Compliant Hospice Admission

DETERMINING ELIGIBILITY AND PROGNOSIS

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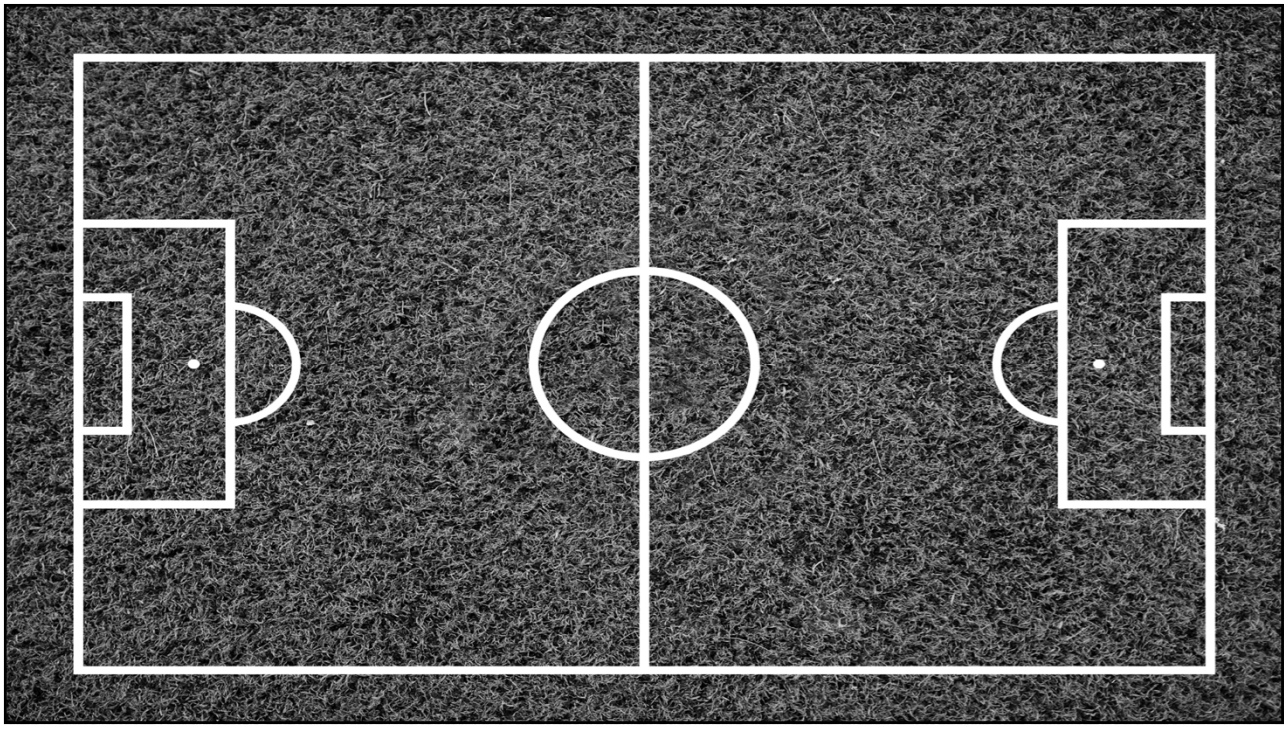
Conflict of Interest Disclosure

None



Goals

1. Effectively and efficiently admit eligible patients to the Medicare Hospice Benefit
2. Use the local coverage determinations (LCDs), prognostic guides, and experience to identify and document a likely life expectancy of less than 6 months
3. Use ICD9 diagnosis codes to logically describe patients with a prognosis of less than 6 months

Hospice Eligibility

MEDICARE HOSPICE BENEFIT (MHB)

Eligibility Regulatory Requirements

1. Entitled to Part A of Medicare
2. Certified as being terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course
3. Elect Medicare Hospice Benefit (MHB)
   - Palliative, not curative, care
   - Waive Medicare payments to other providers (unless unrelated)

