

The physician narrative is a brief explanation of the clinical findings that support a life expectancy of 6 months or less if the terminal illness runs its normal course. It is part of the initial certification and subsequent recertifications. It can be part of certification/recertification forms or can be an addendum to those forms.

For narrative statements to be acceptable, they should consist of several phrases or sentences that described the particular clinical factors that led to the conclusion that the patient was eligible for hospice.

Important Data to Include:

- Objective clinical indicators such as the patient's Palliative Performance Status (PPS), Body Mass Index (BMI), Flacker Mortality Score if in long-term care and oxygen saturation
- Documentation of historical and physical examination findings that changed over time to indicate a poor prognosis
- Illustrate specifically how the clinical factors gave the patient a poor prognosis, allowing you to sign the certification, e.g. using comparative biometric data that draws conclusions such as "weight loss of 4# since last recertification" or "PPS was 40% at last recert and now is 30% with total dependence for all ADLs"
- Any documentation from the acute or post-acute care facility medical record, if applicable

An example of a well-written compliant narrative statement looks like this:

"78-year-old male with NYHA class IV heart failure who has been aggressively treated with diuretics, ACE-inhibitors and nitrates continues to experience massive peripheral edema, dyspnea even during conversation requiring frequent doses of morphine. He has been hospitalized 3 times in the last 2 months. He has comorbid peripheral vascular disease with several lower extremity ulcers. He is not a candidate for invasive cardiovascular procedures. He has a PPS of 50%, down from 70% three months ago. Documentation from

The HMD does the first review and reconciliation with the admitting nurse after the initial nursing assessment is completed. Then, at each IDG meeting, the HMD and group reviews the care plan including all medications and documents the review in the medical record.

The admitting nurse will review all patient medications with the patient and/or their representative, and determine the relationship of the medication to the patient's terminal illness and related conditions. During the admission discussion, the HMD and RN designate each medication as:

- **Related and covered** by hospice provider.
- **Unrelated** to the patient's terminal illness and related conditions but medically reasonable and necessary and covered by Part D or other Pharmacy Benefits Manager (PBM).
- **Related but medically unnecessary** and not included in the hospice plan of care.
 - The patient or their representative must be notified that these medications will not be covered by the hospice provider or Part D, and the patient will have to pay for them out of pocket if they wish to continue taking them

After the medications are placed in one of the 3 categories the hospice case manager will:

- Inform patient/ representative of liability they will incur, if applicable
- Inform patient/representative of appeal rights
- Contact the patient's attending physician or other prescribers regarding those medications in the related but medically unnecessary category
- The HMD must document a brief statement in the record those medications that are unrelated and why
- As soon as a patient is admitted, the hospice should be able to notify the Part D plan that the drug(s) is unrelated, and the hospice can complete the prior authorization documentation