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

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

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)
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

<table>
<thead>
<tr>
<th>Dx. 6 mos.</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly CA</td>
<td>Mostly heart &amp; lung</td>
</tr>
<tr>
<td>Mostly dementia and fraility</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

Eligibility

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

Requires knowledge of

Medical Conditions
Activity Limitations
Environmental Factors
Personal Factors

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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.

**Assessment Tools**

**LCDs**
- Functional Performance
  - PPS
  - FAST
  - NYHA
- Nutritional Status
  - Weights
  - BMI
  - MAC
- Cognitive measurement
  - Mini-Mental Exam

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

**Rapid Decline**

**Diagnostic Studies**
- Crystal Ball

**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

**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
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

Probability of Death within Six Months

<table>
<thead>
<tr>
<th>Condition</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>&gt;60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>98.3%</td>
<td>95.5%</td>
<td>92.8%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>89.8%</td>
<td>74.2%</td>
<td>65.3%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Dementia</td>
<td>73.6%</td>
<td>54.9%</td>
<td>51.4%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Pulmonary disease</td>
<td>92.4%</td>
<td>79.9%</td>
<td>71.6%</td>
<td>63.8%</td>
</tr>
<tr>
<td>Stroke</td>
<td>67.4%</td>
<td>48.4%</td>
<td>39.4%</td>
<td>32.6%</td>
</tr>
</tbody>
</table>

Harris, et al
Can Hospices Predict which Patients Will Die within Six Months?
Journal of Palliative Medicine; Vol 17, Number 8, 2014

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

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%
PPS Example

84 year old male with CHF and Alzheimer’s. His wife transfers out of bed into a recieving 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.

<table>
<thead>
<tr>
<th>% Ability to Ambulate</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>Normal activity, no evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>95%</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80%</td>
<td>Reduced</td>
<td>Unable to do normal work, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>70%</td>
<td>Reduced</td>
<td>Unable to do normal work, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>60%</td>
<td>Reduced</td>
<td>Unable to do normal work, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly sit/lie</td>
<td>Unable to do any work, extensive disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>40%</td>
<td>Mainly sit/lie</td>
<td>Unable to do any work, extensive disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>30%</td>
<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
<td>20%</td>
<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
<tr>
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<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Full</td>
<td>Normal or reduced</td>
</tr>
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Keys to Scoring

The scoring must be done sequentially
- It is 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, standing 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, bath and toilet
- What’s the FAST?

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
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

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

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

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
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/m² 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

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

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](http://apps.usa.gov/bmi-app.shtml)

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
How would you Describe Him?

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.

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

End Stage Heart Disease-Prognostication

<table>
<thead>
<tr>
<th>NYHA Class</th>
<th>1 Year Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>5-10%</td>
</tr>
<tr>
<td>II-III</td>
<td>10-15%</td>
</tr>
<tr>
<td>IV</td>
<td>30-40%</td>
</tr>
</tbody>
</table>

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


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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 comorbidities 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?
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

“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
### 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 was hospitalized due to skin breakdown provided by daughters turning every 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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