It's not the Diagnosis, it's the Prognosis

REGARDLESS OF THE DIAGNOSIS USED, IF DOCUMENTATION SUPPORTS A PROGNOSIS OF LESS THAN 6 MONTHS, THE CLAIM SHOULD BE PAID

If the Prognosis is less than 6 months

THERE'S ALWAYS A DIAGNOSIS

Clinical Case

Mrs. Jones is a 36 year old woman with breast cancer, originally diagnosed 5 years ago and recently found to be metastatic to the brain and liver. She has 2 young children who have not been told about her illness. She was referred to hospice by her oncologist. When seen today by the hospice admission nurse, she reports that she "wants everything done" so that she can have as much time as possible with her children.

POLLING QUESTION

Is Mrs. Jones eligible for hospice?

1. Yes
2. No
3. Only if she signs a do-not-resuscitate (DNR) order

Formulating a Prognosis

COMPLIANT HOSPICE ADMISSION

§418.102 Initial CTI

1. Primary terminal condition
2. Related diagnosis(es), if any
3. Current subjective & objective medical findings
4. Current medication & treatment orders
5. Information about the medical management of any of the patient's conditions unrelated to the terminal illness

"Life expectancy of 6 months or less"

1. Is this someone at high risk of death?
2. General indicators of poor prognosis
3. Disease-specific indicators of poor prognosis, including the local coverage determinations (LCD)

STEP 1:
The "surprise" question

Would you be surprised if this patient died within the next 6 months?

STEP 2:
General Indicators

PERFORMANCE STATUS

- Global measure of patient's functional capacity
- Consistently found to predict survival in advanced disease
  - Karnofsky Performance Status (KPS)
  - Palliative Performance Scale (PPS)
  - KPS/PPS: 100=normal to 0=dead

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

General Indicators, cont.

- Decline in cognitive/physical function (KPS/PPS <50%)
- Recurrent serious infections
- Signs of severe malnutrition
  - Disease-related weight loss >10% in last 6 months
  - Albumin <2.5 gm/dl
  - Prolonged loss of appetite, little oral intake
- Multiple non-healing pressure ulcer, stage 3-4
- Multiple comorbidities (CHF, COPD, ESRD, etc.)

Clinical Case

Mrs. Smith is a 95 year old woman who moved in with her daughter 1 year ago because she could no longer live alone. Her daughter calls the hospice today because, “She’s just stopped eating.” Mrs. Smith does not see a physician but has been to the emergency room twice in the last 6 weeks because of confusion; once, she was admitted with a urinary tract infection. Since then, she has been weaker and spends most of her day in bed or the recliner.

The admission nurse examines her and finds she is very thin and frail, cannot stand or walk without assistance, and has a stage 2 pressure ulcer on her sacrum and another on her left heel.

POLLING QUESTION

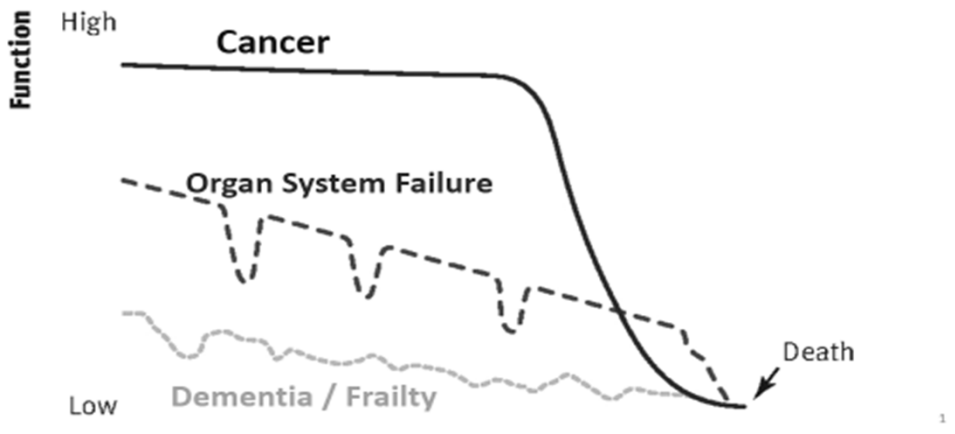
Is Mrs. Smith hospice eligible?

