Clinical Eligibility: Transitions to Hospice with Non-Cancer Diagnoses

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Objectives

• Increase awareness of disease trajectories common at end of life

• Review assessment tools to assist with determining clinical eligibility for hospice

• Discuss determination of clinical eligibility for patients entering hospice with non-cancer diagnoses including COPD and CHF with the use of Local Coverage Determination “LCD” guidelines
Admission to Hospice: Eligibility

1. Technical Eligibility: (not focus for today)
   Complete in format, & executed in timely manner:
   *NOE
   *Initial certification of Terminal Illness
   *Verbal Certification and CTI with Physician narrative by Medical Director
   *Recertification
   *Face-to-Face
   *Plan of Care

2. Clinical Eligibility

Hospice Eligibility

- CMS Manual: “Medicare pays for hospice care when qualifying criteria are met and documented. It is essential for hospice agencies to have a complete understanding of these criteria, as you have the right, and responsibility, in collaboration with the physician, to decide if the beneficiary qualifies for services. The agency then must understand what services are covered, and how to document these services."

- In order to be eligible to elect hospice care under Medicare, an individual must be:
  - Entitled to Medicare Part A and patient/family choosing palliative vs. curative end of life care as it relates to the individual's terminal illness
  - Certified as being terminally ill in accordance with 418.22
    - Definition of 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

Importance of Clinical Eligibility

- Admission to hospice = potential for fraud/abuse
  - California hospice story

- Increased scrutiny by CMS/MEDPAC: looking at whether hospices are admitting the right patients at the right time

Clinical Eligibility

- Based on **prognosis**, not diagnosis (prognosis not exact science)

- Medicare Hospice Benefit based on **proximity to end of life**
  - *Patient must be more than likely than not to die in less than 6 months; physician asked to make a decision about whether patients who present like the patient in question have a 6 month prognosis IF disease runs its normal course*

- **Ultimate eligibility lies with the Hospice Medical Director**
Effects on Prognosis

- **Primary diagnosis:**
  - May be very clear: most contributory to terminal prognosis
- **Secondary diagnosis:**
  - Directly r/t terminal diagnosis
- **Co-morbid conditions- from primary (identify all)**
  - Serious co-morbid conditions increase risk of morbidity
  - Combination of multiple conditions may contribute to prognosis
  - Some co-morbid conditions not terminal by themselves but lead to increased risk of death together
  - (CHF, CVA, CPD, PVD, CHD, Renal, Dementia)

Clinical Eligibility- considerations

- Patient’s story/journey
- Patient’s history and physical
- Burden of illness
- Establish baseline, ask key questions that prompted hospice call (precipitating event)
- Changes in last 1, 6, 12 months (physical: ADL’s, function, pain, PPS, etc., psychosocial)
- Patient’s prior health care utilization
  - (physician visits, ER visits, hospitalizations)
Disease Trajectories

Illness/Dying Trajectories Sudden Death, Unexpected Cause

< 10% (Mortality, accident, etc.)

Health Status

Time

Death

Field & Coen, 1997

Rapid Decline

Illness/Dying Trajectories
Steady Decline, Short Terminal Phase

Health Status

Time

Death
Rapid Decline

- Progressive deterioration while receiving optimum appropriate care
- Increased hospital, ER or other health care services utilization
- Nutritional decline, functional decline
- Example:
  - Cancer- usual progression that ends in steady decline until death
  - Model for original Medicare Benefit for hospice
  - But wait a minute...... always variables for individual patients unique journey

Saw tooth trajectory

Illness/Dying Trajectories
Slow Decline, Periodic Crises, Death

![Graph showing Illness/Dying Trajectories with periods of decline and crises leading to death.](Image)
Saw Tooth Decline

- Examples:
  - COPD, CHF
  - Other organ system failures (liver, renal, etc.)
  - Slow incremental decline with episodes of exacerbations
  - Never really gets back to previous baseline

