Eligible or Not? What to Do Until the Hospice Crystal Ball Is Perfected

Subscriber Audioconference
September 2015

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

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Plan for This Session

1. Review of the Medicare regulations related to eligibility
2. Discuss difference between prognosis and diagnosis
3. Discuss eligibility assessment principles, assessment tools, and documentation

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What Do You Think? Eligible or Not?

- Mr. T, a 94 year old male, experienced some sort of TIA about 3 weeks ago. He did not go to the hospital but saw his doctor about a week later. A poor historian, he was unable to provide much information. His doctor referred him to hospice and says admit if eligible.
- He now presents with the following
  - Rapid functional decline in the past 2 weeks. Now no longer ambulatory without 1 person assist and a walker, unsteady gait, needs assistance with his bathing, some intermittent incontinence of urine.
  - Significant change in mental status – prior to the "TIA" could manage his own affairs, now easily confused and disoriented.
  - Loss of appetite; eating very little. Face appears gaunt; clothes hang loosely. States his weight at the doctors was 145 and 3 months ago it was 155 lbs. He says he has no appetite.
  - Wife of 70 years ago died 3 months ago. Says he "is done," doesn't feel good, no longer wants to live.
- HX of CHF, A Fib, HTN, COPD and mild chronic renal failure

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The Legal Standard

42 CFR 418.20 Eligibility Requirements

In order to be eligible to elect hospice care under Medicare, an individual must be

a) Entitled to Part A of Medicare; and
b) Certified as being terminally ill in accordance with §418.22

42 CFR 418.2 Definitions

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course

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Hospice Eligibility

- Based on *prognosis w*hich is why it ***must*** be done by physicians
- Very unlike other types of physician certifications that are based on "medical necessity"
- MHB is *not* based on medical necessity
- MHB is based on *proximity to end of life*

  Based on reasonable & necessary for the palliation or management of the terminal illness and related conditions (42 CFR 418.20)

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So Who Is a Candidate for Hospice?

Limited prognosis

- < 6-months if disease runs its normal course
- "More likely than not"
- Don't have to die in 6 months
- No penalties unless knowingly fraudulent

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Four Paths to Eligibility

1. Meets **ALL** the Local Coverage Determination (LCD) criteria
2. Meets most of the LCD criteria AND has documented **rapid clinical decline** supporting a limited prognosis
3. Meets most of the LCD criteria AND has **significant comorbidities** that contribute to a limited prognosis
4. **Physician's clinical judgment** is that the patient has a limited prognosis

All four paths lead to the same destination: identification and support of a six-month prognosis

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Local Coverage Determinations: LCDs

- Developed by the MACs
- Provide medical criteria for determining prognosis but are not consistent predictors of prognosis
- Use as guidelines for documenting terminal illness
  - If a patient meets certain criteria, they are deemed eligible
  - If a patient doesn't meet the LCD,
  - May still be eligible for the MHB, but must document why (best done by a physician)
- Not the legal standard for hospice eligibility but are followed by reviewers when reviewing an ADR

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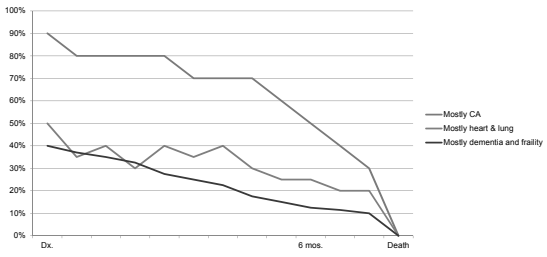
Disease Trajectory



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Prognosis vs. Eligibility

Assessing for eligibility is something anyone can do - comparing a potential patient's characteristics to a listing in a book, guideline, LCD, etc.

