Eligibility for Admission

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 Sec. 418.22.

Election of Hospice Care

Sec. 418.24
- An individual who meets the eligibility requirement of Sec. 418.20 may file an election statement....
- (b) The election statement must include:
  - (2) The individual’s or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care....
  - (3) Acknowledgement that certain Medicare services... are waived by the election.

Palliative Goals of Care

- Palliative care: “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice” (42 CFR 418.3).

"Medicare Program; FY2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform," 78 Federal Register 152 (7 August 2013), p.48235.
Palliative Goals of Care

- The person beginning hospice care, or his or her representative, needs to understand that his or her illness is no longer responding to medical interventions to cure or slow the progression of disease and then must choose to stop further curative attempts while palliative care continues and intensifies, as needed, for continued symptom management. (Italics added)  

Certification: Basis

418.22 Certification of terminal illness.

- Based on the attending physician’s and medical director’s clinical judgment.
  - Must specify individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course
  - Clinical information / other documentation that support the medical prognosis must accompany the certification and be filed in the medical record with the written certification.
  - Initial verbally, then written

What About the LCDs?

- Local Coverage Determination
  - Guidelines for Determining Prognosis
  - Cancer, heart disease, lung disease, liver disease, lung disease, renal failure, stroke and coma, HIV, ALS, Alzheimer’s and related disorders,
  - NOT exclusionary
  - NOT comprehensive
  - NOT definitive
LCDs—NOT Exclusionary

- Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less. Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy not included in these guidelines is provided.

Prognosis: Heart Disease

- Recent cardiac hospitalization, co-morbidities
- LV ejection fraction ≤ 45%
- Functional status, cachexia
- SBP <100 mm Hg and/or pulse >100 bpm
- Labs: anemia, hyponatremia, elevated BUN, Creatinine ≥1.4 mg/dl
- Ventricular dysrhythmias (treatment resistant)
- Seattle Heart Failure Model

Prognosis: Lung Disease

- Ambulatory patients
  - FEV1, age, exercise capacity, low BMI, low PaO2, patient assessment of dyspnea
- Hospitalized patients
  - Age, functional status, co morbidities, severity of illness (APACHE II), need for mechanical ventilation, hypoxia, hypercarbia, low serum albumin, low hemoglobin
### Prognosis: Renal Disease
- Age
- Functional status
- Co-morbidities
- Albumin < 3.5 g/dL
- Creatinine clearance
- Refusal or discontinuation of dialysis

### Prognosis: Liver Disease
- Age
- Co-morbidities
- Hepatorenal syndrome
- Hepatocellular carcinoma
- Ascites
- Encephalopathy
- Labs: bilirubin, albumin, prolonged PTT
- Rate of clinical decompensation

### Prognosis: Cancer
- Cancer
- Poor functional status
  - Karnofsky < 50, ECOG > 3
  - [http://www.ecog.org/general/perf_stat.html](http://www.ecog.org/general/perf_stat.html)
- Malignant effusions
  - Pericardial, pleural, ascites
- Multiple brain metastases or carcinomatous meningitis
- Malignant bowel obstruction
- Serum albumin < 2.5 mg/dl
- Hypercalcemia
  - except in newly diagnosed breast cancer or myeloma
Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility

Prognosis: Cancer

- Cancers with Prognosis < 6 Months
  - Metastatic lung cancer
  - Unresectable pancreatic cancer
  - Progressive metastatic breast or prostate cancer with poor or decreasing functional status
  - Metastatic solid tumor, acute leukemia, or high-grade lymphoma forgoing chemotherapy

Prognosis: Cancer

  - To report cancer presentations with a median survival of 6 months or less and the effect of treatment on survival.
  - Despite different cancer characteristics, found “a fairly universal picture of terminal disease.”

Prognosis: Cancer

- Characteristics
  - Decreasing performance status
  - Advancing age
  - Weight loss
  - Metastatic disease
  - Disease recurrence
  - Lab abnormalities indicating extensive disease
  - Little evidence that treatment improved survival
  - Increased risk for toxicity.
Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility

LCDs—NOT Comprehensive

- Not the only diagnoses that can—or should be—used to enroll patients in hospice care
- Look up diagnoses in the coding manual!

LCDs—NOT Definitive

- Support a prognosis consistent with eligibility when that prognosis continues to be reasonable
- MAC: pts with AFTT expected to have BMI < 22 and a KPS or PPS ≤ 40
  - NHLBI BMI: normal weight = 18.5–24.9
  - PPS 40 = mainly in bed and mainly needing assistance with self-care
- Did that mean that every pt with BMI 20 and PPS 40 is eligible for the Medicare Hospice Benefit—forever?

