HOSPICE MEDICAL NECESSITY

SUPPORTING THE NECESSITY OF CARE PROVIDED BY THE HOSPICE IDT APPROACH.
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Director of Program Integrity for Iowa Hospice

HOW DO YOU PROVE CARE IS MEDICALLY NECESSARY WHEN THE GOAL IS NOT MEDICAL?

• Hospice care is intended for people who are nearing the end of life. Unlike other medical care, however, the focus of hospice care isn't to cure or treat the underlying disease. The goal of hospice care is to provide the highest quality of life possible for whatever time remains.
http://www.mayoclinic.com/health/hospice-care
TITLE 42 – 418.3

Hospice care means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Authority: Sections 1861 (dd) (1) of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C - Conditions of Participation – Patient Care

418.56 (a) The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- i. A doctor of medicine or osteopathy (who is an employee or under contract with the hospice
- ii. A registered nurse
- iii. A social worker - Definition changed in 2008
- iv. A pastoral or other counselor
Subpart C - Conditions of Participation – Patient Care

418.56 (c) The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

- (1) Interventions to manage pain and symptoms.

- (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

Plan of Care Requirements Cont.

- (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

- (4) Drugs and treatment necessary to meet the needs of the patient.

- (5) Medical supplies and appliances necessary to meet the needs of the patient.

- (6) The interdisciplinary group’s documentation of the patient’s or representative’s level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice’s own policies, in the clinical record.
Subpart C - Conditions of Participation  
– Patient Care

§418.64 Condition of participation: Core services. A hospice must routinely provide substantially all core services directly by hospice employees.

These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services.

(b) Standard: Nursing Services

- Nursing services must ensure that the nursing needs of the patient are met as identified in the patient’s initial assessment, comprehensive assessment, and updated assessments.

Note: Hospice Aide Services are non-core services and are assigned and managed by the designated RN Case Manager.
(c) Standard: Medical social services.

- Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient’s psychosocial assessment and the patient’s and family’s needs and acceptance of these services.

(d) Standard: Counseling services.

Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services must include, but are not limited to, the following:

1. Bereavement counseling
2. Dietary counseling.
3. Spiritual counseling.
Subpart F—Covered Services

• To be covered, hospice services must be **reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.** The individual must elect hospice care in accordance with Sec. 418.24 and a plan of care must be established as set forth in Sec. 418.58 before services are provided. **The services must be consistent with the plan of care.**

Sec. 418.202 Covered services.

• All services must be performed by appropriately qualified personnel, but **it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service.** The following services are covered hospice services.

  (a) Nursing Services
  (b) Social Services
  (c) Physician Services
Sec. 418.202 Covered services.

• (d) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Lessons From Other Health Agencies

• **Hospital** DRGs are based upon detailed coding and recent regulations related to re-hospitalization along with quality measures.

• **SNF** has pages of listed services that meet or do not meet medically necessary services, such as maintenance care of a G-Tube.

• **Home Health** has required submission of Oasis form to support level of medical necessity, number of reasonable visits and services. Minimal use of any services other than nurse/aide.
Challenges to Hospice Reimbursement Related to Necessity of Services

• MEDPAC recommendations in 2010 was to alter reimbursement methodology and create "U-shaped curve" with higher payment at beginning and end/death where greater service needs are identified; Congress included directive in Healthcare reform bill

• MEDPAC referred to ‘dark’ side of hospice industry in relationship to rapid increase in number of hospice agencies and patient load and potential change in motive for provision of services.

Hospice Quality Concern

Quality of care—

“We do not have sufficient evidence to assess quality, as information on quality of care is very limited. Efforts completed or under way might provide a pathway for further development of quality measures”.

*MedPac 2010 report
Health Reform Enacted

• HOSPICES MUST REPORT ON QUALITY
  1. To Medicare by 2012
     ...or take a 2% reduction.
  2. To the General Public by 2014

How will quality scores relate to the evaluation of the medical necessity of hospice services?

Health Reform Expansion

Value-based purchasing programs for long-term care providers, including hospice providers, by Jan. 2016.
The goal of VBP is to revamp how Medicare services are paid to better reward value, outcomes and innovations instead of basing payment merely on volume.
CGS “Cigna Government Services”
MAC for Iowa Since June 2011

• Upheld previous LCD requirements for medical necessity of admission to Medicare Hospice Services.
• CIGNA Definition: Except where state law or regulation requires a different definition, “Medically Necessary” or “Medical Necessity” shall mean health care services that are provided, exercising prudent clinical judgment, clinically appropriate and by general Standards of Practice.

