



NHPCO Palliative Care Playbook for Hospices **Policies and Procedures**

This toolkit is part of NHPCO's comprehensive Palliative Care Playbook that is available to members as a benefit of membership. Learn more about Community-Based Palliative Care Resources at www.nhpc.org/palliativecare.



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Because a perception exists that there are no regulations governing palliative care, an organization and its palliative care leaders can make the mistake of overlooking the need for policies and procedures. No matter the type of palliative care program you implement, there are regulations that direct those services. It is important your program develops a set of policies and procedures that governs your program based on your program's administrative home. Your policies and procedures will set your program's boundaries that guide your program staff and organization, govern a consistent approach in the care of individuals in your program, and help mitigate financial and legal risk.

The first step in establishing a set of policies and procedures is to understand your administrative home. Your administrative home is the division or department within your organization that houses your palliative care program. As examples; a home health and hospice organization who develops a palliative care bridge program within their home health division is likely structured to have their home health division set as the administrative home, and a home health and hospice organization who creates a specialty provider practice under a separate tax ID (e.g. Medicare Part B billing) is likely structured to have a separate organizational entity as the administrative home. This is important because your administrative home sets your primary set of policies and procedures based on State and Federal regulations that governs that entity.

Using the first example: A home health and hospice organization develops a palliative care bridge program within their home health division – their administrative home is their home health division. This palliative care bridge program must follow all State and Federal regulations that govern home health services (e.g. face-to-face requirement, home bound status, skilled need, etc.). In this type of program, you cannot admit palliative care patients who do not meet the requirements for home health services as directed by Medicare.

For this type of program your organization should adopt a set of policies and procedures that set the scope of your palliative care program within your home health division. These policies and procedures set the palliative care framework within the home health regulatory conditions that would augment your existing home health policies and procedures to include the nuances directed by the scope of your palliative care program. This may be as simple as adding an addendum to an existing policy or procedure or creating a new policy or procedure for a given area.

Many home health organizations also provide outreach services, or telehealth services to patients who may have been on their home health services and have been discharged because they have met their home health goals. Making sure your policies and procedures outline how you will work with this population of patients is very important to ensure everyone knows the services that will be provided (typically phone calls), the frequency of those services, as well as other aspects. One of the biggest risks to a program is that your patients and your staff may believe medical and or nursing care can be provided. In most cases this relationship should remain informational only as there is not consent for care either before or after their home health episode, and there is not an established plan of care that directs the medical and or nursing care to be provided. Remember the administrative home sets the regulatory structure that must be followed.

Using the second example: A home health and hospice organization creates a palliative care Medicare Part B provider practice as a separate legal entity with its own tax ID – their administrative home is the separate legal entity. This palliative care program must follow all State and Federal regulations that govern their billing practices, and non-physician provider (often represented as NPP) collaboration guidelines depending on the state services will be performed in.

For this type of program your organization should adopt a set of policies and procedures that set the scope of your palliative care program as an independent company or division within your enterprise. Although there are fewer regulations that govern this type of program you must have strong policies and procedures that set program boundaries, govern a consistent approach for the care of individuals, and help mitigate risk the same as before.

Unlike the first example, this type of program provides a different regulatory framework for medical and nursing services. It allows your program to medically engage with patients once written consent is provided. Your palliative care non-physician provider, or physician provider can provide billable medical services for care that is medically necessary. A patient does not need to be on home health services to receive this medically necessary care and can continue to receive medically necessary care if also receiving home health services.

Once you have determined your palliative care program's administrative home you can determine how to augment or supplement your program's policies and procedures so that you align them with your intended structure.

The two lists below are not meant to be all inclusive, and may not apply to each type of program, they are intended as examples of policies and procedures you may want to consider adopting.

List of Suggested Policies

1. Definitions

Purpose: To define terms used in your palliative care program.

2. Scope and Practice

Purpose: To define the practice of palliative care and the services your program will provide.

3. Patient Self Determination

Purpose: To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

4. Informed Consent

Purpose: To outline the guideline for obtain informed consent for palliative care treatment.

5. Ethics Committee

Purpose: To establish ethics committee and define process for handling ethical issues that may arise.

6. Provider Counseling and Coordination

Purpose: To ensure that patients, their families and/or caregivers receive counseling and coordination of care, and training specific to the patient's medical needs and abilities.

7. Treatment and Care Planning

Purpose: To ensure each patients treatment and/or care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

8. Continuity of Care

Purpose: To ensure continuity of care upon referral to other care settings or at discharge for patients receiving palliative care consultative services.

9. Assessment and Treatment of Physical and Emotional Symptoms

Purpose: To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their care.

10. Pain management

Purpose: To ensure that all patients who are experiencing pain are managed with quality and consistency throughout their care.

11. End of Life Care

Purpose: To define the integration of home health, hospice, and palliative care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

12. Care of the Imminently Dying

Purpose: To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families during terminal end of life.

13. Significant Change in Condition

Purpose: To define communication process with the patient, their family, PCP, and other healthcare agencies and staff as appropriate when a significant change is assessed in patient status.

14. QAPI Committee

Purpose: To outline the roles and responsibilities of the Quality Assurance and Performance Improvement (QAPI) Committee.

