Eligibility- the First Steps to a Successful Hospice

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HOSPICE FUNDAMENTALS
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Learning Goals:

- Discuss the steps in determining eligibility at SOC and beyond
- Explain Local Coverage Determinations (LCDs) and the authorities who govern them.
- Apply the components of the CGS/NGS “unipolicy” to show how decline is a strong indicator of prognosis.
- Compare the specific Palmetto LCDs with the other Medicare Administrative Contractors (MACs)
- Discuss what to do when the patient “doesn’t fit”
- Describe how the LCD can be used throughout hospice operations to build a culture of compliance

Chapter 1

First step- the introduction

The Introduction

- How do you “meet” your potential hospice patients?
  - PR barriers cause us to have to work at this!
  - Liasons/marketers
    - Careful of state restrictions
  - Facilities, NFs, ALFs
  - Physicians
  - Hospitals
  - Palliative Care, home health other PAC

What do YOU ask for

- Basics- demographics, diagnoses, recent health history
  - Medical records for our foundation of eligibility
- The STORY! “What brings you here”– (why hospice, why now)
- Understanding of hospice/palliative care as a intentional choice
- Combination of liaison/referral facilities & sources and intake responsibility

What's Next?

- Look at eligibility/insurance
  - On hospice before?
  - VBID plan?
- Discuss with Medical Director/Hospice physician
  - This may happen before or/and after initial assessment, depending on your hospice agency and physician
  - Careful not a barrier- may need to be flexible

The Initial Assessment

- Must be done by RN
  - May be done at time of election
  - Must be done within 48 hours of election being effective
  - Confirms eligibility by marrying all of the information gathered prior to this first assessment- and gathering own assessment to affirm- or change the picture
  - Uses the LCD lenses to view the assessment through CMS eyes to understand eligibility and best prognostication we can make

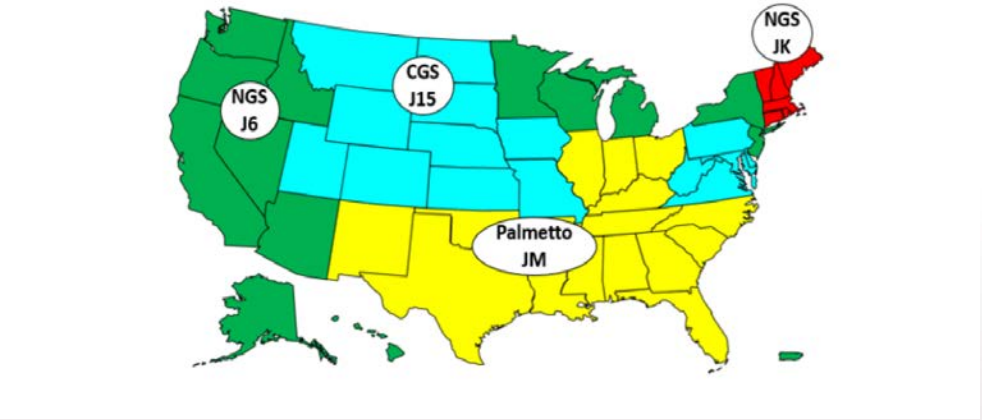
The IDT- because Hospice isn't just "I Do"

- The team will assess on an ongoing basis- individually and come together with the information routinely to determine ongoing eligibility
  - Recertification
  - Every two weeks at IDT, and as needed