Slow Decline

Illness/Dying Trajectories
Lingering, Expected Death

Frailty

Death

Time

Lunney et al. 2003
Slow Decline

- Examples of disease processes:
  - Dementia, stroke, Parkinson’s, other neurological
  - Steady, slow progression leading to death

Assessing clinical eligibility

- Assessment Tools
  - Focus on objective, measurable data
  - Use the correct assessment in the correct way for the correct diagnosis
  - Challenges: lack of knowledge re: use, clinician variability, older scores not re-assessed but re-copied, IDG narrative doesn’t reflect score

- LCD’s- Local Coverage Determinations provide guidance in determining medical necessity of services
  - Allow for the decline of a beneficiary to be a factor in determining prognosis
  - Consists of three parts, and disease specific appendices
  - Used by CGS Medical Review staff as a guideline to aide in consistency of reviews
  - Not definitive or exclusionary

- Painting the big picture of progressive decline that provides the 6 month or less prognosis (clinical descriptions, narratives)
  - Why do we believe this individual patient has a prognosis of 6 months or less?
  - Comprehensive H/P, labs, other diagnostic reports, consults, physician clinic notes, hospital dc summary, facility documentation
Case Study: Alzheimer's Disease

- 80 year old male resident of nursing facility presenting at time of hospice referral, family present:
  - Just returned to NF from hospital admission for pneumonia, family doesn’t want “to take him back to hospital anymore, too hard on him”
  - Assist with ADL’s of bathing, dressing
  - Ambulates with walker and standby assist, but frequent falls out of bed
  - Appears thin, emaciated
  - Incontinent bowel and bladder
  - Eats three meals every day with total assist but staff has to “coax him to take a bite”
  - Spends 50% of time in bed, but without staff prompting, would spend 100% of time in bed
  - No longer smiles, frequently tells staff to “leave me alone”

Assessment Tools for Alzheimer’s Disease

- Functional Decline
  - PPS- Palliative Performance Scale
    - Designed to measure functional performance and progressive decline in palliative care patients
      - Ambulation
      - Activity
      - Evidence of disease
      - Self care
      - Intake/ nutrition
      - Level of consciousness
    - < / > 40 reflects significant debility and decline = high probability of 6 month prognosis
    - Designed to measure what patient capable of doing, not what they choose to do
    - Only score in 10% increments (no 45%)
    - Columns on the left hand side stronger determinants of decline

(http://palliative.info/resource_material/PPSv2.pdf)
FAST Scale

- Reisberg’s Functional Assessment Staging:
  - 16 item scale designed to reflect the progressive activity limitations assoc. with Alzheimer’s Disease
  - 7 step staging system
    - To determine hospice eligibility which identifies progressive steps and sub-steps of functional decline
    - Designed for Alzheimer’s (little research on use with other dementias) (don’t use on heart failure, end stage pulmonary, unless a secondary dx to support prognosis)
    - Stage 7 identifies threshold of activity limitation that would support 6 month hospice prognosis (along with secondary conditions)

Activities of Daily Living

- ADL deficits most important predictor of the 6 month prognosis/ mortality
- Document the level of assistance needed for each ADL- be descriptive (independent, use of device, assist of (1,2,3), total dependence)
- ADL’s include: Ambulation, Transfers, Feeding, Bathing, Dressing, Continence
- Example:
  “On admission or recert assessment, assist with 5 of 6 ADL’s (standby assist with transfers and ambulation, incontinent of bowel and bladder, total assist with bathing and dressing, independent in feeding)”
Nutritional Metrics

- Extreme nutritional status changes associated with increased mortality in elderly
  - >10% weight loss
    - Accurate weight on admit to hospice
    - Obtain weight from 6 mo. prior
    - MAC for all home patients baseline
    - Ongoing- accurate weights and MAC measurements for recert
  - BMI<22 kg/m2
    - Indication of skeletal muscle mass, bone and subcutaneous fat
    - Obtain on every patient at admit
    - Be consistent- standard method
  - Decline in ability to take nourishment
    - Decline in amt / number of meals consumed
    - Loss of consuming solid foods- leading to loss of taking in fluids