15. Documentation Audits

Purpose: To provide a guideline for ongoing review of clinical billing, documentation, quality metrics, and patient and family satisfaction measures.

16. New Hire Billing QA

Purpose: To provide a guideline for ongoing review of provider documentation during probationary period.

17. E&M Coding Guidelines

Purpose: To provide guidelines for coding and reporting services.

18. Billing Patients Not Seen

Purpose: To establish billing guidelines for E&M services when patients are not seen face-to-face and evaluated by providers when the E&M code requires face-to-face evaluation of the patient.

19. Uninsured/Underinsured (Charity)

Purpose: To set consistent process for determining a patient's ability to pay for services.

20. Professional Discounts

Purpose: To establish billing guidelines for services rendered.

21. Collaborative Agreement

Purpose: Provide guideline for Collaborative Agreement.

List of Suggested Processes

1. Intake
2. Admission
3. Provider Admission
4. Follow-up Consult
5. Pre-bill Audit
6. Supportive Care Call Procedure
7. On-call Procedure
8. Care Management Meetings
9. Indication for Patient Visits
10. QAPI Committee
11. Counseling and Coordination

Conclusion

In summary, because a perception exists that there are no regulations governing palliative care, an organization and its palliative care leaders can make the mistake of overlooking the need for policies and procedures. No matter the type of palliative care program you implement, there are regulations that direct those services. It is important your program develops a set of policies and procedures that governs your program based on your program's administrative home. Your policies and procedures will set your program's boundaries that guide your program staff and organization, govern a consistent approach in the care of individuals in your program, and help mitigate financial and legal risk.

The following pages contain examples of palliative care program policies and procedures. It is important for each organization to develop their own policies and procedures based on the administrative home for the program and the model of palliative care selected.

Palliative Care: Scope of Practice

Procedure Statement:

To define the practice of palliative care.

Procedures:

Palliative care team will:

A. Work to optimize patient care through four pillars of care to promote the highest quality of life for each patient and their family.

a. Pain and Symptom Management

- i. Optimize pain and symptom control through evidenced based practice.
- ii. Establish an environment that is comforting and healing to optimize functional status.

b. Medication Management

- i. Optimize medication regime through medication reconciliation and medication migration as patient's diagnoses change from one stage to the next.

c. Setting Management

- i. Promote appropriate referrals to other care types and settings timely.
- ii. Ensure each patient is receiving the right care at the right time.

d. Medical Goals of Care

- i. Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness.
- ii. Promote advance care planning that is framed in the context above.
- iii. Documentation of advance care planning preferences through state sanctioned advance directives.

B. Serves as educators and mentors for staff and referral sources.

C. Assists actively dying patients and their families in preparing for and managing life closure.

The process of providing palliative care services includes:

A. Assessment of the physical and psychosocial problems of each patient, including:

- a. Disease status, treatment history, and expected prognosis.
- b. Comorbid medical and psychiatric disorders.
- c. Physical, psychological and spiritual symptoms and concerns.
- d. Medical goals of care.
- e. Advance care planning preferences.

B. Review of assessment data on a regular basis through patient and surrogate decision maker interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, and diagnostic tests and procedures.

C. Collaborative development of treatment plan with the patient, their surrogate decision maker, PCP, and other specialists as appropriate.

Palliative Care: Patient Self-Determination

Procedure Statement:

To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

Procedures:

The palliative care APRN and/or bridge RN will:

- A. Establish ongoing communication and documentation with the patient and surrogate, the PCP and other specialists that includes discussions of:**
 - a. Health status.
 - b. Current disease(s) and expected future course, including prognosis.
 - c. Treatment options.
 - d. Patient preferences.
 - e. Spiritual and cultural beliefs and values that influence preferences.
 - f. The right of the patient to choose and to change his/her choices at any time.
 - g. The legal options for expressing desires through advance care planning documents/directives.
- B. Begin discussion with the patient and/or surrogate at the time of diagnosis and continue to communicate with the patient throughout the course of care.**
- C. Validate the patient's and/or surrogate's understandings of the information presented and introduce new information and choices as the patient's condition changes.**
- D. Define advance care planning and advance directive terminology, including DNR, POLST, Power of Attorney for Health Care and Living Will, and ensure that all choices are documented on appropriate forms.**
- E. Honor advance directives in accordance to policy and state statutes.**
- F. Provide empathy and support as patients and/or surrogates make decisions.**
- G. Document all communication in the medical record and convey patient and/or surrogate decisions to other health care team members.**

Palliative Care: Informed Consent

Procedure Statement:

To outline the guideline for obtain informed consent for palliative care treatment.

Procedure:

- A. Prior to admission, all patients are given a complete description of the palliative care services.
- B. All patients and/or their legal representative are required to acknowledge that they have been given a complete understanding of the services to be provided by the palliative program.
- C. Patients and/or their legal representatives are informed of the eligibility requirements for palliative care services and that the goal of palliative care is directed toward relief of symptoms of the underlying disease, medical goals of care and advance care planning, medication management, and setting management support.
- D. A copy of the **XX Palliative Care Informed Consent** is provided to the patient and/or legal representative for their personal records, regardless of the patient's place of residence.
- E. Care is not provided unless and until a signed consent form is received.
- F. If a patient has been adjudged incompetent, the person appointed pursuant to State law to act on the patient's behalf (surrogate decision maker), signs the informed consent form.
- G. Regular clinical record audits ensure that a consent form has been signed and received from every patient prior to the start of care.

