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Hospice Case Management

Hospice Team

- Doctors/Nurse Practitioners
- Nurses/Nurse Case Managers
- Counselors/Chaplain
- Social Workers
- Pharmacists
- Physical and Occupational Therapists
- Speech-Language Pathologists
- Hospice Aides
- Homemakers
- Volunteers

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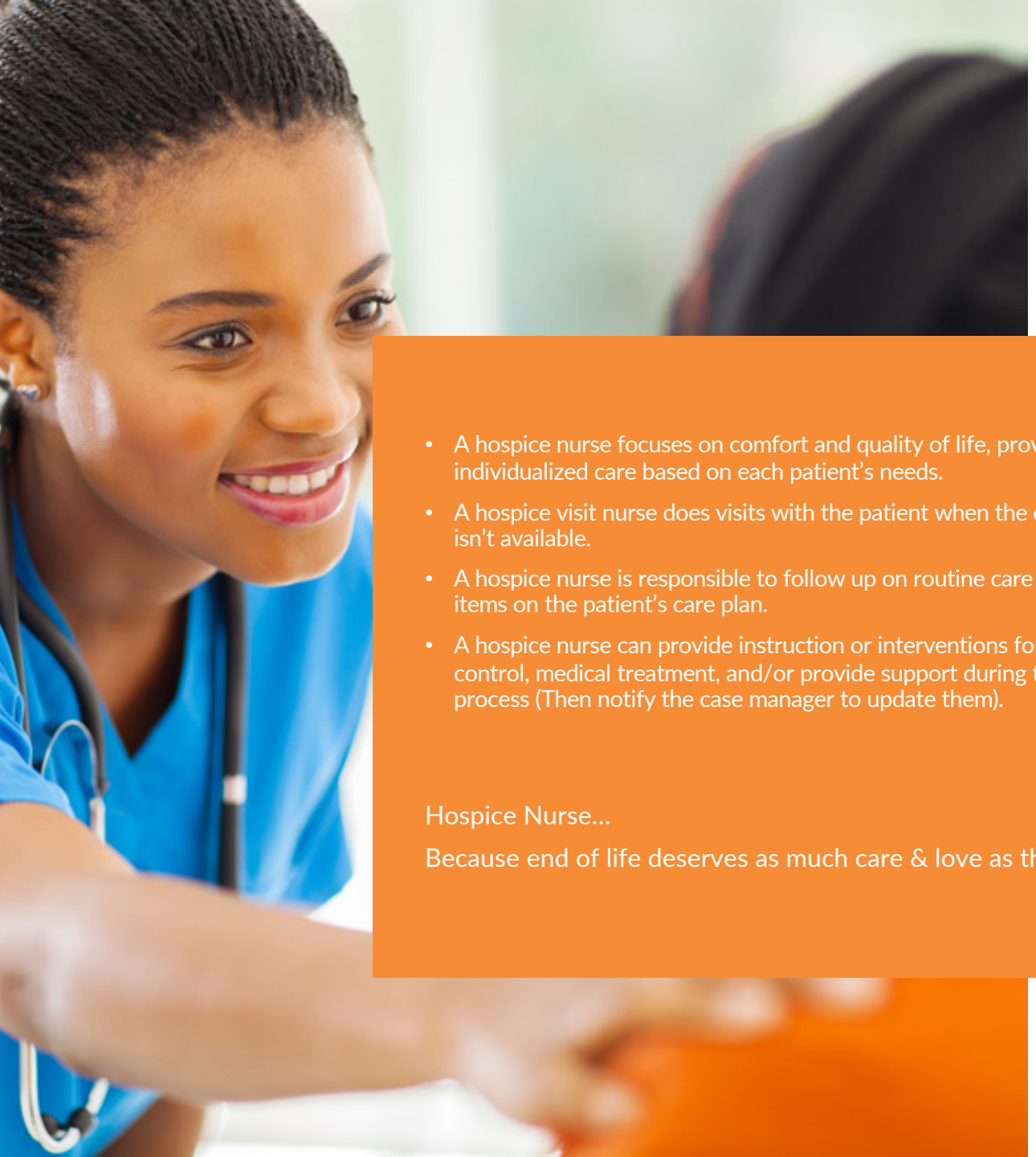

What is a Hospice Nurse?

