Hospice Documentation for the IDT – The Big Picture

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Session objectives

- Discuss impact of FY 2014 2015 hospice regulations on medical director/ hospice physician role
- Discuss hospice responsibility related to terminal prognosis
- Review diagnosis coding in hospice

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Impacts to the hospice physician role

- October 1, 2009
 - Brief physician narrative statement included in certification of terminal illness
- January 1, 2011-
 - Face-to-face encounter included in certification of terminal illness
- FY 2014 Hospice Wage Index Final rule
 - Clarification from CMS about diagnosis coding and relatedness
- FY 2015 Hospice Wage Index Final rule
 - Clarification from CMS about terminal illness and related conditions definitions and relatedness
- FY 2016 Hospice Wage Index Final rule waiting!

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Attending physician



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Patient Choice of Attending

- Effective October 1, 2014, providers must document the patient's choice of attending MD.
- CMS noted concerns with hospices' actions:
 - Changing a patient's attending physician when the patient moves to an inpatient setting for inpatient care, often to a nurse practitioner.
 - Not having the attending MD sign the initial certification (unless the attending is an NP).
 - Assigning an attending physician based upon whoever is available.

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Choice of Attending – CMS Speaks

- Attending physician must be chosen by the patient (or his or her representative) and not by the hospice.
 - §418.52 Patient Rights Patient has the right to choose their attending physician.
- Since the hospice MD is responsible for meeting the medical needs in the absence of the attending physician, there is no need to change attending when admitted to the inpatient setting.

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Documenting Choice of Attending Physician

- Add a field on the election form to capture the attending physician's name on admission
- Add language that states the patient acknowledges that the identified attending is their choice
- Changes in the attending physician require completion of a form with the following elements:
 - Identification of the new attending
 - Acknowledgement that the change is the patient's/representative's choice
 - Date change is effective (no retroactive changes)
 - Signature of patient or representative
 - Date signed by patient or representative

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Eligibility – reminder from CMS

- The hospice medical director must consider at least the following information per our regulations at §418.25 (b):
 - Diagnosis of the terminal condition of the patient
 - Other health conditions, whether related or unrelated to the terminal condition.
 - Current clinically relevant information supporting all diagnoses.

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Clinical Basis for Certification

- Must be a clinical basis for a certification
- A hospice is required to make certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course

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Clinical Basis for Coverage under Part A

- To be covered under Medicare Part A, the care must also be reasonable and necessary.
- Clinical documentation must support a patient's hospice eligibility as hospice services provided must be reasonable and necessary for the palliation and management of the terminal illness and related conditions.

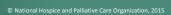
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Process of eligibility documentation Information to evaluate eligibility gathered Physician determines eligibility History & physical Hospital discharge DT documents eligibility Certifies terminal illness information and prognosis of 6 months Labs & other test results Uses physician narrative Clinical findings on initial & information as a cur for Composes narrative eligibility documentation comprehensive assessments statement that includes Face to face findings Documents evidence of specific information that eligibility in every note exemplifies eligibility for hospice

Eligibility Documentation

 Documentation supporting a 6-month or less life expectancy is included in the beneficiary's medical record and available to the MACs when requested.



13

Resources for Eligibility

- Multiple public sources available to assist in determining whether a patient meets Medicare hospice eligibility criteria:
 - Industry specific clinical and functional assessment tools
 - Information on MAC websites
- We expect hospice providers to use the full range of tools available to make responsible and thoughtful determinations regarding terminally ill eligibility

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Level of care eligibility

- General inpatient
 - General inpatient care day is a day in which a patient receives general inpatient care in an inpatient setting for pain control or acute or chronic symptom management which cannot be managed in other settings
- GIP physician oversees medical management of patient in an inpatient setting
 - Responsible for symptom management interventions
 - Deciding time of discharge from GIP
 - If GIP contracted, IDT, including hospice physician, professionally manage patient's care

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Terminal prognosis

CMS Statements on Relatedness

"It is our [CMS'] general view that . . . hospices are required to provide virtually all the care that is needed by terminally ill patients.
 Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related.

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Examples of Unrelatedness

- Two examples are repeatedly offered for unrelatedness
 - Neither has been validated by CMS
- "Glaucoma is pathophysiologically unrelated to the patient's lung cancer, and does not contribute to the terminal prognosis."
- "Hypothyroidism is physiologically unrelated to the patient's COPD, and since it is well managed, it does not contribute to a worsened prognosis."