Chapter 2

Getting to Know You and the Family MAC

Hospice MAC Territories

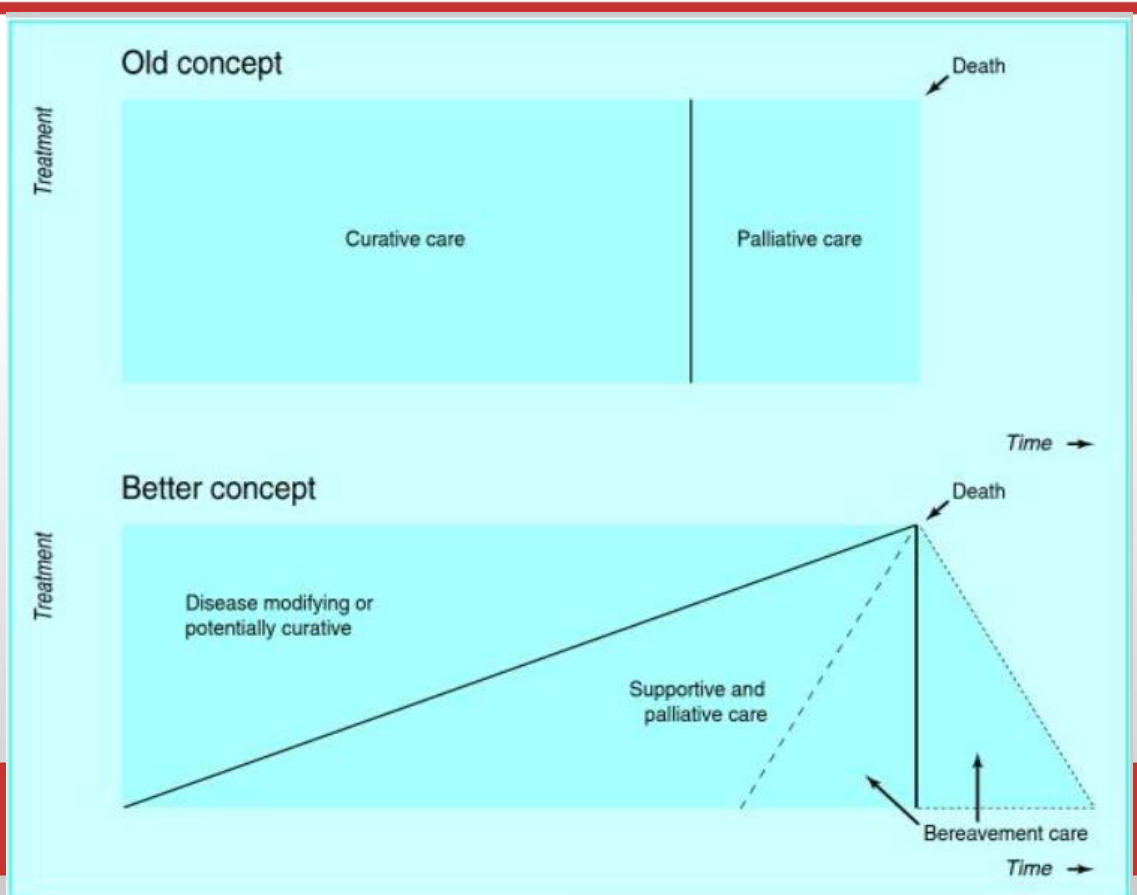


Note there are four distinct jurisdictions awarded by CMS, but NGS owns Two of these. If you are a larger corporate provider and have hospices in Multiple states, each agency will be assigned based on their geographic Location. Therefore, not all of the hospice agencies will be abiding by the Same rules as the parent company, who may be in another state.