- A hospice nurse focuses on comfort and quality of life, providing individualized care based on each patient's needs.
- A hospice visit nurse does visits with the patient when the case manager isn't available.
- A hospice nurse is responsible to follow up on routine care and address the items on the patient's care plan.
- A hospice nurse can provide instruction or interventions for symptom control, medical treatment, and/or provide support during the dying process (Then notify the case manager to update them).

Hospice Nurse…

Because end of life deserves as much care & love as the beginning.

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Medicare Benefit Policy Manual Chapter 9 – Coverage of Hospice Services 40.1.1 – Nursing Care

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

- To be covered as nursing services, the services must require the skills of a registered nurse (RN), or a licensed practical nurse (LPN) or a licensed vocational nurse (LVN) under the supervision of a registered nurse and must be reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions.
- Services provided by a nurse practitioner (NP) who is not the patient's attending physician, are included under nursing care. This means that, in the absence of an NP, RN, LPN, or LVN would provide the service. Since the services are nursing, payment is encompassed in the hospice per diem rate and may not be billed separately regardless of whether the services are provided by an NP or an RN.

What is a Hospice Case Manager?

- The hospice RN is an experienced registered professional nurse who initiates and coordinates the hospice care plan, provides skilled and palliative care and coordinates the services provided to his/her patients. The RN works cooperatively with the attending physician, hospice medical Director, and other members of the interdisciplinary hospice team.
- Hospice case managers are responsible for **overseeing the care of patients who are nearing the end of their lives.** They work with a team of medical professionals to ensure that these individuals receive high-quality palliative care, including physical, emotional, and spiritual support.
- Hospice care is a team approach, **coordinated by a case manager** with a hospice medical director, home health aide, social worker, and chaplain all involved with the plan of care.

Role of the Case Manager

- The role of a case manager is one of the most direct, hands-on nursing roles in a hospice organization.
- Hospice case managers oversee the direction and coordination of a patient's case – and the care provided for their caregivers and family – throughout their time in hospice.
- Working closely with the rest of the hospice care team, case managers decide how care resources are allocated and formulate the plan of care for each patient.
- They also determine what level and what types of counseling, education, and care the patient's family caregiver and family members will need before, during, and after the patient's death.

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Examples of Case Manager Tasks

- Assessing, planning, implementing, coordination, monitoring, and evaluating the options and services required to meet the patient's health and services needs.
- Advocate for patient care.
- Provide emotional support.
- Medication reconciliation.
- Contact the MD with additional medications needed, medication changes, adjustments.
- Monitor and treat symptoms.
- Provide education to patient and family/caregivers.
- Participates in patient care conferences and supervises the home health aides assigned.
- Provides care to patients who have been diagnosed with a terminal illness.
- Regularly revies and updates the plan of care.
- Performs prescribed medical treatments, including pain management and symptom control.
- Conducts assessments and evaluations.
- Provides education and supportive care to patients and caregivers.

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Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

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The POC

- Must be reviewed and updated by the IDG at intervals specified in the POC, but no less frequently than every 15 calendar days.
- Should continually be assessed to ensure that the care the beneficiary receives meets their conditions and needs.
- When revised, must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the POC.
- Should be updated if the beneficiary's condition improves or deteriorates, and when the level of care changes.
- Will include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief.
- Must state in detail the scope and frequency of services needed to meet the beneficiary's and family's needs.
- Acts as a road map for the IDP to provide consistent, cohesive care, and will support the medical necessity of hospice card.

The Hospice Case Managers goals are individual to each patient and frequently include:

- Controlling pain and other symptoms, giving the patient a better quality of life.
- Providing the patient and family the information they need to make informed decisions regarding treatment and the plan of care to ensure the patient has a dignified death.
- Coordinating and facilitating care.

