

# Compliance Tip Sheet

National Hospice and Palliative Care Organization  
www.nhpc.org/regulatory



## MANAGING GENERAL INPATIENT CARE FOR SYMPTOM MANAGEMENT TIPS FOR PROVIDERS

### INTRODUCTION

General Inpatient (GIP) Care is one of the four levels of hospice care required to be available under the Medicare Hospice Benefit (MHB). GIP for symptom management is a valuable tool that allows hospice staff to provide clinical services to a degree that cannot typically be provided in a patient's home. It is intended for specific circumstances and for a short duration of time and thus must be carefully managed from start to finish.

This tip sheet will review:

- ✓ The Medicare hospice Conditions of Participation (CoPs) applicable to GIP care
- ✓ Management of GIP care
- ✓ Documenting GIP care
- ✓ Payment and data reporting requirements

The CoPs that relate primarily to GIP are found at sections:

- ✓ §418.108 (Short-term inpatient care)
- ✓ §418.110 (Hospices that provide inpatient care directly)
- ✓ §418.202 (e) (Covered Services)

There are references to GIP in other sections 42CFR418 Hospice Regulations (i.e.: 418.302, 418.309), but they relate primarily to payment issues.

Providers should also look closely at the corresponding Interpretive Guidelines and the preamble comments to the 2008 CoPs for more insight into the proper use of the GIP level of care. There is useful information in the Hospice Medicare Claims Processing Manual (section 30.1; 80.1) and the Hospice Medicare Policy Manual (section 40.1.5). In addition, a provider should check state specific hospice licensure regulations for specific requirements, keeping in mind that hospices must comply with whichever rules are the most stringent. Beyond the items specific to GIP, all other expectations for quality hospice care remain in effect.

**WHAT IS GIP?** A general inpatient care day is a day in which a patient receives general inpatient care in an inpatient setting for pain control or acute or chronic symptom management which cannot be managed in other settings. An inpatient setting can include a Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110 or a Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (e) regarding 24-hour nursing services and patient areas. (CMS, Subparts D – Conditions of Participation: Organizational Environment and G – Payment for Hospice Care, Updated 2008 and 2009).

The CoPs state GIP may be required for pain control or acute or chronic symptom management that cannot feasibly be provided in any other setting. It is initiated when other efforts to manage

symptoms are ineffective. Note that there is no particular disease, condition, or symptom specified that is a qualifier for GIP. Each patient and his or her symptoms will differ; GIP may be helpful to one patient and not to another with the same disease. GIP care carries specific requirements regarding where the services may be provided as well as types and levels of staffing. GIP care cannot be provided in the home, in an assisted living facility, a hospice residential facility, or in a nursing facility that does not have a registered nurse available 24 hours per day to provide direct patient care.

GIP is intended to be a **short term** intervention (similar to an acute hospital stay). There is no limit on the number of days or number of episodes of GIP each patient receives. GIP is the level of care for patients who cannot comfortably remain in a residential setting and require skilled nursing care around the clock to maintain comfort.

### WHEN IS GIP APPROPRIATE?

GIP may be initiated when the interdisciplinary group (IDG) determines that the patient's pain and symptoms cannot be effectively managed in 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.

When the IDG (including the attending physician and/or the hospice Medical Director) assess that the patient requires a higher level of skilled nursing care to achieve effective symptom management a change to the GIP level of care should be considered. It is the IDG's clinical skills and judgment that determine **when** and **if** GIP is appropriate.

Documentation of the need for GIP is key to provide medical reviewers with a clear understanding of the GIP admission. Industry best practice also states that hospice providers are obtaining a physician's order to change the level of care.

If the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual's home, and if the individual's pain and symptoms can no longer be managed by the hospice IDG at home, then the individual may be eligible for a short term general inpatient level of care.