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Diagnosis and prognosis

§ 418.3 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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Diagnosis versus prognosis

- Hospice eligibility is determined by medical necessity based on <u>prognosis</u>
 - Hospice's primary responsibility is patient care for those with a terminal prognosis
- Most of healthcare is driven by medical necessity based on diagnosis
 - Diagnosis isn't mentioned in the MHB until discussing admission and management
 - Diagnosis <u>coding</u> is even further down the timeline

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Determining prognosis and diagnosis

- Hospice physicians determine *prognosis* from:
 - Records review
 - IDG input
 - Discussions with referral sources/attending physicians
 - Clinical judgment
 - Examination of the patient (if applicable)

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Determining relatedness



Hospice physician reviews all available information







- Relatedness is not determined by the CFO based on cost to hospice provider.
- It is determined patient by patient, case by case related to the palliative plan of care.

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What is contributory?

- Does the diagnosis under consideration contribute to the terminal prognosis?
- Examples:
 - ESRD on dialysis with End-stage heart failure
 - Dementia (FAST 6A) with End-stage liver disease
 - Diabetes mellitus with COPD
- The relationship may change over time
 - Though in general, there is no "going back" unless the patient improves to no longer be terminal

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Other Considerations

- All determinations must be done with consideration of the patient's prognosis
 - Not eligible Discharge or do not admit patient
 - Related Diagnosis or treatment for diagnoses contributes to the terminal prognosis
 - Is a treatment still beneficial within the patient's expected prognosis?
 - May still be related, but should be discontinued

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Example

- Terminal diagnosis
 - Alzheimer's disease (331.0)
- Related diagnoses
 - Adult Failure to thrive (783.7)
 - Dementia in CCE w/o behavioral disorder (294.10)
- Think of "Terminal Illness" as <u>all</u> of the above, combined
 - Document to whichever LCD(s) are pertinent
- The hospice physician documented AD as a new diagnosis in the narrative

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Example: Certification narrative

This elderly gentleman has dementia and adult failure to thrive due to apparent Alzheimer's disease. He meets the AFTT guidelines with his PPS of 40% and BMI of 18.5, along with documented weight loss of 8% over the last 4 months. His dementia is a significant contributor to poor prognosis with a FAST of 6E. It is my medical judgment that his diagnoses, along with his trajectory of functional decline and associated poor nutritional status with irreversible weight loss, will lead to his demise within the next six months.

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Role of the nurse

- Provision of clinical information to the hospice physician.
 - Comprehensive assessment
 - History and physical
 - Discharge summary from hospital
 - Clinical information from attending physician

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Role of the Hospice Physician

- Determining the diagnoses is within the scope of practice of medicine
 - Formal diagnoses for the record vs. nursing diagnoses
- Hospice physician can determine new diagnoses that are present but have not been previously designated formally
 - Example: Dementia is documented in the record,
 but does not state the etiology of the dementia

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CMS Statements on Relatedness

It is also the responsibility of the <u>hospice</u>
 <u>physician</u> to document why a patient's medical
 need(s) would be unrelated to the terminal
 <u>prognosis</u>



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Documenting "Unrelatedness"

- What does the hospice physician document?
- CMS has providing varying guidance on this
 - Recent NHPCO MLC: should be more than "it is unrelated because it is"
 - Recent CMS Open Door Forum call:
 should be a brief narrative that is reasonable in explaining why the condition is unrelated

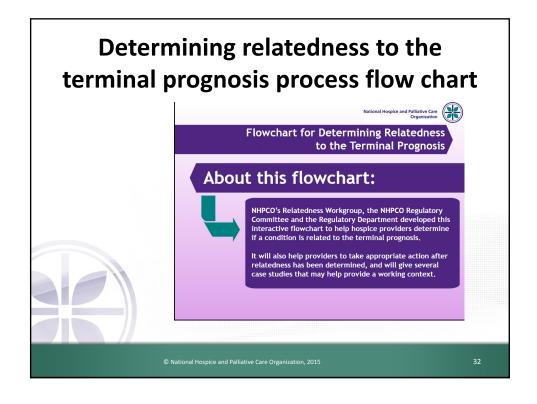
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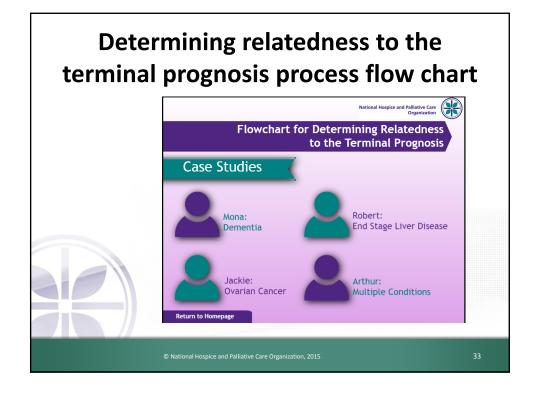
Document it where?

