The *Face-to-Face Encounter* & *Brief Physician Narrative*

Joan Harrold MD, MPH, FACP, FAAHPM, HMDC
VP Medical Services and CMO
Hospice & Community Care
Lancaster and York Counties PA

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Today

- Elements of a useful FTF
- Physician narratives
  - Purpose, process, preparation, product
  - Certs…and recerts!

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The Statute

The Affordable Care Act requires that a hospice physician or nurse practitioner (NP) must have a face-to-face (FTF) encounter with every Medicare Hospice patient to determine the continued eligibility of that patient.

- Within 30 days prior to the 3rd and all subsequent Medicare benefit periods

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Who can do the "Face to Face"?

- Hospice physician: employed or contracted
- Hospice NP
  - W-2 employee of the hospice; NOT contracted
- PAs?
  - *PA **may** be allowed to perform FTFs in 2019* (Medicare Patient Access to Hospice Act of Feb 2018).
  - Awaiting interpretative guidance

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Patient Transfers

- When transferring from one hospice to another, the benefit period does not change, so the *originating* hospice is responsible for any required FTF.
- The *accepting* hospice is advised to have the FTF documentation for the benefit period.
  - *Get copies of the prevailing FTF documentation AND physician narrative*.

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Purpose & Content of the FTF

- Purpose: gather clinical information to be used to determine hospice eligibility
- Physical exam alone is usually insufficient for recert
- Need exam + context and comparison
- How much is gathered in the FTF?
  - Chart review of visit notes
  - Summary documentation (IDT notes, recert prep summaries)

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Content of the FTF for Recert

- HPI
  - Recent new events, changes in status/meds, new infections, decline
- ROS
  - General symptoms, symptoms related to relevant diagnoses (px)
- PE
  - Appearance, wt +/-MAC, vital signs, diagnosis-related findings, decline-related findings
- Functional status/changes
  - ADLs (which ones and how compromised), sleep, PPS, FAST
- ***NO*** finding of eligibility unless physician does FTF

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The Physician Narrative

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.

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The Physician Narrative: Purpose

- The certifying physician MUST ***compose*** a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.
  - 1st benefit period: can be written by EITHER the attending physician or hospice medical director
  - 3rd or later benefit periods: physician must use findings from the FTF to make the recert decision
  - The same physician who performs a FTF does ***NOT*** have to compose the narrative or sign the recert

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The Physician Narrative: Purpose

- For whom?
  - Is NOT clinical documentation of patient care.
  - ***IS*** documentation of eligibility for *payment* for patient care
- For the *reviewers who are determining coverage*
  - May be helpful summary for colleagues, but is NOT for them
- The narrative should be a persuasive, stand-alone statement of prognosis, supported by the record.

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The Physician Narrative

- The physician narrative is a **GIFT**.
- It is a mandated, expected statement of how the physician's clinical judgement has led to an assessment that the patient has a prognosis of 6 months or less.
- Can be a powerful statement for appeals.

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Physician Narrative: Product

- The narrative must be composed by ***the certifying physician***—**NOT** by other hospice personnel.
  - Synthesize individual patient's clinical information in a justification focused on ***prognostic*** factors.
- 1st benefit period: can be written by EITHER the attending physician or hospice medical director
  - *Do you really want a non-HPM physician writing this?*

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Physician Narrative: a Summary Document

- Narrative should summarize and/or interpret what is already documented.
  - It should rarely contain new information.
    - If new information is derived from IDG conversation, it should be documented in the pertinent visit note or the applicable IDG note.
  - It should follow logically from the visit and IDG documentation.
  - It must include information from the FTF.

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Physician Narrative: a Summary Document

- Physician attestation that cert/recert is based on exam **or** review of medical record
  - The physician who performs a FTF does ***NOT*** have to compose the narrative or sign the recert.
  - However, the one who does sign the cert should know that the information is in the record.