1. Yes
2. No
3. She needs to be seen by a physician before eligibility can be determined

Step 3
Disease Specific Indicators

1. Cancer
2. Dementia
3. Cardiovascular disease
4. Pulmonary disease
5. Adult failure to thrive

Disease Trajectories



Advanced Solid Tumor

1. 2+ sites of metastases
2. LDH >600 IU
3. KPS < 60
4. Low serum albumin

Cancer Syndromes with Short Median Survival Times

- Hypercalcemia - 8 weeks
- Pericardial effusion – 8 weeks
- Meningitis – 8-12 weeks
- Ascites - < 6 months
- Multiple brain metastases – 1-6 months

Is Dementia a Terminal Illness?

CASCADE (Choices Attitudes and Strategies for Care of Advanced Dementia at the End-of-Life); followed 323 nursing residents with advanced dementia for 18 months

- 55% died, median survival 1.3 years

Predictors of 6 month mortality

- After a primary nursing home admission 47%
- After a febrile episode 45%
- After eating problems 39%

Dementia Difficult Prognostication

Hospice eligibility criteria and other prognostic tools have a sensitivity of 20% for predicting less than 6-month survival

Tools

- Local coverage determinations (LCDs)
- Functional assessment staging (FAST)
- Advanced dementia prognostic tool (ADEPT)

Dementia LCDs

FAST 7 or greater
- CGS/NGS add "unable to ambulate without assistance"

Comorbid or secondary conditions within last 6-12 months
- Aspiration pneumonia
- Pyelonephritis
- Septicemia
- Pressure ulcers, multiple, stage 3-4
- Fever, recurrent after antibiotics
- Impaired nutritional status – weight loss >10% or albumin <2.5 gm/dl

Functional Assessment Staging

1. No difficulties
2. Subjective forgetfulness
3. Decreased job functioning; difficulty traveling
4. Difficulty with complex tasks, IADLs
5. Needs help selecting proper clothes
6. Impaired ADLs with incontinence
7. Severe dementia

FAST 7
Progression must be ordinal

A. Ability to speak limited to six words
B. Ability to speak limited to single word
C. Loss of independent ambulation
D. Inability to sit unassisted
E. Inability to smile
F. Inability to hold head up

ADEPT Data
Accuracy of Hospice LCD

Patients Studied

41.7% FAST 7c (n = 142,011)

38.7% had 1 or more comorbidities (n = 54,933)

15.9% had both (n = 22,542)

Patients who "met" LCD had 50/50 chance of surviving 6 months

ADEPT
Advanced Dementia Prognostic Tool

Recent NH admission (3.3)

Age >65 years (1-8)

Male (3.3)

Shortness of breath (2.7)

2+ pressure ulcer, stage >2 (2.2)

Total ADL dependence (2.1)

Score >16 = 52% chance of dying in 6 months

Bedfast most of day (2.1)

Insufficient oral intake (2.0)

Bowel incontinence (1.9)

BMI <18.5 kg/m (1.8)

Weight loss (1.6)

Congestive heart failure (1.5)

Score >20 = 73% chance of dying in 6 months

Dementia Summary

No accurate predictors of prognosis

- Use FAST and LCD guidelines
- ADEPT useful new tool to support prognosis

Significant common factors

- Advanced age
- Progressive functional impairment
- Recent nutritional impairment (weight loss, pressure ulcers)
- Serious infections and comorbidities

Is CHF a Terminal Diagnosis?

