



National Alliance
for Care at Home

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A Compliance Guide to Hospice General Inpatient Care

This resource was originally produced by National Hospice and Palliative Care Organization (NHPCO). NHPCO has now joined together with the National Association for Home Care (NAHC) to form a new national organization representing providers of home care, home health, hospice, palliative care, and other health care services mainly delivered in the home – the National Alliance for Care at Home (the Alliance).

General Inpatient Care Compliance Guide

DISCLAIMER

This compliance guide has been gathered and interpreted by NHPCO from various resources and is provided for informational purposes only. It should not be viewed as official guidance from CMS or Medicare Administrative Contractors (MACs). It is always the provider's responsibility to determine and comply with applicable CMS, MAC, and other payer requirements. Further, this guide does not constitute legal advice and is not intended to take the place of legal advice.

The National Hospice and Palliative Care Organization (NHPCO) is pleased to provide this resource on the use of and documentation for hospice General Inpatient (GIP) Care. NHPCO gratefully acknowledges the work of the GIP Workgroup, composed of members of the NHPCO Quality and Standards Committee and the NHPCO Regulatory Committee, whose case studies, content suggestions, and helpful references have all made this compliance guide more complete and an easy reference for hospice providers.

This resource provides a high-level overview of what GIP care is, where it can be provided, when it may be appropriate, and tips for effective documentation. For more insight into the proper use of the GIP level of care, providers should also look closely at the corresponding [Interpretive Guidelines](#) contained in Appendix M of the State Operations Manual and the commentary in the Federal Registrar's final rule regarding the [2008 Conditions of Participation](#). There is also useful information in chapter 11 of the [Medicare Claims Processing Manual](#) (section 30.1; 80.1) and chapter 9 of the [Medicare Benefit Policy Manual](#) (section 40.1.5). In addition, this resource does not cover state law or guidance. Providers should check their state's hospice licensure laws and regulations for specific GIP requirements, such as Certificate of Need (CON) for hospice facility beds or state licensure for a hospice inpatient facility. If the state requires CON and licensure, or licensure for a facility, the hospice must comply.

Overview of GIP Care

GIP care is one of the four levels of hospice care the Federal Medicare hospice regulations require a hospice to provide as a condition of their Medicare certification. CMS guidance regarding GIP in the [2008 Hospice Conditions of Participation Final Rule](#) (page 32096), which revised the hospice Conditions of Participation (CoPs), states that GIP may be required in order to manage acute pain and other symptoms that cannot feasibly be managed in any other setting. The federal regulations, at [§418.302\(b\)\(4\)](#), also state GIP is "for pain control or acute or chronic symptom management which cannot be managing in other settings." GIP may be initiated when other efforts to control symptoms are ineffective. There is no specified disease, condition, or symptom that qualifies a patient to receive 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.

NOTE: GIP is intended to be a short-term intervention (similar to the duration of an acute hospital stay). However, GIP under the Medicare hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit.

The Medicare hospice regulations that relate primarily to the provision of GIP are found at:

- [§ 418.108](#) (Short-term inpatient care)
- [§ 418.110](#) (Hospices that provide inpatient care directly)
- [§ 418.202](#) (e) (Covered services)

It is the expectation that this level of care is to be provided to the patient when appropriate. That includes ensuring that there is at least one contract in place for GIP care in the hospice's service area if the hospice does not have its own inpatient facility or unit. While GIP care is often the subject of scrutiny by the Centers for Medicaid and Medicare Services (CMS) and the Office of the Inspector General (OIG), this should not discourage hospice providers from providing this level of care when needed. Rather, the information provided in this document should be used to guide the hospice in documenting the justification of this higher level of care. Examples of federal scrutiny of GIP can be found in NHPCO's Scrutiny of Hospice General Inpatient Care resource and on the NHPCO website.

