The Clinicians Connection To Eligibility: Assessing and Documenting for Decline

Today’s Questions

• Why is assessing for and documenting decline so important?
• What are effective strategies to support appropriate assessments, measurements and documentation of decline?
• What are the Actions of the Prudent Hospice™?

A Medicare Condition of Payment

• To access the Medicare hospice benefit the benefit must be terminally ill with prognosis of 6 months or less should the illness run its normal course
• The clinical record must support the prognosis
Top Denial Reasons

<table>
<thead>
<tr>
<th>Palmetto GBA</th>
<th>Not Hospice Appropriate-Palmetto</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGS</td>
<td>Six-month terminal prognosis not supported-CGS</td>
</tr>
<tr>
<td>NGS</td>
<td>According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less-NGS</td>
</tr>
</tbody>
</table>

It all means the same thing: the documentation does not tell the reviewer the story of why the patient has a prognosis of 6 months or less.

Decline According to Merriam Webster

1. The process of declining; especially: a gradual physical or mental sinking and wasting away
2. The period during which the end of life is approaching

Therefore decline connotes a change for the worse unless there is no worse a way to be

Palmetto GBA and Decline

Medicare coverage of hospice depends on a physician’s certification that an individual’s prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. It is important that the medical records support the physician’s six month prognosis. Often, during a review of the medical records by the Medicare Administrative Contractor (MAC), the documentation is found to be insufficient to support the terminal prognosis. In some cases, the medical record lacks documentation to show further decline, for example, decreased oral intake, weight loss or increasing signs and symptoms.
Palmetto GBA and Decline

Since determination of decline presumes assessment of the patient’s status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Since weight loss due to decreasing oral intake is often a good predictor of decline, it is essential that hospice staff document this information in the hospice medical record. Obtaining and recording objective data is instrumental in showing the continual decline of a patient when the weight loss and decreased appetite is not caused by other factors such as medication. Patients that have ceased to show ongoing decline or who have plateaued from a trajectory of decline may no longer meet hospice eligibility guidelines despite a significant need for custodial care.

NGS and CGS and Decline

Part I. Decline in clinical status guidelines

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient’s status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

Variation in Disease Trajectories

Graph showing the percentage of patients with various disease trajectories over time.

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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

Research

• The current model does not yet allow for prognostic determination at hospice of what is likely to happen to any particular patient.
• Patients with diagnoses of dementia or debility require a more extensive description of their functional deficits to more fully patient a picture of a patient’s decline.

Harris, et al
Journal of Palliative Medicine
Volume 17, 2014

Challenges
### Common Problems

- Using wrong tool(s) for patient and diagnosis or not using it at all
- Inconsistent scoring by clinicians
- Inconsistent usage – some do, some don’t
- No one picking up if there are scores that don’t make sense

### Documentation Challenges - EMR

**Conflicts and/or variations**

- No explanations
- Multiple places to document
  - Initial nursing assessment
  - Admission summary
  - LCDs/Clinical Indicators/Worksheets for Eligibility

**LCDs/Clinical Indicators/Worksheets for Eligibility**

- Dependent on EMR

**Data clicking without thought**

- Does this really fit this person?
- All look the same (same patient over time and all patients with same diagnoses)

**Cloning and/or pulling forward**

- Not reflective of current condition
- Accuracy and integrity of the documentation becomes questionable

**Data documented consistently in same place**

- retrievable
- trending
Strategies

Admission Assessment: Documentation Reference Point

Status at Admission

Decline
- Document Measurements & Observations of Decline

Maintain
- Document Interventions in Place to Maintain Function or Condition

Improve
- Document Interventions in Place Leading to Improvement

The Key Eligibility Documentation Principle
Painting the Picture

- Must be for all patients but with particular emphasis on those with long length of stays
- Important to pay particular attention also to those with chronic illnesses with more general decline (non-cancers)
- Ensure a monthly period (30 days) supports eligibility on its own

CGS

Documentation to support terminal prognosis should be objective and include quantifiable values/Measures

Examples:
- Pounds: 4 on a 1-5 scale
- Inches

Documentation must "paint a picture" of the patient, their conditions and symptoms which support a life expectancy of 6 months or less.

