The Face-to-Face Encounter & Brief Physician Narrative

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Today

• Elements of a useful FTF
• Physician narratives
  – Purpose, process, preparation, product
  – Certs...and recerts!

The Statute

The Affordable Care Act requires that a hospice physician or nurse practitioner (NP) must have a face-to-face (FTF) encounter with every Medicare Hospice patient to determine the continued eligibility of that patient.
  – Within 30 days prior to the 3rd and all subsequent Medicare benefit periods
Who can do the “Face to Face”?

• Hospice physician: employed or contracted
• Hospice NP
  – W-2 employee of the hospice; NOT contracted
• PAs?
  – PA may be allowed to perform FTFs in 2019 (Medicare Patient Access to Hospice Act of Feb 2018)
  – Awaiting interpretative guidance

Patient Transfers

• When transferring from one hospice to another, the benefit period does not change, so the originating hospice is responsible for any required FTF.
• The accepting hospice is advised to have the FTF documentation for the benefit period.
  – Get copies of the prevailing FTF documentation AND physician narrative.

Purpose & Content of the FTF

• Purpose: gather clinical information to be used to determine hospice eligibility
• Physical exam alone is usually insufficient for recert
• Need exam + context and comparison
• How much is gathered in the FTF?
  – Chart review of visit notes
  – Summary documentation (IDT notes, recert prep summaries)
Content of the FTF for Recert

- **HPI**
  - Recent new events, changes in status/meds, new infections, decline
- **ROS**
  - General symptoms, symptoms related to relevant diagnoses (px)
- **PE**
  - Appearance, wt +/- MAC, vital signs, diagnosis-related findings, decline-related findings
- **Functional status/changes**
  - ADLs (which ones and how compromised), sleep, PPS, PAST
- **NO** finding of eligibility unless physician does FTF

The Physician Narrative

418.22 Certification of terminal illness.

- Based on the attending physician's and medical director's clinical judgment.
  - Must specify individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course
- Clinical information / other documentation that support the medical prognosis must accompany the certification and be filed in the medical record with the written certification.

The Physician Narrative: Purpose

- The certifying physician MUST compose a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.
  - 1st benefit period: can be written by EITHER the attending physician or hospice medical director
  - 3rd or later benefit periods: physician must use findings from the FTF to make the recert decision
  - The same physician who performs a FTF does NOT have to compose the narrative or sign the recert
The Physician Narrative: Purpose

- For whom?
  - Is NOT clinical documentation of patient care.
  - IS documentation of eligibility for payment for patient care
- For the reviewers who are determining coverage
  - May be helpful summary for colleagues, but is NOT for them
- The narrative should be a persuasive, stand-alone statement of prognosis, supported by the record.

The Physician Narrative

- The physician narrative is a GIFT.
- It is a mandated, expected statement of how the physician's clinical judgement has led to an assessment that the patient has a prognosis of 6 months or less.
- Can be a powerful statement for appeals.

Physician Narrative: Product

- The narrative must be composed by the certifying physician—NOT by other hospice personnel.
  - Synthesize individual patient's clinical information in a justification focused on prognostic factors.
- 1st benefit period: can be written by EITHER the attending physician or hospice medical director
  - Do you really want a non-HPM physician writing this?
Physician Narrative: a Summary Document

• Narrative should summarize and/or interpret what is already documented.
  – It should rarely contain new information.
    • If new information is derived from IDG conversation, it should be documented in the pertinent visit note or the applicable IDG note.
  – It should follow logically from the visit and IDG documentation.
  – It must include information from the FTF.

Physician Narrative: a Summary Document

• Physician attestation that cert/recert is based on exam or review of medical record
  – The physician who performs a FTF does NOT have to compose the narrative or sign the recert.
  – However, the one who does sign the cert should know that the information is in the record.

Physician Narrative: Prognostic info

• HPI
  – Age primary dx, co-morbidities affecting px, new events or changes, infections
• ROS
  – General (wt loss, decreased intake, etc.) and those related to relevant diagnoses
• MEDS
  – New meds and any pertinent increases or decreases in meds
• PE
  – Appearance, nutritional changes (wt, MAC, BMI), relevant VS, dx-related findings, decline-related findings
• Function
  – Changes in ADLs (which ones and how compromised), sleep, PPS, FAST
• +/- other objective data: pOx, labs, imaging
• Interpretations of findings
Physician Narrative: Prognostic info

- Document magnitude of changes, not just direction
  - Not "decreased MAC" or "PPS down"
  - 2 cm decrease in MAC from 19 to 17 cm in the past 3 months
  - Decrease in PPS from 60 to 40 over this benefit period

- Get labs and imaging when needed
  - Albumin for nutrition compromise, renal function
  - Unexpected change in trajectory—correct diagnosis?

Physician Narrative: Don't perpetuate inaccuracies

- Are PPS scores calculated correctly?
  - Accurate ambulation calculation. No "partial credit."

- Is FAST calculated correctly?
  - Speaks fairly well and can't walk due to CVA #7C

- And applied to the correct diagnosis?
  - Alzheimer's dementia, not vascular dementia, CVA, Parkinson's

- Do changes in MACs make sense?
- Really dependent for all ADLs?
  - Feeding self, walking with a device

Physician Narrative: Interpretive

- Interpretations of findings: this is why a list is not enough. Narratives require sentences!
  - Decrease in BP and need to discontinue cardiac meds reflects progressive cardiac compromise.
  - Pt's intake of approx. 300 cal/day is insufficient to sustain her long, although with BMI of 9.2, further wt loss can hardly be expected.
Physician Narrative: Include the LCDs

• Underscore expected findings
  – List the elements of ALL pertinent LCDs met by the patient.
    • Primary diagnosis and co-morbidities
• Remember that LCDs are guidelines.
  – If there is no LCD, explain why pt has a 6 month px.
• If eligibility is obvious, may need to write less.
  – Explain and support your decision more when not as obvious.

