Hospice Eligibility
Prognosis or Diagnosis?

Goals & Objectives

- Eligibility: Definition
- Prognostication: Definition
- Understand the Difference
- Fundamental Concepts in Eligibility
Why So Important?

- Proposed Hospice Wage Index for FY 2015
  - Follow the coding guidelines
  - Possible limits on use of debility and AFTT as primary hospice diagnoses
  - Clarification on correct use of dementia diagnoses
- Payment reform
  - An attempt to understanding acuity through coding

Background

- Converting referrals to admissions is one of the most critical tasks we face
  - Allows hospices to bring the benefit to more eligible patients
  - Critical for survival and successful growth
- The referral to admission process = first impression
  - For the patient and family
  - For referral sources
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 Clarification

“The certification regarding terminal illness of an individual shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”

CMS states that the physician does not need to know if the specific individual will die in 6 months, but rather that individuals who present in the same way, generally die in 6 months.

Memo from CMS Tom Hoyer
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

A Difference in Training

- Physicians
  - Trained to think in most of these terms
  - Diagnosis is primary consideration
  - Think in terms of anticipation for “disease”
  - Difficulties considering prognosis & “illness”

- Nurses
  - Trained to think more reactively
  - Present findings are primary consideration
  - Better at thinking of “illness”
  - Difficulties considering anticipation for “disease”
Deconstructing Prognostication

- A means to document what is certified
- Break down prognosis into components
  - To “Paint the picture of the patient” – Some things to consider
    - Diagnosis (or diagnoses)
    - Co-morbid diseases & secondary conditions
    - Age
    - Function
    - Nutrition
    - Cognition
    - ICF criteria
      □ Body function
      □ Body structure
      □ Activity & Participation
      □ Environmental Factors

Hospice Eligibility

- Based on prognosis
  - Which is why it must be done by physicians
- Very unlike all other provider 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)
Process to Determine Eligibility

- Use all information
  - Outside clinical information
  - What was the patient like 3–6 months ago
- Input from all team members – it takes a village!
- Assessment
- Agency guidelines
- Decision
Four Paths to Eligibility

1. Meets **ALL** the Local Coverage Determination (LCD) criteria
2. Meets most of the LCD criteria AND has documented *rapid clinical decline* supporting a limited prognosis
3. Meets most of the LCD criteria AND has *significant comorbidities* that contribute to a limited prognosis
4. **Physician’s clinical judgment** is that the patient has a limited prognosis

All four paths lead to the same destination: identification and support of a six-month prognosis

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Physician’s Clinical Judgment

- Clinical Assessment
- Experience
- Evidence Based Knowledge
So Who Is a Candidate for Hospice?

- **Limited prognosis**
  - < 6-months if disease runs its normal course
  - “More likely than not”
  - Don’t HAVE to be dead in 6 months
  - No penalties unless knowingly fraudulent
- **Question:**
  “Would you be surprised to read your patient’s obituary in the next 6 months?”

If Patient Appears Eligible

- Obtain the attending and medical director verbal certifications
- Admit the patient now
- Clinical records are needed, but not necessary to admit the patient
- Get the clinical records later
- **Remember** – according to § 418.25 Admission to Hospice Care.
  (a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient’s attending physician (if any).
  (b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:
    1. Diagnosis of the terminal condition of the patient.
    2. Other health conditions, whether related or unrelated to the terminal condition.
    3. Current clinically relevant information supporting all diagnoses.
If Patient Appears Ineligible

- Talk to the referring physician or attending physician (if different)
  - What are we missing?
- Talk to your medical director
  - Did I miss anything?
- Define why the patient is not eligible

What do you see?

If Eligibility Is Unclear

- Talk to the doctor!
  - Attending is the expert on the patient
  - Medical director is the expert on eligibility
- Verbal certifications can be given pending more information
  - Gives time to gather medical records and confirm eligibility
  - Don’t bill until written certification is received & eligibility is determined and documented
Your Medical Director’s Role in Eligibility

- Medical Director or hospice physician and the attending physician certify eligibility on admission
- Hospice physician confirms eligibility every recertification period
- Hospice physician is the local eligibility authority
- MACs are demanding clinical (physician) documentation supporting eligibility
  - Narratives
  - F2F

The Tools

- Local Coverage Determinations
- PPS
- FAST
- NYHA Functional Classifications
- Weight Loss / BMI
- ADL’s
- Rapid Decline
- Diagnostic studies
- Crystal Ball
Not Everyone Fits in a Box

Patients demonstrating significant **functional and nutritional decline** that cannot be attributed to a primary clinical condition or conditions that do not fit another category

- Most have a variety of comorbid conditions, usually CNS & cardiopulmonary

Within a few months these patients will:

- Declare a primary diagnosis
- Die or
- Improve and require discharge

These are eligible patients

Documentation: Support Prognosis

- Summary from the physician or nurse that identifies clinical symptoms, tests, treatments to show status of condition
- Discharge Summary or H&P from hospital
- Changes in conditions
- Date of diagnosis and course of illness
- Patient’s desires for palliative, non-curative treatment
Performance Status Over Time

- Change in functional status over time is helpful
- Can be predictable in cancer patients
- Less predictable in non-cancer patients
- Particularly helpful in the absence of a correctable cause

Performance Status

![Graph showing performance status over time for cancer and non-cancer patients](image-url)
MHB and Prognosis Summary

Consider and document

- Patients’ disease-limiting condition
- Important comorbid & secondary conditions
- Pertinent laboratory and other test values
- Performance status and ADL ability
- Nutritional status
- Change in above factors over time

Admission Assessment as 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
MHB and Prognosis Summary

- The Medicare Hospice Benefit is intended for patients with a six-month prognosis
- Physicians struggle with and are often reluctant to prognosticate
- Predicting prognosis in non-cancer patients is nearly impossible
- The LCD criteria ensure payment for services
- The LCD criteria do not reliably predict prognosis

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