Following a new diagnosis of chronic heart failure, 40% of patients survive less than one year

But 1-year mortality ranges from 5 – 75%

Variable clinical course with high incidence of sudden death

Tools

1. Local coverage determinations (LCDs)
2. New York Heart Association Functional Classification
3. Seattle Heart Failure
4. EFFECT cohort study

CGS/NGS Heart Disease LCD

1. NYHA Class IV – unable to carry on any physical activity without symptoms; may have dyspnea or angina at rest, worsened with activity; EF <20% if available
2. Optimally medically treated or not a surgical candidate or declining further intervention

Supporting

3. Treatment resistant arrhythmia, history of cardiac arrest or CPR, history of unexplained syncope, brain embolism of cardiac origin, comorbid HIV disease

Palmetto: Cardiopulmonary LCD

"… the combined effects of the primary cardiopulmonary diagnosis and any identified comorbid condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less"

"… documentation of structural/functional impairments and activity limitations… is thus essential in determination of reasonable and necessary Medicare Hospice Services"

NYHA Functional Classification

I. No limitation of physical activity; ordinary physical activity does not cause undue **fatigue, palpitation, dyspnea, or angina**

II. Slight limitation of physical activity; comfortable at rest; ordinary physical activity results in **fatigue, palpitations, dyspnea, or angina**

III. Marked limitation of physical activity; comfortable at rest; less than ordinary activity causes **fatigue, palpitations, dyspnea or angina**

IV. Unable to carry on any physical activity without discomfort; symptoms of heart failure **may be present even at rest**; any physical activity increases discomfort

Seattle Heart Failure Model

Predicts mortality and survival at 1, 2, and 5 years

Uses clinical, laboratory, and therapeutic measures

- Age, gender, NYHA class, weight, ejection fraction, systolic BP
- Hemoglobin, lymphocyte %, uric acid, total cholesterol, sodium
- ACE-1, beta-blocker, ARB, statin, allopurinol, aldosterone blocker
- Diuretic dose: furosemide, bumetanide, torsemide, metolazone
- BIV pacer, ICD, BIV ICD

EFFECT Cohort Study

Community patients presenting to hospital, n = 4031

Predictors of mortality

- Age
- Respiratory rate
- Systolic blood pressure
- BUN
- Sodium <136,Eq/L
- Hemoglobin <10 g/dl
- Comorbidities (CVA, dementia, COPD, cirrhosis, cancer)

CHF Summary

Unpredictable disease trajectory with a high incidence (25-50%) of sudden death

Heterogeneous study population in literature

Most tools look at survival >1 year, not 6-months

Look for comorbidities, hospitalizations, treatment side effects to support eligibility

CGS/NGS Pulmonary Disease

1. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity e.g. bed to chair existence; FEV1 <30% if available
2. Progression of ES-pulmonary disease – ER visits, hospitalizations, increasing physician home visits

SUPPORTING

3. Hypoxemia at rest (O2 sat <88%) or pCO2 >50 mm Hg
4. Right heart failure secondary to pulmonary disease
5. Unintentional weight loss >10% over preceding 6 months
6. Resting tachycardia >100 bpm

COPD
GOLD Staging

1. Stage I: Mild COPD – Mild airflow limitations with FEV1 > 80% predicted; sometimes with chronic cough & sputum
2. Stage II: Moderate COPD – 50% < FEV1 < 80% predicted; developing SOB on exertion
3. Stage III: Severe COPD – 30% < FEV1 < 50% predicted; greater SOB, reduced exercise capacity, and repeated exacerbations that impact patients' quality of life (QOL)
4. Stage IV: Very severe COPD – Severe airflow limitation FEV1 < 30% predicted or FEV1 < 50% predicted plus chronic respiratory failure; QOL very impaired; exacerbations may be life-threatening

COPD
BODE Index

B BMI

O Obstruction (FEV1, as % predicted)

D Dyspnea (mMRC dyspnea scale)
- 0=SOB only with strenuous exertion; 1=SOB hurrying on level or walking up slight hill; 2=Walk slower than others my age; 3=Have to stop at 100 yds or after a few minutes on level ground; 4=Too breathless to leave house or SOB when dressing

E Exercise capacity (6-minute walk test)

COPD Summary

Progressive impairment, often over years

Episodes of significant decline, sometimes resulting in death but sometimes followed by improvement

Low BMI an independent predictor of mortality

Increasing emphasis on subjective dyspnea

AFTT
Adult Failure to Thrive Syndrome

It exists!

