Case Study Roundtable: Managing and Documenting the "Gray Area" Hospice Patient

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The Ripple Effect: Evolving Care at Home 2026

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Presenter Content

Not every patient fits neatly into a textbook diagnosis or meets criteria with obvious clarity, and that's where clinical leadership must shine. In this interactive session, participants will dive into real-world case studies involving patients who fall into the "gray area" of hospice eligibility, symptom burden, and appropriateness. Through guided discussion and peer sharing, attendees will examine how clinical judgment, documentation, interdisciplinary collaboration, and regulatory awareness intersect in complex cases. Walk away with tools to support your teams in navigating ambiguity while maintaining compliance and providing exceptional care.

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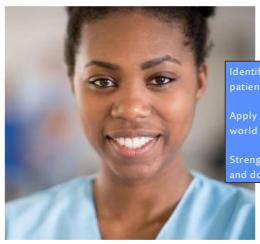
Objectives



- Identify clinical indicators of "gray area" hospice patients
- Apply CMS LCDs and eligibility guidelines to real-world scenarios.
- Strengthen defensibility through clinical judgement and documentation.

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WHAT IS A "GRAY AREA' PATIENT?

- Eligibility not clearly met or not clearly unmet at time of evaluation.
- Decline is subtle, intermittent, or confounded by comorbidities.
- Clinical indicators are borderline (e.g., PPS ≥50; FAST 6C–7A without secondaries).
- Documentation and trends are insufficient to defend a ≤6-month prognosis.

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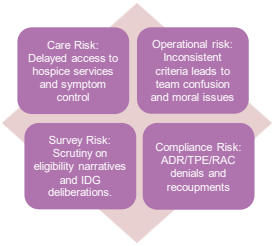
WHY GRAY AREA PATIENTS MATTER



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EVIDENCE BUNDLE DOMAINS

1. Functional Domain
   - ADL decline
   - Caregiver burden increase
   - PPS trajectory

While the PPS has remained at 40%, the patient now requires hands-on assistance for dressing and transferring – representing decline in functional reserve

2. Nutritional Domain
   - Weight loss
   - Decreased appetite
   - PEG tube
   - Decline in tolerance

Appetite has waned, with intake <50% of 2 child sized meals and 8 lb weight loss in 6 weeks – signaling nutritional compromise

3. Acute Events
   - Falls
   - Infections
   - ER visits / hospitalizations

Despite no hospitalizations, the patient experienced two falls and required antibiotics for aspirations pneumonia in the past 30 days

3. Disease Specific
   - CHF: EF, NYHA, Edema, Dyspnea
   - COPD: O2, Dyspnea
   - Dementia: FAST, ADLs, Weight

Now at FAST stage 7D, from 7C 6 months ago, patient exhibits no coherent verbal responses, requires total care and shows signs of aspiration.

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DOCUMENTATION RISKS THAT TRIGGER DENIALS

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CASE STUDY #1 ADMISSION

Patient Name: Mrs. Eleanor Whitman
Age: 79
Residence: Home with daughter
Primary Diagnosis Referral: Protein-calorie malnutrition
Significant Comorbidities: CHF, COPD, CKD stage 3, vascular dementia, generalized weakness, recurrent UTIs
Code Status: DNR
Referral Source: Primary care provider
Reason for Hospice Referral: Progressive weakness, weight loss, sleeping more, poor intake, family concern for overall decline

Referral Narrative

Mrs. Whitman is a 79-year-old female referred to hospice for declining condition. Daughter reports patient has "gone downhill" over the past several months. She is eating less, sleeping more, and is less interested in getting out of bed. Patient has chronic shortness of breath with exertion and increasing weakness. Family is asking for comfort-focused care and does not want future hospitalization.

