THE CONNECTICUT
HOSPICE

Nuvance Health Supportive/Palliative Care Education Day Conference

Hospice, GIP, and CoPs

Joseph Sacco, MD

CMO, The Connecticut Hospice, Inc.

June 8, 2023

GIP: What Does Medicare Say?

THE CONNECTICUT HOSPICE

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services

Under Hospital Insurance

(Rev. 11056, 10-21-21)

What Does Medicare Say?

General inpatient care (refer to §40.1.5);

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.***

What Does Medicare Say?

- General inpatient care is allowed when the patient's medical condition warrants **a short-term inpatient stay** for pain control or acute or chronic symptom management **that cannot feasibly be provided in other settings.**
- **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. If a patient in this circumstance continues to need pain control or symptom management, **which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care**, general inpatient care is appropriate.

What Does Medicare Say?

THE CONNECTICUT HOSPICE

- **Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring.**

What Does Medicare Say?

THE CONNECTICUT HOSPICE

Hallelujah!

But..., wait..., the VERY NEXT SENTENCE says...,

What Does Medicare Say?

"It is **not** **appropriate to bill Medicare for general inpatient care days for situations where the individual's caregiver support has broken down unless the coverage requirements for the general inpatient level of care are otherwise met**. For a hospice to provide and bill for the general inpatient level of care, **the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting."**

***NOT* appropriate!**

What Do I Say?

Marrying for money may not be such a bad idea after all.

What Does The NHPCO Say?

THE CONNECTICUT HOSPICE

A Compliance Guide to Hospice General Inpatient Care

June 2018/Revised February 2022

https://www.nhpco.org/wp-content/uploads/NHPCO_GIP_Compliance_Guide.pdf

What Does The NHPCO Say?

PAGE 1:

GIP may be required in order to manage acute pain and other symptoms that cannot feasibly be managed in any other setting. (Their underlining, not mine.)

What Does The NHPCO Say?

PAGE 1:

While GIP care is *often the subject of scrutiny by the Centers for Medicaid and Medicare Services (CMS) and the Office of the Inspector General (OIG),* this should not discourage hospice providers from providing this level of care when needed. (NOTE: The scary red and soothing purple highlighting is mine, not the NHPCO's)

What *Else* Does The NHPCO Say?

GIP may be initiated when the interdisciplinary group (IDG), ***specifically the hospice physician (that's me!)***, determines that the patient's pain or other symptoms cannot be effectively managed in any other setting, including the patient's home or other residential setting. This may occur suddenly after a period of gradual decline, with a sudden change in symptoms or condition, or when Continuous Home Care (CHC) has failed to relieve the problems.

(Those of you working at hospices with sufficient staff to provide continuous home care on demand raise your hands and please let me know if you are looking for a new CMO.)

Nurse Ralph calls. His patient, Mr. Jones, has had a sudden increase in pain. He's used 5 BT's of morphine 10 mg SL today and still has 8/10 pain. Can we admit him to the IPU, please?

Pretty please?

Ummm...,

THE CONNECTICUT HOSPICE

Well…,

No. No, Ralph, you can’t.

What Does The NHPCO Say?

The nurse should document pain and symptom management interventions that were implemented in the home (or wherever they reside) prior to initiating the GIP level of care and the patient's response.

What Does The NHPCO Say?

Documentation should describe the patient's needs (i.e., for around-the-clock medication adjustments, observation, or stabilizing treatments such as assessment of acute unstable symptoms). For Example: ***"Attempts to manage the patient's escalating pain levels in the home setting over the past two days have failed to achieve the desired level of comfort.*** Patient will require frequent RN/NP/MD assessment and titration of medications in an inpatient setting to control pain."

So, please do this, Ralph. Increase the morphine to 20 mg PO Q4H and Q1H PRN and add Ativan 0.5 mg Q1H PRN.
If that doesn't work, then we can probably bring poor Mr. Jones to the IPU. And yes *of course* you will have to write down everything we did to manage this at home. While you are doing that, I will be drinking margaritas.

Anything Else?

The following is a ***non-exhaustive list*** of examples of patient status triggers ***that may lead to a need to change to the GIP*** level of care:

- Pain or symptom crisis not managed by changes in treatment in the current setting or that requires frequent medication adjustments and monitoring;
- Intractable nausea/vomiting;
- Advanced open wounds requiring changes in treatment and close monitoring;
- Unmanageable respiratory distress;
- Delirium with behavior issues;
- Sudden decline necessitating intensive nursing intervention; or
- Imminent death – only if pain or other symptoms are present and skilled nursing is needed.

