improperly paid under the Medicare Part A benefit.
- 65 hospices included in review
- Sample selected based on length of stay

Documentation Requested

- Documentation to support
  - A precipitating event for GIP care such as pain control or acute or chronic symptom management that cannot reasonably be provided in other settings
  - Interventions tried in the setting prior to GIP admission were unsuccessful
  - Pain control
  - Symptom control
Documentation Requested

- Hospice Plans of Care (POC) covering the entire GIP stay to support
  - change in the level of care including the beneficiary’s response
  - collaboration with physician services, nursing services, medical social services, and counseling
- Any other documentation to support GIP care

RECENT ANALYSIS OF PHYSICIAN AND NURSE PRACTITIONER VISITS IN GIP

Analysis of Physician and NP Visits in GIP

- 91.3 million hospice service days in FY2014
- 1,525,702 (1.7%) were billed for GIP service
- Majority of GIP was provided in hospice inpatient units
- Reported physician or nurse practitioner visits:
  - 2.5 million recorded physician or nurse practitioner line items on hospice claims
- Rate of services
  - 19.5 per 1,000 service days among non-GIP days
  - 503.1 per 1,000 service days among GIP days

Source: Abt Associates analysis (2017)
Episodes Lacking ANY GIP Hospice Services by Physician or Nurse Practitioners

• FY2014:
  – 126,953 episodes of hospice service with at least three consecutive days of GIP care
  – One in five episodes (20.8%) did not have any physician or nurse practitioner services during GIP

• This trend was more likely among episodes where hospice service:
  – Began in long-term care hospitals and skilled nursing facilities
  – Was provided by a new hospice provider, certified in 2010 or later compared to a hospice certified in the 1980s

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  – Documentation is consistent regardless of location of GIP
  – Physician or NP visits standard practice EVERY DAY of GIP

• Review billing practices
  – Billing consistently for physician and NP visits at GIP level of care
  – On hospice claim or in Part B

• Set up Performance Improvement Plan (PIP) as appropriate

Policy Questions

• Was the hospice able to provide GIP?
• Was the hospice “cherry picking” patients who were “less sick?”
• Does the hospice comply with COP requirement for a contract for GIP?
• Was quality of care compromised?
Hospices Not Providing GIP Care

- Per OIG study, 953 hospices (27%) did not provide any GIP to Medicare beneficiaries in 2011
- Of those 953 hospices:
  - 12% provided only routine home care
  - 68% did not provide continuous care
  - 62% did not provide inpatient respite care
- OIG suggests that CMS ensure that these hospices are providing beneficiaries access to needed levels of care
- One option is for CMS to adopt a quality measure regarding hospices’ ability to provide all hospice services

OIG Findings of No GIP Analysis

- OIG concerned that GIP was less likely to begin on the weekend
  - Would expect needs to be similar as weekdays
- Those using inpatient units were more likely to provide GIP to their patients
  - 35% of patients received GIP if hospice used inpatient facility
  - 12% of patients received GIP if hospice used SNF or hospital

% of Hospices Providing GIP by Setting

<table>
<thead>
<tr>
<th>Location of GIP</th>
<th>% of Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Inpatient Unit</td>
<td>23%</td>
</tr>
<tr>
<td>Hospital</td>
<td>60%</td>
</tr>
<tr>
<td>SNF</td>
<td>27%</td>
</tr>
</tbody>
</table>
OIG GIP Specific Issues

Hospice general inpatient care We will review the use of the general inpatient care level of the Medicare hospice benefit.
- We will assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
- We will also review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary.
- We will review beneficiaries’ plans of care and determine whether they meet key requirements.

GIP Basics

GIP Definition

- Per Medicare Benefit Manual: “A general inpatient care day is a day in which a patient receives general inpatient care in an inpatient setting for pain control or acute or chronic symptom management which cannot be managed in any other setting.”
- The IDG determines that symptoms cannot be managed in a home or residential setting
- Need a defined process to make decisions
What Is Short-Term?

- Regulations do not dictate the length of stay
- Length of stay varies from few days to weeks
- Shorter length of stay tends to be seen when the majority of referrals are from hospitals
- Must continually assess need and be working toward a return to a lower level of care

Who decides whether a patient needs GIP?