GIP may also be provided at the end of an acute hospital stay if there is a need for pain control or symptom management which

### HELPFUL RESOURCES

#### 418.108 Condition of participation: Short-term inpatient care.

[Download the 418.108 "All Inclusive" document](#)

(regulatory text + interpretive guideline + preamble language)

[Download the 418.108 tip sheet](#)

#### 418.110 Condition of participation: Hospices that provide inpatient care directly.

[Download the 418.110 "All Inclusive" document](#)

(regulatory text + interpretive guideline + preamble language)

[Download the 418.110 Tip Sheet](#)

[Download the "Restraints and Seclusion Requirements" Tip sheet addendum](#)

#### 418.202 Covered Services

Access the regulatory text for 418.202 at:  
[http://edocket.access.gpo.gov/cfr\\_2002/octqtr/pdf/42cfr\\_418.202.pdf](http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr_418.202.pdf)

#### Hospice Medicare Claims Processing Manual

<http://www.cms.gov/manuals/downloads/clm104c11.pdf>

#### Hospice Medicare Coverage Policy Manual

<http://www.cms.gov/manuals/Downloads/bp102c09.pdf>

cannot be feasibly provided in the home setting at hospital discharge.

The following examples of patient status triggers may lead to the change to 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
- ✓ Imminent death – **only** if skilled nursing needs are present

### WHEN IS GIP NOT APPROPRIATE?

It is also important to keep in mind what GIP is not.

- ✓ It is not intended for caregiver respite. If a caregiver is not in the home, or unable to help the patient adequately, other arrangements can or should be made.
- ✓ It is not intended as a way to address unsafe living conditions in the patient's home.
- ✓ It is not an "automatic" level of care when a patient is imminently dying. There must be pain or symptom management and skilled nursing needs present (intensity of care).

**NOTE:** CMS clarified in the final rule of the 2008 Hospice Wage Index that caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met (CMS, Hospice Wage Index for Fiscal Year 2008, 2007). This clarification may seem to contradict the language in Chapter 9 of the Medicare Benefit Policy Manual. However, CMS expanded upon the Benefit Policy Manual language in the 2008 Hospice Wage Index to clarify when GIP for caregiver breakdown is appropriate (see "When is GIP Appropriate?")

### WHERE CAN GIP BE PROVIDED?

Per CoP 418.108, GIP must be provided in a participating certified Medicare facility as follows:

- ✓ A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110.
- ✓ A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas.

#### **§418.110(b) Standard: Twenty-four hour nursing services** (CMS, 2008)

- (1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.
- (2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

#### **§418.110(e) Standard: Patient areas** (CMS, 2008)

The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

- (1) The hospice must provide—
  - (i) Physical space for private patient and family visiting;
  - (ii) Accommodations for family members to remain with the patient throughout the night; and
  - (iii) Physical space for family privacy after a patient's death.
- (2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

## WHAT ARE THE HOSPICE MANAGEMENT RESPONSIBILITIES FOR GIP?

### Admission and Documentation of GIP Need

- ✓ The hospice should arrange for transfer to the appropriate inpatient setting that can meet the patient's needs. Per CoP 418.56(e)(4) the hospice staff must share information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.
- ✓ The precipitating event (onset of uncontrolled symptoms or pain) which prompted the need to change to GIP level of care should be evident in the comprehensive assessment documentation
- ✓ Documentation of pain and symptom management interventions that were implemented in the home prior to initiating GIP level of care should be documented and available to the inpatient staff.
- ✓ The team needs to provide report to the inpatient staff and furnish a copy of the patient's current plan of care.

### Professional Management and Oversight

Regardless of care setting, the hospice IDG is responsible for the professional management of the patient's care in accordance with the hospice plan of care as set by the IDG. Contracts with appropriate facilities for GIP services should be clear regarding the IDG oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement. The written agreements may also clarify payment rates and procedures (CMS, 2008).

### Visits from the Hospice Team When GIP is in a Contracted Facility

While the frequency of IDG visits to a patient receiving GIP level of care is not specified in the regulations, a good standard of care is daily visits from an IDG member to assure professional management, coordination of the plan of care, communication with the patient and family, continuity of care and evaluation of continued eligibility for this level of care. Coordination through communication with the physician overseeing inpatient care is also essential for professional care management purposes and moving the patient toward discharge from GIP. The IDG should also continue services provided by Social Workers and Chaplains as needed and continue support and communication to the family and caregivers during a GIP stay.

### Discharge Planning

Consideration of the discharge planning needs of the patient should occur the moment the patient transfers to the GIP level of care. The hospice (not the hospital discharge planners when the facility is a hospital) is responsible for managing the discharge. Documentation should show

that the IDG is assessing the situation on a daily basis and planning for the transfer to another setting or level of care.