Avoid the use of vague statements such as: "disease progressing" or "slow decline"

Processes and Competencies

- Staff must understand local coverage determinations (LCDs)
  - Data points
  - Limitations
  - Prognosis versus diagnosis
- Staff must understand the purpose of their assessments
- How to discern changes (subtle and not so subtle)
- How to quantify
Heart Disease LCD (excerpt)

...The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of ≤20%, but is not required if not already available...

Dementia LCD (excerpt)

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia;
2. Pyelonephritis or other upper urinary tract infection;
3. Septicemia;
4. Decubitus ulcers, multiple, stage 3-4;
5. Fever, recurrent after antibiotics;
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl.

Alzheimer’s Disease LCD (excerpt)

Alzheimer’s Disease may be complicated by secondary conditions. The occurrence of secondary conditions in beneficiaries with Alzheimer’s Disease is facilitated by the presence of impairments in such body functions as mental functioning and movement functions. Such functional impairments contribute to the increased incidence of secondary conditions such as delirium and pressure ulcers observed in Medicare beneficiaries with Alzheimer’s Disease.
Processes and Competencies

1. What do the findings mean?
2. What are the impacts to plan of care?
3. Where are findings documented?

It Must Be Quantifiable

...If hospice organizations record “percent weight loss” as an indicator of nutritional status, Palmetto GBA expects to see supporting documentation of the absolute weights used to calculate the percent decrease. The reporting of absolute weights strengthens documentation of percent change in weight over time (e.g., >10% weight loss over the last six months with weight decreasing from 110 pounds to 95 pounds). Palmetto GBA encourages hospice providers to include absolute weights in their responses to Additional Documentation Requests (ADRs)...

Quantifiable Values

- Size (inches or cm - be consistent)
- Timeframe (hours, days, weeks, months)
- Frequency (hourly, daily, weekly)
- Oxygen saturation %
- When did it happen
  - Before admission
  - During benefit periods
  - From one benefit period to the next
Indicators of Decline

What has changed?

- Visits to ED or hospitalizations (before admission) or GIP or CC during admission
- FAST
- NYHA class
- PPS
- Medication
- Weight or anthropometric measurements
- Intake and output
- Lab results
- ADLs

By how much?

- Vital signs
- Dyspnea
- Oxygen usage
- Edema
- Strength
- Sleeping: time & quality
- Speech pattern
- Pain
- Responsiveness
- Skin integrity
- Incontinence

Watch Out for Vagueness

- Stable
- Slow decline
- Disease progressing
- Sleeping more
- Eating less

Make it objective and quantifiable

“As evidenced by....”

Quantifying Trends: Objective Data

<table>
<thead>
<tr>
<th></th>
<th>September 2015</th>
<th>January 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>145</td>
<td>125</td>
</tr>
<tr>
<td>BMI</td>
<td>20.8</td>
<td>17.9</td>
</tr>
<tr>
<td>Oxygen</td>
<td>2L prn uses at bedtime</td>
<td>3L continuous</td>
</tr>
<tr>
<td>Ambulation</td>
<td>50 ft cane</td>
<td>50 ft front wheel walker</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>1-2 times per week with activity</td>
<td>4-5 times per week with or without activity</td>
</tr>
<tr>
<td>Sleep: Hours</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Sleep: Position</td>
<td>2 pillows</td>
<td>recliner</td>
</tr>
</tbody>
</table>
Map It Out

- Where will these be documented?
- If your EMR has LCDs/Clinical Indicators/Worksheets for Eligibility
  - How will you use them?
  - How or do they tie to the nursing assessments?
  - Is it already captured in the nursing assessments?
  - Does it tie you to 1 LCD only?
- How does your EMR or documentation system “handle” the decline indicators?

