Painting a Picture of Eligibility Through Documentation

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What we will discuss today

- ✓Review of the Medicare regulations related to eligibility
- ✓Use of the Local Coverage Determinations (LCDs)
- ✓Prognosis versus diagnosis
- ✓Eligibility assessment principles
- ✓Correct use of assessment tools
  - Palliative Performance Scale (PPS)
  - New York Heart Classification (NYHC)
  - Functional Assessment Staging (FAST)
  - Body Mass Index (BMI)
  - Other objective data supporting eligibility

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The Legal Standard

42 CFR 418.20 Eligibility Requirements

In order to be eligible to elect hospice care under Medicare, an individual must be

a) Entitled to Part A of Medicare; and

b) Certified as being terminally ill in accordance with §418.22

42 CFR 418.2 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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Hospice Eligibility

Based on *prognosis*

- Which is why it ***must*** be done by physicians

Very unlike other types of physician certifications

- Those are based on "Medical Necessity"

MHB is *not* based on medical necessity

MHB is based on *proximity to end of life*

- Based on reasonable & necessary for the palliation or management of the terminal illness and related conditions (42 CFR 418.20)

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Prognosis vs. Eligibility

Assessing for eligibility is something anyone can do
- Comparing a potential patient's characteristics to a listing in a book, guideline, LCD, etc.

Prognostication is the practice of medicine
- Based on experience, knowledge of research, clinical intuition, the art of medicine
- Excluded from other scopes of practice
- No one is very good at it

Research

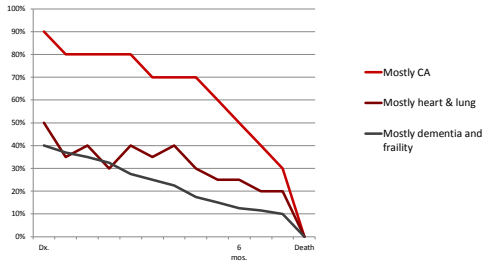
Trajectories of functional decline at the end of life are quite variable

Only short term expected deaths such as may occur with cancer decedents are likely to have a predictable terminal phase

Declining frailty is a particular challenge and may die without a clear terminal period

Lunneu, et al
JAMA, May 2003

Disease Trajectory



Relatedness

Terminal Diagnosis	The condition established after study to be chiefly responsible for the patient's admission to hospice
Related	Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and impact prognosis
Unrelated	Conditions or diagnoses that are independent of the terminal condition

Physician's Clinical Judgement

- Mr. S is 96 years old had some sort of "event" 2 weeks ago, but did not go to doctor and poor historian on what happened. Possibly a TIA. Saw his physician who referred him to hospice, but no defining terminal illness. Mr. S wants no further diagnostic testing.

Now presents with the following

- Rapid functional decline in the past 2 weeks to the point that he is no longer ambulatory without assistance, unsteady gait, needs assistance with his bathing, some intermittent incontinence of bladder.
- Loss of appetite and eating very little. He says he has no appetite.
- Says he "is done", doesn't feel good, no longer wants to live. (Lost his wife of 70 years 3 months ago.)

HX of CHF, A-fib, HTN, COPD and mild chronic renal failure

What Palmetto says …

Medicare rules and regulations addressing hospice services require the documentation of sufficient "clinical information and other documentation" to support the certification of individuals as having a terminal illness with a life expectancy of 6 or fewer months, if the illness runs its normal course.

The identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care-planning.

Palmetto GBA

Effects on Prognosis

Terminal diagnosis

- Sometimes is automatically terminal; e.g. Stage IV lung cancer no longer seeking treatment

Secondary conditions

- Directly related to the terminal prognosis
- Examples
  - Dementia
    - aspiration pneumonia, pressure ulcers, delirium, sepsis
  - Neuromuscular diseases
    - contractures, pressure ulcers
- Co-morbid conditions

Effects on Prognosis

Function

- Seriousness of disease (primary, secondary and co-morbid) is reflected by the degree of lost function
- Decreased function is related to increased mortality

Nutrition

- Extremes of nutritional status are associated with increased mortality

Effects on Prognosis

Cognition
- Delirium
  - Highest risk of mortality
- Dementia
  - Alzheimer's and others
  - At end-stage is terminal in its own right
  - Moderate-Severe: increased mortality as a co-morbid