GIP is **not:**

- an “automatic” level of care when a patient is imminently dying. There must be pain or symptom management issues that cannot be resolved in another setting and the need for skilled nursing.
- intended to address unsafe living conditions in the patient’s home.
- for caregiver respite. If a patient has no caregiver or a caregiver is unable to help the patient adequately, ***other arrangements should be made***.
- allowable when a patient’s acute symptom crisis resolves and there is no further skilled nursing need.

GIP is **not:**

- for instances when a patient/family refuses to leave inpatient care. If a patient or their family refuses to leave the inpatient setting of care, the hospice provider should issue an Advance Beneficiary Notice (ABN) form to the patient/family. The ABN should notify the patient/family that the GIP level of care will not be paid by Medicare on a specific date and going forward and that the patient/family will be financially liable for the difference between the GIP and RHC daily rate. Daily room and board charges would also apply as Medicare does not cover room and board for the routine home level of care.

Raise your hand if you went into social work, nursing, medicine, or another health care profession to give the stressed families of suffering, dying people “ABN’s.”

Guidance from NGS

THE CONNECTICUT HOSPICE

https://www.ngsmedicare.com/documents/20124/121662/1839_0816_GIP+Check+Off+List_508.pdf/07456284-24a9-e4d1-aa1d-9630300dee94?t=1611696419164

www.ngsmedicare.com/documents/20124/121705/2237_0721_hospice_general_inpatient_docu_final_508.pdf/433b40cd-bed3-28e7-e32a-225b824b3704?t=1626356541735

What Do We Do at CT Hospice?

- We try to follow the rules. By “try” I do not mean that there are times we intentionally don’t follow them; but rather that sometimes we are uncertain as to how to interpret them.
- Nursing and social work staff enter “5-day GIP updates” describing their perspective on the patient’s need for inpatient.
- We ask the nurses not to use the word “comfortable” or phrases like “the patient ate 90%.” Instead, we ask them to use phrases like “pain and dyspnea are responding to morphine 10 mg injected Q4H and Ativan 1 mg injected Q4H, oral intake is reduced, and the patient remains dependent in all ADLs.”

Medical staff document GIP eligibility exhaustively:

Hospital course: GIP day 5. The patient's hospital course has been characterized by new and ongoing need for parenteral controlled substances including opioids and benzodiazepines for management of non-verbal cues to **pain and agitation/delirium**, ongoing requirement for close observation and oversight by skilled nursing and a qualified medical provider in the inpatient setting for PRN dosing, dose adjustment, and dose escalation of parenteral controlled substances including opioids and benzodiazepines, with PRN dosing and dose escalation in the last 24 hours for the management of worsening pain, dyspnea, and delirium, possible need for palliative sedation, need for skilled nursing intervention for **complex wound management**, ongoing requirement for close observation and oversight by skilled nursing to prevent self-harm secondary to **hyperactive delirium**, complete dependence in ADLs with PPS now 20%. The above interventions, especially the provision of parenteral controlled substances, with frequent titration of dose and PRN dosing, **cannot feasibly be provided in a setting other than inpatient**. **Conversion to oral medications is not possible as the patient is unable to take oral meds. The patient's response to the current medications represents appropriate and necessary inpatient care.**

Does This Work?

Only an audit of charts in which this documentation is used will tell.

What About Other Hospices?

One large midwestern hospice I spoke to explained that GIP documentation was upgraded in response to targeted probe and education (TPE) audits showing 33% error rate on charges (i.e., daily GIP charges) and 66% on claims (any error for any patient). B/o error rate > 20%, follow up audits were conducted.

They had two provider numbers audited, the first follow up had 0% error on the second round and the second had 14% on claims and 20% on charges -- leading to no follow up audits.

They require nursing and medical confirmation of GIP eligibility for any patient with a GIP LOS of 5 days or more, every five days. SW is not required to participate, but SW takes notes on AM report and writes a summary for each GIP patient.

A primary identified problem area was disagreement between disciplines, e.g., nursing writing that pts were comfortable or stable when the MD note indicated otherwise. They encourage nursing to read the MD notes so the two different discipline's notes agree.

