The Death Knell for Debility and Adult Failure to Thrive as Terminal Diagnoses in Hospice

May 24, 2013 Terri Maxwell

On May 10, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a Proposed Rule entitled FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform [CMS-1449-P]. This rule contains important information, including proposed hospice rates for 2014 (no good news here, rates are going down), changes to the hospice quality reporting program, alterations to the cost report, and an update to hospice payment reform options.

In addition to these proposed changes, CMS "clarified" a number of coding requirements that has had the industry buzzing. Included in these clarifications is a directive to hospices that non-specific diagnoses such as Debility or Adult Failure to Thrive (AFTT) may no longer be listed as a principle terminal diagnosis on the hospice claim. Claims submitted with these diagnoses would be returned to the provider (RTPd) for a more definitive hospice diagnosis. However, Debility and AFTT can and should be listed on the claim as secondary (related) conditions to support prognosis if indicated. CMS states that disallowing these diagnoses is not a new position, which comes as a surprise to most of us

in the industry (otherwise why does CMS' Medicare Administrative Contractor (MAC), Palmetto GBA, have an LCD guideline for AFTT?).

WHY IS CMS MAKING THIS CLARIFICATION NOW?

According to the Proposed Rule, CMS is taking action because of the growing number of patients admitted to hospice with these ill-defined conditions that are inherently symptom syndromes, not actual terminal diagnoses. This is born out by National Hospice and Palliative Care Organization (NHPCO) statistics, listing Debility Unspecified as the leading non-cancer diagnosis in hospice, comprising 13.9% of hospice admissions in 2011. CMS also expressed concern that individualized, patient-centered plans of care are difficult to develop for patients with these conditions and, consequently, the patient may not receive the full benefit of hospice services.

Many in the industry believe that this is another way to achieve CMS' goal of reserving the Medicare Hospice Benefit for those who are terminally, not chronically, ill. Debility and AFTT patients frequently have long length of stays (LOS) in hospice. Hospices with sizeable numbers of patients with these diagnoses with a LOS greater than 180 days have been targeted for payment-related scrutiny through the additional development request (ADR) process. CMS hoped that the Face-to-Face regulation would identify some of these patients as no longer eligible upon recertification and, therefore, would be discharged alive. When that didn't happen, they needed to come up with Plan B.

WHAT IS THE IMPACT ON HOSPICES AND THE PATIENTS FOR WHOM THEY CARE?

Fortunately, some hospices have already reduced or eliminated the use of these diagnoses as the primary terminal diagnosis. For those hospices, there will be little impact. Those programs still admitting and caring for patients with debility/AFTT will need to take a number of actions to be in compliance. Below are some suggested steps that hospices can take:

- Immediately cease using Debility or AFTT and other non-specific diagnoses as the primary diagnosis for any new patients.
- Instead of Debility or AFTT, select a primary diagnosis that is most contributory to the patient's terminal disease trajectory and requires end-of-life palliative interventions.

- Use other health conditions (debility, AFTT, etc.) to support prognosis as needed. This is especially important if the primary diagnosis does not have an LCD guideline associated with it or if the patient's clinical status does not meet the LCD guideline in its entirety.

- Include debility, AFTT and all other prognosis-impacting conditions on the claims form (just not as the primary diagnosis).

- Perform a census analysis to identify any patients that fall into the ICD 9 category of "Symptoms, Signs, and Ill-Defined Conditions" (ICD 9 codes 780-799).

- Have your Medical Director or Hospice Team Physician review each patient's clinical record to identify an alternate primary diagnosis. Tips to identifying an alternate diagnosis include:

1. Review the Plan of Care (POC) to determine the body system, symptoms and psychosocial/spiritual issues that require the greatest amount of palliative interventions.
2. Review the drug profile to identify what medications are being used and for what purpose.
3. Ask yourself, if the patient died tomorrow, what would the physician list as the cause of death on the death certificate?

- When changing a patient's primary hospice diagnosis, remember to do the following:

1. Obtain a physician order for the new diagnosis.
2. Obtain a new physician narrative that paints the picture for eligibility for the new diagnosis that is supported by documentation in the clinical record.
3. Develop a new POC based upon an updated comprehensive assessment.
4. Update the drug profile with appropriate designation of related/covered or not related/not covered.
5. Change billing codes.
6. Communicate these changes with staff members, attending physicians, and referral sources, including nursing facilities and assisted living facilities.

- The diagnosis can be changed on the next claim, or an adjustment may be made to a prior claim if needed. It is not necessary to cancel any claims already processed with the original diagnosis.

- If the patient has no clear alternate diagnosis that is supported by clinical documentation, and if the POC has not changed over time to reflect end-of-life symptom management, it is important that consideration is given to discharge the patient.

  Please see "Tips for Hospices…" below for a printable resource with these tips and more.

  There are patients with these ill-defined diagnoses who will no longer be deemed eligible for hospice care. Sadly, most are elderly, frail, and slowly dying from a myriad of conditions that do not meet today's hospice standards. The Hospice Medicare Benefit was never intended to care for these patients, but neither is there a safety net for these patients and their families if access to hospice is denied. In the end, these patients and families may be without needed care and hospices will be burdened with the difficult job of discharging them.

ADDITIONAL RESOURCES:

Tip Sheet for Hospices

In the next few weeks, look for an announcement about an online education module on the Hospice Education Network to help hospice physicians with overcoming the "dilemma of debility".

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