Hospice Eligibility
Prognosis or Diagnosis?

Hospice Fundamentals Subscriber Webinar
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HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Goals & Objectives

- Eligibility: Definition
- Prognostication: Definition
- Understand the Difference
- Fundamental Concepts in Eligibility

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Why So Important?

- Proposed Hospice Wage Index for FY 2015
  - Follow the coding guidelines
  - Possible limits on use of debility and AFTT as primary hospice diagnoses
  - Clarification on correct use of dementia diagnoses
- Payment reform
  - An attempt to understanding acuity through coding

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Background

- Converting referrals to admissions is one of the most critical tasks we face
  - Allows hospices to bring the benefit to more eligible patients
  - Critical for survival and successful growth
- The referral to admission process = first impression
  - For the patient and family
  - For referral sources

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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 Clarification

- "The certification regarding terminal illness of an individual shall be based on the physician's or medical director's clinical judgment regarding **the normal course of the individual's** illness."
- CMS states that **the physician does not need to know if the specific individual will die in 6 months**, but rather that individuals who present in the same way, generally die in 6 months.

Memo from CMS Tom Hoyer

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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
  - Based on experience, knowledge of research, clinical intuition, the art of medicine
  - Excluded from other scopes of practice
  - No one is very good at it

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A Difference in Training

- Physicians
  - Trained to think in most of these terms
  - Diagnosis is primary consideration
  - Think in terms of anticipation for "disease"
  - Difficulties considering prognosis & "illness"
- Nurses
  - Trained to think more reactively
  - Present findings are primary consideration
  - Better at thinking of "illness"
  - Difficulties considering anticipation for "disease"

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Deconstructing Prognostication

- A means to document what is certified
- Break down prognosis into components
  - To "Paint the picture of the patient" – Some things to consider
    - Diagnosis (or diagnoses)
    - Co-morbid diseases & secondary conditions
    - Age
    - Function
    - Nutrition
    - Cognition
    - ICF criteria
      - Body function
      - Body structure
      - Activity & Participation
      - Environmental Factors

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Hospice Eligibility

- Based on *prognosis*
  - Which is why it *must* be done by physicians
- Very unlike *all* other provider types of physician certifications
  - Those 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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Process to Determine Eligibility

- Use all information
  - Outside clinical information
  - What was the patient like 3 – 6 months ago
- Input from all team members – it takes a village!
- Assessment
- Agency guidelines
- Decision

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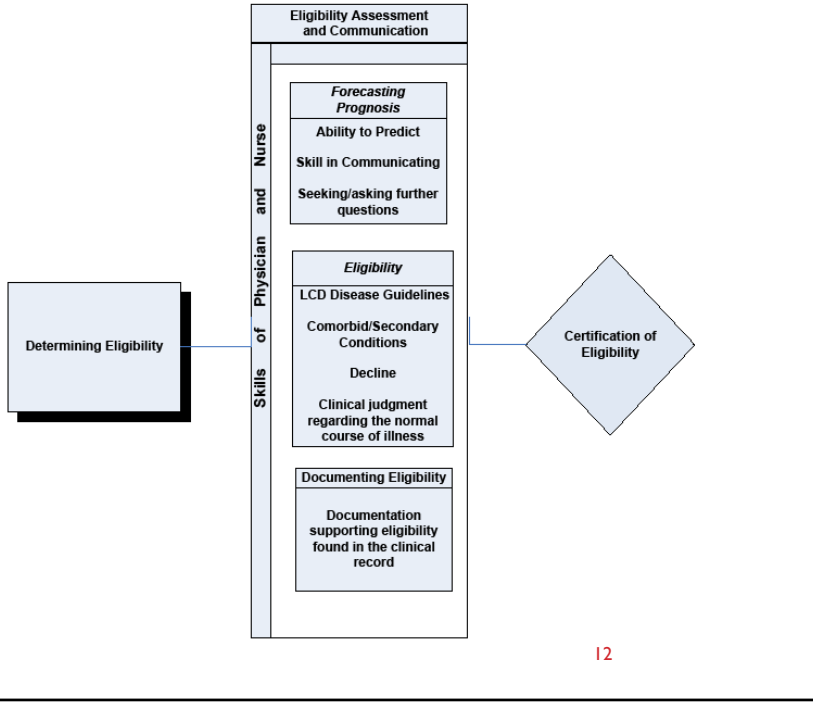

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Four Paths to Eligibility

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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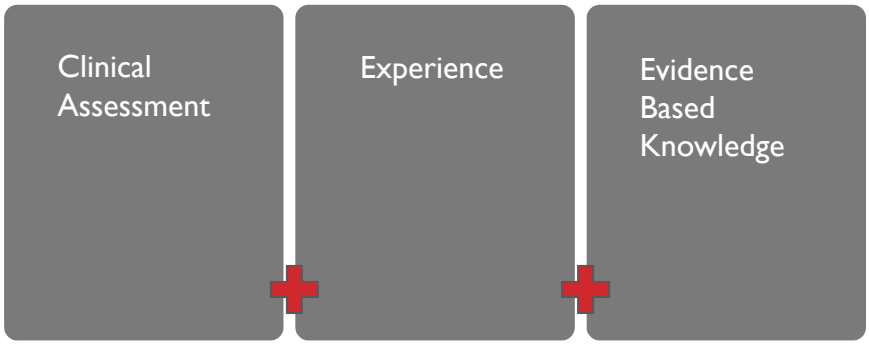
Physician's Clinical Judgment



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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 be dead in 6 months
  - No penalties unless knowingly fraudulent
- Question:
  "Would you be surprised to read your patient's obituary in the next 6 months?"

