Hospice Nursing Documentation: Supporting Terminal Prognosis

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Today's Presenters

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Objectives

- The objectives of this session are to review the coverage requirements for the Medicare hospice benefit and provide information on nursing documentation to support terminal prognosis

Agenda

- Hospice coverage
- Why hospice? Why now?
- Supporting the prognosis
- Local coverage determination
- Nursing documentation scenario
- Questions and answers

Hospice Coverage

- To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill.
- An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

*CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 9, Section 10, "Requirements- General"

Beneficiary Notice of Election

- Identification of the particular hospice that will provide care to the individual;
- The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;
- The individual's or representative's (as applicable) acknowledgment that the individual understands that certain Medicare services are waived by the election;
- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive; and

Beneficiary Notice of Election

- The individual's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician or NP was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.
- The individual's acknowledgment that the designated attending physician was the individual's or representative's choice.
- The signature of the individual or representative.

Physician Certification of Terminal Illness

- A written certification must be obtained no later than 2 calendar days after hospice care is initiated (that is, by the end of the third day)
- If the hospice cannot obtain a written certification within 2 calendar days, it must obtain an oral certification within 2 calendar days

Oral Physician Certification Documentation

- An oral statement documented in the patients medical record needs to include:
  - A statement that the patient is terminally ill, with a prognosis of 6 months or less
  - Signature and date of author
  - Hospice diagnosis (suggested)
  - Statement the patient will be admitted into hospice care (suggested)

Wikipedia Definition of Nursing

- Nursing is a healthcare profession focused on the care of individuals, families, and communities so they may attain, maintain, or recover optimal health and quality of life from birth to death

Documenting the Hospice Appropriate Patient

- Answering the question? “Why hospice, why now?”
  - History, progression of illness, recent changes, current status
  - Should show acuity or trajectory that supports the six-month prognosis
  - Documentation should support the physician’s certification of terminal illness

Why Now?

- What triggered the hospice referral at this time?
  - Hospitalization
  - Symptoms exacerbation
  - Changes in condition
  - Needs for additional care
  - Comorbidities

General Terms that Do Not Support Decline

- Appears to be "losing weight"
- Ate 50% of meal
- Shows "slow decline"
- "Stable"
- "Eating well"

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How do you know?

- Anytime you use a description like:
  - Cachectic, anorexic, nonambulatory, dyspnea (at rest or on exertion),weight loss, poor appetite, fragile, failing, weaker…
- Always follow up with "as evidenced by.." to fully describe what you see

Documenting Objective Measures

- Measurable objectives:
  - Weights
    - Mid arm circumference
    - Abdominal girths
  - Food and fluid intake
  - Labs
  - Signs and symptoms

Supporting Prognosis: Course of Care

- Visit notes must:
  - Continuously and consistently support the terminal prognosis
  - Contain vital signs, weights, body mass measurements, food intake, lab values and/or other objective data
  - Refer to goals identified in the plan of care

Local Coverage Determination

Local Coverage Determination

- Hospice Determining Terminal Status (L33393)
  - www.NGSMedicare.com
- Medical Policy Center
- Active LCDs

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Top LCDs/Policies

- LCD for Hospice - Determining Terminal Status (L25678)
- LCD for Erythropoiesis Stimulating Agents (ESA) (L25211)

- ***CERT Denial Finder***
- ***ADR Timeline Calculator***
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- ICD-10: Jurisdiction 6 Local Coverage Determination List
- ICD-10: Jurisdiction K Local Coverage Determination List

Tip: Search for ICD-10 LCD and related articles on our website by CMS Identifier (L number or A number), title, keyword, as well as CPT, HCPCS, or ICD-10 codes by using our main banner search. Once in the tables, you can also search for ICD-10 LCD and related articles by using the **CTRL+F function** within the LCD/Article Lists.

ICD-9 LCDs for J6 and JK have been moved to the MCD Archive Site at http://localcoverage.cms.gov/mcd_archive/overview.aspx?from2=overview.aspx& EXT and can be searched with the LCD identifier (L number), or with keyword, CPT, HCPCS, or ICD-9 codes. ICD-9 LCDs are also accessible **within** the ICD-10 LCDs by selecting the original ICD-9 LCD link at the top of the ICD-10 LCD.