Palliative Care: Ethical Issues and Ethics Committee

Refer to XX in the **XX** Policies and Procedures manual.

Palliative Care: Counseling and Coordination

Procedure Statement:

To ensure that patients, their families and/or caregivers receive counseling and coordination of care, and training specific to the patient's medical needs and abilities.

Procedures:

- A. During each assessment, counseling and coordination of care needs, and cognition/emotional abilities are assessed and documented. The following is a list of common issues to be addressed, depending on the patient's unique clinical circumstances:**
- a. Pain and symptom management, including side-effect management.
 - b. Medical goals of care and advance care planning discussions.
 - c. Medication management.
 - d. Anticipated future medical needs.
 - e. Transitional care needs.
 - f. Home or institutional support options (e.g., home health, long-term care, home hospice services).
 - g. What to expect in the normal course of the disease trajectory.
 - h. Community services.
 - i. Whom to call for routine and emergency needs.
- B. Counseling and coordination of care needs are routinely assessed and reassessed throughout care and treatment.**
- C. When counseling and coordination of care needs are identified, they are incorporated into the treatment plan.**
- D. If patient is also on a palliative home health episode, the patient's care plan must follow all home health rules and regulations and be implemented in accordance to those policies.**
- E. Age, language, and educationally appropriate educational materials (written, Internet, oral) will be provided to meet the needs identified in the assessment process.**

Palliative Care: Treatment Planning and Care Planning

Procedure Statement:

To ensure each patient's treatment and/or care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

Procedures:

- A. The treatment and/or care plan is based upon an ongoing assessment, determined by goals set with the patient, surrogate decision maker and family, and with consideration of the changing benefit to burden assessment at critical decision points during the course of illness.**
- B. The treatment and/or care plan is developed through the input of the patient, surrogate decision maker and family, the involved health care providers, and the palliative care team with the additional input, when indicated, of other specialists and caregivers (e.g., clergy, friends).**
- C. The treatment and/or care plan process includes structured assessment and documentation including:**
 - a. Physical and psychological assessment, addressing the current disease status, treatment options, functional status, expected prognosis, symptom burden and psychological coping.
 - b. Social and spiritual assessment, addressing the social, practical, religious, spiritual, existential concerns, and legal needs of the patient and caregivers, including but not limited to:
 - i. Relationships
 - ii. Existing social and cultural networks
 - iii. Decision making
 - iv. Work and school settings
 - v. Finances
 - vi. Sexuality/intimacy
 - vii. Caregiver availability and stress
 - viii. Access to medicines and equipment
 - c. Cultural assessment, including, but not limited to:
 - i. Locus of decision making
 - ii. Preferences regarding disclosure of information
 - iii. Truth telling and decision making
 - iv. Dietary preferences
 - v. Language
 - vi. Family communication
 - vii. Desire for complementary and alternative medicine
 - viii. Perspectives on death, suffering and grieving
 - ix. Funeral and burial rituals
- D. Treatment and/or care planning conferences with a patient and family will occur regularly to determine the most appropriate medical goals of care as indicated by the clinical condition and are coordinated by the palliative care APRN and/or bridge RN in conjunction with the PCP and other specialists involved in the patient's care as needed.**
- E. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.**

- F. Treatment or care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex, competing and shifting priorities in medical goals of care.**
- G. The palliative care team provides support for decision making, develops and carries out the treatment and/or care plan, and communicates the plan to the patient, the surrogate decision maker, family, and involved health professionals or agencies in the care of the patient.**

Palliative Care: Continuity of Care

Procedure Statement:

To ensure continuity of care upon referral to other care settings or at discharge for patients receiving palliative care consultative services.

Procedures:

- A. The palliative care APRN, and/or bridge RN are responsible for working with other health care staff (e.g., social service providers, discharge planners) for coordinating the discharge plan.**
- B. The palliative care APRN and/or bridge RN synthesizes the treatment and/or care plan and works to convert the patient's medical treatment goals into orders that are transferable across care settings.**
- C. The palliative care APRN, and/or bridge RN confirms access to services that can assist the patient, family and healthcare systems:**
 - a. Physician specialists
 - b. Nursing home/intermediate care facilities
 - c. Hospice
 - d. Home health care
 - e. Outpatient palliative care services (for those not confined to home)
 - f. Pain clinic (for those not confined to home)
 - g. Durable medical equipment services
 - h. Rehabilitation services
 - i. Counseling services
 - j. Transportation
 - k. Rehabilitation
 - l. Medications
- D. Referrals to other healthcare settings the palliative care APRN, and/or bridge RN:**
 - a. Confirms that the referred to agencies have received copies of the palliative care APRN and/or physician's orders and any other clinical documentation or relevant information.
 - b. Ensures the referred to agencies understand the patient is still being seen by palliative care services.
 - c. Ensures ongoing collaboration as necessary with referred to agencies.
- E. Patients on Medicare Part B palliative care services should not be discharged unless they have:**
 - a. Requested discontinuation of services
 - b. Moved outside service area
 - c. Been admitted to Hospice
- F. If patient is discharged from palliative care services the palliative care APRN, and/or bridge RN:**
 - a. Ensure the patient, family, and/or caregiver understands the discharge plan and provided with the appropriate discharge information.
 - b. Confirms that the referred to agencies have received copies of the palliative care APRN and/or physician's orders and any other clinical documentation or relevant information.

