



Regulatory Lessons Learned from One Family's Hospice Experience.

NHPCO LEARNING MODULE

Regulatory Lessons Learned from One Family's Hospice Experience.

This guide is designed to accompany the NHPCO Learning Module, *"Regulatory Lessons Learned from One Family's Hospice Experience,"* and can be used as new employee orientation or in service education, as a whole or by focusing on each Case Study excerpt. We hope that it provides opportunities for your hospice team to discuss the topics, reflect on your hospice's current practice and consider best practices to provide excellent patient and family communication and services provided by the hospice. The final page is a simple worksheet that may be printed off and shared with those participating in new employee orientation or an in-service.

INTRODUCTION

The content and issues presented in this learning module, *Regulatory Lessons Learned from One Family's Hospice Experience*, provides an important learning opportunity for the field. NHPCO leadership, the board, and the NHPCO Regulatory Committee have been particularly concerned about the family experience that is shared in this learning module. Providers should study this family's experience and incorporate some changes in their processes. Some background may be helpful in explaining why the content of this learning module is particularly relevant for the field.

ONE FAMILY'S HOSPICE EXPERIENCE

In March of 2022, NHPCO held its annual Leadership and Advocacy Conference at the Gaylord National Harbor Convention Center. As part of the conference, NHPCO held a Regulatory CMS Update as an in-person concurrent session. NHPCO has offered this concurrent session for many years as part of the annual conference and traditionally speakers from CMS either attend in person or present virtually, often recording their presentations in the week prior to the conference so the content is timely and relevant. Among the broad content covered as part of the conference's CMS Regulatory Update, speakers from the Centers for Medicare and Medicaid Services addressed what they considered some common "myths and realities" with the Medicare hospice benefit and a powerful case study was shared by CMS that is vitally important for all providers to hear and learn from.

Regarding the case study that CMS shared and is the focus of this learning module, it is helpful to know that CMS shares anecdotal reports collected from a variety of sources, including reports to its policy mailbox, consumer calls that come into the 1-800-Medicare support line, the CMS ombudsman's office, the quality improvement organizations, and even direct reports from beneficiaries and their families. This case study was received by CMS from the family of a beneficiary.

LEARNING OBJECTIVES & OUTCOMES

- **Determine** fact versus myth for Medicare hospice compliance from the family's hospice experience.
- **Recognize** the impact of misinformation shared by hospice staff on family and caregiver's hospice experience.
- **Identify** ways to use this video, discussion guide, and the "fact versus myth" handout for new staff orientation and in-service education.

FACULTY



Jennifer Bauguss, MHA, CPCO, CPC, CPMA, CEMC, AAPC Fellow, Vice President for Compliance and Quality, Trellis Supportive Care, Winston-Salem, North Carolina.

Jennifer Bauguss has over 20 years of diverse healthcare experience in a variety of clinical and administrative roles. She has been the Vice President of Compliance & Quality for Trellis

Supportive Care since February 2018. She serves as the agency's Compliance Officer, Emergency Coordinator, and oversees Health Information Management, Clinical Education, and Infection Control in addition to the Compliance and Quality programs. Jennifer is a third-year Ph.D. student in Organizational Leadership at Carolina University. She is certified through the AAPC as a professional compliance officer, professional coder, professional medical auditor, Evaluation & Management professional, instructor, and fellow. She is currently serving on the NHPCO Regulatory Committee.



Judi Lund Person, MPH, CHC, Vice President, Regulatory and Compliance, National Hospice and Palliative Care Organization, Alexandria, Virginia.

Judi been NHPCO's Vice President, Regulatory and Compliance since July 2002. Judi serves as a key contact with the Centers for Medicare and Medicaid Services, interfacing with hospice payment policy, Part D, survey and certification, contractor management, and program integrity functions, among others. She also represents hospice and palliative care with the Medicare Administrative Contractors and other federal agencies and many national organizations. She is a frequent speaker at state and national meetings and works daily with hospice providers and state hospice organizations on the ever-increasing array of regulatory and compliance issues. She works with her team at NHPCO to develop regulatory and compliance tools, including hospice payment rates and wage index values and compliance guides. She is also a certified compliance professional (CHC).



Lauren Templeton, DO, HMDC, Medical Director and Physician Consultant, with Hendrick Hospice Care in Abilene, Texas, and with Weatherbee Resources.

Lauren Templeton, a medical director with Hendrick Hospice Care for 8 years and a physician consultant with Weatherbee Resources since 2017, has over 10 years specializing in hospice and palliative medicine. In her role at Hendrick Hospice, she assists with compliance, quality improvement and documentation review. She continues to participate in clinical care managing hospice patients in both the home care and inpatient setting. Dr. Templeton also serves as associate medical director for the Palliative Care Department at a local medical center, as well as serving on the foundation board, medical executive committee, and ethics committee for the same facility.