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Physician Narrative: Prognostic info

- HPI
  - Age primary dx, co-morbidities affecting px, new events or changes, infections
- ROS
  - General (wt loss, decreased intake,, etc.) and those related to relevant diagnoses
- MEDS
  - New meds and any pertinent increases or decreases in meds
- PE
  - Appearance, nutritional changes (wt, MAC, BMI), relevant VS, dx-related findings, decline-related findings
- Function
  - Changes in ADLs (which ones and how compromised), sleep, PPS, FAST
- +/- other objective data: pOx, labs, imaging
- Interpretations of findings

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Physician Narrative: Prognostic info

- Document magnitude of changes, not just direction
  - Not "decreased MAC" or "PPS down"
  - 2 cm decrease in MAC from 19 to 17 cm in the past 3 months
  - Decrease in PPS from 60 to 40 over this benefit period
- Get labs and imaging when needed
  - Albumin for nutrition compromise, renal function
  - Unexpected change in trajectory—correct diagnosis?

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Physician Narrative: Don't perpetuate inaccuracies

- Are PPS scores calculated correctly?
  - Accurate ambulation calculation. No "partial credit."
- Is FAST calculated correctly?
  - Speaks fairly well and can't walk due to CVA ≠ 7C
- And applied to the correct diagnosis?
  - Alzheimer's dementia, not vascular dementia, CVA, Parkinson's
- Do changes in MACs make sense?
- Really dependent for all ADLs?
  - Feeding self, walking with a device

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Physician Narrative: Interpretive

- Interpretations of findings: this is why a list is not enough. Narratives require sentences!
  - *Decrease in BP and need to discontinue cardiac meds reflects progressive cardiac compromise.*
  - *Pt's intake of approx. 300 cal/day is insufficient to sustain her long, although with BMI of 9.2, further wt loss can hardly be expected.*

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Physician Narrative: Include the LCDs

- Underscore expected findings
  - List the elements of ALL pertinent LCDs met by the patient.
    - Primary diagnosis and co-morbidities
- Remember that LCDs are guidelines.
  - If there is no LCD, explain why pt has a 6 month px.
- If eligibility is obvious, may need to write less.
  - Explain and support your decision more when not as obvious.

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Physician Narrative: Include the LCDs

- Acknowledge and explain lack of "expected" findings (usually LCDs)
  - Less than 10% wt loss but intake of bites and sips for a week with no reversible cause and decreasing responsiveness
  - Acute MI, CHF, hospitalization x1, persistent hypotension, rapid decline
  - Further wt loss not expected with extremely low BMI

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Physician Narrative: Inconsistencies

- Acknowledge and explain inconsistencies
  - Irregular wts—new scale? Change in fluid status?
- Do not rely on meaningless changes
  - Up and down wts or MAC
    - Do not rely on spurious "wt loss" if pt has fluctuations within a range.
  - Multiple rounds of antibiotics
    - For *significant* infections; don't just count the Rxs.

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Physician Narrative: Inconsistencies

- Explain how "improvements" in condition do NOT change px.
  - With better pain mgmt. and rebound following hospitalization, pt can help more with ADLs . Px remains 6 months or less due to stage 4 pancreatic cancer and worsening mets on CT.
  - Pt's diuretic-resistant edema has improved only with marked decrease in food and fluid intake.
- Explain "mitigated" changes.
  - Pt's nutritional decline and real wt loss is even greater as loss of 10# is dampened by new-onset of 2+ BLE edema from toes to knees.