**NOTE:** General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, 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 (CMS, Chapter 9, IOM-40.1.5 - Short-Term Inpatient Care, 2004).

#### **Quality Assurance & Performance Improvement (QAPI)**

GIP is a challenging care level to manage, and providers may want to include some aspects of this service in their QAPI programs. Consider evaluating internal processes and policies related to assessing needs, providing and/or monitoring care, discharge planning and frequent problems that arise with GIP care such as unnecessary testing and procedures that are not palliative in nature and may add burden to the patient.

#### **Audit Readiness**

Clinical records are subject to review during an audit by a Medicare Administrative Contractor (MAC) and/or other oversight agencies. Providers should train their staff on best practice documentation standards and periodically conduct internal audits to ensure documentation supports the GIP level of care. The Carolinas Center for Hospice and End of Life Care Facility Based Workgroup developed a GIP chart audit tool (See *Resources*), which may be useful for reviewing patient records when the GIP level of care is implemented.

#### **HOW SHOULD THE IDG DOCUMENT GIP LEVEL OF CARE?**

Documentation during GIP level of care must be thorough and reflect the need and intensity of care for this level at all phases of care. Implementation of the plan of care must be directed to stabilizing the acute or chronic symptom management, obtaining a positive palliative outcome (did the care make a difference), and moving the patient to a lower level of care at the appropriate time.

When transferring a patient to GIP level of care, documentation should include:

- ✓ The skilled nursing interventions being provided to the patient and the patient's response
- ✓ A Plan of Care that reflects the change in level of care and interventions to stabilize the patient's acute pain and symptom crises
- ✓ Collaboration with the facility staff if in a contracted facility
- ✓ Discharge planning (**remember: GIP is short-term**)

All IDG members should document to paint a complete picture of the patient, including the pain and symptoms not adequately managed and why GIP level of care is necessary. Physicians and nurses need to address symptom management, observations, medications initiated and changes in medications, other changes in treatment, etc. Other IDG members need to document what they see in terms of symptom management, patient and family coping, discharge planning discussions, options for returning to the routine home care level, etc.

Policies, procedures and the patient's status should dictate visit and documentation frequencies. Keep in mind that the higher level of care demands that documentation and visits are more frequent than for patients at routine level of care. (See the *Resources* section for an example of a GIP documentation tool.)

## WHAT ARE THE GIP BILLING AND DATA REPORTING ISSUES?

**Billing:** Billing for GIP is completed for each day the patient qualifies for GIP level of care. If the patient is in a facility, the day of discharge is billed as routine level of care. (**EXCEPTION:** If the patient dies on the final day, then the day is billed as GIP.) It is important for providers to understand that if a clinical record is requested by an RHHI/ MAC medical review department and it is determined that the patient was not eligible for part of the GIP stay, those days will be downgraded to routine home care days and the corresponding payment rate will apply. To ensure accurate billing to their Fiscal Intermediary or Medicare Administrative Contractor, a provider is encouraged to complete a pre-bill audit of their GIP claims for review of correct Q codes and documentation to support the GIP level of care for all days billed at that level.

**Visit Data:** Change Requests 5567 and 6440 require hospice providers to report visit frequency and time on claims for hospice nurses, social workers and hospice aides. For GIP stays in a contracted facility, only visits by hospice staff in these categories are reported (CMS, CR 5567, 2008). For GIP stays in a hospice owned facility, all services by hospice staff (nurses, social workers and hospice aides) that are medically necessary and included in the patient's plan of care must be included on the claim form as a visit. (Reporting visits in 15 minutes increments is not required for GIP.) See *Resources* for links to CMS guidance on data reporting requirements (CMS, CR 6440, 2009).

Visits which are part of room and board services should **NOT** be reported on hospice claims to Medicare. Room and board services may include, but are not limited to, delivery of meals, changing bed linens, housekeeping tasks, etc. Hospices should only report visits which are reasonable and necessary for the palliation and management of the terminal illness and related conditions (CMS, Q&A - ID 8901, 2010).