Prognostication is the practice of medicine

- oBased on experience, knowledge of research, clinical intuition, the art of medicine
- oExcluded from other scopes of practice
- oNo one is very good at it

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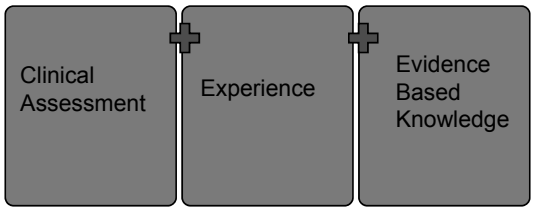
Prognosis & Physician's Clinical Judgment



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Effects on Prognosis

Function

- oSeriousness of disease (terminal diagnosis, secondary and co-morbid conditions) is reflected by the degree of lost function
- oDecreased function is related to increased mortality

Nutrition

- oExtremes of nutritional status are associated with increased mortality

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Effects on Prognosis

- Cognition
  - oDelirium
    - Highest risk of mortality
  - oDementia
    - Alzheimer's and others
    - At end-stage is terminal in its own right
    - Moderate-Severe: increased mortality as a co-morbid

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Effects on Prognosis

- Younger: Need more things "wrong" (i.e. co-morbid diagnoses)
- Older: Usually already have more things "wrong"
- Centenarians
  - o*Almost* automatically eligible, based on statistics
  - oHowever they still need to have a terminal illness/condition & prognosis of 6 months or less

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Rapid Clinical Decline

- Progressive deterioration while receiving appropriate care
  - oHome health care or SNF rehab services
- Hospital Utilization
  - oMultiple recent hospitalizations, emergency room visits or utilization of other health care services which may have prevented a hospitalization
- Serial Lab Assessments
  - oLabs, x-rays, echo, etc. showing progressive illness
- Nutritional Decline
- Functional Decline
  - oADLs
  - oPPS decline by 20 points in past 2 - 3 months

When The Crystal Ball Doesn't Work

The Tools & When to Use them

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Some Tools and Measurements

1. Tools
   - LCDs: Local Coverage Determinations
   - PPS: Palliative Performance Scale
   - FAST: Functional Assessment Staging
   - NYHA Functional Classifications
2. Measurements
   - Weight Loss / BMI / MAC
   - ADLs
   - Cognitive function
   - Pain
3. Diagnostic Studies
4. Crystal Ball

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Tools provide a data point or points that, used in context with the whole person, help to make a determination of eligibility.

It is important to assess the data points over time.

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Palliative Performance Scale (PPS)

- Designed to measure functional performance and progressive decline in palliative care patients
  - oAmbulation
  - oActivity
  - oEvidence of disease
  - oSelf care
  - oIntake
  - oLevel of consciousness
- Designed to measure what a person is capable of doing, not what they choose to do

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Chance of Death at 6 Months

* Applies only to patients who have been to a hospice program

PPS Level	Chance of Death at 6 months* Cancer	Chance of Death at 6 months* Non-cancer
50	84%	75%
40	95%	85%
30	95%	85%
20	100%	96%
10	100%	96%

From Harrold J, Rickerson E, et al
Is the PPS a Useful Predictor of Mortality in a Heterogeneous Hospice Population
Journal of Palliative Medicare Volume 8, No. 3, 2005

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FAST

- The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's Disease
- A 7-step staging system, to determine hospice eligibility which identifies progressive steps and sub-steps of functional decline
- Designed for Alzheimer's Disease
  - o Little information on other dementias
  - o Problems of "non-ordinate" patients
- Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis
  - To qualify under Alzheimer's Disease the patient should have a FAST of 7 along with secondary conditions

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Activities of Daily Living

- ADL deficits are the most important predictor of 6-month mortality
- Ambulation, Continence, Transfers, Feeding, Bathing, Dressing
- Stronger than diagnosis, mental status, or ICU admission

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Nutritional Measurement

- Extremes of nutritional status are associated with increased mortality
- >10% weight loss in elderly, over 6 months associated with high mortality
- BMI < 22 kg/m^2 in the elderly associated with increased mortality
- Decline in ability to take nourishment
  - Decline in # or % of meals consumed
  - Loss of ability to take solid food precedes loss of ability to take fluids