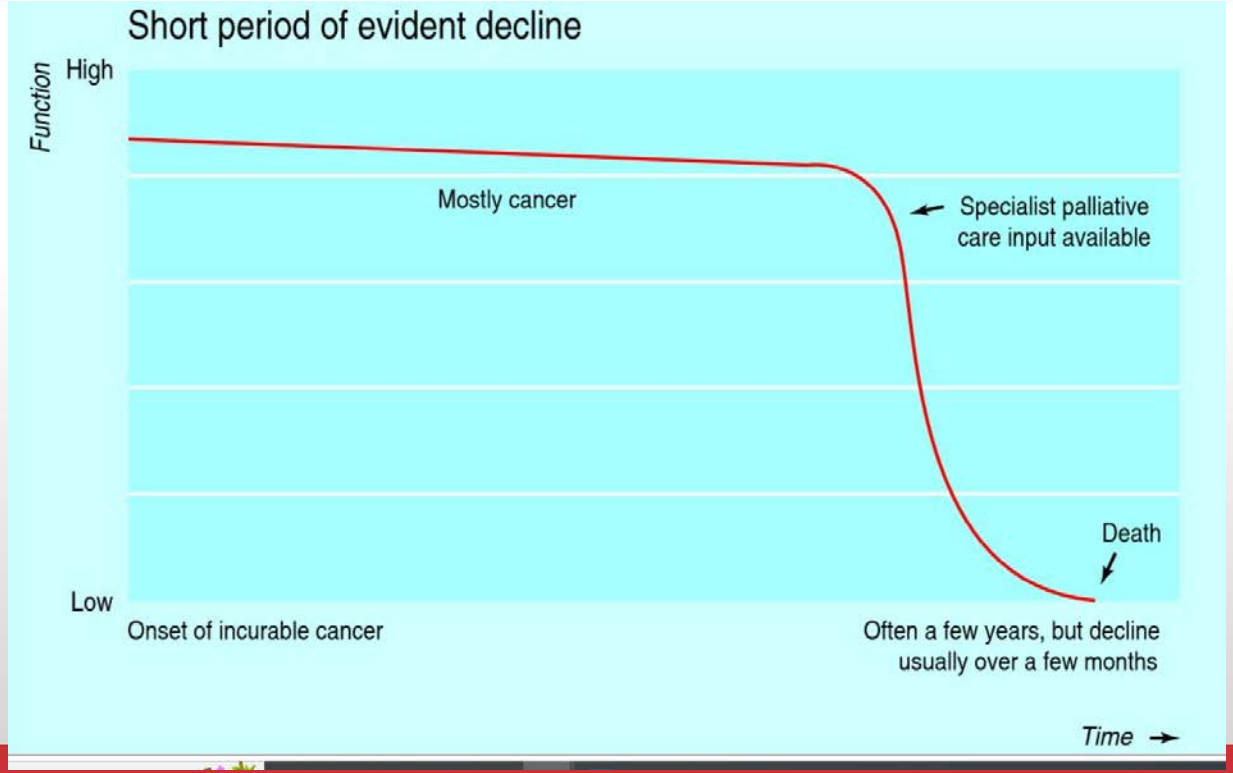
Hospice LCD Current Use

- Provides guidelines to hospice agencies
  - Admissions
  - Recertifications
- Used by MACs in medical review
- Provides consistency
- Educational for identifying hospice-eligible patients for referrals and liaisons