LCDs: Co-morbidities

The presence of diseases, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson’s)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired immune deficiency syndrome
- Dementia
General Guidelines

- The amount and detail of documentation will differ in different situations. Thus a patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than a chronic lung disease patient.
- Patients with chronic diseases, long term survival in hospice, or apparent stability can still be eligible for hospice benefits, but sufficient justification for a less than six month prognosis should appear in the record.

General Guidelines

- If the documentation includes findings inconsistent with/tending to disprove a < 6-month prognosis, they should be addressed, refuted, and/or explained.
- Many observations suggestive of a greater than 6 month prognosis are predictable and apparent, such as a prolonged stay in hospice or a low immediate mortality diagnosis.
- Specific findings may also call for an answer, such as recovery of ADLs when they were part of the basis for the initial eligibility.

General Guidelines

- Recurrent or intractable infections
  - Pneumonia ≠ URI
  - Upper urinary tract = pyelo ≠ simple UTI
  - Symptoms of pyelonephritis can vary depending on a person’s age and may include the following:
    - Fever, chills, nausea, vomiting
    - Back, side, and groin pain
    - Frequent, painful urination
  - Older people may not have any symptoms related to the urinary tract either; instead, they may exhibit confusion, disordered speech, or hallucinations.
Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility

General Guidelines
- Progressive inanition
- Irreversible weight loss
- Irreversible and decreasing anthropomorphic measurements (MAC, abdominal girth)
- Decreasing serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake (documented decreasing food consumption)

Palmetto GBA on weight loss
- Palmetto GBA expects to see supporting documentation of the absolute weights used to calculate the percent decrease. The reporting of absolute weights strengthens documentation of percent change in weight over time (e.g., >10% weight loss over the last six months with weight decreasing from 110 pounds to 95 pounds).
- Unsupported percent weight loss in the medical record may result in a denial if other documentation does not lend support to impaired nutritional status.

Palliative Performance Score
- PPS scores are determined by reading horizontally at each level to find a ‘best fit’ for the patient which is then assigned as the PPS% score.
- ‘Leftward’ columns are ‘stronger’ determinants and generally take precedence over others.
- If several columns are easily placed at one level, make a ‘best fit’ decision. Choosing a ‘half-fit’ value of PPS (ex: 45%) is not correct.

http://palliative.info/resource_material/PPSv2.pdf
**Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility**

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**Functional Assessment Staging**
- FAST for **Dementia** (not other conditions)
- Speech: *capability*, not content
- 7A = ability to speak limited to approximately a half dozen different words or fewer, in the course of an average day or in the course of an intensive interview
- 7B = speech ability limited to the use of a single intelligible word in an average day or in the course of an interview (the person may repeat the word over and over)

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**Functional Assessment Staging**
- Ambulation and posture: impaired due to **dementia**
- 7C = ambulatory ability lost (cannot walk without personal assistance).
- 7D = ability to sit up without assistance lost (e.g., the individual will fall over if there are no lateral rests [arms] on the chair).

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**Mortality Risk Index (Score)**
- Estimate of 6 month px in NH residents with advanced dementia
- Composite score: 12 risk factors derived from MDS
- Validated: 11,000 newly admitted residents with advanced dementia

<table>
<thead>
<tr>
<th>Total Risk Score is...</th>
<th>% Estimate of Death Within 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8.9</td>
</tr>
<tr>
<td>1 or 2</td>
<td>10.8</td>
</tr>
<tr>
<td>3, 4, or 5</td>
<td>23.2</td>
</tr>
<tr>
<td>6, 7, or 8</td>
<td>40.4</td>
</tr>
<tr>
<td>9, 10, or 11</td>
<td>57.0</td>
</tr>
<tr>
<td>12</td>
<td>70.0</td>
</tr>
</tbody>
</table>
Mortality Risk Index (Score)

- Cut score of ≥ 9
  - 59.7% would die within 6 months of admission (PPV)
  - Only 28.7% of residents with advanced dementia who died within that period would be eligible (sensitivity).
- Cut score of ≥ 6
  - Only 46.6% of enrollees would die within 6 months
  - 72.8% of residents with advanced dementia who died within that period would be eligible for hospice care.