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INITIAL CLINICAL PICTURE

Functional Status
- Mostly chairbound but can still stand and pivot with help
- Walks very short distances occasionally with walker
- Requires assistance with bathing and dressing
- Needs setup or prompting for meals
- Incontinent of bladder at times
- Increasing daytime sleeping
- Daughter says patient "used to go to the kitchen and living room on her own but now mostly stays in recliner"

Nutritional Status
- Current weight: 112 lbs
- Weight 6 months ago: 121 lbs
- Weight 3 months ago: 116 lbs
- Intake reported as "fair," usually 25–50% of meals
- Drinks protein shakes inconsistently
- Clothes fitting looser
- Daughter reports patient says she is "just not hungry"

Cognitive Status
- Alert to person and place most of the time
- Forgetful
- Needs cueing
- Some confusion in evening
- Able to answer simple questions
- Still recognizes daughter and can participate in conversation

Respiratory/Cardiac Status
- COPD history
- CHF history
- Shortness of breath with exertion
- No continuous oxygen
- Uses oxygen PRN at night about 2–3 times/week
- Trace ankle edema
- No recent chest pain
- No recent acute respiratory distress

Recent History
- No hospitalizations in past 4 months
- Treated for UTI 2 months ago
- No falls with injury
- No pressure injuries
- No dysphagia formally documented
- No recurrent aspiration events documented

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ADMISSION DOCUMENTATION EXCERPTS

Physician Certification Narrative

"Patient has multiple chronic conditions including malnutrition, dementia, COPD, CHF, and weakness. She has had gradual decline with reduced intake, weight loss, functional dependence, and increased sleeping. Due to overall decline, patient appears hospice appropriate."

Nursing Admission Note Excerpt 1

"Patient found sitting in recliner, awake, pleasant, and cooperative. No acute distress noted. Able to answer simple questions appropriately. Denies pain. Respirations even and nonlabored at rest. Appetite fair per daughter. Patient eats small meals and snacks throughout day. Daughter states patient has been weaker and sleeps more than before. Patient requires assistance with most ADLs. No skin breakdown noted. Patient appears comfortable during visit."

Nursing Admission Note Excerpt 2

"Patient ambulates short distance with walker and one-person assist when willing. At other times prefers to remain in recliner most of day. Daughter reports patient is increasingly fatigued and less interested in meals or conversation. Weight loss of approximately 9 pounds over six months. Patient sleeping estimated 14–16 hours/day. Intake variable, averaging 25–50% of meals. Occasional urinary incontinence. Shortness of breath noted with exertion greater than 10–15 feet."

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ADDITIONAL DOCUMENTATION

To make this admission more defensible, the team should try to document:

- exact decline in mobility over time
- exact decline in ADLs over time
- whether patient now needs hands-on help where she did not before
- meal percentages over several days
- whether fatigue prevents completing meals
- whether dyspnea limits toileting, transfers, or speaking
- any dysphagia, coughing with meals, food pocketing, prolonged chewing
- recurrent infections
- worsening cognition affecting self-care
- more precise sleep hours
- why underlying CHF/COPD/dementia create terminal prognosis
- whether patient is refusing restorative treatment or no longer benefiting from it
- whether there has been ongoing decline despite medical management

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ADMISSION EXCERPTS

Social Work Note

"Daughter reports caregiver burden has increased because patient needs more help with bathing, dressing, toileting reminders, and meal encouragement. Daughter states patient has declined over the past 6 months and no longer enjoys previous activities such as gardening, television programs, or family meals. Daughter wants patient kept comfortable at home and does not want future hospitalization."

Face-to-Face Findings

Patient thin, frail-appearing, seated in recliner. Responds to direct questions. Limited spontaneous conversation. Requires assistance to stand. Ambulation limited to a few steps with walker and assistance. No acute distress at rest. Appears chronically ill and fatigued. Functional decline reported by daughter, though patient remains able to participate minimally in own care.

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CASE STUDY #2 RECERTIFICATION

Patient Name: Mr. James Holloway
Age: 84
Residence: Assisted living facility
Primary Diagnosis: Congestive Heart Failure (CHF), unspecified systolic/diastolic failure
Related Conditions: CKD stage 3, atrial fibrillation, hypertension, diabetes, generalized weakness
Benefit Period: Recertification scenario (entering 3rd benefit period)
PPS: 50%
Code Status: DNR
Oxygen: 2 L/min PRN
Weight History:
- 6 months ago: 168 lbs
- 3 months ago: 162 lbs
- Current: 160 lbs

Recent Utilization:
- 1 hospitalization 5 months ago for CHF exacerbation
- No hospitalizations since
- No ER visits in current benefit period