Evolution of End of Life Care

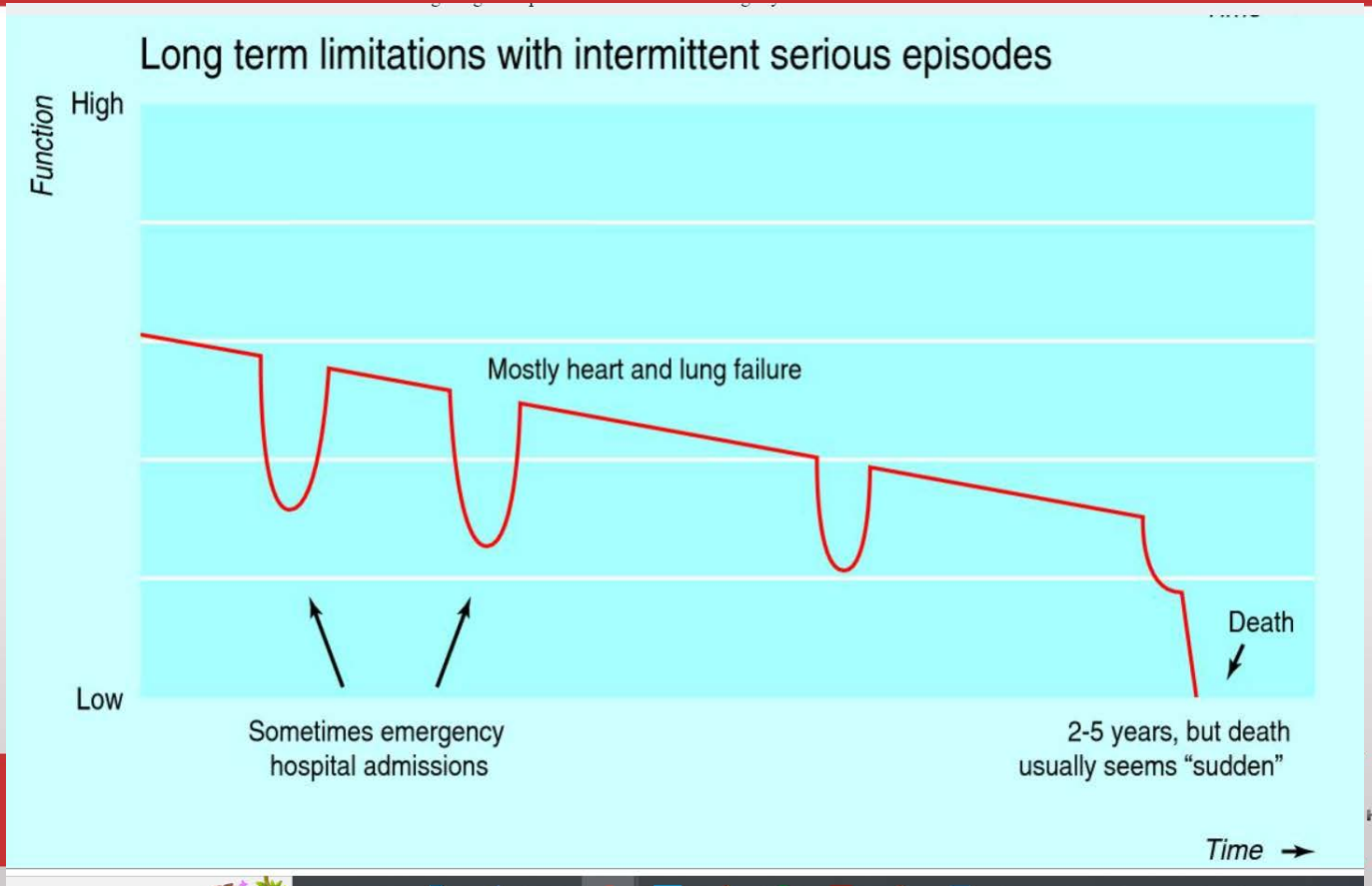


Every Path is Different… Cancer

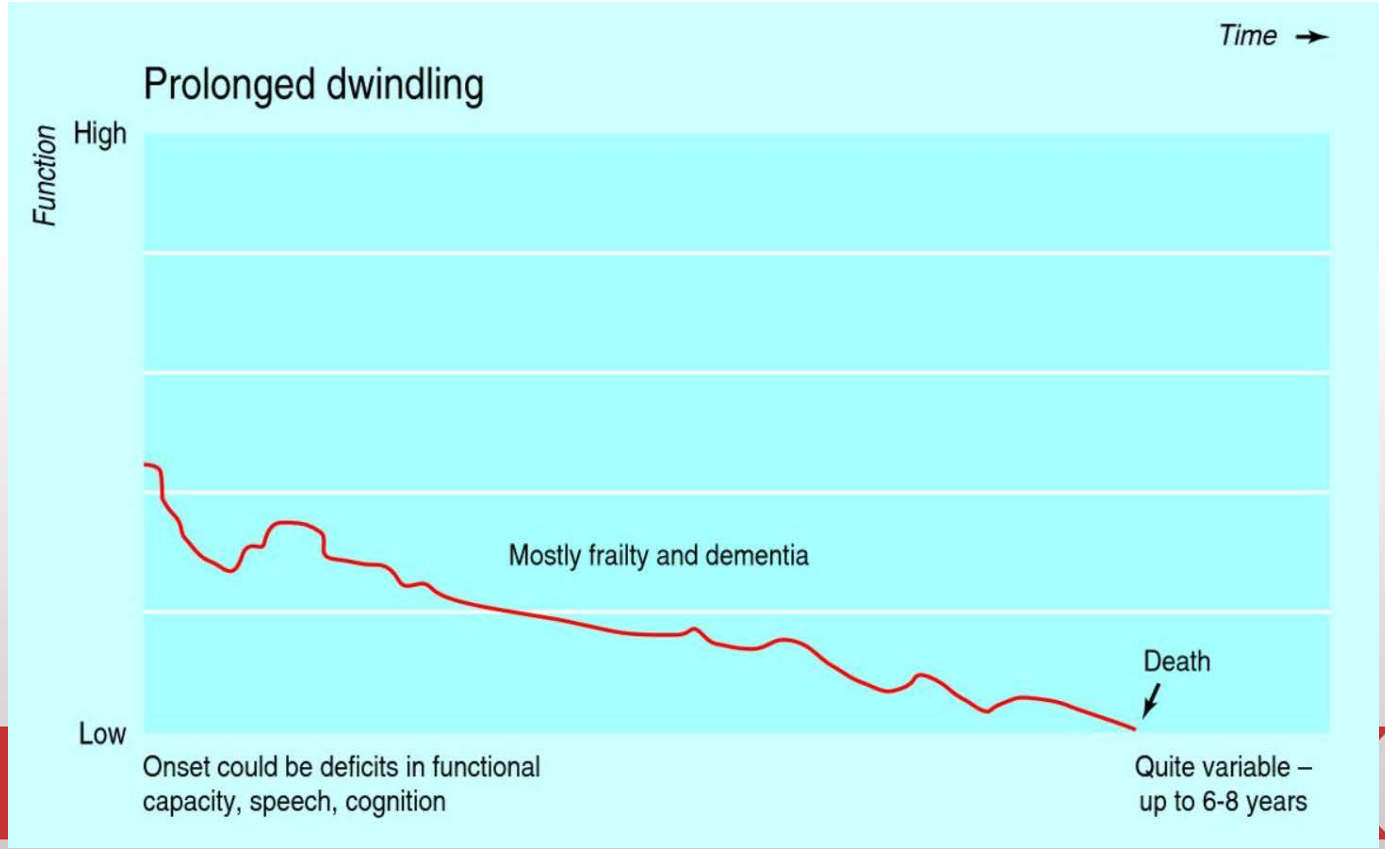


From British Medical Journal, #5 in Resources

Chronic Progressive Organ Disease



Dementia/Frailty



The Four Paths to Elligibility

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

Path One

Meets **ALL** the Local Coverage Determination (LCD) criteria

The LCDs

- Developed by the MACs • Provide medical criteria for determining prognosis but 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 however, are followed by reviewers when reviewing for payment determinations

Path Two

Meets most of the LCD criteria AND has documented **rapid clinical decline** supporting a limited prognosis

Indicators of Rapid Clinical Decline

- Nutritional decline
- Functional decline
- Progressive deterioration while receiving appropriate care
- Hospital utilization
- Serial lab assessments

Path Three

Meets most of the LCD criteria AND has **significant comorbidities** that contribute to a limited prognosis

Terminal Diagnosis: The condition established after study to be chiefly responsible for the patient's admission to hospice

Related: Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and impact prognosis

Unrelated: Conditions or diagnoses that are independent of the terminal condition

Path Four

Physician's clinical judgment is that the patient has a limited prognosis

Clinical assessment + experience + evidence based knowledge

Chapter 3

The “Uni-policy” of NGS and CGS

Structure of the LCD