As a Physician Consultant with Weatherbee, Dr. Templeton assists hospice providers and physicians with education, coaching, and mentoring for hospice physicians, auditing physician and other clinical record documentation (e.g., thoroughness and appropriateness with regard to hospice eligibility; compliance with regulatory requirements; appropriateness with regard to coverage determinations; etc.), and record review or expert witness testimony on legal matters involving patient eligibility. Dr. Templeton graduated from Pennsylvania State University with a Bachelor of Arts and received her doctor of osteopathy from Ohio University College of Osteopathic Medicine in 2009. She completed a residency in Internal Medicine and is board certified with the American College of Osteopathic Internists. She completed a fellowship in Hospice and Palliative Medicine at Texas Tech University and became board certified in hospice and palliative medicine in 2013. She obtained additional certification with the Hospice Medical Director Certification Board in 2018. Dr. Templeton also serves as a current member of the NHPCO Regulatory Committee.



Alix Ware, JD, MPH, Director, Health Policy, National Hospice and Palliative Care Organization, Alexandria, Virginia.

Alix Ware joined NHPCO in December 2021. In her role, she tracks and prepares materials related to hospice regulations, legislation, policies, and sub regulatory guidance. Her focus is on improving access, promoting health equity, and enhancing health care innovation. In previous roles, Alix has provided support to local health departments in the areas of public health law, ethics, and health in all policies as well as support the Pitt Law Health Care Compliance Program. She holds a Master of Public Health in health policy and management and a Juris Doctor with a certificate in health law and concentration in public policy from the University of Pittsburgh. She also holds a Bachelor of Science in community health from the University of Illinois at Urbana-Champaign. She is certified in public health.



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CASE STUDY

The following story is an actual family's story that was shared with the Centers for Medicare and Medicaid Services (CMS). CMS provided the content with NHPCO as an anecdotal report.

This is the experience of Ruth, an 83-year-old female who was diagnosed with an aggressive kidney cancer. After surgery and a few rounds of immunotherapy, scans showed rapid and extensive metastasis and the decision was made to forgo any disease altering treatment and she elected hospice care.

The primary caregivers are her 84-year-old husband, Dave, who is an amputee with his own chronic health issues. They also have two adult children, Claire and her brother, who live approximately 30 minutes away, but who provide support and additional caregiving.

At the admission visit, Claire and Dave were provided information about the services hospice provides.

They were given information on the medications, equipment, and supplies the hospice would furnish. They were informed about the levels of hospice care. The patient and family were told that Medicare only allows for one routine nursing visit and up to three hospice aide visits per week. They were also told that the hospice could not provide continuous homecare as the hospice did not have the bandwidth to provide that intensity of nursing care in the home. Ruth and Dave were given the phone number for the hospice nurse line and were instructed to call that number instead of 911 if there were any changes in condition or concerns.

Ruth was admitted to hospice for routine home care on February 4th and the patient and family were told that the next scheduled nurse visit will be on February 17th. When asked why it would be so long for the next visit, they were told that Medicare only requires hospice to make the visit once every 14 days, but they were instructed to call the nurse line if there were any issues in the interim.

After her hospice admission, Ruth experienced a myriad of symptoms, including intractable diarrhea, a new pressure ulcer, increased anxiety, restlessness, and insomnia, as well as unrelenting pain not relieved with the ordered Oxycodone and Fentanyl patch. She developed terminal agitation and would go 48 hours or more without sleep. Over the course of a week, she could no longer ambulate, and her husband, an amputee, and her children would have to do a full lift to get her in a wheelchair and to the bathroom.

From the time that she was admitted until her next scheduled visit, her husband and children called the hospice on almost a daily basis. Often, there were multiple calls in one day to the nurse line. The nurses would triage the hospice care over the phone.

Frequent changes to the medications, dosages, and frequencies were made. Her husband, Dave, was becoming increasingly distraught and was often worried about an accidental overdose because of the sheer volume of medications that had been ordered. It was overwhelming for him to be her nurse, her pharmacist, her aide, and her physical and occupational therapist.

Within a few days of the hospice admission, Ruth developed significant dysphagia and could no longer swallow the pain and anxiety pills. She was not eating and only taking minimal sips of water. The hospice was called to request liquid medication. Dave was instead instructed to crush the pills, mix them with a little water, and give them to Ruth in a syringe. He was also told that Medicare would not pay for liquid Oxycodone because it was non-formulary.

After several more days of crushing pills, and many more phone calls to the hospice, a nurse did make an unscheduled visit and liquid morphine was finally ordered. However, Dave had to continue crushing anxiety pills for the ever-increasing restlessness.

Ruth continued with insomnia, and escalating agitation and Haldol was ordered. After several doses of Haldol, and just as many calls to the nurse line, it was evident that the Haldol was ineffective to control her symptoms and yet another medication was ordered for Dave to administer to Ruth.

