Eli's Hospice Insider

DOCUMENTATION: Polish Your Hospice GIP Documentation Skills

Make sure your inpatient claims for hospice patients can stand up to tough review.

Now's the time to make sure your hospice general inpatient (GIP) claims will pass muster with reviewers. A recent whistleblower lawsuit highlights GIP's status as a hospice hot spot (see the articles on pages 49 and 51).

While reviewers haven't made GIP care review as high a priority as they could have, they are probably looking harder at documentation for the level of care compared to previous years, says **Jay Mahoney,** a consultant with Summit Business Group in Penfield, N.Y.

As with so many reimbursement and compliance issues, a hospice's GIP fate relies heavily on the quality of documentation in the patient record, experts agree. If documentation does not support eligibility for GIP-level care, "then it does not matter whether the patient was eligible or not," cautions consultant **HeatherWilson** with Weatherbee Resources and the Hospice Education Network in Hyannis, Mass. "The hospice can't prove it if it is not documented."

"It actually just comes down to one word -- documentation!" stresses consultant **Judy Adams** with Adams Home Care Consulting in Chapel Hill, N.C. Improving and perfecting documentation is a simple concept but a difficult challenge to execute, Wilson acknowledges. "It all comes back to the same thing -- what does the medical record say -- or not."

Tip: Wilson recommends working with all levels of hospice clinical staff, from the medical director to the aides, to "know the importance of documentation and how to document accurately, thoroughly, and clearly in each patient's clinical record."

It's irrelevant whether the person reviewing your claim and medical records is from the intermediary, the OIG, the U.S. Attorney's Office, the Recovery Audit Contractor, etc. in response to an audit, probe edit, an investigation, a whistleblower lawsuit, or whatever, Wilson notes. "It does not matter -- the only evidence they have to go on is the medical record."

Do this: For GIP care specifically, "the documentation must clearly demonstrate the patient's need for this more intensive level of care," Adams advises. And it must show the skilled services provided relate to the reason the GIP care is necessary. "Clinical notes cannot read like the ones when a patient is in routine home care," Adams warns. "They should focus on the short-term acute issues that necessitate the hospital stay and what is being done to address those needs." They should also show discharge planning to return the patient to routine home care.

Consider Daily Review for Inpatient Stays

Consultant **Beth Carpenter** with Beth Carpenter & Associates in Barrington, Ill. and **Samira Beckwith** with Hope Hospice and Community Services in Ft. Myers, Fla. recommend a daily review to assess whether patients continue to qualify for the higher level of care, which should also be documented.

Bottom line: "The key is the description of the patient's condition with articulate, objective, supportive documentation," Carpenter concludes. "Each note for inpatient care should clearly show the necessity for the inpatient level of care, the actions being done to control the identified problem/issue, and the progress toward return to routine home care," Adams adds.

Red flags: You may have a tough time defending your claims if your records have one of these common pitfalls, Adams says: * "Long lengths of stay in inpatient units; * Moving the patient to less intensive areas like step-down units;

* Documentation of custodial care;

* Documentation that reflects the same type of care/services as routine home care."

Beware: Increased scrutiny of GIP care has Beckwith worried that the service will be underutilized by cautious hospices, resulting in beneficiaries who have trouble accessing a needed service. "We don't want people to get scared and not provide it," she tells **Eli.**