- The LCD for hospices used by CGS and NGS is sometimes called the “uni-policy” because it is all gathered into one LCD
- Part I is the “Decline Policy” where the patient’s functional decline and other symptoms can stand alone to show terminal trajectory
- Part II is a gateway of minimal functional limitations, which opens the door to diagnosis specific guidelines
- Comorbidities are also listed that would supply extra support

LCD – Part I: The Decline Policy

- Decline in clinical status guidelines.
  - Listed in order of their likelihood to predict poor survival – the most predictive first and least predictive last.
  - Progression of disease as evidenced by worsening:
    - Clinical status.
    - Symptoms.
    - Signs.
    - Laboratory results.

LCD Part I- Clinical Status

1. Recurrent or intractable infections
   - Such as pneumonia, sepsis or upper UTIs
2. Progressive inanition
   - Weight loss
   - Decreasing MAC
   - Decreasing serum albumin or cholesterol
3. Dysphagia leading to recurrent aspiration
   - And/or inadequate oral intake- documented consumption

LCD Part I- Clinical Symptoms

1. Dyspnea with increasing respiratory rate
2. Cough- intractable
3. Nausea/vomiting- poorly responsive to treatment
4. Diarrhea- intractable
5. Pain requiring increasing doses of major analgesics
   - More than just briefly

LCD Part I- Clinical Signs

1. Decline in systolic blood pressure
   - Below 90
   - Progressive postural hypotension
2. Ascites
3. Obstruction of venous, arterial or lymphatic systems due to metastatic disease
4. Edema
5. Pleural/pericardial effusion
6. Weakness
7. Change in level of consciousness