After four more after-hours calls to the nurse line and two same night nurse visits, it was finally decided that Ruth's symptoms could not be managed in the home, and she was transported to inpatient hospice. Upon admission to inpatient hospice, Ruth received IV medications to control her symptoms, and for the first time in three weeks Dave could be just her husband, instead of her full-time caregiver in constant crisis mode.

After Ruth was settled in her room, a social worker met with Dave and told him that Medicare only allows for five days of general in-patient care, and after those five days, the family would have to pay for room and board. However, the hospice doctor stated that Ruth would not be able to return home as her symptoms could not be managed in the home, and she would continue to need IV medications. Dave said he was stunned when the social worker told him this as his wife had not even been at the hospice facility for four hours, and he thought that hospice will cover everything for his wife as she approached the end of her life.

MYTHS (MISREPRESENTATIONS)

- Hospice only provides one nursing visit and up to 3 aide visits per week.
- Hospice does not provide Continuous Home Care – "hospice don't have the bandwidth."
- Next scheduled nursing visit two weeks away – "Medicare only requires us to make a nursing visit every 14 days."
- "Medicare would not pay for liquid Oxycodone."
- Haldol prescription not working. Four more after hours calls to nursing line.
- "Medicare only allows for five days of inpatient care," after that the family would have to pay room and board.
- No mention of physician or NP working with the family.

REALITIES

- Hospice develops plan of care and provides visits according to patient and family need.
- Providing all four levels of care is a condition of payment. Not providing one level of care could lead to termination of Medicare certification.
- There is NO requirement for nursing visits every 14 days. Nursing visits, as well as visits from other disciplines, should be dictated by the plan of care.
- Medicare pays for drugs as determined by the hospice and their formulary; this is the hospice's decision.
- GIP is provided for as long as the patient needs GIP. Documentation for continued need is expected.



CASE STUDY EXCERPTS AND KEY TAKEAWAYS

Excerpt #1: Nursing and Aide Visits

They were informed about the levels of hospice care. The patient and family were told that Medicare only allows for one routine nursing visit and up to three hospice aide visits per week.

Excerpt Start: Minute 12:55 seconds

Target Hospice Team Audience:

- Hospice Compliance and Quality Professionals
- Hospice case managers
- Team leaders
- Admissions staff
- Nurses

Suggested Communication:

- Provide services based on the patient's need
- Assess each patient individually
- Stop and listen to the family, answering questions and addressing confusion
- Provide extra support

How would our hospice respond?



Excerpt #2: No Continuous Home Care

They were also told that the hospice could not provide continuous homecare as the hospice did not have the bandwidth to provide that intensity of nursing care in the home.

Excerpt Start: Minute 17:03 seconds

Target Hospice Team Audience:

- Hospice C-Suite
- Administrators
- Hospice Compliance and Quality Professionals
- Hospice case managers
- Team leaders
- Admissions staff
- Nurses

Communication Concerns:

- Was this the stance of the provider? Or did the staff person hear staffing was a problem for CHC?
- A hospice must provide all four levels of care to continue to be Medicare certified – this is a Condition of Payment
- Hospice PEPPER, Hospice Care Index and audits will identify no CHC as an issue

How would our hospice respond?



Case Study: Excerpt #3
Frequency of Nursing Visits

Excerpt #3: Frequency of Nursing Visits

Ruth was admitted to hospice for routine home care on February 4th and the patient and family were told that the next scheduled nurse visit will be on February 17th.

Excerpt Start: Minute 21:23 seconds

Target Hospice Team Audience:

- Administrators
- Hospice Compliance and Quality Professionals
- Hospice case managers
- Team leaders
- Admissions staff
- Nurses

Concerns and Suggested Communication:

- What did the hospice intend to say?
- Where did the nurse get this information?
- Describe the care planning process and discuss how visit frequency is determined
- Assure family the nurse will visit as the patient and family need visits
- Know the CoP requirement

How would our hospice respond?

Excerpt #4: Family Calls on an Almost Daily Basis

From the time that she was admitted until her next scheduled visit, her husband and children called the hospice on almost a daily basis.

Excerpt Start: Minute 27:45 seconds

Target Hospice Team Audience:

- Administrators
- Hospice Compliance and Quality Professionals
- Hospice case managers
- Team leaders
- Admissions staff
- Nurses
- On call staff

Hospice Best Practice:

- If a family calls more than one time after hours, nurse should make a visit
- The hospice should have policy and procedure for frequent after-hours calls
- Does the hospice have a way to track how many times the family calls during the day?
- If the family is calling for a clinical reason, the hospice should visit.

How would our hospice respond?