- Not in the physician narrative statement
- Your choice!
 - Any other place in the clinical record that your hospice program designates as appropriate

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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

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Do not use!

- CMS designated multiple ICD-9 codes as not allowable for the primary diagnosis on the claim form
- Claims will be returned
- CR8877 outlines do not use codes
- NHPCO Diagnosis Codes That Cannot Be Used As Primary Diagnosis Codes on the Hospice Claim

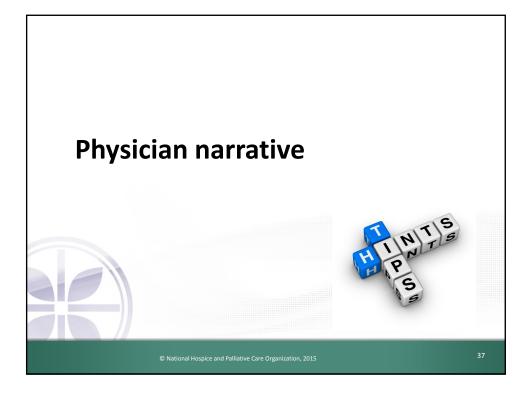
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Bottom line....

- If it is related, hospice covers the cost
 - Care (services, treatment, etc...)
 - Medications
 - DME & supplies
- Documentation should appear in the clinical record that it is related.
 - Physician narrative
 - POC
 - Medication profile

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Physician Narrative: Regulation

- Must be composed by the certifying physician.
- Must reflect the patient's **individual** clinical circumstances.
- Must not contain check boxes or standard language used for all patients. (Individualized)
- · Can be hand written of electronic.
- Must contain an attestation that states the physician composed the statement.

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Suggested narrative components

- Age
- Principle diagnosis
- Secondary diagnoses that contribute to the prognosis of 6 months or less
- Do NOT include a list of non-contributory, non-related diagnoses.

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Suggested narrative components

- Clinical factors associated with a prognosis < 6 months
- History
- Relevant hospitalizations and/or ED visits
- · Evidence of disease progression
- Trajectory of decline
- Symptoms indicating progression and/or severity
- Prognostic signs noted on comprehensive assessment

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Suggested narrative components

- Lab and/or XR data (as applicable)
- Other LCDs factors
- Lack of LCD factors
- Pertinent, published data
- Individual clinical circumstances

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Documentation Quality An IDT responsibility Excellent Good Average

Focused quality documentation

- Document limits to daily activities of living for a patient with end-stage heart disease.
- Describe the extent of oxygen for a patient COPD and shortness of breath.
- State facts with objective information:
 - "Clothing no longer fits due to weight loss"
 - "Sleeping XX number of hours of day"
 - "Pain is severely limiting activities of daily living"

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Comparative Documentation

- Contrasts the patient's present condition to his/her prior condition.
- Individualizes patients by focusing on their trajectory of decline.
- Presents specific information, not generalizations
 - One week ago, patient was eating ½ ¾ of 2 meals
 per day. Now eating only ¼ of 1 meal each day.

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Insufficient documentation

- Does not paint a picture of the patient.
- Insufficient documentation uses words/ phrases like:
 - Slow, progressive decline
 - Appears to be losing weight
- Lacks sufficient detail to support prognosis.

