Hospice Documentation Checklist

Requested Claim Information	
Dates of Service Under Review:	
Start of Care:	

Hospice Election Statement

An individual (or his/her authorized representative) must elect hospice care to receive it. The initial election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods and unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice. Hospices obtain election statements for the individual and file a Notice of Election (NOE) with the Medicare Contractor, which transmits to the Common Working File (CWF) in electronic format. Once the initial election is processed, the CWF maintains the beneficiary in hospice status until a final claim indicates a discharge (alive or due to death), or until an election termination (revocation) is received.

For more information regarding content requirements for the Hospice Election Statement, refer to 42 CFR 418.24(b) and CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.2.1.1 Hospice Election Statement

Note *CMS has provided the Model Example of Hospice Election Statement (PDF) located in the Downloads section at the bottom of the CMS website's Hospice webpage. The Model Example Hospice Election Statement includes ALL of the required items. It is* ***never*** *recommended to rely on any internet searches to find these forms.*

Important

Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

The hospice election statement **must include these 8 items:**	1. Identification of the particular hospice that will provide care to the individual.
	2. The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment.
	3. The individual's acknowledgement that the individual has been provided information on the hospice's coverage responsibility and that certain Medicare services are waived by the election. For hospice elections beginning on or after 10/1/2020, this would include providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice.
	4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no later than the date of the election statement. An individual may not designate an effective date that is retroactive.

	5. The individual's designated attending physician (if the beneficiary has one). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician, Nurse Practitioner (NP), or Physician Assistant (PA) was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.
	6. The individual's acknowledgment that the designated attending physician was the individual's or representative's choice.
	7. For hospice elections beginning on or after 10/1/2020 the hospice must provide: • Information on individual cost-sharing for hospice services; • Notification of the individual's (or representative's) right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice; • Information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information ***Note** Best Practice: document the local BFCC-QIO contact name and phone number that services that beneficiary's specific area.*
	8. The signature of the individual or representative.

<table>
<tr><th colspan="2">Hospice Election Statement Addendum</th></tr>
<tr><td colspan="2">For hospice elections beginning on or after 10/1/2020, in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the hospice election statement.

If the election statement addendum is requested within five days from the date of a hospice election, then the hospice would have five days from that request date to furnish the addendum. If the addendum is requested during the course of hospice care (that is, five days after the effective date of the hospice election), the hospice must provide this information, in writing, within three days of the request to the requesting individual (or representative), non-hospice provider, or Medicare contractor. If there are any changes to the content on the addendum during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative).

For more information on the content requirements and timeframes for the hospice election statement addendum, please refer to 42 CFR 418.24(c) and CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.2.1.2 Hospice Election Statement Addendum

Note If the claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum would result in a claims denial. However, the Medicare Administrative Contractor may request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).

Note CMS has provided the following Model Hospice Election Statement Addendum - July 2021 (PDF) located in the Downloads section at the bottom of their Hospice webpage which includes all of the required items</td></tr>
<tr><td rowspan="6">The Hospice Election Statement Addendum must include these 10 items:</td><td>1. The addendum must be titled “Patient Notification of Hospice Non-Covered Items, Services, and Drugs.”</td></tr>
<tr><td>2. Name of the hospice.</td></tr>
<tr><td>3. Individual's name and hospice medical record identifier.</td></tr>
<tr><td>4. Identification of the individual's terminal illness and related conditions.</td></tr>
<tr><td>5. A list of the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.</td></tr>
<tr><td>6. A written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions.</td></tr>
</table>

	7. References to any relevant clinical practice, policy, or coverage guidelines.
	8. Information on the following: • Purpose of Addendum. The purpose of the addendum is to notify the individual (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions. • Right to Immediate Advocacy. The addendum must include language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice's determination.
	9. Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the individual's (or representative's) agreement with the hospice's determinations. *If the individual (or representative) refuses to sign a requested addendum, the hospice must document why (on the addendum itself) and it would become a part of the medical record.*
	10. The date the hospice furnished the addendum. The date furnished must be within the required timeframe (that is, three or five days of the beneficiary or representative request, depending on when such request was made).

<table>
<tr><th colspan="2">Certification of Terminal Illness (CTI)</th></tr>
<tr><td colspan="2">For the first 90-day period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

For more information on attending physician requirements as well as timing and content of CTI see 42 CFR 418.3, 42 CFR 418.22(b) and CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1 Timing and Content of Certification.