Palliative Care: Assessment and Treatment of Physical and Emotional Symptoms

Procedure Statement:

To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their care.

Procedures:

A. The palliative care APRN completes a comprehensive medical assessment:

- a. Chief complaint
- b. History (HPI, ROS, PFSH)
- c. Examination
- d. Current treatments, medication profile and side effects
- e. Diagnoses
- f. Patient concerns
- g. Patient, family, and/or caregiver preferences
- h. Spiritual and cultural beliefs and values that influence treatment
- i. Risk of morbidity and mortality

B. Using approved assessment scales, the patient is to characterize their symptom burden at the time of initial assessment and at regularly prescribed intervals following the assessment, and after initiation of therapy.

C. The palliative care APRN:

- a. Proposes a comprehensive treatment plan and confers with the patient and family and confirms plan elements.
- b. Instructs the patient, family, and/or caregiver on any self-care procedures.
- c. If other care settings are actively providing concurrent care for the patient, the palliative care APRN works with nursing staff to ensure the implementation and monitoring of the treatment plan. This includes the palliative bridge RN as appropriate.

D. The palliative APRN, bridge RN, and other nursing staff works with the palliative care APRN to assess the patient's response to treatment, including:

E. Response to medications or non-pharmacological interventions.

F. Symptom relief measured on a consistently utilized scale.

G. Adverse events, reactions, or side effects.

H. Satisfaction with intervention.

I. The treatment plan is modified based on ongoing assessment.

J. The palliative Medicare Part A care plan is updated based on the modified treatment plan.

K. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.

L. The palliative care APRN ensures that all assessments, recommendations, interventions and responses to therapy are documented in the medical record, and that changes in the treatment or care plan are communicated to the nursing staff in writing and verbally at the time they occur.

M. Prior to a palliative discharge a plan is established for continuing care requirements and family, and/or caregiver education and support.

Palliative Care: Pain Management

Procedure Statement:

To ensure that all patients who are experiencing pain are managed with quality and consistency throughout their care.

Procedures:

A. Standards for assessment:

B. The fundamental principles of pain management will be followed as defined in *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain of the American Pain Society*, and the *Palliative Care Consultant Reference Guide*.

C. The patient's culture and age will be assessed upon admission. The assessment and treatment of pain will be consistent with the patient's cultural and age specific needs.

D. All patients will be assessed for pain by using the Pain Assessment Hierarchy:

- a. Self-report of pain.
- b. Presence of pathological condition or procedure that usually causes pain.
- c. Pain behavior.
- d. Proxy pain rating.
- e. Autonomic response.

E. The pain rating tool:

- a. Visual Analog Scale (VAS) that includes a numeric, face, color and/or descriptive scoring scale.
- b. Pain Assessment in Advanced Dementia Scale (PAINAD) based on objective observable indications by the clinician.

F. The pain assessment includes:

- a. Quality and location of pain.
- b. Functional limitations caused by pain.
- c. Expectations and perceptions of patients and their significant others.

G. Pain is the fifth vital sign and will be assessed on admission, and upon self-report of pain, and when pain of the nonverbal patient is presumed.

H. Pain will be reassessed after each intervention and documented as a VAS score or behavior change.

I. A treatment and/or care plan will be established to deal with pain. The plan should involve both pharmacological and non-pharmacological interventions.

J. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.

K. The patient's pain goal will be identified (functional improvement and/or VAS score) and will be documented as such so that all palliative care team members and other healthcare professionals will know the expectations of care and will incorporate the pain goal.

Palliative Care: End of Life Care

Procedure Statement:

To define the integration of home health, hospice, and palliative care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

Procedures:

- A. Meeting patient and family needs is the central focus of care when cure or maintaining the continuum of health is no longer possible.
- B. Optimal care requires exceptional communication among clinical staff and recognition that a team approach, inclusive of many health care disciplines, is necessary.
- C. Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion and philosophy.
- D. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.
- E. The palliative care consultation and bridge service is available to assist with symptom management, prognosis determination, patient and family support, disposition planning and other issues related to end-of-life decisions.
- F. Home health and hospice services are recognized as an integral part of the continuum of care.
- G. Patients who are homebound and have skilled need should be offered home health services. These services should include a palliative plan of care as appropriate. The patient's goals of care may include and be focused on:
 - a. Restorative health goals
 - b. Maintenance health goals
 - c. Comfort goals
- H. Patients can receive home health services and Medicare Part B palliative care services concurrently.
- I. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.
- J. In the event of questions or differences of opinion among the patient, family or health care team members about the treatment goals, consultation is available from the ethics committee.

