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# Admissions and Discharges – Final Rule Recognizes That It Should Be a Process Over Time

On November 22, 2005, Centers for Medicare and Medicaid ("CMS") released a Final Rule (the "Rule") which amends the Code of Federal Regulations by revising 42 C.F.R. § 418. This revision effective January 23, 2006, has several important changes. In this article we briefly address 42. C.F.R. § 418.26(d), discharge planning:

1. The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
2. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

In its Commentary, CMS recognized that hospice patients' conditions might stabilize or otherwise change and that it is important to conduct discharge planning prior to actual discharge. Significantly, CMS recognized that sometimes in hospice, the provision of services given to a patient can "create the impression that the individual is no longer 'actively dying' and therefore no longer eligible for hospice." In the Commentary, CMS notes that "we see this issue as one requiring physician/IDG judgment and would only ask that the judgment be supported by documentation in the medical record indicating the reason why hospice should continue if there seems to be improvement such that discharge is under consideration." The importance of this Commentary is that it recognizes the need for discharge planning and the need for the hospice IDG to follow patients over some period of time to determine whether or not discharge is indicated:

> "We do not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather we would expect that the hospice's IDG is following their patient, and if there are indications of improvement in the individual's condition such that hospice may soon no longer be appropriate, then planning should begin. If the patient seems to be stabilizing and the disease progression has halted, then it could be

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the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge. We have tried to avoid prescriptive time frames for discharge planning, since we have long been aware that merely the attention that hospice services give to a patient can have a beneficial effect, creating the impression that the individual may no longer be actively dying and therefore ineligible for the Medicare hospice benefit. Therefore, we cannot offer a specific number of days or weeks that a patient may be stable and thus not eligible. We see this issue as one requiring physician/IDG judgment and would only ask that the judgment be supported by documentation in the medical record indicating the reason why the hospice should continue if there seems to be improvement such that discharge is under consideration."

This important statement in the Commentary provides guidance to hospices in the appropriate discharge planning of their patients. It underscores the need for careful, thoughtful IDG involvement when a patient may be stabilizing. Clearly there is a distinction between a stabilization of the disease process versus a stabilization of symptoms due to provision of hospice services. Hospices are encouraged to carefully develop systems for evaluating ongoing eligibility and addressing through the IDG, the appropriateness of ongoing services. When it is determined that care may no longer be necessary, the discharge planning process should be addressed through careful documentation, in accordance with the Conditions of Participation, federal requirements and state licensure laws.