Map It Out

- What does minimal intake mean?
- What does moderate assistance with ADLs mean?
- Where will the nurses clinical summaries be written?
Focus on the Fundamentals

Opportunities for Improvement

• Weights
  • Prior to admission (outside clinical records if at all possible)
  • Admission
  • Actual
  • MACs too!
• PPS 40 or higher percent or explain why not
• At least monthly

Opportunities for Improvement

PPS
  • Accurate understanding and scoring
  • Assessment of current condition not just that very minute
  • Documentation supports the score
Opportunities for Improvement

Incontinent
• Bladder
• Bowel
• Sometimes
• Daily
• Always

Nutritional intake
• Actual consumption
• Meals per day
• What meal consists of

A Word about FAST
• Specific for Alzheimer’s Disease and related disorders
• It is not intended to measure function or decline (mental or physical) in other disorders or diseases
• Remember its sequential (no skipping around)
• Declining
  • 7a to 7b to 7c …..

Opportunities for Improvement

ADLs
• Consistent definitions in your EMR
• Documentation supports the data
• Tie to care planning
## ADL Assistance Guidelines

<table>
<thead>
<tr>
<th>ADL</th>
<th>Independent</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulation</strong></td>
<td>Ambulates without assistance.</td>
<td>Uses walker or cane for ambulation and/or needs standby assistance.</td>
<td>Physical assistance of another person required. Can propel self in wheelchair.</td>
<td>Non-ambulatory. Cannot propel own wheelchair.</td>
</tr>
<tr>
<td><strong>Continence/Toileting</strong></td>
<td>Goes to bathroom or uses bedside commode or urinal, cleans self and arranges clothes without assistance. Empties urinal or bedside commode. May use walker or wheelchair.</td>
<td>Receives assistance sometimes in going to bathroom or using bedside commode or urinal or in cleaning self and arranging clothes after elimination.</td>
<td>Receives assistance at all times in going to bathroom or using bedside commode or urinal or in cleaning self and arranging clothes after elimination. Incontinent of bowel and bladder occasionally.</td>
<td>Incontinent of bowel and bladder most or all of the time. Cannot go to bathroom or use urinal or bedside commode at all.</td>
</tr>
<tr>
<td><strong>Transfer</strong></td>
<td>Moves in and out of bed and chair without assistance.</td>
<td>Needs assistance of device or some assistance such as helping scoot to edge of chair/bed, or steadying chair or walker.</td>
<td>Requires physical assistance of one person who does some of the lifting and balancing.</td>
<td>Doesn't get out of bed unless lifted by person or device.</td>
</tr>
<tr>
<td><strong>Dressing</strong></td>
<td>Gets clothes from closets and drawers and gets dressed and undressed without assistance.</td>
<td>Gets clothes from closets and drawers gets dressed and undressed without assistance except for footwear and buttons.</td>
<td>Receives assistance in getting dressed or undressed or stays partly or completely underdressed.</td>
<td>Unable to assist in any way.</td>
</tr>
<tr>
<td><strong>Eating</strong></td>
<td>Feeds self without assistance. Preparation of food may be by other person.</td>
<td>Feeds self after food is cut up or bread buttered.</td>
<td>Receives some assistance in getting food to mouth and is untidy.</td>
<td>Totally fed or receives tube feedings or IV fluids for nutritional support.</td>
</tr>
<tr>
<td><strong>Bathing (sponge bath, shower or tub)</strong></td>
<td>Receives no assistance (gets in and out of shower or tub by self).</td>
<td>Receives assistance in bathing only one part of the body (such as feet or back). Bath / shower or sponge water is prepared by another.</td>
<td>Receives assistance in bathing more than one body part. Bath / shower or sponge water is prepared by another.</td>
<td>Unable to assist in any way.</td>
</tr>
</tbody>
</table>
ADL Measurements
Same Patient – 3 Different Examples