Palliative Care: Care of the Imminently Dying

Procedure Statement:

To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families during terminal end of life.

Procedures:

A. In the event that a patient and their family choose not to be admitted to hospice for terminal end of life care; the palliative care APRN and/or bridge RN will provide care to include:

- a. Documentation in the medical record that the patient is "imminently" or "actively" dying.
- b. Communicate with the patient, family and surrogate decision makers that death is imminent.
- c. Prepare patient and family for what to expect during the normal dying process.
- d. Manage pain and other physical/psychological symptoms effectively.
- e. Educate/counsel patients and families concerning the appropriate use of pain and symptom treatments.
- f. Provide treatment of symptoms according to the wishes of the patient or family.
- g. Respect the patient's privacy, values, religion, culture and philosophy.
- h. Involve the patient and family in all aspects of care.
- i. Respond to the psychological, social, emotional, spiritual and cultural concerns of the patient and family, including children and teens affected by the death.
- j. Treat the body post-death with respect according to the cultural and religious practices of the family and in accordance with local law.
- k. Address issues of body or organ donation, autopsy and funeral planning with sensitivity.
- l. Provide bereavement resources through the community.

B. Provide ongoing discussion and options for out-of-hospital care, including home or residential hospice services.

Palliative Care: Significant Change

Procedure Statement:

The APRN will discuss with the treatment options and care plan the patient, their family, PCP, and other healthcare agencies and staff as appropriate when a significant change is assessed in patient status.

Procedures:

A significant change is a major decline in a patient's status that will not normally resolve itself without further interventions by implementing standard disease-related clinical interventions. These interventions should have an impact on more than one area of the patient's health status and requires the patient's treatment and/or care plan to be revised.

A. A significant change reassessment is generally indicated if decline is consistently noted in two or more areas:

- a. Decline in ADLs.
- b. Increase in the number of areas where behavioral symptoms are not easily altered.
- c. Decision-making changes.
- d. Incontinence pattern changes.
- e. Emergence of sad or anxious mood not easily altered.
- f. Emergence of unplanned weight loss.
- g. Emergence of a pressure ulcer or Stage II or higher wound when no wounds were previously present.
- h. Overall deterioration of patient's condition, patient requiring more support.

B. APRN performs follow-up consultation visit, diagnoses the problem(s) and updates treatment plan based on patient and family goals.

C. APRN refers patient for other healthcare support as appropriate.

D. APRN determines next follow-up consult.

Palliative Care: Quality Assurance and Performance Improvement

Purpose:

To outline the roles and responsibilities of the Quality Assurance and Performance Improvement (QAPI) Committee.

Procedures:

- A. The agency palliative care team will form a palliative care QAPI committee that consists of the following members as applicable:**
 - a. Clinical representatives (RN, APRN, MD).
 - b. One representative from administration (Clinical Director or Administrator)
 - c. At large representatives as needed (SW, chaplain, and pharmacist, or corporate leadership).
 - d. Representative from the ethics committee as needed.
- B. The agency palliative care QAPI committee will establish and direct efforts to meet the Palliative Operational and Clinical Quality Standards. These standards are based on the National Quality Forum (NQF) recommendations. As part of this effort, the palliative care QAPI committee is responsible for:**
 - a. Monitoring the palliative care clinical care practices through:
 - i. Evaluation of data concerning pain and other symptom control
 - ii. Advance directives and medical goals of care.
 - iii. Utilization of agency resources.
 - iv. Home health and hospice referrals.
 - v. Patient and family satisfaction.
 - vi. Financial goals.
 - vii. Documentation and billing findings.
 - b. Assisting in the development and implementation of palliative care education initiatives for agency staff, community health professionals that include relevant competency-based metrics.
 - c. Making recommendations to the Governing Body regarding appropriate changes in patient care policies, guidelines, and procedures.
- C. The agency palliative care QAPI committee will establish at least one performance improvement plan (PIP) based on either operational or clinical quality measures that are under performing.**
- D. The agency palliative care QAPI committee will meet monthly*.**
- E. Meeting minutes will be submitted to the Governing Board monthly*.**

** Program should determine the frequency, could be quarterly*

Palliative Care: Documentation Audits

Purpose:

To provide a guideline for ongoing review of clinical billing, documentation, quality metrics, and patient and family satisfaction measures.

It is the policy of XX Palliative Care to conduct routine and random documentation audits that will assess the ICD and CPT coding accuracy, and documentation quality of its providers.

Procedures:

Random Clinical Billing Audits:

- A. Random audits will be conducted for all providers for whom XX bills.**
- B. When possible, audits will be conducted on a prospective basis (unbilled claims).**
- C. A minimum sample of three (3) records will be reviewed for each provider quarterly by the Director of Palliative Care and assesses the following for each provider:**
 - a. Documentation of note for services provided
 - b. Legibility of documentation
 - c. Substantiation of all reported diagnoses in the note
 - d. Accuracy of reported ICD codes
 - e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
- D. Findings will be reviewed with each provider.**

Monthly Quality Metrics Audits:

- A. Monthly quality audits will be performed by designated staff members by the XX of each month using the palliative care audit tool.**
- B. The quality metrics will be established for each year to include, but not limited to:**
 - Symptoms
 - Goals of Care/Advance Care Planning
 - Avoidable re-hospitalization rates
 - Consent compliance
 - LOS trends
 - Referrals to home health
 - Conversion rates to hospice
- C. Monthly quality data will be reviewed and included as part of the agency's monthly* palliative QAPI meeting.**
 - a. See QAPI Committee procedures

**Frequency of QAPI meetings as determined by the program, could be quarterly*

Quarterly Clinical Billing Audits:

- A. Quarterly audits will be conducted for all providers for whom XX bills.**

- a. These audits are separate from the required documentation review established as part of the APRN and primary physician collaborative agreement.