MDs copy forward interval histories from prior days to create a trail of the patients' progress. (This will lead to very long MD notes.)

RNs are encouraged to document patient and family education and families that interfere with patient care, complicating and prolonging stays.

All GIP LOS of >12 days gets a senior review, and days are sometimes, though not often, down-coded by administration regardless of the MD's opinion.

The medical director of a large hospice in Indiana told me she vets all questionable inpatient admissions, clarifies GIP eligibility, and rejects those not meeting criteria.
This is what I do and seems fairly standard.
She requires medical staff document need for, PRN dosing, dose escalation, and changes in parenteral symptom management meds, and documents that it is not medically or ethically appropriate to discharge a patient well managed on a regimen of parenteral analgesics when death is imminent.
Aligns nursing and medicine documentation; not “patient is comfortable,” “Patient continues to require IV analgesics, which are currently effective for management of [symptoms].”

The medical director of two IPUs in PA with 30 beds said much the same:

- Medical staff emphasis parenteral meds, PRN dosing, dose adjustment, and rationale for parenteral meds,
- Aligns nursing and medical documentation,
- Said, “Auditors would have a hard time arguing with use of IV meds.”

What Can We Do to Effect Change ?

We can try to effect change at the policy level by joining and working with an advocacy group.

For example, the NHPCO's legislative affairs committee.

CoPs?

CoPs are Conditions of Participation;

Organizations choosing the deemed status option for hospice are evaluated against both Joint Commission standards and the Hospice Medicare Conditions of Participation.

NATIONAL ARCHIVES

Code of Federal Regulations

A point in time eCFR system

THE CONNECTICUT HOSPICE

ECFR CONTENT

	Part / Section
▼ **Title 42** Public Health	
▼ **Chapter IV** Centers for Medicare & Medicaid Services, Department of Health and Human Services	400 – 699
▼ **Subchapter B** Medicare Program	405 – 429
▼ **Part 418** Hospice Care	418.1 – 418.405
▼ **Subpart D** Conditions of participation: Organizational Environment	418.100 – 418.116

- **§ 418.100** Condition of Participation: Organization and administration of services.
- **§ 418.102** Condition of participation: Medical director.
- **§ 418.104** Condition of participation: Clinical records.
- **§ 418.106** Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment.
- **§ 418.108** Condition of participation: Short-term inpatient care.
- **§ 418.110** Condition of participation: Hospices that provide inpatient care directly.
- **§ 418.112** Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.
- **§ 418.113** Condition of participation: Emergency preparedness.
- **§ 418.114** Condition of participation: Personnel qualifications.
- **§ 418.116** Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.

EP 13-The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff. Note: For	**Department of Medicine Bylaws,** ARTICLE II MEMBERSHIP IN THE DEPARTMENT OF MEDICINE Section 2, Qualifications for	**NOTE Medical Staff bylaws says:** **ADVANCED PRACTICE**	Bylaws approved by Medical Board Dec 2, 2019 and BOD Dec. 5, 2019; Revised and approved by Medical Board 12/15/2020 and Governing Body	Medical Staff Bylaws Final CT Hospice Medical Staff Bylaws revised 1.2023.pdf The collaborative agreements are in the credentialing file of each relevant APRN
hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of Doctor of Medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body	Membership in The Medical Staff **NOTE The following is from the DPH website:** A Connecticut licensed APRN who has maintained his/her Connecticut license for a period of not less than three (3) years, and who has engaged in Connecticut in the performance of advanced practice level nursing activities in collaboration, (in accordance with provisions in CGA 20-87a) with a Connecticut licensed physician for a period of not less than three (3) years and for not less than two thousand (2,000) hours, may thereafter practice alone or in collaboration with a physician or another health care provider licensed to practice in this state.	**REGISTERED NURSES SHALL:** "Have a mutually agreed upon written and signed collaborative agreement with the Chief Medical Officer unless C Collaborative agreements, when in place, shall specify the level of direction if any, the Chief Medical Officer and APRN agree upon, the level of consultation and referral, a method to review outcomes, the level of	(BOD) on December 17, 2020 A minor revision was made by the BOD on January 26, 2023 and approved by the MB on Jan. 30, 2023	maintained in the office of the Director of Human Resources.