ADEPT

- Estimate of 6 month px in NH residents with advanced dementia
- Composite score: 12 risk factors derived from MDS
  - Recent NH admission, age, male, shortness of breath, pressure ulcers, ADL score, bedfast, insufficient oral intake, bowel incontinence, BMI < 18.5 kg/m², weight loss, and congestive heart failure.
- Validated: 218,000 NH residents with advanced dementia
- Possible total score and the 6- and 12-month probabilities of death with each total score

Functional Status

- Address the patient’s functional status with an appropriate scale
- Give a historical perspective of what the patient’s ability was in the previous time period and then document current status
- BUT REMEMBER...
  - Decline ≠ eligibility
  - Decline ≠ necessary or sufficient
418.25 Admission to hospice

- 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).
- 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.

Determining the Principal Dx

- The principal diagnosis should reflect the condition to be chiefly responsible for the services provided.
- The principal diagnosis reported on the hospice claim form should be determined by the hospice as the diagnosis most contributory to the terminal prognosis.
- It is often not a single diagnosis that represents the terminal prognosis of the patient, but the combined effect of several conditions that makes the patient’s condition terminal.

78 Federal Register 152 (7 August 2013), pp. 48236, 48242.

Determining the Principal Dx

- The principal diagnosis should be the condition determined by the certifying hospice physician(s) as the diagnosis most contributory to the terminal decline.
- Certifying physicians should use their best clinical judgment in determining the principal diagnosis and related conditions, based on the hospice comprehensive assessment and review of any and all other clinical documentation.

**Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility**

**Most Contributory Dx**
- LCDs: not the only diagnoses that can—or should be—used to enroll patients in hospice care
- Look up diagnoses in the coding manual!
- *This may be difficult for some providers to accept as they may not understand how malnutrition, anemia, or depression, for example, could be reported as a principal hospice diagnosis.*


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**Determining the Terminal Dx**
- Unable to determine the principal terminal diagnosis...did not meet criteria for being terminally ill per LCDs.
- We are clarifying that in a scenario such as this, the certifying physician would select the condition he or she feels is most contributory to the terminal prognosis.
- We are clarifying that this principal diagnosis, along with the other related diagnoses, would be included on the hospice claim.


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**Determining the Terminal Dx**
- We are stating that all diagnoses contributing to (that is, related to) the terminal prognosis of the individual are to be reported on the hospice claims in order to account for the individual needs of each and every Medicare hospice beneficiary.
- Having all related conditions reported on the hospice claim form, and not just a single diagnosis, such as ill-defined, symptom diagnosis, will ensure that hospices are aware of and provide all of the expert care, including services, drugs, supplies, and DME, that a Medicare hospice beneficiary requires as he or she approaches end-of-life.

Determining the Terminal Dx

- Malnutrition, dysphagia, and decreased functional status and muscle weakness. ... There are ICD-9-CM codes for all of the clinical presentations listed above.
- …eligibility should always have been based on the terminal prognosis of the patient, and this prognosis would typically involve more than one diagnosis.


Certification: 6 Month Prognosis

- Based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness
- Specify that the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course
- Clinical information and other documentation that support the medical prognosis
  - Must accompany the certification and be filed in the record
  - May be provided verbally
  - Must be documented in the record
  - Is included as part of the eligibility assessment

Organizational processes

...to confidently support certification

- Information
- Documentation
- Collaboration
- Deliberation
  and, of course...
- Education!
Information

- Clinical summaries
  - Checking boxes on forms is NOT enough
  - Patient's story
  - Diagnostic tests, dates, results
- Additional medical records
  - Hospital, physician, NH
  - Copies and quotes

Information

- Avoid the "sterility" of the EMR
- General appearance
- Subjective statements
  - About how they are, not "random" or social comments
- SOAP (subjective) is NOT:
  - "Can someone mow my yard this week?"
- And SOAP (objective) is NOT just:
  - "Pt lying in recliner with eyes shut and a cat on his lap."
- Physical assessment/observations should be relevant to the diagnosis and prognosis

Information

- Expand on checklists and pic lists for physical assessment
- Note changes from previous visits (more/less)
- Functional status = ability, not activity
  - Independent or only doing what can be done independently?
- Course of care/Status/Recert summaries
  - Check against clinical documentation
  - Include dates and values for measures
  - Wts, MAC, ambulatory ability, etc.
- Summarize and explain
Collaboration

- **Certification** = medical decision with IDT input
- **POC** = interdisciplinary decision with medical input
- **Documentation** = everybody’s input
  - And the notes from different disciplines must be consistent and support one another—or explain why they don’t