- The hospice IDG must make a determination based on the patient’s clinical condition whether the patient requires GIP care to manage the patient’s pain or symptoms.
- The hospice physician will review the available clinical information about the patient’s status to determine if an increase in level of care to general inpatient is required to manage the patient’s acute symptom crisis.
- Documentation of the IDG discussion and physician determination is a MUST!

Potential Indicators of GIP

- Uncontrolled pain
- Unmanaged respiratory distress
- Severe delirium
- Complicated wound care
- Imminent death with symptom management issues — only if skilled nursing needs are present
- Other symptoms not managed effectively by changes in the treatment plan at home or in another setting
Important to Remember

Severity of symptoms

Intensity of care to manage symptoms

Scenario 1

• Patient seen at home by hospice MD at request of RN. Patient had been using increased doses of opioid for reported pain and respiratory distress. Based on opioid use patient was changed to methadone equivalent. Patient became somnolent and it was assessed that she was declining. Family uncomfortable with care at home. Patient was admitted to the inpatient facility for question of terminal care and/or medication management.

• GIP appropriate for close observation and potential titration of medications

Are there any limits to the number of GIP days that can be provided?

• Each day of GIP must have documentation of ongoing assessment of the patient and a determination that this level of care continues to be appropriate. Longer stays in GIP (> 5 days at the GIP level of care) are under increased scrutiny.
When GIP Is Not Appropriate

• When Continuous Home Care is more appropriate
• Caregiver breakdown in the absence of skilled needs
• Imminent death in the absence of skilled need
• Unsafe home situation
• Awaiting placement in another facility

Scenario 2

• Call from weekend on-call nurse for a home care patient: Patient is actively dying, family adamant that death cannot occur in the home. Patient using minimal medications. Requesting an inpatient bed.
• GIP not appropriate – consider respite

Scenario 3

• 47 yr. old hospitalized patient with 18 year history of brain tumor. Now rapid decline and requesting comfort care. Hospitalist requesting hospice GIP in the hospital. Has multiple medications, intractable nausea and vomiting, and new onset of seizure activity. Prognosis expected to be less than one week.
• GIP appropriate for aggressive symptom management
DOCUMENTATION AND COORDINATION OF GIP

Patient Choice of Attending

- Must document the patient’s choice of attending MD
- CMS noted concerns with change in attending when the patient moves to an inpatient setting for inpatient care, often to a nurse practitioner
- Attending physician must be chosen by the patient (or his or her representative) and not by the hospice
- Since the hospice MD is responsible for meeting the medical needs in the absence of the attending physician, there is not a need to change attending when admitted to the hospice facility

Care Coordination

- CoP 418.56 (e)(4) – must share information among all staff in all settings
- Team members must coordinate internally prior to the transfer
- While at GIP level, IDG must coordinate care, education and discharge planning
- IDG must coordinate with facility staff if care provided in hospital or SNF
Scenario 4

- Patient was being cared for in an LTAC for osteomyelitis and sepsis. Plan of care reassessed and patient requested no further aggressive measures nor antibiotics. No longer eligible to remain in the LTAC. Patient has multiple wounds requiring pre-medication, 3 staff to change dressing requiring approximately 45 minutes for each dressing change. Admitted to SNF at GIP level. Wound care nurse consulted to assess for simpler dressing protocol.

Transfer Documentation

- Documentation prior to and at transfer must include the following:
  - The precipitating crisis – Why is GIP required?
  - Interventions tried at home or at lower level of care that did not manage needs
  - Involvement of the IDG and attending MD in the decision to change to GIP
- Be aware that any GIP care provided in another location must be considered before transfer to the hospice facility

Inpatient Documentation

- Documentation during the GIP stay must include the following:
  - Supportive data that the crisis is ongoing – symptoms being managed, education provided
  - Ongoing measures utilized to meet the needs
  - The patient’s response to interventions
  - Quantitative data - Weight, vital signs, meal % eaten, calories counts, intake/output, pain ratings and quotes from the patient and/or family
  - Education to the patient and family
**Narrative Comments**