Tools

- Local coverage determinations (LCDs)

LCD
Adult Failure to Thrive Syndrome

1. Nutritional impairment severe enough to impact weight
   - BMI < 22 kg/m²
2. Significant disability
   - KPS or PPS <= 40%

REVIEW
Establishing the prognosis

1. Would you be surprised if this patient died in 6 months?
2. General indicators of prognosis
3. Disease specific indicators of prognosis
   - Cancer
   - Dementia
   - Cardiopulmonary disease
   - Adult failure to thrive syndrome

Documenting Prognosis

COMPLIANT HOSPICE ADMISSION

Just because the patient doesn't meet the LCD

DOESN'T MEAN THEY'RE NOT HOSPICE ELIGIBLE

Determining the Principle Diagnosis

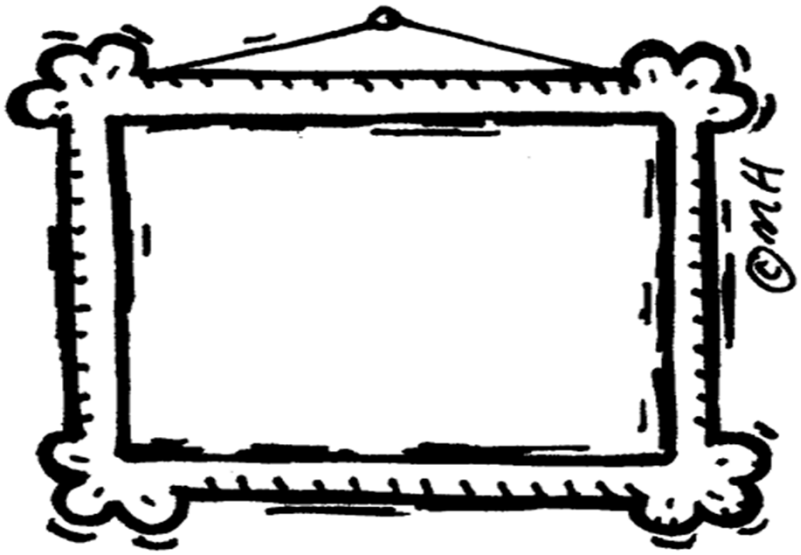
Patients may not meet the LCDs yet still have an LCD diagnosis as the principle hospice diagnosis

Condition “most contributory to the terminal prognosis”

All diagnoses contributing to the terminal prognosis should be listed on the claim form

- May be related or unrelated to the principle diagnosis

78 Federal Register 152 (7 August 2013), p.482.47



Documentation of prognosis

- Age
- Where they reside, with whom
- Primary hospice diagnosis
- Secondary diagnoses and comorbid diagnoses contributing to the terminal prognosis
  - If unrelated diagnoses are described, be sure to specify that they are stable/controlled and not contributing to the terminal prognosis

Documentation of prognosis, cont.

- Functional status – PPS, KPS, ADL
- Nutritional status – weight, BMI, albumin
- Cognitive status – FAST if appropriate or describe impairment

Diagnosis-specific findings supporting the prognosis

Records or diagnostic studies, if available – plans to obtain

Decision not to seek treatment or hospitalization

SUMMARY
Documentation of Prognosis

Paint the picture – narrative is necessary!