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Physician Narrative: Inconsistencies

- Do not ignore long lengths of stay
  - *Although pt has unexpectedly outlived initial prognosis, pt has a px of 6 months due to….*

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Physician Narrative: Remember to add…

- Include other pertinent info
  - New and/or other co-morbidities
    - New MI, CHF exacerbation in previously stable CAD, new hip fx due to increased weakness and fall
  - New information in the literature that supports px
    - Advanced Dementia Prognostic Tool (ADEPT), Six Month Median Px in Cancer
  - Include pertinent citations in the narrative
    - Support eligibility
    - Potential support for future appeal

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Then and Now

- Then
  - *If we saw this pt for the first time today, would we admit?*
- Now
  - *Knowing this pt the way we do (esp. after a longer LOS), why do we now think the pt has a px of 6 months or less?*

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Writing the Physician Narrative

- Have a consistent order to your narrative, not a hard and fast recipe.
  - age, primary diagnosis, other diagnoses affecting px
  - recent events, infections, new or worsening symptoms
  - changes in nutritional, physical, and functional assessment
  - Pulse oximetry, labs, imaging
  - F2F findings: name of provider and date of visit
  - Interpretations
  - Pt wants palliative plan of care (second element of eligibility)

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Physician Narrative: Product and Process

- *Presence* of the narrative is a matter of compliance
- *Content* of the narrative is a matter of eligibility
- Will your physician narratives support eligibility if the records are reviewed?

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Physician Narrative: Process

- Have you taught your physicians to write them?
  - Do they understand the purpose?
  - Do they understand the possible uses?
  - Do they focus on prognostic factors?
- Narratives require sentences!

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Physician Narrative: Process

- Accountability
  - Who reviews the narratives?
  - How is feedback given?
- *Must take these seriously!*

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Physician Certification: Staff Preparation

- Do admission staff and IDT members all know how to support certification?
- Nurses
  - History, physical, and course of illness
  - Prognostic information per LCDs and diseases
  - Physical findings on assessment

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Physician Certification: Staff Preparation

- Not only nurses:
- SWs and Chaplains
  - What do you observe? What is different?
    - Posture, speech, dress
    - Pain, breathing, ability to converse, cognition
    - Activity, stamina, need for help
- Aides
  - Plan of care, efficiency, narrative content

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Physician Narrative: Staff Preparation

- Do the forms make it easy to support eligibility?
  - Ask the best questions for the discipline—and have a specific place to answer
  - Assessments
  - Scope of practice
    - Not all documentation is an "assessment"
- Do you have places to summarize events and findings?
  - IDT notes
  - Recert summary forms—not just check boxes!

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Strong Narratives

- Require clinical skills
  - IDG members
    - Accurate and complete clinical documentation
  - Physicians
    - Prognostic awareness and analysis
- Forms that ask the right questions
- Well-developed writing skills

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Physician Narrative: A Case

- 84 year old NH resident with Alzheimer's dementia
- Renal insufficiency, irritable bowel syndrome
- Pneumonia and delirium with hospitalization 2 months ago
- Continues on O2 for shortness of breath
- Ht 5'10". Wt 120 lbs. 30 lbs. loss in the last 6 months
- FAST 7C; ADEPT 19.5
- Holds food and medications in his mouth with poor intake
- Diet changed due to choking episodes
- FTF by hospice NP for admission into 4th benefit period.

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Physician Narrative: A Case

- 84 year old with Alzheimer's dementia
- Renal insufficiency, irritable bowel syndrome
- Pneumonia and delirium with hospitalization two months ago
  - Pneumonia with hospitalization is significant; may be aspiration-related per below info. Delirium assoc'd with increased mortality.
- Ht 5'10". Wt 120 lbs. 30 lbs. loss in the last 6 months
  - Ongoing and not reversible
- FAST 7C; ADEPT 19.5
- Holds food and medications in his mouth with poor intake
  - Expect further wt loss
- Diet changed due to choking episodes

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Physician Narrative: A Case

- 84 year old with Alzheimer's dementia
- Renal insufficiency, irritable bowel syndrome
  - How severe? Trajectory?
- Pneumonia and delirium with hospitalization two months ago
- Weighs 120 lbs with 30 lb loss in the last 6 months
- FAST 7C
- Holds food and medications in his mouth [with poor intake]
  - Does pt eat with cuing? Without poor intake, significance not clear.
- Diet changed due to choking episodes
  - Successful strategy to improve intake and reduce choking?