B. When possible, audits will be conducted on a prospective basis (unbilled claims).

C. A minimum sample of five (5) records will be reviewed for each provider quarterly by the designated staff and assesses the following for each provider:

- a. Documentation of note for services provided
- b. Legibility of documentation
- c. Substantiation of all reported diagnoses in the note
- d. Accuracy of reported ICD codes
- e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
- f. Pre-bill process

D. Overall scores will be evaluated based on:

- a. Process compliance
- b. E&M documentation requirements against billed codes
- c. Quality documentation sufficient to substantiate understanding for medically necessary care.

E. Additional training will be mandated for staff if:

- a. The established processes are not followed (i.e. correct setting/location used, correct billing process followed, diagnoses entered correctly, pre-bill audits process, scanning and attaching records to patients, and others as identified).

F. If a provider has more than one (1) billing error identified within the five (5) records:

- a. an additional five (5) records will be reviewed.

G. If more than 10% of the ten (10) records audited are identified with billing errors:

- a. Additional training will be mandated for the provider whose records were audited.
- b. Five (5) additional clinical billing audits will be done post mandated re-training for two (2) consecutive months.
- c. Threshold of 90% must be met and maintained during this period to be placed back on quarterly review process.
- d. If the provider continues to trend with billing errors:
 - i. The provider will be placed on an action plan.
 - ii. Immediate compliance with billing standards must be met.

H. Weekly review by Clinical Services will provide oversight of re-training, and ongoing compliance.

I. Additional training will be mandated for provider if:

- a. It is determined the quality of their documentation needs to be improved to better enhance the documentation requirements for the three areas of an H&P (i.e. History, Examination, Medical Decision Making), and substantiate medical necessity.

Patient and Family Satisfaction Survey:

A. Patient and family satisfaction survey data must be a component of the agency's monthly QAPI meeting.

B. You need to determine your process on this

Palliative Care: New Hire Billing Quality Assurance and Continued Competency

Purpose:

To provide a guideline for ongoing review of provider documentation during probationary period.

Procedures:

General:

- A. The agency will conduct billing and clinical quality reviews for all providers on a weekly basis during their 90-day probationary period.**
 - a. Use palliative audit tool.
 - b. Scores are reviewed weekly with provider.
- B. The APN's minimum passing threshold of 90% is expected by the end of their probationary period.**
- C. After the 90-day period, and if the provider maintains a passing threshold of 90% during the probationary period, audits will be done quarterly.**
 - a. See Quality Audits

Weekly Documentation Audits:

- A. Weekly audits will be conducted for all newly hired providers for whom XX bills.**
 - a. These audits are separate from the required documentation review established as part of the APRN and primary physician collaborative agreement.
- B. Audits will be conducted on a prospective basis (unbilled claims).**
- C. A minimum sample of three (3) records will be reviewed for each newly hired provider weekly by the designated staff and assesses the following for each provider:**
 - a. Documentation of note for services provided
 - b. Legibility of documentation
 - c. Substantiation of all reported diagnoses in the note
 - d. Accuracy of reported ICD codes
 - e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
 - f. Pre-bill process
- D. Overall scores will be evaluated based on:**
 - a. Process compliance
 - b. E&M documentation requirements against billed codes
 - c. Quality documentation sufficient to substantiate understanding for medically necessary care.
- E. Additional training will be mandated for staff if:**
 - a. The established processes are not followed (i.e. correct setting/location used, correct billing process followed, diagnoses entered correctly, pre-bill audits process, scanning and attaching records to patients, and others as identified).
- F. If more than 10% of the records audited are identified with billing errors:**
 - a. Additional training will be mandated for the newly hired provider whose records were audited.

- b. Threshold of 90% must be met and maintained during this period to move out of the probationary period and be placed on quarterly review process.
- c. If the provider continues to trend with billing errors:
 - i. The provider will be placed on an action plan.
 - ii. Immediate compliance with billing standards must be met.

G. Weekly review by Clinical Services will provide oversight of re-training, and ongoing compliance.

H. Additional training will be mandated for newly hired provider if:

- a. It is determined the quality of their documentation needs to be improved to better enhance the documentation requirements for the three areas of an H&P (i.e. History, Examination, Medical Decision Making), and substantiate medical necessity.

Palliative Care: ICD Coding Guidelines for Professional Services

Purpose:

To provide guidelines for coding and reporting services.

