

Hospice Recertification Narrative Kit

The narrative is where eligibility holds or fails in an audit. This kit helps your team put the evidence in front of the physician before they write it.

1. The recertification timeline

Benefit period	Length	What's required
1st	90 days	Initial certification of terminal illness (CTI) with a physician narrative
2nd	90 days	Recertification with a physician narrative
3rd and each one after	60 days each, no limit	Recertification with a narrative plus a face-to-face encounter by a hospice physician or hospice nurse practitioner, no more than 30 calendar days before the period starts

The face-to-face clinician attests the encounter happened and the findings went to the certifying physician. Source: 42 CFR §418.22 and the Medicare Benefit Policy Manual, Chapter 9.

2. The four-sentence structure

1. **Terminal condition and trajectory.** The hospice diagnosis and how it has progressed.
2. **Objective evidence.** Measurable findings: weight, PPS or FAST, intake, wounds, dyspnea, events this period.
3. **Comorbidity burden.** Secondary conditions speeding the decline.
4. **Prognostic conclusion.** Why these findings together support six months or less if the illness runs its normal course.

Important: the certifying physician must compose the narrative from their own review or examination and attest to it. Boilerplate, check boxes and copied text from prior periods fail review. Use the worksheet on page 2 to gather evidence, not as narrative text.

3. Two worked examples

Initial certification: end-stage cardiac disease

Mr. [Patient] has end-stage heart failure (NYHA Class IV) with symptoms at rest despite optimized diuretic and vasodilator therapy. Over the past 60 days he has had two episodes of acute decompensation managed at home, a 9-pound involuntary weight loss, and decline in PPS from 50% to 40%. He is now dyspneic with transfers and dependent in bathing and dressing. Comorbid stage 4 CKD limits further diuresis, and he has declined hospitalization and advanced interventions. Given refractory symptoms, functional decline, and renal limitation of therapy, his prognosis is six months or less if the disease follows its expected course.

Recertification: dementia, third benefit period

Mrs. [Patient] remains hospice-appropriate for end-stage Alzheimer's dementia, FAST 7D, with progression since her last certification period. She is now nonverbal beyond single words, has lost 6% of body weight in 90 days despite hand-feeding assistance and diet liberalization, and developed a stage 2 sacral pressure injury reflecting her immobility. She had one aspiration event this period managed with comfort-focused care per family goals. Continued weight loss, new skin breakdown, and swallowing decline demonstrate ongoing progression supporting a prognosis of six months or less.

Recertification Evidence Worksheet

The team completes this before the IDG meeting. The physician reads it before writing the narrative. Every entry should point to a dated note in the chart.

Indicator	Last period	This period	Source note and date
Hospice diagnosis			
Weight or BMI			
Mid-arm circumference			
PPS or KPS			
FAST stage (dementia)			
ADL dependence (count)			
Oral intake (% of meals)			
Dyspnea, O2 use			
Skin: new or worsening wounds			
Infections, falls, ED visits, hospitalizations			
Cognition and communication			
Symptoms needing new or higher-dose meds			
Comorbidities adding to decline			

Red flags auditors look for

- **Cloned narratives.** Same wording across periods or patients.
- **Stability without context.** Long-stay patients need the severity that persists and the reserve that is gone.
- **Notes that disagree.** A narrative citing decline next to visit notes reading "no change, tolerating well".
- **Missing physician voice.** The physician must compose and attest.

Before you send it to the physician

- ☐ Every value has a dated source note
- ☐ Visit notes this period agree with the trend
- ☐ Face-to-face done and attested (3rd period onward)
- ☐ IDG discussion documented
- ☐ Written recertification on file before the claim is billed

The narrative is only as strong as the visit notes under it. When notes capture weight, intake, function and symptoms every visit, the evidence is already there at recertification. Lime's Sentinel QA checks every visit note so gaps surface before recert day. getlimeai.com/sentinel-qa/