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- **Draft LCDs** EXT for your region EXT
- **In Notice (Future) LCDs** for your region EXT
- **Retired LCDs** for your region EXT

LCD L25678 Hospice Determining Terminal Status

- Part I. Decline in Clinical Status Guidelines
- Part II. Non-Disease Specific Baseline Guidelines (both A and B should be met)
- Part III. Disease Specific Guidelines

Part I

- Progression of disease as documented by worsening:
  - Clinical status
  - Symptoms
  - Signs
  - Laboratory results

Part I – Clinical Status

- Clinical status:
  - Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;
  - Progressive inanition as documented by:
    - Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics
    - Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics

Part I – Clinical Status

- Clinical status:
  - Progressive inanition as documented by:
    - Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight
    - Decreasing serum albumin or cholesterol
    - Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption

Part I – Symptoms

- Symptoms:
  - Dyspnea with increasing respiratory rate
  - Cough, intractable
  - Nausea/vomiting poorly responsive to treatment
  - Diarrhea, intractable
  - Pain requiring increasing doses of major analgesics more than briefly

Part I – Signs

- Signs:
  - Decline in systolic blood pressure to below 90 or progressive postural hypotension
  - Ascites
  - Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
  - Edema
  - Pleural/pericardial effusion
  - Weakness
  - Change in level of consciousness

Part I – Laboratory Results

- Laboratory results (when available):
  - **Note: Lab testing is not required to establish hospice eligibility**
  - Increasing pCO2 or decreasing pO2 or decreasing SaO2
  - Increasing calcium, creatinine or liver function studies;
  - Increasing tumor markers (e.g., CEA, PSA)
  - Progressively decreasing or increasing serum sodium or increasing serum potassium

Part I – Laboratory Results

- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease
- Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST)
- Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2)
- Progressive stage 3-4 pressure ulcers in spite of optimal care
- History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit

Part II – Non-Disease Specific Baseline Guidelines (both A and B should be met)

- Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%
  - **Note: two of the disease specific guidelines (HIV disease, stroke and coma) establish a lower qualifying KPS or PPS**
- Dependence on assistance for two or more activities of daily living (ADLs):
  - Ambulation
  - Continence
  - Transfer
  - Dressing
  - Bathing
  - Feeding

Part II – Non-Disease Specific Baseline Guidelines (both A and B should be met)

- Comorbidities – although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.
  - COPD
  - Congestive heart failure
  - Ischemic heart disease
  - Diabetes mellitus
  - Neurologic disease (CVA, ALS, MS, Parkinson's)
  - Renal failure
  - Liver disease
  - Neoplasia
  - AIDS
  - Dementia
  - AIDS/HIV
  - Refractory severe autoimmune disease (e.g., Lupus or Rheumatoid)

Part II – Non-Disease Specific Baseline Guidelines (both A and B should be met)

- See Part III for disease-specific guidelines to be used with these baseline guidelines
- The baseline guidelines do not independently qualify a patient for hospice coverage

Part III – Disease-Specific Guidelines

- Cancer diagnoses
- Noncancer diagnoses
  - Amyotrophic Lateral Sclerosis
- Dementia due to Alzheimer’s disease and related disorders
- Heart disease
- HIV disease
- Liver disease

Part III – Disease-Specific Guidelines

- Pulmonary disease
- Renal disease
- Acute renal failure
- Chronic kidney disease
- Stroke
- Coma (any etiology)

Scenario

- Silver is a 72-year-old female with a diagnosis of Alzheimer's. Silver was hospitalized on 6/5/2015 for pneumonia. Silver's hospital admission weight was 85 lbs. Hospice admission weight was 82.5 lbs. After discharge from the hospital, Silver returned home with her daughter and was admitted into hospice on 6/10/2015. All necessary paperwork was completed and met CMS requirements. Silver's daughter is her primary caregiver.

Poor Documentation to Support Terminal Prognosis

- Documentation reviewed for 10/1/2015-10/31/2015 shows:
  - Hospice admission weight was 82.5 lbs. (hospital weight 85 lbs.)
  - Has poor appetite
  - Appears thin, clothes are loose fitting
  - Totally dependent for all ADLs
  - Incontinent of urine and feces
  - Nonconversive
  - Sleeps most of the time

Qualitative Documentation

- October 1-31, 2015 the documentation shows:
  - Has poor appetite- eating 3 to 4 bites of food with difficulty
  - Drinks 2-3 sips of thickened liquids and aspirates easily
  - Family reports patient sleeps 19 of 24 hours
  - Totally dependent for all Activities of Daily Living (ADL)
  - Hospitalized 06/05/2015 for pneumonia
  - Weights
    - 06/05/2015- 85.0 LBS
    - 06/10/2015- 82.5 LBS