Procedures:

- A. It is the responsibility of the provider to document all patient diagnoses in the medical record and for each service submitted for reimbursement.
- B. Because the ICD-10-CM code substantiates medical necessity, and patient complexity, multiple diagnosis codes, including medical conditions, should be submitted by the provider when applicable.
- C. The appropriate code or codes must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the visit encounter.
- D. For accurate reporting of the ICD-10-CM code, the documentation should describe the patient's condition using terminology that includes specific diagnoses as well as symptoms, problems or reasons for visit encounter.
- E. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been diagnosed (confirmed) by the provider.
- F. ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury.
- G. The first code should be the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided.
- H. Do not code diagnoses documented as 'probable', 'suspected', 'questionable', 'rule-out', or 'working'. Rather code the condition(s) to the highest degree of certainty for the visit encounter, such as signs or symptoms, abnormal test results, and other reasons for the visit.
- I. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- J. Code all documented conditions that coexist at the time of the visit encounter and require or affect patient care treatment or management.
- K. Do not code conditions that were previously treated or no longer exist unless they are pertinent to the visit encounter.
- L. For patients receiving only diagnostic services during a visit encounter, sequence the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided during the visit encounter first.
- M. For patients receiving only therapeutic services during a visit encounter, sequence the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided during the visit encounter first.

Palliative Care: CPT Coding Guidelines for Professional Services

Purpose:

To provide guidelines for coding and reporting services.

Procedures:

- A. It is the responsibility of the provider to document all services and procedures provided to the patient in the medical record and submitted for reimbursement.
- B. Each E&M service and or procedure provided and documented should be reported on the claim.
- C. There should be documentation in the patient's medical record that correlates to each service and/or procedure reported for billing.
- D. Diagnoses substantiate the reported CPT codes.
- E. Diagnoses shall be coded in accordance with ICD-10-CM Coding Guidelines established by the AHA, AMA, CMS and National Center for Health Statistics
 - See ICD Coding Guidelines
- F. E&M services shall be selected and documented in accordance with the most recent version of the CMS/AMA Documentation Guidelines.
- G. E&M code assignment shall be based upon the patient's medical complexity, which should be substantiated by documentation in the progress note. For specific documentation requirements for each CPT code, refer to the CMS/AMA Documentation Guidelines for E&M Services.

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>

E&M Coding:

A. When determining the appropriate E&M code, the following guidelines should be followed:

- a. Determine the location of the service:
 - Home, nursing facility, assisted living facility, ER, hospital.
- b. Determine the patient type:
 - New Patient – those patients new to the 'practice', or those who have not been seen by the provider or practice within the past three years.
 - Established – those patients known to the 'practice'.
 - Initial Patient – those patients being seen in an acute care setting for the first time (ED, Hospital).
 - Subsequent Patient – those patients being seen in an acute care setting for follow-up post initial visit encounter.
 - **Note:** A provider who is covering for, or who is on call for another provider should not classify the patient encounter as 'New' unless the patient has not been seen by a member of the 'practice' within the past three years.
- c. Determine the type of service:
 - Comprehensive assessment, follow-up assessment, self-limited problem (focused), patient/family medical conference, etc.
- d. Review the guidelines found in the Billing Tool Kit.
- e. Assign the CPT code based on the complexity of the patient.
- f. Document the extent of the History, Examination, and Medical Decision-Making components required in accordance with the CPT and CMS/AMA Documentation Guidelines.
 - New patient/Initial visit – require documentation of all 3 key components
 - Established patient/subsequent visit – require documentation of 2 or the 3 key components.

- Interval histories do not require documentation of past family social history (PFSH) unless new data is obtained. The provider should indicate that the PFSH was reviewed with no changes. For the review of systems (ROS) re-documentation of non-pertinent systems is not required; however, documentation of relevant systems should be part of each follow-up visit encounter.
- g. If the visit encounter is driven from time codes, assess the total amount of time spent on the encounter and document on the consult note.
- h. If time is the determining factor because the provider spent great than 50% of the visit face-to-face with the patient providing counseling and/or coordination of care, time must be indicated in the medical records.
 - Time spent by other staff cannot be included in the total amount of face-to-face time.

Time Billing:

- A. Time is the controlling factor when assigning an E&M code only when counseling and/or coordination of care dominated more than 50% of the provider/patient encounter**
- B. When time is used to assign a CPT code, the provider must document the total time spent in the encounter and the counseling and coordination activities**
- C. Counseling and/or coordination of care activities include discussion regarding the following:**
- Diagnostic results, impressions and/or recommended diagnostic studies
 - Prognosis
 - Risk and benefits of disease management options
 - Instructions for disease management and/or follow-up
 - Importance of compliance with treatment options
 - Risk factor reduction
 - Patient/family education
 - Discussions related to decreasing or stopping life-sustaining treatments

Multiple E&M Services Rendered on Same Day by Same Provider:

- A. In the event the same provider evaluates a patient more than once in a 24-hour period because a change in the patient's status or assessment of a new problem, the provider should combine the services provided into one E&M code.**
- B. Typically, this will result in a higher E&M code based upon review of the medical decision-making components.**
- C. It is the provider's responsibility to ensure appropriate history and examination elements are documented in the medical record if a higher E&M code is reported.**