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IMPROVED DOCUMENTATION

To support recertification, the chart would need more concrete evidence such as:
- exact change in ambulation distance
- increased recovery time after exertion
- whether patient now misses meals due to fatigue/SOB
- increased assistance with transfers, toileting, or dressing
- worsening orthopnea or need to sleep upright
- more frequent edema despite treatment
- reduced intake with measurable weight/MUAC decline
- greater dependence on wheelchair versus walker
- frequent need to rest during ADLs
- inability to attend dining room consistently
- increased weakness affecting safety
- worsening PPS or clear functional trajectory across benefit periods

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CHAIRBOUND

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DOCUMENTATION TIPS

- Within Normal Limits (WNL)
- Instead of "Non-ambulatory" or "Chairbound"
  - Slumped over in chair
  - Head resting on shoulder, chest
  - Extremities are flaccid
  - Only out of bed for __ meal(s)
  - Leans to one side
  - Total lift to wheelchair, pivot, Hoyer lift (explain how the patient got to the chair)

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DOCUMENTATION TIPS

- Instead of "Ambulatory":
  - Ambulatory with 2 person assist
  - Utilizes cane or walker to ambulate
  - Ambulates __ feet with a recovery time of __ minutes
  - Noncompliance with use of cane/walker
  - History of falls
  - Shuffles feet when walks
  - Increased fatigue with activity as evidenced by __
  - Decreased endurance / SOB with ambulation as evidenced by __
  - Unsteady gait
  - Steadies' self when ambulating by holding onto wall/furniture

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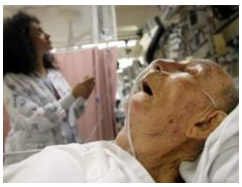
BEDBOUND

How would you document this

Versus



This?

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DOCUMENTATION TIPS

- Instead of "Bedbound":
  - Lying in bed motionless
  - Time spent in bed is __ (increasing, decreasing)
  - __ / 24 hours spent in bed
  - No spontaneous movement
  - Contracted
  - Does not tolerate sitting in Geri chair or wheelchair as evidenced by __
  - Turned every __ hours with # of people required to turn patient with pillows utilized for positioning
  - Length of time patient is out of bed
  - Activities tolerated while out of bed (meals, shower)
  - Sits in chair motionless

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THIN / FRAIL / UNDERWEIGHT


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DOCUMENTATION TIPS

- Instead of "Thin":
  - Shoulder blades protruding
  - Skin sagging from bones
  - Protruding cheek bones
  - Eyes are hollow or sunken
  - Loose clothes
  - Muscle wasting
  - Temporal wasting
- Instead of "x% diet taken":
  - Patient feeds self or requires assist of others (amount of assistance required) Amount of time it take to feed patient
  - Type of diet (50% of cup of soup or 50% steak)
  - Swallowing or chewing difficulties
  - Pocketing food
  - Change in diet taken (from __ % taken in the past X months /average consumption __% of __ diet X months ago, now __ % of __ diet)
  - Difficulty swallowing
  - Episodes of choking since last visit
  - Takes only sips of fluid

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SHORTNESS OF BREATH

A

B

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IDG DISCUSSION TEMPLATE

- Diagnosis + key comorbidities; PPS; FAST (if dementia); weight/nutrition.
- Recent acute events: infections, ER/hospital, falls, aspiration.
- Eligibility review: LCD criteria met? If not, what supports ≤6-months?
- Team input (RN, MD/NP, SW, Chaplain) and decision with next steps.

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Best Practice Framework

- Baseline evidence bundle (function, nutrition, acute events, disease markers).
- Map to LCD; explain exceptions; show why prognosis ≤6 months.
- Re-evaluation cadence: 30–60 days with trend data every time.
- Embed phrase bank into templates; audit a small sample monthly.

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Hospice Peer Review Audit Tool Aligned with Targeted Probe & Educate (TPE) Risk Areas

https://acrobat.adobe.com/id/urn:aaid:sc:US:5decfed3-c2b1-4e9d-a1e6-b557aa802c14

Hospice Recertification Narrative Template

https://acrobat.adobe.com/id/urn:aaid:sc:US:d3d7f4a7-d828-433c-944c-c8c388a5368f

Gray Area Patient Hospice Risk and Eligibility Checklist

https://acrobat.adobe.com/id/urn:aaid:sc:US:894246cc-54b3-4860-9b98-b52eda0c7d35

IDG Discussion Template

https://acrobat.adobe.com/id/urn:aaid:sc:US:b13100d7-3815-4513-a77a-16ccd9d60ebb

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SUMMARY

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