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Insufficient documentation example #1

- "Inability to ambulate independently" could mean:
 - Needs help of one caregiver (supervision, guidance, support)
 - Needs assistance of two caregivers
 - Needs assistance of two caregivers and assistive devises
 - Ambulates 30 steps
 - Ambulates 2 steps to get over to the chair

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Insufficient documentation example #2

- "Inability to dress self" is vague and could mean:
 - Patient is physically unable to dress self
 - Patient may be able to assist dressing self
 - Patient is physically capable, but is behaviorally unable to comply with dressing activity
 - Patient is bedbound and cannot dress self
 - Patient refuses to dress self

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Insufficient documentation example #3

- "Patient losing weight" could mean:
 - Patient is eating less than before.
 - Patient is not eating at all.
 - Patient has lost two pounds.
 - Patient has lost twenty pounds.
 - Patient appears cachectic

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Inconsistent documentation

- Inconsistent documentation
 - Nursing notes: non-ambulatory
 - Chaplain notes: walked in hall



- Pain assessment without documentation of interventions.
- "First-line" documentation (nurse, aide, SW, volunteer) does not match "second-line" documentation (IDG notes, narratives, clinical summaries).

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Levels of Care: Inpatient respite

418.204 Special coverage requirements.

- (b) Respite care.
 - (1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.
 - (2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.
- Should document reason for respite care.
- Frequent use may send red flags to RHHI/MAC.

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Levels of Care: Continuous care

418.204 Special coverage requirements.

- (a) Periods of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home.
- A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

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Levels of Care: Continuous care

- Describe the crisis in detail and the patient/family's desire to remain at home
- A new POC should be established detailing the problems, interventions and expected outcomes. Staff progress notes should include the issues identified in the POC.
- Physician order for Continuous Home Care?

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Levels of Care: Continuous care

- Describe frequency, severity, and intensity of symptoms
 - Diaphoresis, chest pain; vomiting resulting from severe coughing
- Document previous attempts to relieve symptoms
 - Pain unrelieved by multiple doses of the patient's current analgesic
- Document interventions utilized to relieve patient's discomfort
 - Medications, O2, positioning, massage, bathing, music, lighting, verbal support, nebulizers, fans, suctioning, etc.
- Document all teaching to patient, family, or caregiver

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Levels of Care: GIP

General Inpatient

- Describe the patient's condition and the patient/family problems in detail. Elaborate on why the issues cannot be managed in the home setting, or at routine level of care if in a facility.
- The hospice maintains professional management of the patient so daily staff visits are appropriate.
- Documentation should include the coordination of care between the hospice and the facility providing GIP.

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Levels of Care: GIP

- A new POC should be established detailing the problems, interventions and expected outcomes. The staff progress notes should include the issues identified in the POC
- Physician order for GIP?

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Electronic Medical Record (EMR) Risks

- Deficiencies in documentation can have significant consequences.
- Good documentation is:
 - Legible
 - Accurate
 - Timely
 - Objective

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Common issues with electronic documentation

- Not enough detail (appears standardized)
- Cut & paste option (duplicating information)
- Not timely (depending on accountability of staff to upload)
- Inconsistent between disciplines (appears multidisciplinary vs. interdisciplinary)

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EMR documentation detail

- Increase detail in electronic documentation.
 - Expand on "point and click" selections in a note.
 - Record observations about details the "drop down" does describe.
 - I.e.: state the number of feet a patient can ambulate.
 - Document subjective comments from the patient and family to support continued eligibility.
 - I.e.: "I sat outside last week, but this week I just don't have the energy to go out".
 - I.e.: "He has been sleeping more during the day and is not interested in waking up to eat".

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"Fast is fine, but accuracy is everything."

Wyatt Earp

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Documentation Pearls



- Gather a comprehensive, useful history
- Assess the patient
 - Overall and based on the diagnoses
- Describe the patient
 - Overall and based on the diagnoses
- Use prognostic tools accurately
 - Use the right tool for the right diagnosis in the right way

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Documentation Pearls



- Ensure that the Plan of Care is more than "report"
 - In IDT and in documentation
- Expect all members of the IDT to document patient appearance on every visit
 - Especially differences and changes
- Ensure that information included in summaries, narratives, and prognostic worksheets is supported by visit documentation.

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6

Resources and References

- The Centers for Medicare & Medicaid Services (CMS) proposed rule Medicare hospice wage index and Medicare hospice payment rates for fiscal year (FY) 2015 (CMS-1609-P)
- Medicare Benefit Policy Manual, Chapter 9, Coverage of Hospice Services Under Hospital Insurance, 20.1- Timing and Content of www.cms.gov/Regulations-and-

<u>www.cms.gov/Regulations-and-</u> Guidance/Guidance/Manuals/Downloads/bp102c09.pdf

OIG FY 2014 Work Plan

 http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf

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