LCD Guidelines for Dementia

- Alzheimer’s Disease accepted for coding primary hospice diagnosis- be very specific
- Fast 7 or beyond
  - Complete dependence in all ADL’s
  - Incontinent of bowel and bladder (intermittent or constant)
  - Unable to ambulate, dress, or bathe without assistance
  - feeding
  - No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to 6 or < intelligible words
- Supporting factors: aspiration pneumonia, pyelonephritis/ sepsis, pressure ulcers (stage 3 or 4), fever recurrent after antibiotics, >10% wt. loss in 6 months, albumin <2.5gm/dl
- Note about: vascular dementia (not good primary diagnosis) use primary cause of the vascular dementia :Atherosclerotic Vascular Disease, atrial fibrillation, hypertension, multiple lacunar strokes
Alert

• No longer using Debility or AFTT as primary hospice diagnosis
  • Notable increases between 2002 and 2007 with patients admitted to hospice with non-cancer diagnosis
  • Significant increases in use of non-specific symptom classified diagnoses, such as “debility” and “adult failure to thrive” (in 2012, both in the top 5 claims reported hospice diagnosis (1st and 3rd)
  • Instead, use Debility and AFTT as secondary and choose the primary disease process leading to these symptoms
  • Must determine the most definitive, contributory terminal illness as the primary hospice diagnosis

CMS: this does not change admission criteria, but coding must be different- need for more comprehensive and specific Dx- use best clinical judgment

Assessment Tools for Heart Failure

• NYHA IV
  • Specifically for heart failure
  • Patients must have had optimal treatment or explain why meds not used (ACE inhibitors, diuretics, vasodilators, beta blockers, aldosterone antagonists, device therapies)
  • There are challenges (floor effect, may not demonstrate disease progression)
  • Labs, Diagnostic tests: LVEF<+ 45%, elevated BUN >/= 43, creatinine >/= 2.75, anemia, SBP <100 and or pulse >100, hyponatremia,
  • Nutritional status
  • PPS, ADLs- reduced functional capacity
  • Seattle Heart Failure Model: [http://depts.washington.edu/shfm/app.php?accept=1&enter=Enter](http://depts.washington.edu/shfm/app.php?accept=1&enter=Enter)
LCD guidelines for Heart Failure

- Optimal Treatment (NYHA IV)
- Declines further intervention/surgery
- EF 20% or less **
- Cachexia, declining functional status
- Recent cardiac hospitalizations
- Supportive co-morbidities
  - Arrhythmias
  - Previous cardiac arrest
  - Syncope
  - Embolic stroke
  - Critical A.S.
  - HIV

Wait a minute......

Caveats about HF diagnosis/qualifications
- 50% of HF patients have preserved EF
- Diastolic dysfunction
- LVH
- Pulmonary HTN
- Systemic HTN
- Atrial fibrillation

- Echo very IMPORTANT

Heart failure follows unpredictable disease trajectory with application of always new evidence based therapies, yet still marked with high incidence of sudden death
Case Study: Pulmonary Disease

- Hospice referral on a palliative care patient: Mr. J discharged home from recent hospitalization with end-stage pulmonary fibrosis. Over the past three weeks he has experienced:
  - increasing dyspnea - prompting the hospital admit for a lung infection and now the hospice referral
  - On admit: respiratory rate 24-32, pulse 110, and pulse ox, 89% saturated on 2 liters oxygen by nasal prong
  - Reports he has an advance directive and has had an OOH DNR with Palliative Care.
  - Wife reports that “he has lost so much weight and can hardly get from his recliner to the bathroom without resting.”
  - Current treatments for the dyspnea include oxygen by np, and hand-held nebulizer.
  - He also takes MS Contin 60 mg every 12 hours for pain, with good relief of back pain from spinal compression fractures (secondary to long-term steroid use) and has an order for 15 mg of MSIR every 2 hours prn/ pain.