**Note:** Additional Q&A's related to visit data are located in the CMS Hospice General Inpatient Q&A's attachment.

## CAP ON INPATIENT CARE

There is a Cap on the amount of inpatient care that a hospice provider may provide. The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries. This standard applies to **Medicare** beneficiaries only. Compliance with this regulation is based on the total number of **Medicare** beneficiaries enrolled in the hospice program, and does not include patients from other payor sources (CMS, Hospice Conditions of Participation; Final Rule, 2008).

### RESOURCES

Sample GIP Documentation Tool and GIP Chart Audit Tool

<http://www.carolinasendoflifecare.org/> - Click the link, select the 'Resources' tab and then select 'General Inpatient Documentation Tool.'

NHPCO Document with full Medicare Rules 42 CFR 418 Subparts A – H:

[http://www.nhpco.org/files/public/regulatory/Medicare\\_RegHospice.pdf](http://www.nhpco.org/files/public/regulatory/Medicare_RegHospice.pdf)

Hospice General Inpatient Care: its Proper Use and Supporting Processes

[http://www.nhpco.org/files/public/regulatory/Medicare\\_COPS\\_Updated\\_072911.pdf](http://www.nhpco.org/files/public/regulatory/Medicare_COPS_Updated_072911.pdf)

NHPCO Information Sheet on Hospice Inpatient Care (more specifically addresses regulatory language applicable to this level of care)

[http://www.nhpco.org/files/public/regulatory/Criteria\\_for\\_General\\_Inpatient.pdf](http://www.nhpco.org/files/public/regulatory/Criteria_for_General_Inpatient.pdf)

NHPCO Tip Sheet on CoP 418.110 Hospices that provide inpatient care directly (Contains Regulatory text, interpretive guidelines, & preamble to the CoPs)

[http://www.nhpco.org/files/public/regulatory/418.110\\_Provide\\_inpatient\\_directly.pdf](http://www.nhpco.org/files/public/regulatory/418.110_Provide_inpatient_directly.pdf)

Caregiver Breakdown & GIP Information – Hospice Wage Index for Fiscal Year 2008

<http://www.gpo.gov/fdsys/pkg/FR-2007-08-31/pdf/07-4292.pdf>

Regulatory Resources – State Hospice Licensure Regulations

<http://www.nhpco.org/custom/iMAP1123/index.htm>

#### **Data Collection & Reporting**

Change Request 5567 - Reporting of Additional Data to Describe Services on Hospice Claims

<http://www.cms.hhs.gov/transmittals/downloads/R1494CP.pdf>

Change Request 6440 - Additional Data Collection on Hospice Claims

<http://www.cms.hhs.gov/transmittals/downloads/R1738CP.pdf>

Change Request 6791 - Associating Hospice Visits to the Level of Care

<http://www.cms.hhs.gov/Transmittals/downloads/R1897CP.pdf>

### **WORKS CITED**

CMS. (2004, Sep). *Chapter 9, IOM-40.1.5 - Short-Term Inpatient Care*. Retrieved from CMS:

<http://www.cms.gov/manuals/Downloads/bp102c09.pdf>

CMS. (2008). CR 5567. Retrieved from CMS: <http://www.cms.gov/Transmittals/downloads/R1494CP.pdf>

CMS. (2009, May). CR 6440. Retrieved from CMS:

<https://www.cms.gov/transmittals/downloads/R1738CP.pdf>

CMS. (2008, June). *Hospice Conditions of Participation; Final Rule*. Retrieved from Federal Register :

<http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf>

CMS. (2007, Aug). *Hospice Wage Index for Fiscal Year 2008*. Retrieved from CMS:

<https://www.cms.gov/MLNProducts/downloads/cms-1539-p.pdf>

CMS. (2010, June 30). Q&A - ID 8901 . Retrieved from Centers for Medicare & Medicaid Services:

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/8901/session/L3NpZC9DMVFYeWg4aw%3D%3D](http://questions.cms.hhs.gov/app/answers/detail/a_id/8901/session/L3NpZC9DMVFYeWg4aw%3D%3D)

CMS. (2009, Aug). *Subpart G—Payment for Hospice Care*. Retrieved from Electronic Code of Regulations:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=f68bea3476c8cf404d19b02a81480f3d&rgn=div6&view=text&node=42:3.0.1.1.5.7&idno=42>

*Special thanks to the NHPCO Regulatory Committee for the development and review of this resource.*