Resources:

[GIP FAQs – common questions and answers about hospice GIP](#) (July 2021)

[NHPCO's Scrutiny of Hospice General Inpatient Care](#) (August 2021)

Where GIP Can Be Provided

GIP can be provided in a hospice-owned inpatient facility, or the care may be contracted if a hospice does not own a facility. If a hospice does not have its own free standing inpatient facility or unit where it can provide GIP care directly, it must contract with a participating Medicare hospital, skilled nursing facility (SNF) or another hospice inpatient facility to provide GIP services under arrangement. If GIP is contracted or provided under arrangement, the federal hospice CoPs at [§ 418.108](#), require that GIP be provided in a facility as follows:

- A Medicare-certified hospice that meets the CoPs for providing inpatient care directly, as specified in [§ 418.110](#).
- A Medicare-certified hospital or skilled nursing facility that also meets the standards specified in [§ 418.110\(b\) and \(f\)](#) regarding 24-hour nursing services and patient areas.

It is important to note that when GIP is contracted from an allowable facility, providers must be compliant with the requirements for twenty-four-hour nursing services and patient areas:

§ 418.110(b) Standard: Twenty-four hour nursing services

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.** (emphasis added).

§ 418.110(f) Standard: Patient areas

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.

See Code of Federal Regulations, [42 CFR §418.110](#)

GIP care cannot be provided in the home, in an assisted living facility, a hospice residential facility, or in a long-term care nursing facility (NF). These environments are not equipped to provide skilled nursing and medical care to manage an acute symptom crisis.

Elements of a Written Agreement for GIP Services

If a hospice is contracting for GIP care, [§ 418.108\(c\)](#) requires that there be a written agreement describing the arrangement. While, there are several regulatory requirements that apply to the provision of GIP under arrangements, [§ 418.108\(c\)](#) only requires certain elements to be explicitly included in the written agreement. Those elements that Medicare dictates must be included in the written GIP agreement are as follows:

- a. That the hospice will supply the inpatient provider with a copy of the patient's plan of care and specify the inpatient services to be provided;
- b. That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the protocols and plan of care established by the hospice for its patients;
- c. That the hospice patient's inpatient clinical record includes a record of all inpatient services received and events regarding care that occurred at the facility;
- d. That the patient's discharge summary be provided to the hospice at the time of discharge;

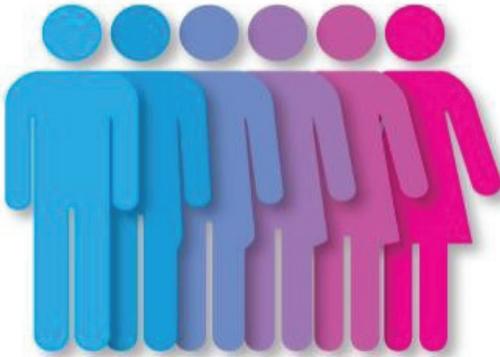
- e. That a copy of the patient's inpatient clinical record be available to the hospice at the time of discharge;
- f. That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;
- g. That the hospice retains responsibility for training personnel from the facility who will be providing inpatient services and documenting both a description of the training along with the names of those giving the training; and
- h. A method for verifying that the above requirements are met.

Change in Level of Care, But Not Location of Care

GIP TO RHC LEVEL OF CARE IN A HOSPITAL

Unless a patient is discharged from GIP deceased, the day a patient is discharged from GIP is to be billed and paid at the RHC rate. On a rare occasion, a patient may remain in the hospital after a GIP stay at the routine home care level of care. Because of this rate decrease, along with other regulatory concerns, hospices should generally not care for patients at the RHC level of care in a hospital setting. While a claim can be submitted for RHC with the hospital as the location of care, a hospice would be “down coding” their own claim. Likewise, because the Medicare hospice benefit does not cover “room and board” in a residence unless it is part of the GIP or respite level of care, the hospice would be expected to charge the patient for “room and board,” unless there is a provision for coverage in state regulations. Therefore, RHC should not be provided in a hospital setting on a regular basis.

GIP TO RESPITE LEVEL OF CARE



In 2014, CMS revised the respite guidance in [Chapter 9, section 40.1.5](#) of the Medicare Benefit Policy Manual to include specific examples of when respite may be appropriate, one of which includes transitioning a patient directly from GIP to respite level of care “if the usual caregiver has fallen ill.” While this guidance appears to allow respite in instances where the patient is not currently residing at home, the qualifying language is important and signals an expectation that these transitions will not be the norm. Therefore, hospices should be cautious when making such transitions and ensure they have supportive documentation consistent with the guidance to justify the level of care change.