- Must individualize documentation
- Check boxes can be used for symptoms and interventions
- BUT, narrative information is critical to help further support the need for GIP
- Must show specifics of each patient’s situation
- Since various disciplines document individually, a clinical note can help pull it all together
- **Documentation must support each day of GIP**

**Narrative Comment Focus Areas**

- Specific reason for GIP beyond generic terms
- Symptoms – to what extent are pain or other symptoms impacting comfort – include physical, mental, and emotional symptoms
- Frequency of nausea, shortness of breath, or other distressing symptoms
- Frequency of need for staff intervention to monitor behavior
- Summary of interventions to manage symptoms and patient’s response

**Narrative Comment Focus Areas**

- Symptoms – frequency, severity, impact on comfort and quality of life
- Medications – frequency of PRNs used, changes in orders, effectiveness of changes
- Wounds – specify location, size, drainage, treatment, changes in appearance, what makes the care complex
- Other Interventions – Suctioning, positioning, spiritual support
Narrative Comment Focus Areas

- Extent of education needed to patient and family, including response to education
- Details of staff involvement in discharge planning and family response to discussion
- Reason why GIP LOC is needed for a longer length of stay patient – address the care being provided that cannot be managed at a lower level of care

Sample Documentation

- GIP Note: “Patient continues to rate pain at an 8, with a desired pain level of a 4 or below. IV Morphine and Promethazine initiated 2 hours ago (see medication flow sheet). Has vomited 75 ml clear liquid since Promethazine was given, no oral intake. Will continue to monitor pain and vomiting and titrate medications to alleviate symptoms.”

Suggested Language

<table>
<thead>
<tr>
<th>Not Enough Detail</th>
<th>Alternate Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Complaints</td>
<td>Interventions effective in managing (insert symptom)</td>
</tr>
<tr>
<td>Patient Stable</td>
<td>Care needs being managed by (insert intervention)</td>
</tr>
<tr>
<td>Patient sleeping</td>
<td>Patient resting quietly after earlier (insert intervention)</td>
</tr>
<tr>
<td>GIP for pain management</td>
<td>GIP to manage uncontrolled pain in (insert location); continues to require titration of (insert med)</td>
</tr>
<tr>
<td>Requires monitoring</td>
<td>Condition monitored ongoing for (insert symptom)</td>
</tr>
<tr>
<td>Patient nonverbal</td>
<td>Requires skilled nursing assessment for nonverbal signs of pain/discomfort</td>
</tr>
</tbody>
</table>
Suggested Language

<table>
<thead>
<tr>
<th>Not Enough Detail</th>
<th>Alternate Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions effective</td>
<td>Effectiveness of symptom management is continuously re-evaluated to achieve optimal comfort</td>
</tr>
<tr>
<td>Support Given</td>
<td>Listened to patient express fear of dying; provided education on disease process</td>
</tr>
<tr>
<td>Complaints of shortness of breath</td>
<td>Voiced complaint of SOB with evidence of use of accessory muscles, pursed lip breathing, unable to carry on conversation</td>
</tr>
<tr>
<td>Patient Anxious</td>
<td>Patient asks not to be left alone, fidgeting with buttons on shirt, talking rapidly</td>
</tr>
<tr>
<td>Education provided</td>
<td>Explained medication changes to wife – purpose, expected outcome, side effects</td>
</tr>
</tbody>
</table>

Social Worker & Chaplain Notes

- Full IDG needs to document to support GIP
- Chaplains and SWs can address family coping, education, support systems
- Also need to note symptom management issues they identify or that are reported by family
- Increase visits when patient at GIP level of care as indicated
- Assist with care coordination – facility staff, clergy
- Assist with financial and legal issues

Plan of Care Documentation

- Revise the plan of care – include the problems, interventions and expected outcomes
- Ensure that assessments and the plan of care correlate
- A physician order for GIP must be in place
- Involve attending MD in discussion of GIP prior to transfer
Education & Transition Planning

• Need ongoing documentation of education to the patient/family to help prepare them to resume care
• Communicate the short-term nature of GIP is communicated prior to and during the stay
• **Begin transition planning at admission** – discuss options to return pt. to another setting or lower level of care
• Document patient and family response to education
• Determine options if patient cannot return home – may need to change to RHC