LCD Part I- Labs (when available)

- Increasing:
  - pCO2
  - Calcium
  - Creatinine
  - Liver function studies
  - Tumor markers
  - Serum sodium
  - Serum potassium
- Decreasing
  - SaO2
  - Serum sodium
  - Serum potassium

LCD – Part I

- Decline in clinical status guidelines (cont.)
  - Decline in Karnofsky performance studies (KPS) or palliative performance score (PPS) from ≤70% due to progression of disease
  - Increase in:
    - ED visits
    - Hospitalizations
    - Physician's visits related to hospice primary diagnosis

LCD – Part I

- Decline in clinical status guidelines (cont.)
  - Progressive decline in functional assessment staging (FAST) for dementia (from ≥7A on the FAST)
  - Progression to dependence on assistance with additional ADLs (see part II, section 2)
  - Progressive stage 3-4 pressure ulcers despite optimal care

LCD – Part II: The Gateway

- Non-disease specific baseline guidelines (both must be met)
  - Physiologic impairment of functional status as demonstrated by: KPS or PPS ≤70
  - Dependence on assistance for two or more ADLs (feeding, ambulation, continence, transfer, bathing and dressing)

LCD – Part II

- Part II must be used in conjunction with LCD appendix
- Part II guidelines alone do not qualify a beneficiary for hospice

LCD – Part III/ Comorbidities

- Co-morbidities (Not the primary diagnosis, but help support prognosis of < 6 months.)
  - CHF
  - COPD
  - Ischemic heart disease
  - DM
  - Neurological disease (CVA, ALS, MS, Parkinson's)
  - Renal failure
  - Liver disease
  - Neoplastic Disease
  - AIDS
  - Dementia

Chapter 4

Disease Specific Guidelines (NGS/CGS)

Cancer Diagnoses

- Disease with distant metastases at presentation
  -or-
- Progression from an earlier stage with either:
  1. a continued decline in spite of therapy.
  2. patient declines further therapy.

Non-Cancer Diagnoses

- Amyotrophic Lateral Sclerosis
- Dementia
- Heart Disease
- HIV Disease
- Liver Disease
- Pulmonary Disease
- Renal Disease
- Stroke and Coma

Example of LCD Usage: Heart Disease

- Must start with “Part II” of LCD (as a ‘gateway’)
- Non-disease specific baseline guidelines (both must be met)
  - Physiologic impairment of functional status as demonstrated by: KPS or PPS ≤70
  - Dependence on assistance for two or more ADLs (feeding, ambulation, continence, transfer, bathing and dressing)

Example of LCD Usage: Heart Disease

Appendix: Heart Disease:

1 and 2 should be present. Factors from 3 add supportive documentation:

1. At initial or recertification, must show optimal treatment for heart disease or not a candidate for surgical procedures, or declines these procedures
2. New York Heart Association (NYHA) Class IV and significant symptoms of heart failure or angina *at rest.* Significant CHF with ejection fraction of ≤20% - EF is not required if not already available

Example of LCD Usage: Heart Disease

3. The following factors support the eligibility for hospice, but are not required.
   a. Treatment resistant symptomatic SVT or ventricular arrythmias
   b. History of cardiac arrest or resuscitation
   c. History of unexplained syncope
   d. Brain embolism of cardiac origin
   e. Concomitant HIV

Alzheimer's Example

- 92 year old- Long history AD, FAST 7f
- Referred after weight loss and aspiration pneumonia
- SLP initially recommended pureed and thick liquids

- On service one year, and now:
- Remains non-ambulatory, dependent in all ADLs and non-verbal, except a few words
- No further aspiration
- Weight gain +10 pounds to 120# since admit

Alzheimer's and other related Dementia LCD Guidance

1. Stage seven or beyond according to the Functional Assessment Staging Scale;
2. Unable to ambulate without assistance;
3. Unable to dress without assistance;
4. Unable to bathe without assistance;
5. Urinary and fecal incontinence, intermittent or constant;
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Alzheimer's and other related Dementia LCD Guidance (continued)