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What is Medication Reconciliation?

Is a clinician's comparison of the prescribed medications a patient is using against the new medications ordered for the patient during an encounter, resolving any discrepancies, and updating the medical record to reflect them.

Why is Reconciliation needed?

- Reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
- It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care.
- The intent is to avoid errors of omission, duplication, incorrect doses or timing, and adverse drug-drug or drug-disease interactions.
- A comprehensive list of medications should include all prescription medications, herbals, vitamins, nutritional supplements, over-the-counter drugs, vaccines, diagnostic and contract agents, radioactive medications, parenteral nutrition, blood derivatives, oxygen, and intravenous solutions (hereafter referred to collectively as medications)
- Over-the-counter drugs and dietary supplements are not currently considered by many clinicians to be medications, and thus are often not included I the medication record. As interactions can occur between prescribed medication, over-the-counter medications, or dietary supplements, all medications and supplements should be part of a patient's medication history and included in the reconciliation process.

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Medication Reconciliation is Intended to Identify and Resolve Discrepancies

"There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies – it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future."

Quote from the Joint Commission

"Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor."

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Six Steps to Comply with Medication Reconciliation Requirements:

- Document medication regimen
- Strive to perform complete, accurate medication reconciliation
- Compare the reconcile all medications identified
- Update the patient's record with the reconciled, accurate medication list
- Provide information about new or changed medications
- Emphasize the importance of managing medication information

Whenever you make a change to a patient's regimen following an encounter, take the time to **explain the reason(s) for the change, cover any new information** about the frequency and route, and **provide a summary** of this information in writing to the patient and any accompanying family members. Using **teach-back methods** can help ensure a patient and/or family member understands the new instructions.

Be sure patients understand that any new over-the-counter medications and supplements should be added to the list and communicated to the primary care physician during their next visit.

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Using Clinical Pathways/Teaching Tools in Documentation

A clinical pathway is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care are defined, optimized, and sequenced either by hour (ED), day (acute care) or visit (homecare). Outcomes are tied to specific interventions.

Clinical pathways aim for greater standardization of treatment regimens and sequencing as well as improved outcomes, from both a quality of life and a clinical outcomes perspective.

How can teaching tools assist with your documentation?

- Gives steps to teach the patient that aren't overwhelming with too much information all at once.
- Easy to see what you've taught and what is next on the list to teach.
- Ask the patient questions from the prior visit to see what information they retained. Review and add another snippet of information to build on.
- Assists with showing skilled education when under medical review.

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Centers for Disease Control and Prevention

Heart Disease Patient Education Handouts | cdc.gov

Easy-to-Read Health Information: MedlinePlus

Krames Patient Education Materials: Krames Store

Fact Sheets

- Aortic Aneurysm
- Atrial Fibrillation
- Cardiomyopathy
- Heart Disease and Mental Health Disorders
- Heart Failure
- High Blood Pressure
- Heart Disease Facts
- Know Your Risk for Heart Disease
- Marfan Syndrome
- Peripheral Arterial Disease (PAD)
- Prevent Heart Disease
- Pulmonary Hypertension
- Valvular Heart Disease

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Example of Teaching Tools:
(Pritchett & Hull Associates www.p-h.com)

- Deep Breathing Exercise 1: Front

(1) Sit comfortably or stand with good posture (with back straight) or lie on your back with your head and knees supported by pillows.

(2) Place one hand on your chest to check for movement of the rib cage muscles.

(3) Place the other hand on your belly to feel the movement of the diaphragm.

(4) Breathe in through your nose, feeling your belly relax and push out to the front.

(5) Pull your belly muscles in as you breathe out slowly through pursed lips.

(6) Rest after 3 or 4 breaths.