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Effects on Prognosis

Younger
- Need more things "wrong" (i.e. co-morbid diagnoses)

Older
- Usually already have more things "wrong"

Centenarians
- *Almost* automatically eligible, based on statistics
- However they still need to have a terminal illness & prognosis of 6 months or less

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Rapid Clinical Decline

Progressive deterioration while receiving appropriate care
- Home health care or SNF rehab services

Hospital Utilization
- Multiple recent hospitalizations, emergency room visits or utilization of other health care services which may have prevented a hospitalization

Serial Lab Assessments
- Labs, x-rays, echo, etc. showing progressive illness

Nutritional Decline

Functional Decline
- ADLs
- PPS decline by 20 points in past 2 - 3 months

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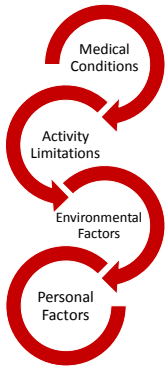
Eligibility

The Interaction between all factors plays an important role in supporting eligibility

Requires knowledge of



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Tools provide a data point or points that, used in context with the whole person, help to make a determination of eligibility.

It is important to assess the data points over time.

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Assessment Tools

LCDs

Functional Performance
- PPS
- FAST
- NYHA

Nutritional Status
- Weights
- BMI
- MAC

Cognitive measurement
- Mini-Mental Exam
- FAST

Pain Measurement
- Numeric
- Faces
- Non-verbal (PainAd)

Rapid Decline

Diagnostic Studies

Crystal Ball

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Common Problems

Using wrong tool(s) for patient or diagnosis or not using it at all

Inconsistencies among clinicians
- Scoring
- Usage – some do, some don't
- Documentation placement (especially with EMRs)

Not identifying scores that don't make sense or are in conflict with others

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LCDs

Developed by the MACs

Provide medical criteria for determining prognosis
- But not consistent predictors of prognosis

Use as guidelines for documenting terminal illness

If a patient meets certain criteria, they are deemed eligible

If a patient doesn't meet the LCD,
- May still be eligible for the MHB,
- But must document why (best done by a physician)

Not the legal standard for hospice eligibility
- However, are followed by government contractors when reviewing medical records

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Palliative Performance Scale (PPS)

Designed to measure functional performance and progressive decline in palliative care patients

- Ambulation
- Activity
- Evidence of disease
- Self care
- Intake
- Level of consciousness

Designed to measure what a person is capable of doing, not what they choose to do

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Probability of Death within Six Months

PPS	30	40	50	>60
Cancer	98.3%	95.5%	92.8%	89.1%
Cardiovascular disease	89.8%	74.2%	65.3%	51.8%
Dementia	73.6%	54.9%	51.4%	36.6%
Pulmonary disease	92.4%	79.9%	71.6%	63.8%
Stroke	67.4%	48.4%	39.4%	32.6%

Harris, et al
Can Hospices Predict which Patients Will Die within Six Months?
Journal of Palliative Medicine; Vol 17, Number8,2014

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Using the PPS

Scores are determined by reading horizontally at each level to find a best fit

Begin at the left hand column and read downward until the patient's appropriate ambulation level is reached

Move to the self care column and determine that score

- Ambulation and self care are more easily discernable so begin with those two

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Using the PPS

Only score in 10% increments

Repeat the steps until all five columns have been evaluated

Columns on the left hand side are stronger determinants and generally take precedence over others

Exception is that to reach 30% PPS a patient MUST require total care

- A patient who is "totally bed bound" but who can assist in their own self care would be 40%

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PPS Example

84 year old male with CHF and Alzheimer's. His wife transfers out of bed into a reclining chair occasionally. He requires total assistance with ADLS and self care due to his dyspnea. He feeds himself and eats about 50% due to his shortness of breath. He is confused which gets worse when he doesn't wear his oxygen.