- Patients should have had one of the following within the past 12 months:
  1. Aspiration pneumonia;
  2. Pyelonephritis or other upper urinary tract infection;
  3. Septicemia;
  4. Decubitus ulcers, multiple, stage 3-4;
  5. Fever, recurrent after antibiotics;
  6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin Note: This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia

Chapter 5

When the LCDs Just Don’t Fit…

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

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The Man with Sudden Broken Heart

- Referral from ALF
- Patient declined to go to ER
- Rapid change in ability to care for self, to ambulate to meals, etc due to dyspnea
- AP 30s-50s
- Prior H&P for cardiac disease, pretty non-specific, had an ejection fraction of 35%- but this was >1 year ago

Facility Favorite

- Referral for dementia- ALF states “getting more forgetful”
- Having increased behaviors- wandering- inappropriate
- Good appetite
- No recent infections, or changes in s/s, diagnoses, weight or labs

Mel- with the Best Wife

- Mel was a 97 year old gentleman in a NF with long term Alzheimer's dementia.
- Mel's wife, Alice, was the most sincere, doting caregiver- showing up to feed him all three meals every day.
- Mel was mostly bedbound, but did get up by hoyer into a reclined Geri-chair for periods of time

Mel's Disease

- Mel only had lost his ability to hold his head up- FAST7F
- Mel had no functional ability, nor vocabulary
- Mel had no weight loss, no infections, no skin breakdown- all due to the incredible level of care provided for the two years I knew him in a NF
- Did he qualify for hospice?
- At dinner one day, he coughed and sputtered when he swallowed. Mel developed aspiration pneumonia. Now did he qualify?
  - The rest of the story– he pulled through this! Oral Atbx, wife did percussion
  - Lived until I left this job for more than another six months! (What if it was a year?!)

Creating a "Culture of Eligibility" in Your IDT Meeting

- Be sure every clinician in your organization has a current copy of the LCD guidelines.
- Keep a copy in IDT, and review one at the beginning of every meeting; "LCD of the Week."
- Use LCD-specific worksheets for admissions and recertifications, if your EMR doesn't contain the language
- Review the LCD guidelines for every admission and recertification before it is presented.

Actions of the Prudent Hospice™

Know your MAC's LCDs

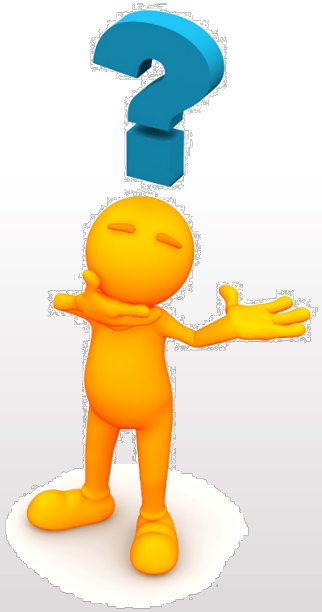
- Cancer
- Non-Cancer
- Terminal Decline

Incorporate the LCDs into documentation and decision making at SOC, recertifications and discharges

Use the LCDs for IDG culture of compliance, but in the context of the "Four paths"

Bibliography

1. CMS Medicare Benefit Policy Manual, Chapter 9, Hospice. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf, Accessed June 28, 2020
2. White N, Reid F, Harris A, Harries P, Stone P. A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts?. *PLoS One*. 2016;11(8):e0161407. Published 2016 Aug 25. doi:10.1371/journal.pone.0161407
3. National Government Services Local Coverage Determination: Hospice, Determining Terminal Prognosis https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33393, Accessed June 28, 2020
4. CGS Local Coverage Determinations: Hospice, Determining Terminal Status, https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538&ContrId=236&ver=8&ContrVer=2&CntrctrSelected=236*2&Cntrctr=236&DocType=2&bc=AgACAAQAAAAA&, Accessed June 28, 2020
5. Murray SA, Kendall M, Boyd K, Sheikh A. Illness trajectories and palliative care. BMJ. 2005 Apr 30;330(7498):1007-11. doi: 10.1136/bmj.330.7498.1007. PMID: 15860828; PMCID: PMC557152.
6. Multiple Hospice Disease Specific Palmetto LCDs: https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Home%20Health%20and%20Hospice~Medical%20Policies~LCDs%20and%20Related%20Articles, Accessed June 28, 2020



Questions????

Thank you!