Discharge from Hospice Care PC.D20

Regulation(s):	42 CFR 418.26; 418.104(e)
L-Tag(s):	682, 683, 684

POLICY: Lifesong Hospice and Palliative Care follows a consistent plan for discontinuance of services and supports the patient/family with referrals and planning for continued care as appropriate.

PROCEDURE:

1. A patient may be discharged from hospice under the following circumstances:
    a. the patient dies;
    b. the patient revokes his/her election of the Medicare Hospice Benefit;
    c. the patient's condition stabilizes or improves, and s/he is no longer considered terminally ill;
    d. the patient moves outside the geographical area serviced by the hospice or transfers to another hospice;
        i. including if the patient chooses to receive treatment from a hospital or a skilled facility with which Lifesong Hospice and Palliative Care does not have and/or cannot obtain a written agreement;
    e. if the patient no longer desires hospice services; and/or
    f. for cause, if the hospice determines that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice to operate effectively or safely is impaired.

2. Before the patient can be discharged for cause, the hospice:
    a. advises the patient that a discharge for cause is being considered;
    b. makes a serious effort to resolve the problem(s) caused by the patient's behavior or the situation;
    c. ensures that the decision to discharge the patient is not related to the patient's use of necessary hospice services; and
    d. documents in the patient's clinical record the problem(s) and the efforts made to resolve the situation.

Created:	Reviewed:	Revised:	Effective:
6/18	2/11/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

3. When a patient is discharged from hospice (and is not transferring to another hospice), s/he is no longer covered under the Medicare Hospice Benefit, resumes Medicare coverage of the benefits waived by the election of hospice care and may, at any time, elect to receive hospice care again in the future if s/he meets the eligibility requirements.

4. Prior to discharge, the hospice obtains a written physician's discharge order from the hospice physician and consults with the patient's attending physician (if there is one), documenting his/her review of the discharge decision in the discharge note or summary.

5. If the IDG determines that the patient no longer meets the hospice's eligibility requirements, discharge planning occurs as follows:

    a. the hospice nurse consults with the patient's attending physician (if there is one) or the hospice physician regarding the need for other health care services and obtains appropriate discharge and referral orders;

    b. the hospice nurse or Social Worker arranges for these services at the request of the patient/family after acquiring physician approval;

    c. the patient/responsible party is provided with a copy of the Notice of Medicare Non-coverage (NOMNC Medicare Form CMS - 10123) at least 48 hours prior to scheduled date of discharge and the signed form is placed in the patient's financial file or medical record.

    d. If the patient/responsible party choose to receive services after the scheduled date of discharge, then the Advanced Beneficiary Notice (ABN, Form CMS-r-131) will be provided, signed and placed in the patients record.

    e. the patient and his/her caregivers are included in the discharge planning process and members of the IDG provide appropriate education and support as needed; and

    f. notification of the discharge date is provided to the patient and to the patient's attending physician (if there is one) as soon as it is determined.

6. When the patient is discharged from hospice, the hospice provides a copy of the clinical record (if requested) and the hospice discharge summary to the patient's attending physician. This discharge summary is filed in the clinical record and includes:

    a. the date of discharge;

    b. the reason for the discharge;

    c. a summary of the patient's stay including treatments, and symptom and pain management;

d. a copy of the patient's current plan of care, including the current drug profile;

e. the patient's latest physician orders; and

f. any other documentation that will assist in post-discharge continuity of care.

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6/18	2/11/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**