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The Good…

- *84-year-old with end-stage Alzheimer's disease is certified to have a 6 month px based on recent aspiration pneumonia, persistent dysphagia and aspiration risk, ongoing poor intake, 20% wt loss in past 6 months, BMI underwt at 17.2, ADEPT score 19.5 (with 67% probability of mortality in the next 6 months), FAST 7C, FTF (confirming wt loss, dysphagia, and ADEPT) by C Smythe CRNP on Mar 5, and desire for hospice support of palliative plan of care.*
- Focuses on prognostic factors.
- References FTF
- Includes preference for palliation, not life prolongation

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…the Bad…

- *84 year old with advanced dementia, wt loss, decline, pneumonia. Pt appropriate.*
- How advanced is dementia (FAST)?
- Timing and continuation of wt loss?
- When was pneumonia?
- What kind of decline?
- Probably supported in the record, but does not stand alone.

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…and the Ugly

- *Pt died.*
- Insufficient
- No justification of hospice eligibility.
- No stand-alone defense of prognosis
  - And what does that suggest to a reviewer if pt didn't die in 6 months or was discharged.
- Need a supported px—won't always be right.

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Also … Ugly

- "ES disease with decline—eligible for hospice"
- "Next decline will be death"
- "Pt with ESRD does not want dialysis."
- What about:
  - *Pt meets LCD with BMI < 22 and PPS 40.*
  - *Pt with DM and dementia is certified based on hospitalization last month for L BKA, hospital-acquired UTI (requiring IV abx), and 10% TBW loss (112# to 100#) within the past 6 months.*

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Also … Ugly

- Copy and paste
  - No copying and pasting from someone else's visit, FTF, IDT, or summary notes
    - The information—and even the words—may be similar.
    - But a physician note should read like a physician note.
  - No copying and pasting of last narrative with date change.
  - Worse: your copying makes the narrative ***WRONG!***
    - Records can't support.
    - Integrity of judgement and record are now questionable.

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Physician Narrative: Success

- Admission and IDG staff have the forms and training to document pertinent information
- Physician narratives
  - Composed by physician
  - Focused on prognosis
  - Well-written
  - Reviewed with feedback

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Physician Narrative: Success

- Have a consistent order, such as:
  - age, primary diagnosis, other diagnoses affecting px
  - recent events, infections, new or worsening symptoms
  - changes in nutritional, physical, and functional assessment
  - Pulse oximetry, labs, imaging
  - F2F findings: name of provider and date of visit
  - Interpretive conclusions about findings
  - Desire for palliative plan of care

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Physician Narrative: Success

- Presence of the narrative = compliance
- *Content* of the narrative = *eligibility*
- Exercise of physician's *clinical judgement* per the CoPs
  - A persuasive, stand-alone justification of prognosis of < 6 months for an individual patient
  - Supported by the record
- Written for the *reviewers* who determine coverage

A ***GIFT*** to hospices to support care delivery & reimbursement

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Resources

- Prediction of 6-month survival of nursing home residents with advanced dementia using ADEPT vs hospice eligibility guidelines. www.ncbi.nlm.nih.gov/pubmed/21045099
- Can hospices predict which patients will die within six months? www.ncbi.nlm.nih.gov/pubmed/24922330
- Estimating prognosis for nursing home residents with advanced dementia. www.ncbi.nlm.nih.gov/pubmed/15187055

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Resources

- Systematic review of cancer presentations with a median survival of six months or less. www.ncbi.nlm.nih.gov/pubmed/22023378
- Accuracy of prognosis prediction by PPI in hospice inpatients with cancer: a multi-centre prospective study. www.ncbi.nlm.nih.gov/pubmed/24644751

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To Contact Us

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundamentals.com

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