Resources:

- Palmetto GBA [GIP Video about Eligibility](#) (Scroll down the listings of Education on Demand until you see the Hospice General Inpatient Care (GIP) video)
- [Script for GIP video](#)

Hospice Management of Care Responsibility

PROFESSIONAL MANAGEMENT AND OVERSIGHT

Regardless of care setting, the hospice is responsible for the professional management of the patient's care in accordance with the hospice plan of care as set by the IDG. The federal CoPs, at [§ 418.100\(e\)](#), state that contracts with appropriate facilities for GIP services should be clear regarding the hospice's oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement. The written agreements should also clarify payment rates and procedures.

CARE COLLABORATION



When a patient transitions from RHC to the GIP level of care, the home hospice team continues to have a role in the patient's care. While the frequency of IDG visits to a patient receiving the GIP level of care is not specified in the federal regulations, a good standard of practice is a daily visit from an IDG member to assure professional management, coordination of the plan of care, communication with the patient, family, and hospital or SNF staff, continuity of care and evaluation of continued eligibility for this level of care. The IDG needs to ensure that the focus of the GIP care is palliative and based on the plan of care. If the patient decides to shift to a more aggressive course, then a plan of care conversation should occur.

It is also essential there is frequent coordination and communication with the physician overseeing inpatient care, the attending physician (if any), and the hospice physician. Professional care management is essential during the inpatient stay and during the decision-making process for transitions from GIP to a lower level of care. 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 inpatient stay.

TRANSITION PLANNING

Transitioning the patient from GIP to RHC requires planning and should begin the moment the patient moves to the GIP level of care. The hospice (not the hospital or SNF staff) is responsible for managing the transition back to RHC or any other level of care. Documentation should show the IDG is assessing the situation daily and planning for the transition to another setting or level of care.

NOTE: GIP 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.

Resources:

- [Hospice General Inpatient Care Fact Sheet for Hospitals](#) – teaching tool to use with hospital partners about hospice GIP (September 2021). This document that can be customized to add a hospice provider’s logo and contact information.
- [Hospice General Inpatient Care Fact Sheet for Skilled Nursing Facilities](#) – teaching tool to use with SNF partners about hospice GIP (September 2021). This document can be customized to add a hospice provider’s logo and contact information.

When GIP Is Appropriate and Not Appropriate

**APPROPRIATE FOR GIP**

GIP may be initiated when the interdisciplinary group (IDG), specifically the hospice physician, determines that the patient’s pain or other symptoms cannot be effectively managed in any other setting, including 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.

GIP may also be provided at the end of a hospital stay if there is a need for pain control or symptom management that cannot be feasibly provided in the home setting at hospital discharge. However, not every patient who reaches the end of a hospital stay will qualify for GIP. Additionally, CMS has acknowledged that GIP care may be appropriate when a patient needs medication adjustment, observation, or other stabilizing treatment (e.g., psycho-social monitoring). Careful assessment of pain and other symptoms is required in all instances to determine whether a patient is GIP appropriate.

When the IDG assesses 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. Ultimately, it is a physician’s medical judgment that determines when and if GIP is appropriate for a given patient. The hospice physician should review the available clinical information about the patient’s status to determine if a change in level of care to GIP is required to manage the patient’s acute symptom crisis.

The following is a non-exhaustive list of examples of patient status triggers that may lead to a need to change to the 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; or
- Imminent death – only if pain or other symptoms are present and skilled nursing is needed.

NOT APPROPRIATE FOR GIP

- GIP is not an “automatic” level of care when a patient is imminently dying. There must be pain or symptom management issues that cannot be resolved in another setting and the need for skilled nursing.
- GIP is not intended to address unsafe living conditions in the patient’s home.
- GIP is not intended for caregiver respite. If a patient has no caregiver or a caregiver is unable to help the patient adequately, other arrangements should be made.

NOTE: CMS clarified in the preamble to the 2008 Hospice CoPs Final Rule that caregiver breakdown should not be billed as GIP care unless the coverage requirements for this level of care are met.