CMS Initiated Visit Reporting - 2008

• CMS is utilizing a phased increase in data required of hospices, in order to improve hospice benefit payment accuracy and analyze the services provided in this evolving and growing benefit.
• CMS recognizes that the reported visits do not represent all care provided under the hospice benefit.
• Reporting has expanded to include SW calls.
When Reporting Visits: **What is “medically reasonable and necessary”?** Per CMS

- Services (visits) reported must be reasonable and necessary for the palliation and management of the terminal illness and related conditions, as described in the patient’s plan of care.
- Tasks should not be distributed across multiple visits for the purpose of inflating the patient’s visit count.
- CMS has clarified that, for social workers, counseling or speaking with a patient’s family or arranging for placement would constitute a visit.

Examples of Reactions to Medical Necessity Language

1. Medicare/ Medicaid adds Face to Face visits in of 2011 by the hospice physician or ARNP.
2. Montana Medicaid Plan of Care to support billing adds section for acuity of need.
3. Magnolia Health Plan in Louisiana/Mississippi adds preauthorization based upon medical necessity of services.
4. CIGNA Private Insurance identifies non-Medically Necessary services.
2. Montana Medicaid Plan of Care Requires Severity Coding

<table>
<thead>
<tr>
<th>ASSESSMENT</th>
<th>PROBLEM SEVERITY CODE</th>
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<tbody>
<tr>
<td>Altered Urinary Elimination</td>
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<tr>
<td>Altered Bowel Elimination</td>
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<tr>
<td>Altered Sleep Pattern</td>
<td></td>
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<tr>
<td>Altered Grief/Spiritual (patient)</td>
<td></td>
</tr>
<tr>
<td>Altered Grief/Spiritual (family)</td>
<td></td>
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<tr>
<td>Altered Oral Mucosa</td>
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**PROBLEM SEVERITY CODES**

0 – No Problem Identified  
1 - Problem – Controlled at time of assessment  
2 - Mild – Function could be impaired  
3 – Moderate – Able to function with support  
4 – Marked – Able to function only with daily intervention  
5 – Severe – Incapacitated by the problem
### Medical Necessity Qualified to Determine Visit Frequency

<table>
<thead>
<tr>
<th>Services Required</th>
<th>Frequency</th>
<th>Expected Outlook</th>
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</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
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</table>

- **O. SERVICES:** Document the proposed services for this benefit period (include frequency and expected outcome).

3. **Magnolia Health Plan Change:**

- Effective August 15, 2011, the required documentation to support medical necessity for hospice admissions will change. Magnolia Health Plan will require in addition to the physician certification, a patient election form, **a history and physical by the attending physician with the terminal diagnosis listed. All hospice prior authorizations will be evaluated for medical necessity** using the medical necessity criteria developed by the Louisiana Mississippi Hospice and Palliative Care Organization.
4. CIGNA PRIVATE INSURANCE
CIGNA does not cover ANY of the following hospice care services because each is specifically excluded from coverage or is considered not medically necessary as hospice care (this list may not be all inclusive):
- services for individuals no longer considered terminally ill
- services, supplies or procedures that are directed towards curing the terminal condition

4. CIGNA PRIVATE INSURANCE, cont.
- services to primarily aid in the performance of activities of daily living
- nutritional supplements, vitamins, minerals and non-prescription drugs
- medical supplies unrelated to the palliative care to be provided
- services for which any other benefits apply
Supporting Medical Necessity of Nursing Services

- Areas to be addressed are identified thru the skills of nursing assessment.
- Need to include objective measurement scales and include patient/caregiver goals.
- Plan of Care addresses interventions needed to reach objective goal level.
- Must involve direct patient care and assessment at each visit.

Supporting Medical Necessity of Nursing Services, cont.

- Document at each visit what plan of care area of need or intervention is being provided or assessed for effectiveness.
- Intervention required for any issue assessed to be out of acceptable goal range.
- Family or caregiver contact required for any change in interventions or outcomes.
- Any change in intervention requires reasonable follow up for effectiveness.
Supporting Medical Necessity of Nursing Services, cont.

- Patient/PCG goals need continual assessment for ongoing changes throughout the hospice care.
- For Medical Review purposes:
  - each claim billed stands alone and requires sufficient support of the ongoing medical necessity of the hospice services being provided.
  - all interventions must be in direct response to the established plan of care.