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If Patient Appears Eligible

- Obtain the attending and medical director verbal certifications
- Admit the patient now
- Clinical records are needed, but not necessary to admit the patient
- Get the clinical records later
  - **Remember** – according to § 418.25 Admission to Hospice Care.

(a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

1. Diagnosis of the terminal condition of the patient.
2. Other health conditions, whether related or unrelated to the terminal condition.
3. Current clinically relevant information supporting all diagnoses.

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If Patient Appears Ineligible

- Talk to the referring physician or attending physician (if different)
  - What are we missing?
- Talk to your medical director
  - Did I miss anything?
- Define why the patient is not eligible

What do you see?

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If Eligibility Is Unclear

- Talk to the doctor!
  - Attending is the expert on the patient
  - Medical director is the expert on eligibility
- Verbal certifications can be given pending more information
  - Gives time to gather medical records and confirm eligibility
  - Don't bill until written certification is received & eligibility is determined and documented

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Your Medical Director's Role in Eligibility

- Medical Director or hospice physician and the attending physician certify eligibility on admission
- Hospice physician confirms eligibility every recertification period
- Hospice physician is the local eligibility authority
- MACs are demanding clinical (physician) documentation supporting eligibility
  - Narratives
  - F2F

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The Tools

- Local Coverage Determinations
- PPS
- FAST
- NYHA Functional Classifications
- Weight Loss / BMI
- ADL's
- Rapid Decline
- Diagnostic studies
- Crystal Ball

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Not Everyone Fits in a Box

Patients demonstrating significant **functional and nutritional decline** that can not be attributed to a primary clinical condition or conditions that do not fit another category

- Most have a variety of comorbid conditions usually CNS & cardiopulmonary

Within a few months these patients will:

- Declare a primary diagnosis
- Die or
- Improve and require discharge

These are eligible patients

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Documentation: Support Prognosis

- Summary from the physician or nurse that identifies clinical symptoms, tests, treatments to show status of condition
- Discharge Summary or H&P from hospital
- Changes in conditions
- Date of diagnosis and course of illness
- Patient's desires for palliative, non-curative treatment

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Performance Status Over Time

- Change in functional status over time is helpful
- Can be predictable in cancer patients
- Less predictable in non-cancer patients
- Particularly helpful in the absence of a correctable cause

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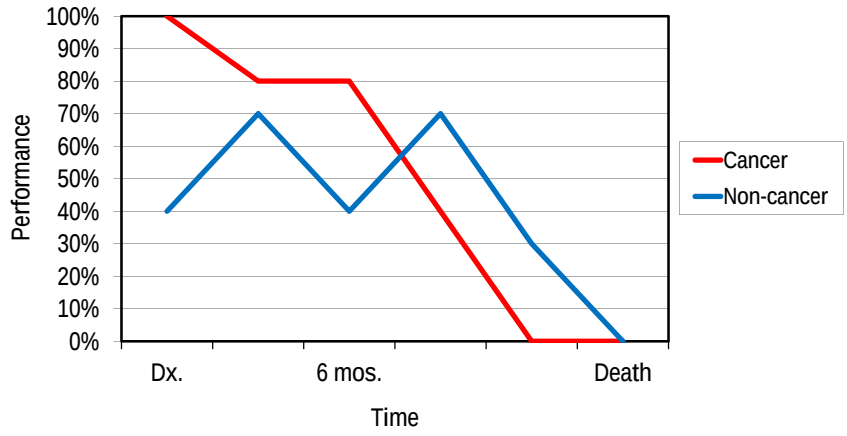
Performance Status



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MHB and Prognosis Summary

Consider and document

- Patients' disease-limiting condition
- Important comorbid & secondary conditions
- Pertinent laboratory and other test values
- Performance status and ADL ability
- Nutritional status
- Change in above factors over time

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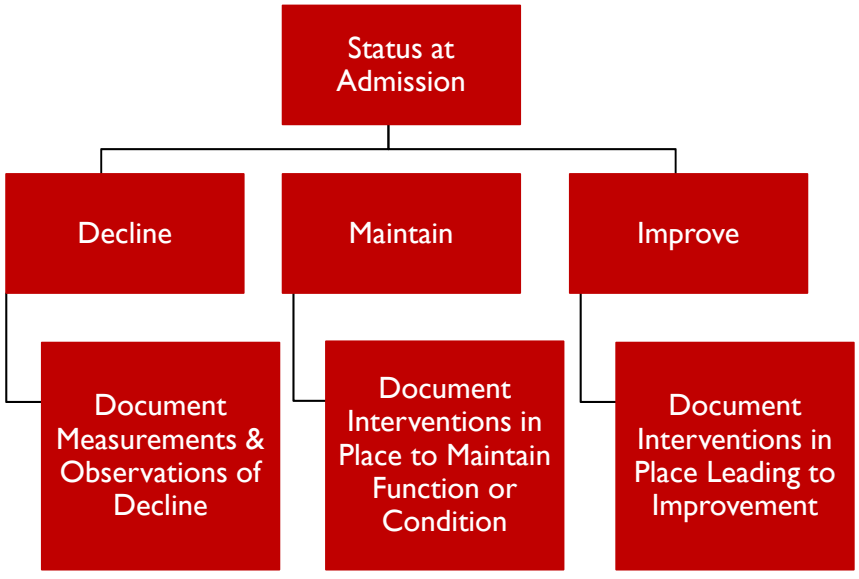
Admission Assessment as Documentation Reference Point



MHB and Prognosis Summary

- The Medicare Hospice Benefit is intended for patients with a six-month prognosis
- Physicians struggle with and are often reluctant to prognosticate
- Predicting prognosis in non-cancer patients is nearly impossible
- The LCD criteria ensure payment for services
- The LCD criteria do not reliably predict prognosis

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