%	Ability to Ambulate	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious.
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or housework, Evidence of significant disease	Occasional assist 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 any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Normal or reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	-	-	-	-

FAST

The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's Disease

A 7-step staging system, to determine hospice eligibility which identifies progressive steps and sub-steps of functional decline

Designed for Alzheimer's Disease
- Little information on other dementias
- Problems of "non-ordinate" patients

Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis
- To qualify under Alzheimer's Disease the patient should have a FAST of 7 along with secondary conditions

Keys to Scoring

The scoring must be done sequentially
- Its not the lowest score for which the patient qualifies, it's the lowest ***uninterrupted*** score

Unable to ambulate without assistance
- This means personal assistance, someone holding them up so they can walk
  - It is not: walker, cane, standby assist

Verbal communication
- Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview

Deficits are a result of the dementing process
- Walking limitation can not be from osteoarthritis or other non related disease processes

Case Study

Patient with Alzheimer's living in a SNF
- Unable to ambulate safely without assistance, but tries and falls frequently
- Cannot hold his balance on the edge of the bed
- No longer smiles.
- Frequently tells staff things like "don't touch that", "leave me alone", "this isn't my house", "I want ice cream"
- Is incontinent of bowel and bladder
- Needs assistance to dress, bathe and toilet
- What's the FAST?

Score

6a	Needs assistance putting on clothes
6b	Unable to bathe properly
6c	Inability to handle the mechanics of toileting occasionally or more frequently recently
6d	Occasional or more frequent urinary incontinence
6e	Occasional or more frequent fecal incontinence
7a	Speech limited to approximately 6 intelligible words in a day or interview
7b	Speech limited to approximately 1 intelligible word in a day or interview
7c	Ambulatory ability is lost (without personal assistance)
7d	Cannot sit up without assistance
7e	Loss of ability to smile

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Activities of Daily Living

- ADL deficits are the most important predictor of 6-month mortality
- Ambulation, Continence, Transfers, Feeding, Bathing, Dressing
- Stronger than diagnosis, mental status, or ICU admission



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Activities of Daily Living Measurement

ADLS
- Ambulation
- Continence
- Transfers
- Feeding
- Bathing
- Dressing

Amount of assistance required-describe
- Independent
- Uses device
- Personal assistance- how much
- Completely dependent

- Determine the level of assistance needed for each ADL and any increase in need over the past 3 – 6 months
- Be descriptive

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Which Is More Descriptive?

Assist in 5 of 6 ADLs at admission and at recert

Or

Admission: Standby assistance with ambulation with walker; occasional incontinence; minimal assistance with transfers; independent in feeding, moderate assistance with bathing and dressing

Recertification: Personal assistance with ambulation with walker; incontinent bowel and bladder; maximum assistance with transfers; independent in feeding, moderate assistance with bathing and dressing

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Nutritional Measurement

Extremes of nutritional status are associated with increased mortality

>10% weight loss in elderly, over 6 months associated with high mortality

BMI < 22 kg/m^2 in the elderly associated with increased mortality

Decline in ability to take nourishment
- Decline in # or % of meals consumed
- Loss of ability to take solid food precedes loss of ability to take fluids

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Weights

Admission
- Accurate actual weight (not reported)
- For NF patients, if weights fluctuate find out why and then get an accurate admission weight
- Obtain weight from 6 months ago (if available)
- Obtain MAC for baseline future need

Ongoing
- Accurate actual weight (not reported)
- For NF patients, don't accept wide discrepancies

Take into account impact of fluid retention

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BMI

Accurate actual weight (not what is reported)

Maximum adult height (reported)

Half arm-span
- Multiply the half arm span measurement by 2

BMI App
- IPhone: http://apps.usa.gov/bmi-app.shtml
- Droid: http://www.freewarelovers.com/android/app/bmi-calculator

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Nutritional Assessment-MAC

Provides an indication of skeletal muscle mass, bone and subcutaneous fat

Used for patients who cannot be weighed

Key point is consistency in measurement
- Standard method
- Centimeters

Obtain a MAC on every patient at admission

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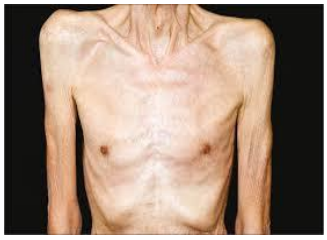
How would you Describe Him?