Assessment Tools for Pulmonary Disease

- FEV1
- BODE Index Score
- Functional status: PPS, ADL’s
- Labs, diagnostic tests
LCD guidelines for pulmonary disease

- Disabling dyspnea at rest, oxygen dependency, poor or unresponsive to bronchodilators, resulting in decreased functional capacity
- Increased ED and hospital admissions, clinic visits
- RA hypoxia with pO2<=55 mmHg
- O2 Saturation<= 88%
- Hypercapnia with pCO2>=55mmHg (within 3 months of hospice admit)
- Bed to chair limited activity
- RHF secondary to pulmonary disease
  - Weight loss unintentional progressive >10% of body weight
  - Resting tachycardia >100/min
  - Recurrent lung infection
  - FEV1 <30% predicted for COPD

Additionally .....

- Patients may have:
  - High PA pressure
  - Edema, decreased muscle mass
  - Need for morphine for dyspnea
  - Low DLCO- RLD
  - Increasing O2 requirements from baseline 2L to 5L/np
  - Co-morbid heart disease CAD- chest pain, arrhythmia
Importance of Documentation

- CGS
  - Generally, beneficiary will show decline from benefit period to period
    - Some may not and may be temporarily unchanged
    - Documentation needs to show that patient still has a prognosis of 6 months or less
    - Suggestions for Improved Documentation to support Medicare Hospice Services- (resource)
  - Avoid “slow decline” and “disease progressing” without some objective support
    - The more objective, the better
      - Mean arm circumstance
      - Weight loss
      - Nutrition
      - Functional status
      - Labs (gather what you can at admit, for recert consider as last resort)

IDT Documentation

- Physician narrative should explain the clinical findings that support the prognosis of 6 months or less... (and IDT documentation should reflect)....
  - Paint the picture
  - Bring in evidence of decline
    - Declining PPS score
    - Decreased socialization
    - Withdrawal from enjoyable activity
    - Worsening pain/symptom management
      - Increased O2, increased opioids, anxiolytics, diuretics, changes in meds for symptom management
    - New complications
      - Falls, complicated fractures, pressure ulcers
    - Refractoriness to treatment efforts
      - Still hypoxic despite increase O2 and nebs
      - Edema won’ resolve
Other Resources

E-prognosis.com website [www.eprognosis.org]
- Estimates prognosis for older adults
- Algorithms to entry clinical data
- Not designed specifically for hospice - may not predict life expectancy within 6 month time frame

End Stage Renal Disease
- Simple screening tool hemodialysis mortality predictor
  - online: http://touchcalc.com/calculator
  - Needs serum albumin assessment

End Stage Liver Disease
- MELD Score- [www.mayoclinic.org/meld]
- INR, bilirubin and creat. needed for calculation

Advanced Dementia
- ADEPT for Nursing Facility Residents
  - 12 Risk factors derived from MDS
  - Mortality Risk Index (Score)
    - Estimate of 6 mo. prognosis in NH residents

In Summary

- The Medicare benefit created for individuals with 6 month or less prognosis (still have very short LOS across the country)
  
- Prognostication is challenging, even for the most experienced

- Assessment must be comprehensive and objective with use of assessment tools and the LCD’s that are helpful in assessing and documenting the patient’s clinical eligibility (and are expected to be present for those reviewing and approving payment)

- IDT documentation that is clear, accurate, objective, and detailed is critically important
Compassion and Determination

“Love and steel, how kind. Anyone doing hospice work will need plenty of both.”

— Dame Cicely Saunders, nurse, physician and writer, and founder of hospice movement (1918 - 2005)

References

• CGS website: https://www.cgsmedicare.com/hhh/coverage/Coverage_Guidelines/SNF.html
• CMS.gov: Local Coverage Determinations: Hospice Determining Terminal Diagnosis (L32015)
• EPERC Fast Facts and Concepts: #030, #150, #141, #143
• Medicare Benefit Policy Manual (CMS Pub 100-02) Ch. 9
• Palliative Performance Scale: https://palliative.info/resource_material/PPSv2.pdf