Supporting Medical Necessity of Social Worker Services

- Areas to be addressed are identified thru the skills of social worker assessment.
- Equal assessment of the patient and the family/patient caregivers is required.
- Plan of care interventions must be acceptable to the family/PCG and this acceptance needs to be documented.
Objective Measurement to Support Social Worker Services

- SWAT “Social Worker Assessment Tool”
  Qualitative interviewing of the social workers in pilot use test indicated some lack of readiness in the field to conduct quantitative outcomes measurement. Additional measures are needed in addition to the SWAT, including qualitative measures, and measures of mezzo and macro practice.


Objective Measurement to Support Social Worker Services

- Bereavement Risk Assessments
- General Safety Risk Assessments
- Fall Risk Assessments
- Suicidal Risk Assessments
- Mini Mental Exams with time frame comparisons.
- Family Satisfaction Outcomes related to identified preferences
New Initiatives in Determining Preferences

- The Wall Street Journal: **The Informed Patient: New Efforts To Simplify End-Of-Life Care Wishes** The programs are known as Physician Orders for Life-Sustaining Treatment, or Polst.
- A Polst, which is signed by both the patient and the doctor, spells out such choices as whether a patient wants to be on a mechanical breathing machine or feeding tube and receive antibiotics

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New Initiatives in Determining Preferences

- WBUR's CommonHealth Blog: Massachusetts Unveils Plan For Better Dying [The] "Massachusetts Expert Panel On End-Of-Life Care"... laid out its plan today for how the state can begin to improve the end.
- **every patient with a serious illness that may be fatal should be fully informed of the range of ways they might be taken care of... patient preferences should be known, documented, and always available when decisions are going to be made...** 3-14-2011
Iowa Hospice PIP “PCAT”

- The PCAT scorecard was developed to identify psychosocial needs as part of the Hospice Plan of Care and to evaluate the IDT response in addressing these needs for improved overall patient care outcomes.
- Response to identified needs should be timely and reassessed by the 30th day of care, and again at the first recertification date if patient remains on service.
- 16 areas assessed with total score of 16-48 possible. Urgency and frequency of response is driven by score.

<table>
<thead>
<tr>
<th>Areas Assessed</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Admission</th>
<th>30 Days Score Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of Prognosis</td>
<td>Stable</td>
<td>In Process</td>
<td>Unwilling to discuss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funeral Plans</td>
<td>Complete</td>
<td>In Process</td>
<td>Unwilling to discuss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Decision Maker</td>
<td>Complete</td>
<td>In Process</td>
<td>Unwilling to discuss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Caregiver Established</td>
<td>Stable</td>
<td>Need Identified</td>
<td>Immediate Need</td>
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Iowa Hospice PIP “PCAT”

- By selecting 16 primary areas to assess for immediate intervention, focus within the first 30 days is more likely to capture patient/PCG needs in a timely fashion in relationship to the decreased median length of stay in hospice.
- The patient/family/PCG attention is focused on preferences in away to enhance outcomes being met.
- Solidifies the necessity of social worker services.

Supporting Medical Necessity of Counseling Services

- Unexplored service area - Visits are not presently measured by Medicare.

- Competency and Preparation varies greatly as no consistent requirements for serving in “Chaplain” role due to limited availability across the country.

- Wide-range of response to concept of providing “spiritual care” with government funding.
Supporting Medical Necessity of Chaplain Counseling Services

- Look at patient/family/PCG as a group client and as separate clients.
- Use a formal Assessment Tool to improve consistency in care: EXAMPLE:
  - **H**: Sources of hope, meaning, comfort, strength, peace, love and connection
  - **O**: Organized religion
  - **P**: Personal spirituality and practices
  - **E**: Effects on medical care and end-of-life issues

Barriers to Supporting Medical Necessity of Dietary Counseling Services

- Not viewed as a primary focus area at end of life and remains under assessed.
- Many cultural norms related to food continue to affect end of life decision making.
- Continuous stigma related to the concept of natural death vs. withholding nutrition.
- Major portion is still handled by nurses.
- Assisted Living barriers to specialized diets.
Supporting Medical Necessity of Bereavement Counseling Services

• Expanded definition in 2008 COPs updates enhanced the role of pre-death bereavement care. Not a reimbursed service so not as scrutinized for medical necessity.
• Services should be provided in relationship to Bereavement Risk Assessments and individualized plan of care.
• Increased number of geographically distant bereaved complicates provision of services.
• Need to identify complicated bereaved for external referrals

What about Non-Core Services

• Aide Services

• PT/OT/ST

• Alternative Therapies: Massage/Music/Pet

• What “Innovative Services” will we see in the future?
GROUP INPUT