Teaching Tool: High Potassium Foods

- Dried fruits: raisins, prunes, apricots, dates
- Fresh fruits: bananas, watermelon, cantaloupe, oranges, kiwi, nectarines
- Fresh vegetables: avocados, white potatoes, broccoli, greens, spinach, peas, tomatoes, mushrooms
- Dried vegetables: beans, peas
- Fresh meats: turkey, fish, beef
- Fresh Juices: Orange
- Canned Juices: Prune, apricot

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Education Is Broken Into Visits

UTI V1	1
UTI V3	2
UTI V2	2
UTI V4	6

Visit Topics: Broken Down Into Things to Discuss Per Visit (Example)

- Visit One: What is a UTI
- Visit Two: A word about incontinence & tips for comfort
- Visit Three: Female Perineal Care/Male Perineal Care
- Visit Four: Guarding Against Infection: Aseptic Technique

Additional teaching items: Bedside drainage bag attached to a catheter, suprapubic catheter site care, using a condom catheter, using an indwelling foley catheter, and self-catheterization.

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Teaching Tools

- Broken down per visit with instruction in lay terms so non-clinical patients and caregivers can understand.
- Pictures are used to provide a visual picture of things to do.
- Written instructions and handouts that can be left in the home for the patient and caregivers to refer back to.

Multiple Sclerosis

- Multiple Sclerosis Outcome Goals Assessment
- Multiple Sclerosis Pathway
- Multiple Sclerosis Patient Outcome Goals
- Multiple Sclerosis Teaching Documentation Form

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Education Materials for: Suggested Initial Visit

Patient Learning Assessment and Needs

- Pain Assessment and Control
- Outcome Goals Assessment
- Advance Directives
- Patient Need for Therapy Assessment

Visit 1 – Begin discharge instruction for patient, family and/or caregiver on:

- Outcome goals
- Disease characteristics (a word about MS)
- Medicines and side effects
- Your healthcare team
- Infection control guidelines

Visit 2 – Continue teaching as in visit 1 adding:

a. Fatigue
b. Numbness
c. Walking, coordination, balance problems
d. Bladder problems
e. Bowel problems
f. Vision problems
g. Dizziness
h. Sexual dysfunction
i. Pain
j. Cognitive problems
k. Emotional changes
l. Spasticity
m. Depression
n. Speech problems
o. Swallowing problems
p. Tremors

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Education Materials for: Suggested Initial Visit

Visit 3 – Continue teaching as in visit 2, adding:

a. Skin infection
b. Urinary tract infection
c. Respiratory infection

Visit 4 – Continue teaching as in visit 3, adding:

a. Weight management

Visit 5 – Continue teaching as in visit 4, addition:

a. Saving energy
b. Assisted self-care devices

Visit 6-8 – Continue teaching as in visit 5, adding:

a. Catheter irrigation
b. Comfort measures for pain

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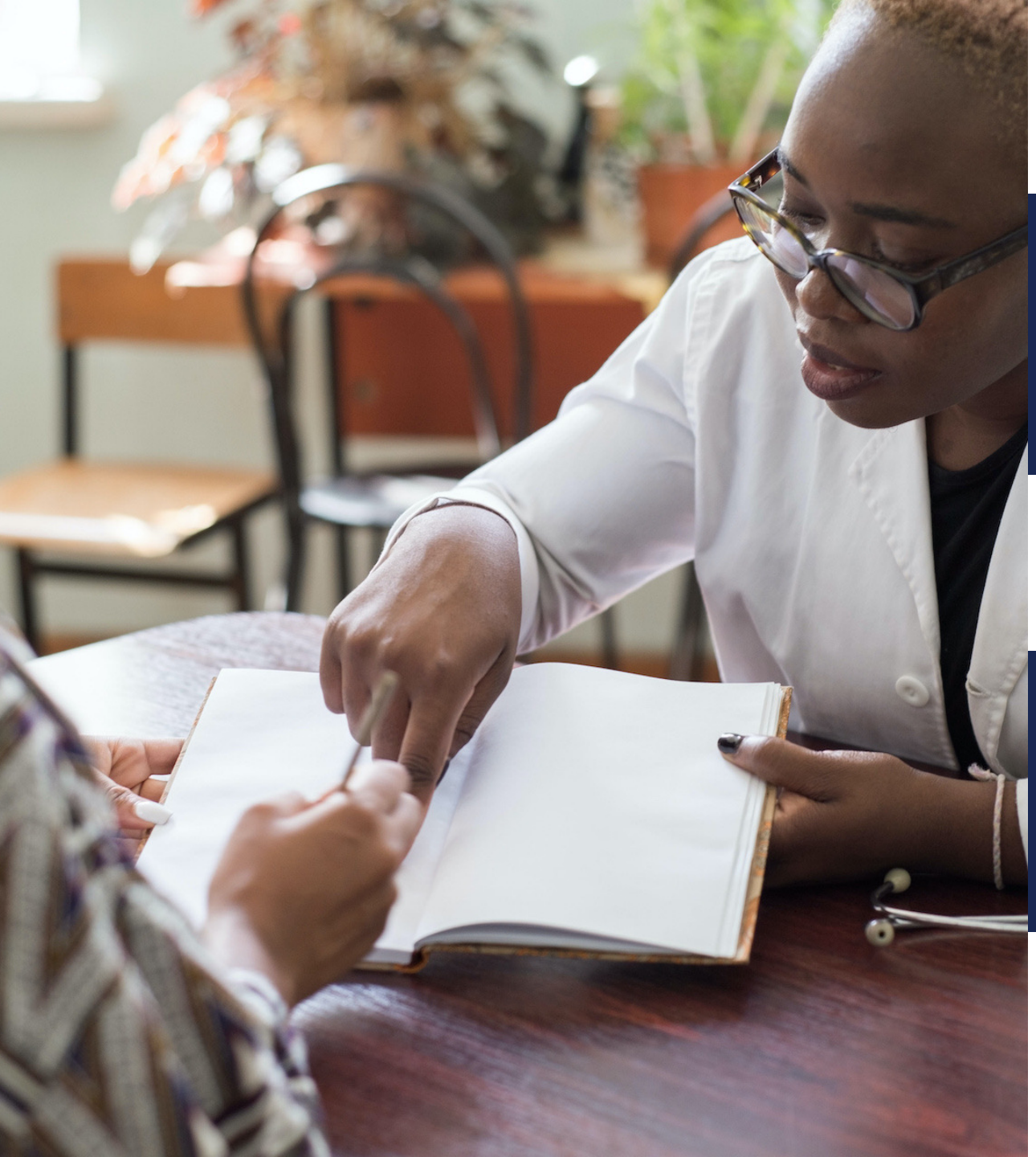

Additional Suggested Education Visits for MS:

- Home Safety Measures
- Safety Outside the Home
- Diet
- Bowel and Bladder Measures
- Catheter Care
- Exercise Needs

Teaching Tools:

- Provide clinician with reminders and what teaching has been provided and what teaching still needs to be done.
- Bridges the gap between clinician knowledge and lay person knowledge.

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Hospice Resources:

- Medicare Benefit Policy Manual (cms.gov)
- www.cgsmedicare.com/hhh/education/index/html
- Hospice Documentation Checklist Tool (Home Health & Hospice) (cgsmedicare.com)
- J15 HH&H FAQs (cgsmedicare.com)
- Hospice Quick Resource Tools (cgsmedicare.com)
- Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patients (cgsmedicare.com)
- Suggestions for Improved Documentation to Support Medicare Hospice Services (cgsmedicare.com)
- Hospice Documentation: Painting the Picture of the Terminal Patient (ngsmedicare.com)

References:

- Hospice Certification of Terminal Illness Resources (cgsmedicare.com)
- Denial Reason 5PM01: Six-Month Terminal Prognosis Not Supported (Home Health & Hospice) (cgsmedicare.com)
- Hospice Denial Fact Sheet: Denial Reason 5PC01– 5PC07: Missing/Incomplete/Untimely Certification/Recertification (cgsmedicare.com)
- SE1628 (cms.gov)
- SOM (cms.gov)

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Thank You

Celeste Miller
RN, BS, HCS-D, COS-C

Director of Operations
Celeste@Oraclebcc.com
C (435) 757-8416
www.oraclebcc.com