Education

- **Election** = choosing hospice care
- **Using the tools**
  - LCDs, functional scales, disease-specific characteristics
  - Clinical summaries—what to include, how to write
- **Ongoing documentation**
  - Disease-specific and general symptoms
  - Observations to record
  - Periodic summaries that go beyond checkboxes

Education

- **Physicians and narratives**
  - Reason and purpose of the narrative
  - Prognostic content of the narrative
  - Explanation of data that is unexpected
  - Training, tools, and forms that encourage good narratives
Determined & Documenting Terminal Prognosis for Hospice Benefit Eligibility

Physician Narrative: Regulation
- Effective October 1, 2009
- The physician **must compose** a brief narrative explanation that supports a life expectancy of six months or less as part of certification and recertification
  - Written by EITHER the attending or hospice medical director
  - Part of the certification form or
  - Attached as an addendum
- The narrative is documentation unique to physicians.
  - a **GIFT** to be used wisely and well

Physician Narrative: Regulation
- Must reflect the patient’s individual clinical circumstances
  - Must **NOT** contain check boxes or standard language used for all patients
  - Must include the clinical findings of required FTFs
  - Interdisciplinary team
    - Visit and summary documentation MUST support the narrative.

Physician Narrative: Regulation
- The narrative must be composed by the physician performing the certification or recertification—**NOT**
  - by other hospice personnel.
- The narrative should include a statement that the physician confirms that the narrative is based on review of the patient’s medical record, or if applicable, examination of the patient.
Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility

Physician Narrative: Rationale
- Ensure that only eligible patients are certified.
- Have the physician justify prognosis, not merely sign a form.
- Encourage greater physician engagement in the certification process by highlighting the physician's responsibility to articulate the clinical basis for the terminal prognosis.

Physician Narrative: Process
- Distill the available clinical information into a succinct form that supports eligibility.
- Ensure that the narrative follows logically from the information that is documented from IDT visits and discussions.
- Include and/or interpret the information from the Face to Face documentation.

Physician Narrative: Product
- The physician’s summary of what should already be documented:
  - Should rarely contain new information.
  - May interpret information in a newly documented way.
  - Focuses on factors of prognostic importance.
  - Synthesizes the patient’s comprehensive medical information in order to justify admission/to/continuation of payment for hospice services.
Physician Certification

REMEMBER
- All certifications and re-certifications must be signed and dated by the physician
- They must also include the benefit period dates to which the certification or recertification applies.

Recertifications: IDT Meetings
- Patients are discussed every 2 weeks in the IDT meeting
- Eligibility and re-certifications should be discussed as a matter of routine
  - Ask in advance if there are any concerns about upcoming recertifications
  - No recertification decision should be a surprise or an emergency. We have the entire benefit period to gather data, make clinical decisions, and determine eligibility.

(Re)certification: Then and Now
- THEN
  - Would we admit if we saw this person today?
- NOW
  - Knowing what we now know about this patient (after months of care), why do we still think she has a prognosis of 6 months or less?
Physician Narrative: A Case
- 84 year old with advanced dementia, wt loss, decline, pneumonia. Pt appropriate.
- Is he?

Physician Narrative: A
- 84 year old with Alzheimer’s dementia
- Renal insufficiency, irritable bowel syndrome
- Pneumonia and delirium with hospitalization a year ago
- Weighs 190 lbs with 10 lb loss in the last 6 months
- Bedbound
- Intermittently holds food and medications in his mouth

Physician Narrative: B
- 84 year old with Alzheimer’s dementia
- Renal insufficiency, irritable bowel syndrome
- Pneumonia and delirium with hospitalization two months ago
- Weighs 120 lbs with 30 lb loss in the last 6 months
- Bedbound
- Holds food and medications in his mouth
- Diet changed due to choking episodes
The Good...

Based on advanced Alzheimer's disease, recent aspiration pneumonia, persistent dysphagia and aspiration risk, and 20% wt loss in past 6 months, pt is certified.

- Focuses on prognostic factors.

...the Bad...

84 year old with advanced dementia, wt loss, decline, pneumonia. Pt appropriate.

- Timing of wt loss not clear
- Decline not clear
- Pneumonia not recent

...and the Ugly

Pt died.