- GIP is not allowable when a patient’s acute symptom crisis resolves and there is no further skilled nursing need.
 - In this situation, the patient needs to transition back to the routine home level of care (RHC).
- GIP is not for instances when a patient/family refuses to leave inpatient care. If a patient or their family refuses to leave the inpatient setting of care, the hospice provider should issue an Advance Beneficiary Notice (ABN) form to the patient/family.
 - The ABN should notify the patient/family that the GIP level of care will not be paid by Medicare on a specific date and going forward and that the patient/family will be financially liable for the difference between the GIP and RHC daily rate. Daily room and board charges would also apply as Medicare does not cover room and board for the routine home level of care.

Examples of When GIP Care May Be Appropriate – Patient Case Studies

Please note, the below case studies are hypothetical and should not be used as a basis for admitting or discharging a patient from GIP care. As mentioned above, whether the GIP level of care is appropriate for a given patient is determined on a case-by-case basis.



1. CASE STUDY #1 – ACUTE, COMPLICATED PAIN MANAGEMENT

56-year-old man with a principal hospice diagnosis of non-small cell lung cancer, now metastatic to his left kidney. Patient diagnosed four years ago. He has been on hospice routine home care, but his pain is now severe, in spite of team attempts to manage his pain at home. He rates his pain level at an 8/10, unless he lays perfectly still, with which it drops to a 4/10. He is using two fentanyl 100 mcg patches every 72 hours and is on a morphine CADD pump, with a basal rate of 11 mg/hour, with 1 mg bolus every 10 minutes prn pain. He has a history of chronic post-laminectomy

pain, but also has generalized pain. He lives with his 10-year-old daughter. He has an extreme narcissistic personality disorder, with a tendency to manage his medications as he pleases. He believes he knows best how to manage his opioids. He has a long history of opioid use. He can still swallow medications. His BMI is 17.3, he is sleeping 16-18 hours per day, and his PPS is 50%. He is admitted to the GIP level of care at the hospice inpatient

unit for conversion to methadone, skilled management of his conversion in a very controlled setting, and reassessment of adjuvant treatment options and other factors which could be contributing to his pain.

2. CASE STUDY #2 – OTHER ACUTE SYMPTOM MANAGEMENT

A 75-year-old female with ovarian cancer was admitted to hospice at home one month ago. She has had intermittent episodes of nausea that have generally been managed with Compazine.

Over the past 48 hours she has been vomiting. The Compazine was scheduled yesterday, and the vomiting has persisted. She has been unable to keep her pain medication down, so her abdominal pain has been worse today. She was referred for admission to the GIP level of care to manage her nausea and her pain.

This 82-year-old male has a long history of chronic obstructive pulmonary disease (COPD) and last week was admitted to hospice after a recent diagnosis of lung cancer which was metastatic, and he had decided not to proceed with chemotherapy or radiation. Since admission he has developed worsening dyspnea. He has been using his inhalers, but these have not helped. He has not been hypoxic. His wife reports he took some morphine and then became lethargic. She is not clear how much he took. He is more awake now but reporting severe dyspnea. He was referred for admission to the GIP level of care for management of dyspnea.



3. CASE STUDY #3 – ACUTE TERMINAL RESTLESSNESS

62-year-old male admitted to hospice services following aggressive treatment for liver cancer. He could no longer tolerate chemotherapy and he and his family opted for comfort care with the desire to remain in his own home. His wife was the primary caregiver and extended family was available for additional support. Palliative performance scale (PPS) score at admission was 60% and there were no identified symptoms to be managed.

The first night of service, the patient was restless and had difficulty sleeping. When assessed by the hospice nurse on her visit, the patient had only vague complaints of not being able to sleep and wanting to move around. The current Trazadone at sleep order was discontinued and Benadryl at sleep was initiated by the hospice physician. This was not effective and Seroquel at sleep was added. This addition was not helpful and the night-time restless continued with the addition of pacing and a sense of being unsettled both day and night.