Initial certifications may be completed no more than 15 calendar days before hospice care is elected. If the hospice cannot obtain the written certification within two calendar days, after a period begins, it must obtain an oral certification within two calendar days and the written certification before it submits a claim for payment.

Payment normally begins with the effective date of election, which is the same as the admission date. If the physician forgets to date the certification, a notarized statement or some other acceptable documentation can be obtained to verify when the certification was obtained.

Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

Note Subsequent CTI, oral certification, and FTF requirements are covered in separate sections.</td></tr>
<tr><td rowspan="3">Initial Certification of Terminal Illness (CTI) must include/conform to the following requirements:</td><td>1. Written statement that the individual's medical prognosis is that their life expectancy is six months or less if the terminal illness runs its normal course.</td></tr>
<tr><td>2. Specific clinical findings and other documentation supporting a life expectancy of six months or less.</td></tr>
<tr><td>3. The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers (for more on signature requirements, see Publication 100-08, Medicare Program Integrity Manual, chapter 3, section 3.3.2.4).

* Example of Benefit Period Dates* 01/11/23 through 04/10/23</td></tr>
</table>

	4. As of 10/1/2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms; • If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature. • If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum. • The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative. • For recertifications on or after 1/1/2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.
	5. FTF encounter. For recertifications on or after 1/1/2011, a hospice physician or hospice nurse practitioner must have a FTF encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the FTF encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

<table>
<tr><th colspan="2">Subsequent Physician CTI</th></tr>
<tr><td colspan="2">For the subsequent periods, recertifications may be completed up to 15 days before the next benefit period begins.

For subsequent periods, the hospice must obtain, no later than two calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG.

If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days.

For subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group

For more details on subsequent CTI requirements please refer to 42 CFR 418.22(a)(3)(iii), 42 CFR 418.22(c)(2), and CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1 Timing and Content of Certification.

Note Oral certification requirements are covered in the next section.</td></tr>
<tr><td rowspan="3">Subsequent CTI must include the following requirements:</td><td>1. Obtain written certification statement from the medical director of the hospice or the physician member of the hospice's IDG</td></tr>
<tr><td>2. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

• If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.
• If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
• The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient.
• The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.
• The narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.</td></tr>
<tr><td>All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.</td></tr>
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<tr><th colspan="2">Oral Certification</th></tr>
<tr><td colspan="2">An oral certification is an interim certification until a written certification can be obtained.

If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days (that is by the end of the third day).

When making an oral certification, the certifying physician(s) should state that the patient is terminally ill, with a prognosis of six months or less. Because oral certifications are an interim step sometimes needed while all the necessary documentation for the written certification is gathered, it is not necessary for the physician to sign the oral certification.

Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.

A written certification of terminal illness must be on file in the hospice patient’s record prior to submission of a claim to the Medicare contractor.

For more details on oral certifications see 42 CFR 418.22(a) and CMS IOM, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1 Timing and Content of Certification.</td></tr>
<tr><td rowspan="2">Oral Certification of Terminal Illness (CTI) must include the following:</td><td>1. Appropriate documentation entered into to the patient’s medical record by a hospice staff person at the time the oral certification was received.</td></tr>
<tr><td>2. The author signed/dated oral certification entry as well as named the physician. The physician does not have to sign the entry.</td></tr>
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<table>
<tr><th colspan="2">Face-to-Face (FTF) Encounter</th></tr>
<tr><td colspan="2">Failure to meet the FTF encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

The encounter must occur prior to the beginning of the hospice patient's third benefit period, and prior to each subsequent benefit period, a hospice physician or hospice nurse practitioner must complete a FTF encounter with each hospice patient.

Starting with the third benefit period please include documentation to support the FTF encounter for ALL benefit periods when responding to an ADR

Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility.

For more information on administrative discharge as well as timeframe exceptions, refer to section 20.1.5.d in the CMS IOM, Pub.100-02, Medical Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance.</td></tr>
<tr><td rowspan="3">FTF encounter requirements must include the following:</td><td>1. Timeframe: The encounter must occur no more than 30 calendar days before the third benefit period recertification and each subsequent recertification.

FTF encounter may occur on the first day of the benefit period and still be considered timely.</td></tr>
<tr><td>2. Attestation: The hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a FTF encounter with the patient, including the date of the encounter.

The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled as such.

If the nurse practitioner or non-certifying hospice physician perform the FTF encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.</td></tr>
<tr><td>3. Practitioners who can perform: Only a hospice physician who is employed by the hospice or working under contract with the hospice or a hospice nurse practitioner employed by the hospice can perform the FTF encounter.