- Insufficient justification of hospice eligibility on admission
Determining & Documenting Terminal Prognosis for Hospice Benefit Eligibility

Other Uses of the Narrative
- Findings inconsistent with less than 6-month prognosis, should be answered or refuted by other entries, or specifically addressed and explained.
- Patient doesn’t meet LCDs but is eligible
  - Dementia, FAST 6, losing weight
- Most facts and observations tending to suggest a greater than 6 month prognosis are predictable and apparent
  - A prolonged stay in hospice
  - Low immediate mortality diagnosis

Other Uses of the Narrative
- Specific entries can also call for an answer
  - An opinion by one team member
  - Recovery of ADLs when they were part of the basis for the initial declaration of eligibility
- Lack of certain documentation elements may also necessitate other supportive documentation
  - No tissue diagnosis for a hospice diagnosis of cancer

Components of a Narrative . . .
- Age
- Principle diagnosis
- Secondary diagnoses that contribute to the prognosis of 6 months or less
Components of a Narrative . . .

- Clinical factors that support/associated with a prognosis of 6 months or less
  - History
  - Relevant hospitalizations and/or ED visits
  - Disease progression and trajectory of decline
  - Symptoms
  - Signs noted on nursing assessment
  - Lab and/or XR data
  - Other LCDs factors
  - Published data
  - Individual clinical circumstances

Components of a Narrative . . .

- PPS, ECOG, FAST, other functional assessment
- Desire for hospice support for palliative goals of care
- Interpretation of factors typically associated with a prognosis longer than 6 months
- References (yes, in the narrative)

*Patient is a 91 year old female with primary diagnosis of aortic stenosis. Past medical history significant for hypothyroidism and hypertension. She has had a previous MI in the past. She had been living at Loving Personal Care. 1 week ago she had increased confusion, was walking naked in the halls, and staff was unable to obtain a urinalysis. She was taken to AGH and treated for a UTI. While she was there it was found that she was in atrial fibrillation and her sodium was decreased. Last ECHO with 25-30% EF. She was discharged 2 days ago to LNH. She became unresponsive at LNH and was not able to move her arms at all. They were not able to obtain a pulse ox and after applying oxygen, her pulse ox was very low. She was transferred to AGH where the physician believes she was having a silent MI. She is now in CHF and has been diuresed. Her family has decided on comfort care measures. She is minimally responsive, able to open her eyes for short periods, with no purposeful movement. She is oxygen dependent. She is receiving 10mg CLM every one hour for pain and dyspnea. She has short 15-20 second periods of apnea, and her color is noted to be gray. She is a DNR.*
91 year old with aortic stenosis is certified with EF 25-30%, apparent MI heralded by syncope and hypoxia, CHF requiring diuresis, minimal responsiveness, 15-20 sec apnea, PPS 10, and palliative goals of care.

GIP Level of Care
- Acute care which cannot be provided in another setting:
  - Management of active symptoms
  - Pain control or symptom management, including family education, following hospitalization while the patient prepares to receive home hospice care
  - Monitoring effectiveness and/or complications following medication adjustment or other recent interventions, including those performed in hospital

GIP Level of Care (cont.)
- Skilled interventions, including, but not limited to, care of extensive wounds, frequent medication administration, monitoring and/or management of fluctuating and distressing symptoms that cannot be managed in the home setting
- Care of a patient whose family is unwilling to permit needed care to be furnished in the home
Documentation to support GIP
- Chart should include the precipitating event as well as what interventions were tried prior to the initiation of GIP.
- For patients who are being monitored following med changes but no longer having obvious sx, MUST DOCUMENT approximately how long you expect to monitor for med effectiveness.
- Changes are not made until AFTER orders are written and new doses may not be given until much later.

Documentation to support GIP
- Opioids increased last night. Will need to monitor for pain and use of BT meds for approx. 48 hours to see if new dose effectively and reliably controls pain so pt can return home.
- Remember to document conversation with pt/family: “If the medications are working well to manage your pain, then we’ll plan for you to go home the day after tomorrow. If not, we’ll make a new plan.”
  - Supports the plan, models language, and shows DC planning

Documentation to support GIP
- For actively dying patients without obvious sx: document that pt is actively dying, cannot be moved, and what is being monitored. Not just “pt looks comfortable” or “no symptoms” or “symptoms managed”. Need to focus on what we are still doing, not that it worked.
  - Pt actively dying with no intake, minimal responsiveness, and inability to report pain or distress. Pt is critically ill and unstable for transfer. Will continue to monitor for pain, respiratory distress, delirium, and/or other sx that pt cannot self-report.
References

- “Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform,” 78 Federal Register 152 (7 August 2013), pp.48234-48281.

References

- Palliative Performance Scale (PPSv2) version 2 at http://palliative.info/resource_material/PPSv2.pdf

References