Ethical Considerations

• Caregiver issues vs. symptom management needs
• Family doesn’t want death to occur at home
• Drug diversion issues
• Hospital relationships – using hospice facility as a step-down unit before transfer home
• Pressure from referrals for higher level of care due to higher reimbursement
• Actions of competitors

Discharge plan

• Discharge planning begins on admission and continues throughout the GIP stay
• It is time to discharge when
  – Reason for admission stabilized
  – Appropriate discharge plan has been developed that addresses the patient’s
    • Physical needs
    • Psychosocial needs
    • Emotional needs
    • Spiritual needs
Discharge plan

• Inpatient hospice staff coordinates with home hospice staff about discharge date and needs
  – There should be evidence of coordination in the documentation
• Documentation should evidence discharge planning
  – Referrals
  – Alternative care environment
  – Family support

Scenario 5

• Newly admitted patient with a non-cancer diagnosis is cared for by a daughter who is managing care fairly well. Other family members question her ability to provide care based on a past substance use issue. One family member removed medications from the home. Medical Director requests an inpatient bed.
  • GIP may be appropriate, but need more information

MODERATING RISKS
Managing the Provision of GIP

• Educate administrative, clinical and marketing staff on proper utilization of GIP
• Educate referral sources on triggers for GIP
• Establish a process for review of each patient’s situation to determine if GIP is the most appropriate course of action – Have interventions been implemented and proven ineffective?
• Ensure patients who are imminently dying have symptom management issues warranting GIP

Managing the Provision of GIP

• Address the need for staff of contracted providers, i.e., hospitals and skilled nursing facilities, to document to support GIP need
• Ensure patients who are imminently dying have symptom management issues warranting GIP
• Ensure decisions are made based on clinical need and not economic need, i.e., to keep hospice inpatient facility beds at capacity
• Maintain contracts to provide respite when the issue is caregiver fatigue/breakdown

Important Actions to Manage GIP Care

• Educate administrative, clinical and marketing staff on proper utilization of GIP
• Educate referral sources on triggers and eligibility criteria for GIP
• Establish a process for review of each patient’s situation to determine if GIP is the most appropriate course of action – Have interventions been implemented and proven ineffective?
Eligibility for GIP in Other Settings

- Need to ensure that higher level of care is warranted
- What care is needed that can’t be managed in another setting or at a lower level of care?
- Remember that imminent death without skilled care or symptom management needs is not a reason for GIP
- Document what interventions were tried in the hospital and what symptom management needs remain
- Visit patient before transferring to hospice facility to ensure eligibility

Internal Audits

- Establish criteria for audits
- Have experienced staff review GIP documentation
- Utilize pre-bill audits to determine if level of care should be billed
- Consider auditing 100% of long stay patients – set agency threshold
- Audit a defined % of all lengths of stay
- Use Palmetto GBA audit tool to ensure all elements documented
- Share results of audits with all staff and provide additional education

Documentation of GIP Care

- Five topics need to be addressed to help ensure documentation supports GIP level of care:
  1. Identify the precipitating event that led to GIP status
  2. Describe failed attempts to control symptoms that occurred prior to admission
  3. Identify specific symptoms that are being actively addressed
  4. Describe the services provided
  5. Document care that patient’s caregivers cannot manage at home. Some examples are frequent changes in the dose or schedule of medications or the need for IV medications.
Monitor Federal Data

• Review reports from OIG, Abt Associates, etc.
  – Abt Associates reports are on Hospice Center page of CMS website
  – OIG reports are published online
• Compare statistics to national statistics
• If red flags are raised consider performance improvement project

Monitor Data

• Monthly data analysis
  – Location of GIP
  – Average and Median LOS
  – Number of long stay patients – set a threshold
  – Setting and level of care day before GIP admission
  – Variations in GIP utilization by RN case manager
  – Utilization of GIP

Characteristics of a Good Audit Tool

FORMAT/STRUCTURE
• Keeps data separate
• Allows ease of compilation
• Paper or electronic
• Timeframe clear (e.g., closed record; after admission)
• Instructions for reviewer(s)
Characteristics of a Good Audit Tool

**YIELDS ACTIONABLE INFORMATION:**
- Identifies Problems
- Supports decision making (scoring)
- Detects differences and deficiencies
- Consistent results across multiple reviewers
- Ease of use
- GIP Audit Tool prepared by Palmetto GBA on NHPCO website

