

The Hospice benefit is provided to beneficiaries with clinical evidence and descriptive notes to show the beneficiary is terminally ill and progressing in a manner that a physician would reasonably conclude that the beneficiary's life expectancy is months or less.

## **Importance of Descriptive Narratives in Clinical Records**

Descriptive information completes the picture started with check-based assessments. Comparative information establishes longitudinal decline and may indicate decline suggestive of terminal status.

Each Clinical Note must be able to stand alone and show how the patient remains terminally ill or it may appear the patient has stabilized, becomes chronically ill and requires discharge planning to occur. Failure to document a distinct different will result in payment denial for a month, certification period or even an entire admission.

Surveyors appear to be focusing on severe, unrelenting symptoms as a basis for terminal status/medical necessity. Examples include: dyspnea at rest in patients with COPD or heart failure; and dysphagia with aspiration pneumonia in patients with dementia. Inconsistency decreases the clinical record's credibility in the eyes of reviewers and makes it harder for those trying to identify the patient's true clinical status and to defend your claims. Examples of inconsistency include:

- PPS assessments not supported by other assessment data in the clinical record
- Incorrectly applied FAST assessments and/or scores not supported by other assessment data
- Disparity between physician narratives and clinical information in the clinical record
- Lack of consistency in recording weights, anthropomorphic measurements, other objective data
- Absent or inconsistent data for a specific LCD has the appearance of disregard for or lack of awareness of the LCD which can also send up red flags.

Decline is inherent to the dying process in most diseases and most hospice staff are attuned to documenting the slightest signs. But decline is also associated with chronic conditions and advanced age. In denial statements, reviewers often state there is evidence of decline, but deny the claim because terminal status is not established.

Nursing narratives repeated verbatim across Clinical Notes, IDG Notes, and Plans of Care can have the effect of reducing credibility of documented assessments and narratives. This also may contribute to a clinical picture of stability for the patient. Documentation must support the patient's decline. Each Clinical Note must show evidence of signs and symptoms of decline despite optimal care.

Document using International Classification of Functioning: impairments in function, activity limitations, participation limitations, and communication impairment. Include in narrative documentation information about how so morbid conditions and secondary conditions affect the patient's decline. Consider ways to document which systems of the body are in a terminal condition.

Allow documentation to describe changes in a patient's health status. Compare historical assessment data with current assessment data and changes in the patient's functional status from the past to the most current assessment.

Clinical Notes from all disciplines should demonstrate a consistent picture of terminal. Avoid vague statements such as: "slow decline," "disease progressing." The more objective the documentation, the better. Remember: Hospice is for those needing true "skilled palliation of end of life symptomatology".

# How To Document Decline In Hospice Patients



**RM Cervero**

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