By day 4, the patient began to exhibit irritability along with restlessness, refusing Lactulose and other medications and not eating or drinking well. The hospice nurse received orders to begin Haldol and Ativan prn. This combination did allow the patient to sleep a few hours. At this time his PPS score was 50% due to increased need for supervision and assistance.

Hospice nursing visits continued daily in effort to determine the most effective medication regimen and assess the level of restlessness/agitation and now confusion and fatigue. Hospice social work visits identified that the patient was fearful of dying in his sleep and was “not ready to go”. Family members were now taking shifts to provide care and supervision. All family members wanted to honor the patient’s desire to remain in his own home. The family declined a GIP admission for symptom management.

During a hospice nurse visit, it became apparent that the medication regimen was not being followed

consistently due to varying opinions of the multiple family members involved in his care. Also, the hospice team noted increased tensions and frustrations on the part of all the family members. Again, hospice offered a GIP admission, but the family declined.

By day 7, the patient had declined further, his PPS was 40%. He had become increasingly confused, weaker with an unsteady gait, and continued restlessness and agitation. Nursing noted an increased abdominal girth, bruising, and evidence of jaundice. Both hospice nursing and social work met with the family and provided end-of-life education and offered care planning. At this time the family accepted the offer of a GIP admission to further assess and manage the increasing symptoms.

Throughout his 4-day GIP stay, multiple adjustments to the medication regimen were made and he was seen by the hospice physician daily. It became clear that this was a terminal admission with continued restlessness, confusion, and lethargy. He became hypoxic with apnea; jaundice and ascites increased. With regular medication dosing he was able to rest quietly with family at the bedside. Hospice team members, including music therapy and chaplain, provided support for the family and the patient died quietly on day 4 of GIP admission.

4. CASE STUDY #4 – ACUTE BEHAVIORAL SYMPTOMS

83-year-old female with Alzheimer's dementia with psychosis and moderate protein calorie malnutrition. The patient had exhibited significant agitation and paranoia behaviors for a year prior to being admitted to hospice. She lost 25% of her body weight at the time of hospice admission. She lived in an assisted living facility (ALF).



The hospice team held regular conferences with the family and staff at the ALF to address the patient's care plan. During her second benefit period, the patient's agitation and psychosis escalated significantly, as the patient refused to take all medications, including her antipsychotics. The team switched to liquid dosing, but during her periods of heightened agitation, she would refuse PRN (as needed) doses.

With the consent of the family, the Hospice Medical Director ordered injectable medications. The patient was given subcutaneous injections through a subcutaneous SubQ button of morphine (1 mg) and Midazolam (1 mg) initially, and dosages for each drug were titrated to 2 mg. Unable to achieve the desired medication effect, the hospice nurse remained in the ALF with the patient for several hours, dosing the patient per physician orders.

Morphine 2 mg was given at 11:53 with patient continuing to be notable for agitation, although it was less than prior to administration. A second dose of Morphine 2 mg was administered at 12:45. As of 13:15, patient still showed notable agitation. A dose of Midazolam 2 mg given at 13:17. Patient continued to be agitated and refused cares. The next dose of Midazolam 2 mg was administered at 14:15. Despite some sedation, the patient still exhibited hitting and biting whenever care was attempted and was unable to tolerate any touch. It took four people to change the patient's briefs or to bathe her.

The hospice team was also concerned that the patient may have underlying pain, but the patient's inability to communicate or cooperate with any assessment limited investigating any further. During a conference with hospice medical director and patient's husband and daughter, the family expressed wishes that the patient be comfortable, even if the trade-off was increased sedation. The patient was admitted to a local hospital under GIP status, as her level of agitation and restlessness were a risk for her safety and the safety of others.

At the time of GIP admission, the patient was initially started on a continuous morphine drip at 1 mg/hour, which was eventually titrated up to 3 mg/hour over the first day; Midazolam drip also administered at 1 mg/hr. Nursing assessments around the clock were required over a several day- period while medications were adjusted, as even though the combativeness had decreased, the patient showed signs of tension during initial dosing. On the third GIP day, plans were initiated to transfer the patient to a skilled nursing facility. However, on day four, the patient's breathing became labored and nursing assessments were required in anticipation of possible increases in morphine dosing. The patient also received IV Robinul for secretions. The patient passed away on day five of the GIP stay.