On the Quality Side

FY 2018 Hospice Wage Index Final Rule

The OIG- CMS Process
Measures Under Development

Priority Area 2: Access to levels of hospice care
• Claims based measure
• Appropriate use of CHC and GIP
• Appropriate use of CHC and GIP increases the likelihood of a hospice patient dying in his or her location of choice, decreases health resource utilization resulting in potential cost savings, and increases patient and caregiver satisfaction

Measures Under Development

Priority Area 2: Access to levels of hospice care
• Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs

CASE STUDIES
ZPIC Decision 1

• Dates of GIP Reviewed: October 3 – 13
• Diagnosis: End-stage Dementia
• History: Transferred from dialysis to the emergency department on 10/3. Found to have a hemoglobin of 4 and possible pneumonia. Family opted for comfort measures only. Transferred to hospice facility for end of life care. Had multiple Stage III decubiti – sacrum and bilateral heels. SNF had been providing extensive wound care.

ZPIC Decision 1 (cont.)

• Documentation:
  – The inpatient nursing notes indicated that he would yell out if touched but otherwise lying in bed with no signs or symptoms of pain.
  – Received scheduled Morphine concentrate per PEG tube prior to wound care. Dressing changes required two staff members due to patient not able to assist with turning and packing required.
  – No other documentation of interventions necessitating GIP level of care noted.

• On 10/11, patient was moaning, had prolonged periods of apnea and terminal congestion necessitating suctioning multiple times per shift.
  – Atropine drops added to regimen.
  – 10/12-13, required Ativan, Morphine concentrate and/or Atropine drops every two hours for comfort. Patient died on 10/13.

• Decision: Partially Favorable – 8 days denied at GIP, 3 days GIP paid
ZPIC Decision 2

- **Dates of GIP Reviewed:** February 1 – 3
- **Diagnosis:** End-Stage CVA
- **History:** CVA in early January. Received treatment and was discharged to SNF for rehabilitation. Sudden onset of altered mental status. Transferred to ED on 1/28 and found to have pneumonia. Noted to be essentially unresponsive and not responding to therapy. She was transferred to the hospice inpatient unit for supportive care.

ZPIC Decision 2 (cont.)

- **Documentation:**
  - Nursing note indicated beneficiary was "awake, pleasant and speaking much better."
  - Additional documentation notes positive bowel sounds, no pain, bilateral lower extremity edema, diminished breath sounds, confused and skin intact.
  - She was noted to have periods of restlessness and attempting to get out of the bed for which she received oral Haldol on four occasions.
- **Decision:** Unfavorable – 3 days GIP denied

ZPIC Decision 3

- **Dates of GIP Reviewed:** July 1 – 15
- **Diagnosis:** Amyotrophic Lateral Sclerosis
- **History:** Admitted to Hospice Facility for GIP with distended abdomen, probable ileus, and nausea. Had PEG tube for feedings. Wife very involved in care.
ZPIC Decision 3 (cont.)

• **Documentation:**
  - Nursing notes indicated pain medication titrated to comfort for abdominal discomfort and nausea.
  - Feedings withheld 7/1-7/3. Abdominal distention resolved 7/3.
  - Then multiple changes in method of feeding and type of formula used were documented through 7/5.
  - MD note of 7/5 indicates spouse is managing the PEG feedings and symptoms are well managed with current medication regimen.

• Remained GIP through 7/15 with ongoing observation of symptoms noted, but no significant changes in medications.
• Patient did not appear to have any uncontrolled symptoms or pain after 7/4. Feedings managed by 7/5

**Decision:** Partially favorable – 9 days denied at GIP, 5 days paid at GIP

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Wrap Up

• Criteria must be met for every day of GIP care
• Documentation must reflect severity of the symptoms and intensity of the care/services each day of GIP care
• Planning for patient transition back to RHC begins as soon as GIP begins
• The hospice is the manager of the patient’s POC in a contract GIP situation
• Monitor GIP care and documentation in real time
NHPCO members enjoy unlimited access to Regulatory Assistance
Feel free to email questions to regulatory@nhpco.org