Multiple E&M Services Rendered on Same Day by Different Providers:

- A. CMS will only reimburse one E&M service per day by clinicians in the same specialty and/or under the same group number.**
- B. If there is documented medical necessity substantiating an additional evaluation because a change in the patient's status or assessment of a new problem, CMS may reimburse both providers in the same specialty and practice.**
- C. The providers should submit the service rendered for payment.**
- D. If there is a denial because multiple E&M service were reported on the same day, the billing department will request copies of the notes and appeal the denial with the carrier.**

Critical Care Services (99291-99292):

- A. Critical care services may be billed when a provider renders care to a critically ill patient.**

- B. Under CPT guidelines, critical care is defined as a 'critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition'.**
 - a. Examples: organ system failure, renal, hepatic metabolic and/or respiratory failure.
- C. Critical care is used to report the total duration of time spent by the provider providing the critical care service**
- D. In order to bill critical care services, there must be a minimum of 30-minutes of critical care services provided to the patient.**
- E. In the absence of 30-minutes, the provider should bill the services under the appropriate E&M code.**
- F. Documentation requirements for services billed as critical care include:**
 - a. Labeling the note as 'critical care services'
 - b. Total time spent providing critical care services
 - c. Documentation of the services provided to the patient which should reflect the critical nature/status of the patient's condition.

Procedure Services:

- A. Procedures personally performed by the provider should be captured on billing form.**
- B. E&M services should not be billed with a procedure unless an E&M service was performed which is 'separate and distinct' from the procedure.**
- C. Procedures should be sequenced in descending order of the Medicare Fee Schedule.**
- D. Medicare reduces payment for each subsequent procedure when multiple procedures are listed.**
- E. Procedure codes with the greatest amount of work effort should be sequenced first.**

After Hours Services:

- A. After hours reimbursement is available to the provider who responds to a request for services after designated operating hours.**
- B. While Medicare will not reimburse typically for this, other payers will in some instances.**
- C. After hours is reported in addition to the E&M service and/or procedure service code.**
- D. Services provided between 10p and 8a are coded 99053*.**
- E. Services provided on Sundays and holidays are coded 99051*.**

**American Academy of Ophthalmology. (2016). CPT codes for unscheduled patients. Retrieved from <https://www.aaao.org/practice-management/news-detail/cpt-codes-unscheduled-patients>*

**American Academy of Pediatrics. (2017). Coding for visits after hours and in other special circumstances. Retrieved from <https://www.aappublications.org/news/2017/06/21/Coding062117>*

Palliative Care: Billing for Patients Not Seen

Purpose:

To establish billing guidelines for E&M services when patients are not seen face-to-face and evaluated by providers when the E&M code requires face-to-face evaluation of the patient.

Procedure:

- A. It is the policy of **XX** to adhere to CMS billing guidelines and not charge for E&M services when patients are not seen face-to-face.**
- B. APRNs will complete a daily encounter record that records the total number of patients seen and those where a request or appointment was made that were attempted but not performed due to unforeseen circumstances.**
- C. In the event a provider is called to a facility to evaluate a patient who is unavailable for the consult:**
 - a. Document that the consult was attempted
 - b. Provide a brief statement of why the evaluation was not completed
 - c. Document any discussion with staff
- D. Because the patient was not evaluated, there are no billable services and charges should not be submitted for billing.**

Palliative Care: Professional Discounts

Purpose:

To establish billing guidelines for services rendered.

No individual employed or contracted by XX Palliative Care program may provide free or discounted services as a 'professional courtesy' to any patient, including physicians, their families, employees or a physician's office, nursing facility staff, etc.

Provisions of free or discounted services based on professional courtesy potentially impacts the Medicare Fraud and Abuse laws, the Stark Bill and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Professional courtesy discounts implicate the anti-kickback statute because services at less than 'fair market value' may be viewed as a financial benefit provided as an inducement for the future referral of business by the provider.

The practice of providing free or discounted services would constitute a financial arrangement under the Stark law so that a physician receiving such a discount could not make any referrals for designated health services under the Stark law.

The practice of waiving copayments and deductibles may also be a violation of HIPAA or relevant state statutes which prohibit the submission of false or fraudulent statements to third party payers in connection with delivery of, or payment for, healthcare services.

Procedure:

- A. XX palliative care staff shall not extend professional courtesy, waive deductible or copayments or provide free or discounted services to any patient, including physicians, their families or employees of physician's offices, and employees of nursing facilities.**
 - a. All services provided to such persons shall be billed at established rates adhering to normal billing practices.
- B. Charges for services provided by the APN or other providers may only be adjusted under very limited circumstances**
 - a. The person to be billed for services is indigent or suffering from severe financial hardship as determined by guidelines established in accounting policies.
 - b. There has been a billing error that needs to be corrected.
 - c. The cost of additional collection efforts exceeds the likely financial recovery.
- C. No one should adjust, waive or discount charges without discussion with XX's Compliance Officer, or other responsible individual**
- D. No one should make promises to a patient with respect to the patient's bill prior to consulting with authorized staff.**
- E. Charges that have not been collected will be discussed through the A/R process.**



NHPCO Palliative Care Playbook for Hospices



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