5. CASE STUDY #5 – ACUTE WOUND CARE

Mr. M. is a 35-year-old man with a diagnosis of necrotizing fasciitis of the right leg admitted to a hospice facility from an acute care hospital. While hospitalized, multiple IV antibiotics were used along with debridement and intense wound care in an effort to control the condition. Mr. M. declined an above the knee amputation offered to save his life. While hospitalized, a plan of care meeting was held and Mr. M. consented to a transfer to a hospice facility for further management of symptoms including pain, extensive wound care, and continued antibiotic therapy.

Pain was both physical and emotional. Medications needed to be titrated prior to dressing changes to assure comfort and to decrease anxiety. Wound care involved astute daily skin assessment and documentation in order determine the progression of the condition as a means to care plan future care needs. Dressing changes initially involved 4 staff and took over one hour.

With intervention from all team members after a period of 7 days at the GIP level of care, dressing changes took 2 people less than 30 minutes and an established plan for supplies and medication needs for the dressing changes was established. Anxiety and generalized somatic pain were also addressed. Team members were actively involved in this man's physical and emotional suffering.

Tips for Documenting GIP Care



It is critical that providers appropriately and effectively document GIP services to support why this higher level of care was necessary. Claims for GIP are often denied on review/audit because the records fail to adequately demonstrate the patient's need for a change in level of care or continued GIP services. Below are some tips for documenting GIP care.

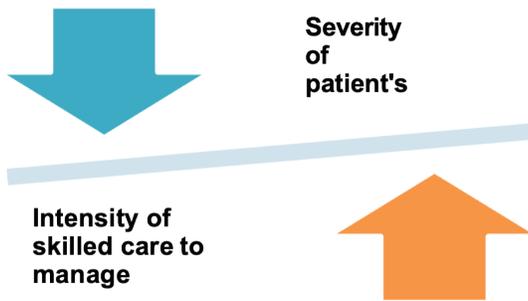
TRANSITIONING TO THE GIP LEVEL OF CARE

- The precipitating event (onset of uncontrolled symptoms or pain) that prompted the need to change to the GIP level of care should be evident in the comprehensive assessment documentation.
 - Ensure that a detailed description of the acute symptoms or situation is documented in the clinical record.
- The nurse should document pain and symptom management interventions that were implemented in the home (or wherever they reside) prior to initiating the GIP level of care and the patient's response.
- Documentation should describe the patient's needs (i.e., for around-the-clock medication adjustments, observation, or stabilizing treatments such as assessment of acute unstable symptoms).
 - **Example:** "Attempts to manage the patient's escalating pain levels in the home setting over the past two days have failed to achieve the desired level of comfort. Patient will require frequent RN/NP/MD assessment and titration of medications in an inpatient setting to control pain."
- The hospice should arrange to transport the patient to the appropriate inpatient setting that can meet the patient's needs. Per CoP 418.56(e)(4), the hospice staff must share information among all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

Note: Hospice providers are not responsible for covering ambulance transportation costs prior to the initial assessment and therefore prior to the plan of care's development. Ambulance transports of a hospice patient, which are related to the terminal illness, and which occur after the effective date of election, are the responsibility of the hospice.

- When transitioning a patient to the GIP level of care, documentation should minimally include:
 - A summary of the patient's current status for the inpatient staff
 - › Include interventions implemented prior to change in level of care
 - A copy of the patient's current plan of care
 - A copy of current physician orders
 - › Industry best practice recommends that the hospice provider obtain a physician's order to change the level of care even though it is not expressly required in the federal hospice regulatory text. A surveyor/auditor will also most likely expect this physician's order for a change to GIP care.
 - A copy of the patient's advance care directives and MOLST/POLST form (as applicable).
 - A copy of the patient's current medication profile.

DOCUMENTATION DURING THE GIP STAY



Documentation during GIP must be thorough and reflect the severity of the symptoms and the intensity of skilled care to manage the crisis.