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Weights

Weights

Admission

- Accurate actual weight (not reported or estimated)
- For NF patients, if weights fluctuate find out why and then get an accurate admission weight
- Obtain weight from 6 months ago (if available)
- Obtain mid arm circumference (MAC) for baseline future need
- Obtain BMI at admission if have height and weight

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Nutritional Assessments-Descriptions

- A visual assessment of the patient's general appearance can provide a relatively accurate assessment of his general nutrition status
  - oEmaciated
  - oThin
  - oNormal
  - oOverweight
  - oObese
- Emaciation-weight loss is extreme and is accompanied by skeletal muscle wasting
  - oAs a consequence, the affected individual's cheeks are sunken and bony landmarks of maxilla, major joints, ribs, scapulae, and pelvis are unusually prominent

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NYHA Functional Classification

- Provides a simple way of classifying the extent of heart failure
- Places patients in 1 of 4 categories based on
  - oHow much they are limited during physical activity
  - oLimitations / symptoms are in regards to normal breathing
  - oVarying degrees in shortness of breath and / or angina pain

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End Stage Heart Disease- Prognostication

NYHA Class	1 Year Mortality
I	5-10%
II-III	10-15%
IV	30-40%

Fast Facts and Concepts #143
Gary M Reisfield, MD & George R Wilson, MD

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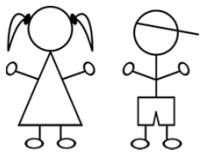
New York Heart Association Functional Classification

Class I	Mild No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath)
Class II	Mild Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea
Class III	Moderate Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea
Class IV	Severe Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased

Documenting Eligibility

Painting the Picture



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Documentation Is…

- The final chapter of the life story of a person
- Subjective description of objective reality
- How we communicate about the patients' and families' needs, goals and care
- Accurate & detailed documentation reflects their most pressing needs, which in turn should foster good care

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Documentation-Admission

- Why hospice?
- Why now? What is the trigger for referral?
  - Acuity or trajectory supports 6 month prognosis
  - Hospitalization
  - Change in condition
  - Decline
  - Symptom exacerbation
  - Additional care needs
- Compare to Local Coverage Determinations (LCDs)
- Documentation should support the physician certification of terminal illness

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Documentation - Admission

- Functional status, changes, and decline
  - Changes in ability to do own ADLs in past 3 – 6 months
  - Baseline functioning prior to decline or triggering event
  - Ability to adhere to medication regime
  - Amount of time in bed and how it has changed over the past 3 – 6 months
- Nutritional status, changes, and decline
  - Weight loss over the past 3 – 6 months (% of body weight)
  - BMI
  - Changes in appetite
  - Any difficulties with eating/ chewing

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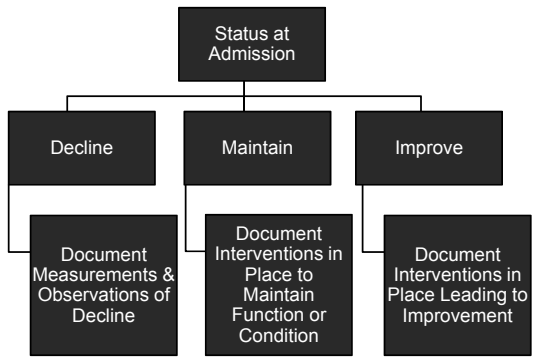

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Documentation-Recertification

- Have benefit of 60-90 days (or more) of documentation
- Still compare to LCDs
- Decline from admission
- Disease progression
- Comparison over time (3 – 6 months)
- Hospice care is managing what symptoms

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Remember, When a Patient Appears to Have "Stabilized"

- Get back to the diagnosis—why was this person admitted to hospice?
- Have you been managing the symptoms or the disease?
- What do you expect the disease process to look like?
- What are you monitoring for?
- What secondary conditions are present?
- What co-morbidities are present?
- How does this person look compared to a well person of the same age?
- What interventions are in place that is contributing to this plateau?