Example 1
Dependent in 6 of 6 ADLs at admission and at recertification

Example 2

<table>
<thead>
<tr>
<th>Admission</th>
<th>Recertification</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minimum assistance</td>
<td>• Moderate assistance with ambulation with rolling walker</td>
</tr>
<tr>
<td>• Occasional incontinence</td>
<td>• Incontinent bowel and bladder</td>
</tr>
<tr>
<td>• Minimal assistance with transfers</td>
<td>• Complete assistance with transfers</td>
</tr>
<tr>
<td>• Moderate assistance with dressing</td>
<td>• Moderate assistance with dressing</td>
</tr>
<tr>
<td>• Minimal feeding</td>
<td>• Moderate in feeding</td>
</tr>
<tr>
<td>• Moderate assistance with bathing</td>
<td>• Moderate assistance with bathing</td>
</tr>
</tbody>
</table>

Example 3
Recertification
Mr. Edwards has declined from needing standby assistance with ambulation to requiring the use of rolling walker along with someone to help steady him with a gait belt. He can no longer rise from his bed alone and he must be lifted to a standing position with use of gait belt. He is now completely incontinent bowel and bladder and requires adult briefs. He continues to require moderate assistance with bathing and dressing and gets more easily fatigued during these activities taking longer and having to rest afterwards. He can no longer use utensils, can only feed himself finger foods and has difficulty with getting fluids and takes at least 30 minutes to eat.
Connection to Care Planning

ADLs
• Equipment
• Increasing visits
• Family relationships/strengths/support
• Future planning for needs

Summaries

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Writing a Nursing Clinical Summary

• Admission
  • Age, reason for admission, i.e., terminal and related conditions
  • Why hospice, why now, i.e., what lead to the hospice referral
  • Past and current treatments, test results, surgeries and therapies related to terminal and related conditions and relevant
  • Mental and functional status prior to decline and how long ago that status was
  • Describe the decline
  • Describe current status this allows you to compare and contrast
• Make sure the summary is consistent with data in the nursing assessment and LCDs/Clinical Indicators/Worksheets for Eligibility
Writing a Nursing Clinical Summary

- Recertification
  - Age, reason for continued hospice eligibility, i.e., terminal and related conditions
  - Why hospice, why still, i.e., what demonstrates still eligible
  - Decline
  - Mental and functional status prior to admission or last 4 to 6 months compared to now
  - Describe the decline
  - Describe current status this allows you to compare and contrast
- Make sure the summary is consistent with data in the nursing assessment and LCDs/Clinical Indicators/Worksheets for Eligibility

IDG Documentation

- Social worker and chaplain and hospice aide
  - Document as to how they were and how they are now
  - Subtleties of decline
    - Can no longer come to the door
    - Unable to hold head up this visit as compared to last
    - Lack of focus, only able to carry on conversation for a few minutes compared to last month when was engaged for 15 minutes
    - No longer wearing dentures and when asked why, its because they are too loose
    - Sitting in a wheelchair with head hanging down and leaning to one side

Physician Narrative

Remember the purpose...
- Content is matter of eligibility
- Focuses on prognosis
- Addresses the terminal condition
- Explains the rationale used by the physician to determine that the patient has a terminal prognosis

Information in narrative should be available in the record

Purpose of the F2F is to gather clinical information on which to base recertification decision – be sure to incorporate into the narrative
Actions of the Prudent Hospice

• Ensure staff know the fundamentals of using the tools and scales
• Develop or refine guidelines how to document assessment data and write clinical nursing summaries in your EMR or paper-Map it out!
  * Use your EMR to help you
• Educate staff on importance of what is expected in documentation to support eligibility
• Monitor and audit those most important areas
  * Prebilling
  * Keep it focused
  * Peer reviews
  * Report in usable manner
  * Connect results to what is important to clinicians

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