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What Palmetto Says…

If documenting weight loss to demonstrate a decline in condition, include how much weight was lost over what period of time, past and current nutritional status, current weight and any interventions

Document use of supplements & stimulants and patient continues to lose weight or are providing a short term stabilization of weight

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NYHA Functional Classification

Provides a simple way of classifying the extent of heart failure

Places patients in 1 of 4 categories based on

- How much they are limited during physical activity
- Limitations / symptoms are in regards to normal breathing
- Varying degrees in shortness of breath and / or angina pain

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End Stage Heart Disease- Prognostication

NYHA Class	1 Year Mortality
I	5-10%
II-III	10-15%
IV	30-40%

Fast Facts and Concepts #143
Gary M Reisfield, MD & George R Wilson, MD

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New York Heart Association Functional Classification

Class I	Mild No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath) or angina
Class II	Mild Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea or angina
Class III	Moderate Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea, or angina
Class IV	Severe Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency or the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased

The Criteria Committee of the New York Heart Association. *Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels*. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.

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Documentation-Admission

Why hospice?

Why now? What is the trigger for referral?
- Acuity or trajectory supports 6 month prognosis
- Hospitalization
- Change in condition
- Decline
- Symptom exacerbation
- Additional care needs

Compare to Local Coverage Determinations (LCDs)

Documentation should support the physicians' certification of terminal illness

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Documentation-Recertification

Have benefit of 60-90 days of documentation

Still compare to LCDs

Decline

Disease progression

Comparison

Hospice care is managing what symptoms

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Remember, When a Patient Appears to Have "Stabilized"

Get back to the diagnosis—why was this person admitted to hospice?

Have you been managing the symptoms or the disease?

What do you expect the disease process to look like?

What are you monitoring for?
- What secondary conditions are present?

What co-morbidities are present?

How does this person look compared to a well person of the same age?

What interventions are in place that is contributing to this plateau?

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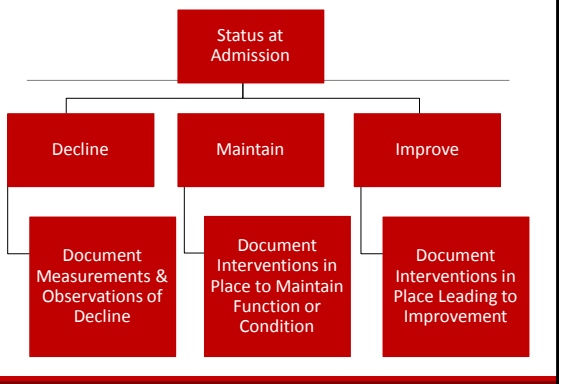

Painting the Picture

- Use LCD (or LCDs) that best fits the patient
- Clarify all secondary and co-morbid conditions for consistent documentation and their impact on prognosis
- Use standard assessment tools and measurements for the right diagnosis
  - PPS, FAST, BMI, NYHA, MAC
- Care Planning
  - Should change with decline
  - Support eligibility

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The Documentation Should

Be specific to that individual patient

Document what distinguishes the patient as terminal and not chronic

Have narrative notes to explain information noted on a checklist - use comment sections

Distinguish between exacerbation with stabilization and exacerbation with deterioration

Compare current to previous

Exacerbation and resulting decline/deterioration

Purpose and need for aggressive palliative treatments

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"As Evidenced By…"

When you use descriptors like: cachectic, anorexic, non-ambulatory, 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

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Common Documentation Problems

Admission documentation does not contain description of why hospice/why now and what patient "looked" like 3 to 6 months ago

Inconsistent
- FAST 7C but chaplain states patient told him about his Navy days
- PPS 30% but documentation describes patient ambulating with a walker
- Weights 121 pounds one month and 142 pounds the next

Imprecise
- "Assist with all ADLs"
- "Weight loss" or "estimated weight"

Common Documentation Challenges

Using words like … stable, unchanged, deteriorating
- Document abnormal findings consistently
- Need to have the associated contextual description

Failure to regularly weigh or measure
- Obtain baseline measurements

No consideration of intensity of care
- Plan of care
- Patient has had no skin breakdown due to the 24 hour RTC attention provided by daughters turning ever 2 hours

Failure to report injuries or falls, episodes of confusion or abnormal behaviors
- Document them all in the record

Summary

Consider and document
- Patient's end stage disease trajectory
- All important comorbid & related secondary conditions & impact on the terminal prognosis
- Any relevant laboratory and other test values
- Decline in performance status, amount of assistance required for ADLs
- Decline in nutritional status
- Any changes in status / condition over time

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