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Painting the Picture

- Comparison charting
- Subjective writing
- Use of comment boxes
- Clear and detailed descriptions
- Avoiding "stable, uncooperative, appears weak, slow decline, etc." phrases
- Specific discipline's documentation
- Illustrate why beneficiary is considered terminally ill

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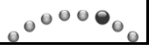
Documentation

- Use LCD (or LCDs) that best fits the patient
- Clarify all secondary and co-morbid conditions for consistent documentation and their impact on prognosis
- Use standard assessment tools and measurements for the right diagnosis
  - PPS, FAST, BMI, NYHA, MAC
- Care Planning



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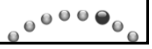
The Documentation Should

- Be specific to that individual patient
- Document what distinguishes the patient as terminal and not chronic
- Have narrative notes to explain information noted on a checklist - use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Compare current to previous
- Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments



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"As Evidenced By…"

When you use descriptors like: cachectic, anorexic, non-ambulatory, dyspnea (at rest or on exertion),weight loss, poor appetite, fragile, failing, weaker…

Always follow up with "as evidenced by.." to fully describe what you see

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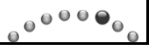
Common Documentation Problems

- Admission documentation does not contain description of why hospice/why now and what patient "looked" like 3 to 6 months ago
- Inconsistent
  - FAST 7C but chaplain states patient told him about his Navy days
  - PPS 30% but documentation describes patient ambulating with a walker
  - Weights 121 pounds one month and 142 pounds the next
- Imprecise
  - "Assist with all ADLs"
  - "Weight loss" or "estimated weight"



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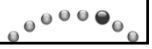
Actions of the Prudent Hospice™

- Educate staff on importance of documentation
- Monitor and audit those most important areas
  - Prebilling
  - Report in usable manner
  - Connect results to what is important to clinicians
- Look at how well the documentation paints the picture of a terminally ill person
- Hold staff accountable



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Eligibility

What are you going to look at?

- Fundamentals
  - Weights
  - FAST
  - PPS
  - ADLs
- Are they documented and does the documentation make sense
- Admission
- Recertification
- Long length of stays

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Sample Work Plan: Eligibility

What / How Many	When	Who	Comments
Eligibility audits for all patients with a LOS > 180 days focusing on current benefit period	Until completed	Compliance	Audit One time only review
Eligibility audits for all patients with LOS > 1 year	Monthly for patients to be recerted in month	Compliance/ Clinical Ops	Audit Established once above review is completed
Hospice Eligibility Audit –total of 15% of all recerts for the month to include those with LOS > 1 year	Monthly	Compliance	Audit
Hospice Eligibility Audit – 20% of admissions			

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Audit Tool Example

	Eligibility	Score	Comments
1	Weights (MACS if can't weigh) are documented	❒Yes ❒ No ❒NA	
2	Weights / MACs support decline	❒Yes ❒ No ❒NA	
3	Weights are consistent without wild fluctuations	❒Yes ❒ No ❒NA	
4	Assistance with ADLs is descriptive	❒Yes ❒ No ❒NA	
5	Assistance with ADLs supports decline	❒Yes ❒ No ❒NA	
6	PPS is documented	❒Yes ❒ No ❒NA	
7	Documentation supports the PPS score	❒Yes ❒ No ❒NA	
8	FAST is documented (for patients with dx or co-morbidity of dementia)	❒Yes ❒ No ❒NA	
9	Documentation supports the FAST score	❒Yes ❒ No ❒NA	
10	NHYA Class is documented for patients with dx or co-morbidity of heart disease)	❒Yes ❒ No ❒NA	
11	Documentation supports the NHYA Class score	❒Yes ❒ No ❒NA	

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Common Problems

- Using wrong tool(s) for patient or diagnosis or not using it at all
- Inconsistencies among clinicians
  - oScoring
  - oUsage – some do, some don't
  - oDocumentation placement (especially with EMRs)
- Not identifying scores that don't make sense or are in conflict with others

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In Summary

- Eligibility
  - Step One: Does prognosis meet six month requirement?
  - Step Two: What about diagnosis(es)?
- Is your staff documenting well to provide a full picture?
- Are your staff using the right assessment tools properly?

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To Contact Us

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundamentals.com

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