Case Study: Excerpt #4
Family Calls on an Almost Daily Basis



Excerpt #5: Patient Can No Longer Swallow – Medication Challenge

Within a few days of the hospice admission, Ruth developed significant dysphagia and could no longer swallow the pain and anxiety pills.

Excerpt Start: Minute 36:03 seconds

Target Hospice Team Audience:

- Hospice Compliance and Quality Professionals
- Hospice case managers
- Team leaders
- Nurses
- Pharmacists

Suggested Communication and Practice:

- Med review and family teaching
- Look for family signs of hesitation or worry
- Is the family comfortable with process?
- Look at formulary – is there another alternative for patients who can no longer swallow?
- Contact the doctor
- Formulary should not be a barrier to finding a successful treatment plan

How would our hospice respond?



Excerpt #6: Haldol Not Working

Ruth continued with insomnia, and escalating agitation and Haldol was ordered. After several doses of Haldol, and just as many calls to the nurse line, it was evident that the Haldol was ineffective to control her symptoms and yet another medication was ordered for Dave to administer to Ruth.

Excerpt Start: Minute 43:39 seconds

Target Hospice Team Audience:

- Hospice medical director
- Hospice physicians
- Hospice Compliance and Quality Professionals
- Pharmacists
- Hospice case managers
- Team leaders
- Nurses

Hospice Practice Concerns:

- Number of after-hours calls should be a sign for the after-hours team
- Were there other things that could be tried?
- Could there be a physician consult or NP visit?
- How do you decide a higher level of care is needed?

How would our hospice respond?



Case Study: Excerpt #7
Number of Inpatient Care Days

Excerpt #7: Number of Inpatient Care Days

Four hours after Ruth was settled in her room, a social worker met with Dave and told him that Medicare only allows for five days of general in-patient care, and after those five days, the family would have to pay for room and board.

Excerpt Start: Minute 48:50 seconds

Target Hospice Team Audience:

- Administrator
- Hospice inpatient management
- Hospice Compliance and Quality Professionals
- Social workers
- Hospice case managers
- Team leaders
- Finance/billing

Hospice Practice Concerns:

- Was social worker confused about the 5-day maximum? Did they think it was respite?
- If GIP, where did the information come from?
- Timing of social worker meeting so soon after admission?
- What else should the hospice do?

How would our hospice respond?



Hospice Physician GIP
Documentation

Hospice Physician GIP Documentation

A discussion of hospice physician GIP documentation, including three vital components:

1. **Medical Necessity/Physician Decision Making**
 - Clear delineation from administrative duties
2. **Evaluation & Management (E&M) Coding requirements**
 - Fulfill Complexity or Time-Based billing components
3. **Demonstration of Level of Care**
 - Documentation of acute symptoms

Excerpt Start: Minute 56:34 seconds

Target Hospice Team Audience:

- Administrator
- Hospice medical director
- Hospice physicians
- Finance/billing
- Hospice inpatient management
- Hospice Compliance and Quality Professionals

GIP Documentation Best Practices

- Individualized, up-to-date, accurate documentation. Specific to each patient each visit
- Clear documentation of physician services above & beyond administrative duties
- Describe acute symptom burden requiring the higher level of care
- Must also collaborate with core members of the IDG to lead care

A purple rectangular graphic with a white geometric pattern. The text "Case Study: Excerpt #8" is in white, and "Call to Action" is in a smaller white font below it. The NHPCO logo is in the bottom right corner.

Case Study: Excerpt #8
Call to Action

Excerpt #8: Call to Action

"Beneficiaries and their families are vulnerable, and they are scared. They trust you to tell the truth about the full range of hospice services covered on Medicare. They trust you to show up and be there when you are needed the most. We must do better. You must do better. I never want to receive another report, in which a beneficiary and their family says that routine home care under the Medicare hospice benefit wasn't enough. Even enough care is unacceptable, but for terminally ill patients and their families, hospice routine home care should always be more than enough."

–Kelly Vontran, Deputy Director

CMS Center for Medicare, Chronic Care Policy Group,
Division of Home Health & Hospice

RESOURCES OF NOTE

1. [Electronic Code of Federal Regulations, Hospice Care](#)
2. [NHPCO Regulatory and Compliance Center, Levels of Care](#)
3. [Hospice GIP Audit Tool](#)



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Learning Module Worksheet: Regulatory Lessons Learned from One Family's Experience

Name: _____ Date: _____

Immediately after watching the case study and the faculty discussion, reflect on your reactions:

LESSONS LEARNED

Based on this case study, what are some of the missteps made in communicating with the patient and family?

Based on this case study, identify a change you will make in your professional practice/job function (i.e. what will you do differently)?

Based on this case study, what will you communicate to your team and translate into changes to improve team performance.

Reflect on this case study. What was your key takeaway and who on your team will you share or discuss it with:

ADDITIONAL NOTES

What would we do in our hospice?