Note A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice. If the hospice is a subdivision of an agency or organization, an employee of that agency or organization assigned to the hospice is also considered a hospice employee.

Physician Assistants (PAs), clinical nurse specialists, and outside attending physicians are not authorized to perform the face-to-face encounter for recertification.</td></tr>
</table>

Responding to a Hospice Additional Documentation Request (ADR)
Hospice agencies should monitor for ADRs on a daily basis to ensure a timely response/submission of medical record documentation to the MAC. ADRs can be found through the following: • Fiscal Intermediary Standard System/Direct Data Entry (FISS/DDE) (refer to the *(FISS/DDE) Provider Online Guide*) + • NGSConnex (refer to the *NGSConnex User Guide* on how to check the status of an ADR) • Notification Letters (USPS): NGS will mail ADRs as a courtesy. Please be sure your agency address is current and up to date in the PECOS system. (Do not rely solely on USPS for receipt of ADR's) ****Important** Upon receipt of an ADR, carefully review the entire request for information regarding what documentation needs to be returned.**
Beneficiary Hospice Election Statement; are all required items present as indicated
Documentation should support CMS guidelines and criteria for hospice eligibility.
All physician CTIs and narratives including ALL FTF when applicable.
Plan of Care (Physician and Interdisciplinary Group (IDG))
Interdisciplinary Team Notes
Any additional documentation to support terminal prognosis
Physician Progress notes
Nursing Notes
Social Worker and/or Clergy, Counselor notes/Hospice aide
Hospital admission and/or discharge summary, including the initial comprehensive assessment.
Labs or radiology exams (applicable to the terminal diagnosis)
Medication administration record
Objective data (i.e., weights, mid-arm circumference, abdominal girths, PPS)
History (including dates) of infections, falls, hospitalizations, and other relative events (recent or recurring)
Concurrent diseases and/or medication management

Medical Record Submission - Preparation Checklist	
****Important**** Verify that each ADR submission includes a contact name, phone number, and/or email of the hospice staff member within the agency who can respond to any possible missing or unreadable document inquiries.	
Black ink copies best	Verify all pages are for the right patient
Copy both sides of the documents	Check for accuracy of all documentation, especially anything handwritten
Copy all pages as one PDF if submitting electronically	Identifiable credentials for each clinician signature. (Signature sheets as appropriate from outside agency and referring facility/office)
Organize the documents and paginate each page	Proof of Provider Enrollment, Chain & Ownership System (PECOS) – Validation for all physicians involved in the patient's care for all DOS in the period of care
Verify the correct dates of service for the claimed period of care	Check for patient's name on each page (front and back where applicable)
When providing a cover letter, place it directly beneath the ADR. (**Cover letters are optional;** sometimes used as a way to direct the medical reviewer to where specific information is within the medical record. (i.e., the hospice discharge summary is located on page 45))	Confirm all dates and signatures are clear, identifiable and appropriate
Verify the correct ADR is placed on top of the right medical record	Utilize the NGS ADR Timeline Calculator to determine the target date MR ADRs or claim ADRs must be received
Return records to the MAC within the requested 45-day time frame (Best practice is to return between day 35-40)	Each ADR submission should be sent separately; however, when responding to multiple responses in a single mailing via USPS, UPS, FedEx, individually compile each medical record with a copy of the corresponding ADR on top

Methods for Submitting Medical Records	
***NOTE* Always check NGSMedicare.com for the most up-to-date information at time of submission**	
Jurisdiction 6 - Ways to submit Medical Records: Paper, Fax, CD, esMD	**Jurisdiction K - Ways to submit Medical Records: Paper, Fax, CD, esMD**
1. NGSConnex 2. USPS National Government Services, Inc. P.O. Box 6474 Indianapolis, IN 46206-6474 3. UPS/FedEx National Government Services, Inc. 6345 Castleway Court Indianapolis, IN 46250 Attn: Mail & Distribution *Add/insert the operational unit record to be scanned 4. Direct Fax 315-442-4154	1. NGSConnex 2. USPS National Government Services, Inc. P.O. Box 7108 Indianapolis, IN 46207-7108 3. UPS/FedEx National Government Services, Inc. 220 Virginia Ave Indianapolis, IN 46204 Attn: Mail & Distribution *Add/insert the operational unit record to be scanned 4. Direct Fax 315-442-4390