Qualitative Documentation

- Weights
  - 07/20/2015- 82.0 LBS
  - 08/15/2015- unable to weigh patient
  - 10/02/2015-81.0 LBS
- Comorbidities-CHF, diabetes, ischemic heart disease
- 02@2L min per N/C
- Oxygen saturation
  - 08/15/15 92% on 2L per N/C
  - 08/20/15 88% on 3L per N/C
- Blood sugars family reports
  - 08/15/2015 AM blood sugar 62
  - 08/15/2015 HS blood sugar 386

Summary

- Objective data
- Avoid using general terms
- Clear concise documentation

CERT A/B MAC Outreach & Education Task Force

CERT A/B MAC Outreach & Education Task Force

- A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
- Shared goal of reducing the national improper payment rate as measured by the CERT program
- Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions
- **Disclaimer:** The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

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CERT A/B MAC Outreach & Education Task Force

- The CERT Task Force educates on common billing errors and contributes educational Fast Facts to the CMS website
  - CMS MLN Provider Compliance Fast Facts web page
    - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html
  - In addition, the CERT Task Force section on the NGSMedicare.com website provides a link to the CMS MLN Provider Compliance Fast Facts

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- ## Task Force Scenarios
  - Complying with medical record documentation requirements
  - Documenting therapy and rehabilitation services
  - Look for new articles added to this page and provided in your Email Updates

CERT A/B MAC Outreach & Education Task Force

- CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force
  - CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
    - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html

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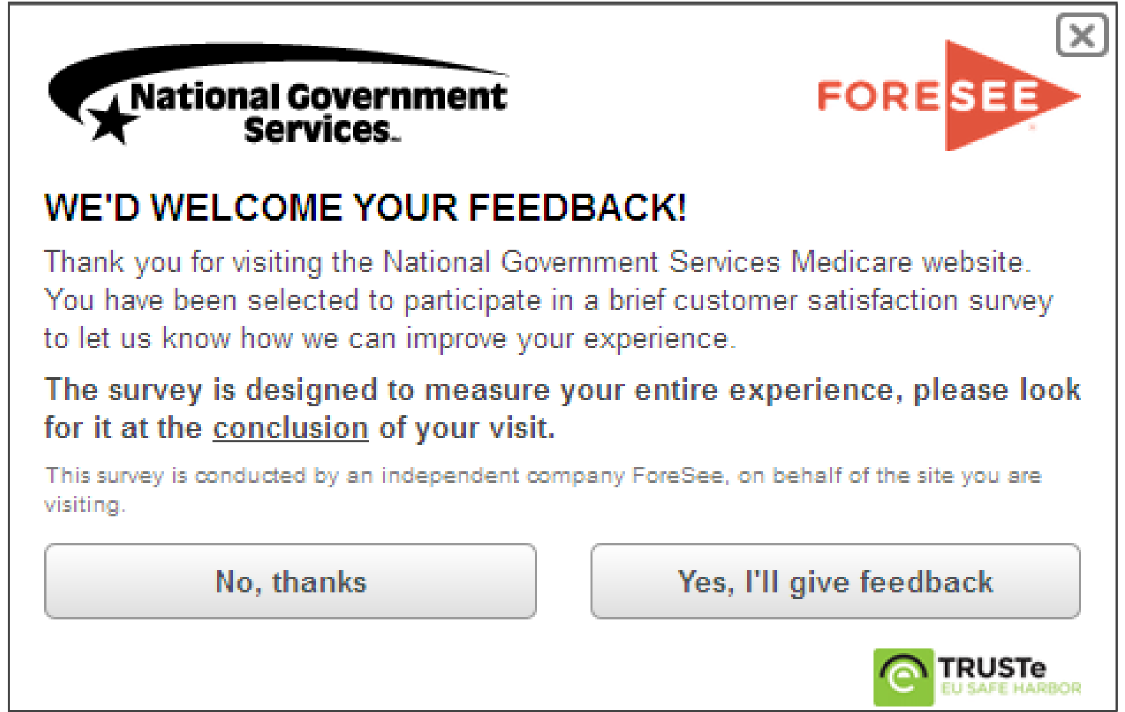

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