- Implementation of the plan of care must be directed towards stabilizing acute symptoms, obtaining a positive palliative outcome (i.e., documenting whether the care is making/made a difference), and moving the patient to a lower level of care at the appropriate time.
- When a hospice provider contracts with a hospital or SNF for GIP care, the facility staff needs to be educated related to documentation content.
- 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 or another level of care, etc.
- All IDG members should document to paint a complete picture of the patient, including the pain and symptoms not adequately managed and why GIP is necessary each day the patient receives this level of care.
- Documentation should be clear prospectively, not just retrospectively. Many times, during a retrospective medical review of a clinical record, the care provided during part of the GIP stay may not appear to be “skilled.” Each day of care must reflect the intensity of skilled care and the severity of the patient’s symptoms.

NOTE: When documentation in the clinical record states that the patient’s acute symptoms are stabilized, then GIP care must end. If a patient’s symptom stability is being evaluated for its long-term effect, then the documentation should state that fact, particularly if medication is being titrated or tried to determine whether it will stabilize the crisis.

- While not required by the federal hospice regulations, documentation should integrate the hospice’s Medicare Administrative Contractor’s (MAC) relevant Local Coverage Determination (LCDs), as applicable.
- Policies, procedures, and the patient’s status should dictate visit and documentation frequencies. Keep in mind that a higher level of care typically demands that documentation and visits are more frequent.
- Documentation of transition planning should also appear in the clinical record throughout the GIP stay.
- Documentation content – suggestions for GIP documentation are contained in The Carolinas Center [Resource Guide For General Inpatient \(GIP\) Level of Care: Utilization, Coordination, & Documentation](#) (January 2016)

Resources:

- Medicare Administrative Contractor guidance
 - [CGS General Inpatient Care](#) (Jul 2012)
 - [NGS GIP Job Aid](#) (Feb 2015)
 - [NGS Hospice General Inpatient Check Off List](#) (August 2016)
 - [Palmetto Hospice GIP Audit Tool](#) (August 2017)
 - [Palmetto Hospice GIP Video](#) (February 2015) ((Scroll down the listings of Education on Demand until you see the Hospice General Inpatient Care (GIP) video)

- Medicare Benefit Policy Manual guidance related to GIP
 - Chapter 9 - [40.1.5 - Short-Term Inpatient Care](#)

Quality & Compliance Considerations

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI)

GIP is a challenging level of care to manage, and providers should self-assess their GIP processes, performance, and any compliance issues or reports to determine if it is an area needing improvement. The goal for the hospice provider is to not only provide acute symptom relief for the patient but to also facilitate a smooth transition to the GIP level of care for the patient, family, the hospice IDG, and facility staff, as applicable.

Hospice providers should consider evaluating internal processes and policies related to assessing patient needs, providing and/or monitoring care, transition 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. Identified issues should be added to the provider's QAPI plan for targeted improvement per the guidance in the federal CoPs at [§ 418.58 Quality Assessment Performance Improvement](#).

HOSPICE QUALITY REPORTING

The Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey outcomes can be used as data for performance improvement. CAHPS survey topic areas include:

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms
- Getting Hospice Care Training
- Rating of Hospice
- Willingness to Recommend

The CAHPS survey is designed to capture outcomes including the decedent's last location/setting of care (e.g., home, assisted living facility, nursing home, acute care hospital, freestanding hospice inpatient unit). Hospice providers can work with their CAHPS survey vendor to determine which survey responses encompass inpatient care.

AUDIT READINESS

Clinical records are subject to review during an audit by a MAC and/or other oversight agencies or CMS contractors. Providers should train their staff on standard practice and documentation standards and periodically conduct internal audits to ensure documentation supports the need for the GIP level of care. Palmetto GBA developed a Hospice GIP Audit Tool, linked below, to assist hospice providers in evaluating documentation for GIP criteria.

As noted above, there is often scrutiny of hospice GIP services and billing by CMS and the OIG. Examples of some of this scrutiny is located in NHPCO's [Scrutiny of Hospice General Inpatient \(GIP\) Care](#) resource and on the NHPCO website.

Resources:

- Palmetto [Hospice GIP Audit Tool](#)
- NHPCO's [Scrutiny of Hospice General Inpatient \(GIP\) Care](#) (August 2021)



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