Remember Function, Cognition, Nutrition

Use objective LCD data when it's available

If the patient doesn't "meet" the LCD, describe why they are terminally ill anyway; often more than one diagnosis is contributing to the prognosis

Choosing the Terminal Diagnosis & ICD9 Code

COMPLIANT HOSPICE ADMISSION

NHPCO Regulatory Update Diagnosis Coding Requirements

http://www.nhpco.org/alerts/invalid-hospice-diagnosis-codes-effective-10012014

CANNOT Use ICD9 Codes

ICD9 Coding Guidelines and Conventions

- Certain codes cannot be used as a primary diagnosis
- Codes that require specific sequencing
- Codes that have etiology or manifestation guidelines

Hospice Specific Guidance

- Codes listed under Symptoms, Signs, and Ill-defined Conditions
  - Debility 799.3 and Adult Failure to Thrive 783.7
- 290-dementia codes

Dementia Codes

331 Other cerebral degenerations

331.0	Alzheimer's disease
331.2	Senile degeneration of the brain
331.82	Dementia with Lewy bodies
331.89	Other cerebral degeneration
	AVOID 331.9 Cerebral degeneration, unspecified
332.0	Paralysis agitans (Parkinson's Disease)
	NOT 332.1 Secondary Parkinsonism

NOT Allowed

294.10 "Dementia *in diseases classified elsewhere* without behavioral disturbances"

294.11 "Dementia *in diseases classified elsewhere* with behavioral disturbances"

AVOID dementia codes that are "**unspecified"**

WATCH OUT for codes that have a **"code first"** sequencing

More Complex Dementia Coding

USE ADDITIONAL CODE

Vascular dementia

1st 437.0	Cerebral atherosclerosis
2nd 290.40 – 43	Vascular dementia

CODE FIRST

Multiple sclerosis

1st 340	Multiple sclerosis
2nd 294.1	Dementia in conditions classified elsewhere

USE ADDITIONAL DIGITS

Painting the Picture Secondary Codes

707.20-25	Pressure ulcer (stages)
799.4	Cachexia
995.91-2	Sepsis CODE FIRST underlying organism
	ADDITIONAL CODES 584.5-9 acute kidney failure, etc.
038.12	MRSA
590.1-2	Pyelonephritis (without & with medullary necrosis)
	ADDITIONAL CODES to identify organism
783.7	Adult failure to thrive

AFTT/Disability

Determine existing diagnoses

Do any of them contribute to the terminal prognosis?

Which one contributes MOST?

"Dwindles and keel-overs"

440.9	Generalized & unspecified atherosclerosis
715.09	Osteoarthritis, generalized
772.6	Degeneration of intervertebral disc, site unspecified

Paint the Picture Secondary Codes

781.2	Abnormal gait
782.3	Edema
780.3	Anorexia
783.21-22	Loss of weight/underweight
787.20-29	Dysphagia
724.5	Backache, unspecified
780.96	Generalized pain
780.54	Hypersomnia, unspecified

SUMMARY
Hospice Diagnosis Coding (ICD9)

What contributes MOST to the terminal prognosis?

Be sure that the chosen code can be used as a principal terminal diagnosis

Any valid principal diagnosis can be used as a terminal diagnosis

Add secondary codes to describe prognosis

Be sure that your documentation supports the codes chosen

Clinical Case

Mrs. Henry is a nursing home resident referred with a diagnosis of dementia. She has comorbid diabetes mellitus, COPD, CHF, and CRF. She has had 3 hospitalizations over the past 6 months.

On assessment, she needs assistance with all ADLs and is incontinent of urine and sometimes bowel. She is confused but conversant and able to walk on her own. She fatigues with walking down the hall. She has 2+ pedal edema. Her lungs are clear and she does not use oxygen. Her PPS is 40%.

POLLING QUESTION

Is Mrs. Henry hospice eligible?

1. Yes
2. No
3. Need more information

POLLING QUESTION

What is Mrs. Henry's primary terminal diagnosis?

1. 428.23 Acute on chronic systolic heart failure
2. 331.0 Alzheimer's disease
3. 250.40 Diabetes mellitus with renal manifestations
4. 799.9 Other unknown and unspecified cause of morbidity or mortality

SUMMARY

Formulate a prognosis
- Surprise question
- General indicators
- Disease specific indicators, including LCDs

Document a prognosis
- Structured narrative
- ICD9 diagnostic coding

Use these tools to admit eligible hospice patients!

QUESTIONS