Physician Narrative: Include the LCDs

• Acknowledge and explain lack of “expected” findings
  (usually LCDs)
  – Less than 10% wt loss but intake of bites and sips for a week with no
    reversible cause and decreasing responsiveness
  – Acute MI, CHF, hospitalization x1, persistent hypotension, rapid
    decline
  – Further wt loss not expected with extremely low BMI

Physician Narrative: Inconsistencies

• Acknowledge and explain inconsistencies
  – Irregular wts—new scale? Change in fluid status?
• Do not rely on meaningless changes
  – Up and down wts or MAC
    • Do not rely on spurious “wt loss” if pt has fluctuations within a range.
  – Multiple rounds of antibiotics
    • For significant infections, don’t just count the Rxs.
Physician Narrative: Inconsistencies

• Explain how "improvements" in condition do NOT change px.
  – With better pain mgmt. and rebound following hospitalization, pt can help more with ADLs. Px remains 6 months or less due to stage 4 pancreatic cancer and worsening mets on CT.
  – Pt's diuretic-resistant edema has improved only with marked decrease in food and fluid intake.

• Explain "mitigated" changes.
  – Pt's nutritional decline and real wt loss is even greater as loss of 10# is dampened by new-onset of 2+ BLE edema from toes to knees.

Physician Narrative: Inconsistencies

• Do not ignore long lengths of stay
  – Although pt has unexpectedly outlived initial prognosis, pt has a px of 6 months due to....

Physician Narrative: Remember to add...

• Include other pertinent info
  – New and/or other co-morbidities
    • New MI, CHF exacerbation in previously stable CAD, new hip fx due to increased weakness and fall
  – New information in the literature that supports px
    • Advanced Dementia Prognostic Tool (ADEPT), Six Month Median Px in Cancer
  – Include pertinent citations in the narrative
    • Support eligibility
    • Potential support for future appeal
Then and Now

• Then
  – If we saw this pt for the first time today, would we admit?

• Now
  – Knowing this pt the way we do (esp. after a longer LOS), why do we now think the pt has a px of 6 months or less?

Writing the Physician Narrative

• Have a consistent order to your narrative, not a hard and fast recipe.
  – age, primary diagnosis, other diagnoses affecting px
  – recent events, infections, new or worsening symptoms
  – changes in nutritional, physical, and functional assessment
  – Pulse oximetry, labs, imaging
  – F2F findings: name of provider and date of visit
  – Interpretations
  – Pt wants palliative plan of care (second element of eligibility)

Physician Narrative: Product and Process

• Presence of the narrative is a matter of compliance
• Content of the narrative is a matter of eligibility
• Will your physician narratives support eligibility if the records are reviewed?
Physician Narrative: Process

- Have you taught your physicians to write them?
  - Do they understand the purpose?
  - Do they understand the possible uses?
  - Do they focus on prognostic factors?
- Narratives require sentences!

Physician Narrative: Process

- Accountability
  - Who reviews the narratives?
  - How is feedback given?
- Must take these seriously!

Physician Certification: Staff Preparation

- Do admission staff and IDT members all know how to support certification?
- Nurses
  - History, physical, and course of illness
  - Prognostic information per LCDs and diseases
  - Physical findings on assessment
Physician Certification: Staff Preparation

- Not only nurses:
- SWs and Chaplains
  - What do you observe? What is different?
    - Posture, speech, dress
    - Pain, breathing, ability to converse, cognition
    - Activity, stamina, need for help
- Aides
  - Plan of care, efficiency, narrative content

Physician Narrative: Staff Preparation

- Do the forms make it easy to support eligibility?
  - Ask the best questions for the discipline—and have a specific place to answer
  - Assessments
  - Scope of practice
    - Not all documentation is an “assessment”
- Do you have places to summarize events and findings?
  - IDT notes
  - Recert summary forms—not just check boxes!

Strong Narratives

- Require clinical skills
  - IDG members
    - Accurate and complete clinical documentation
  - Physicians
    - Prognostic awareness and analysis
- Forms that ask the right questions
- Well-developed writing skills
Physician Narrative: A Case

- 84 year old NH resident with Alzheimer’s dementia
- Renal insufficiency, irritable bowel syndrome
- Pneumonia and delirium with hospitalization 2 months ago
- Continues on O2 for shortness of breath
- Ht 5’10”. Wt 120 lbs. loss in the last 6 months
- FAST 7C; ADEPT 19.5
- Holds food and medications in his mouth with poor intake
- Diet changed due to choking episodes
- FTF by hospice NP for admission into 4th benefit period.
The Good...

• 84-year-old with end-stage Alzheimer’s disease is certified to have a 6 month px based on recent aspiration pneumonia, persistent dysphagia and aspiration risk, ongoing poor intake, 20% wt loss in past 6 months, BMI underwt at 17.2, ADEPT score 19.5 (with 67% probability of mortality in the next 6 months), FAST 7C, FTF (confirming wt loss, dysphagia, and ADEPT) by C Smythe CRNP on Mar 5, and desire for hospice support of palliative plan of care.
  • Focuses on prognostic factors.
  • References FTF
  • Includes preference for palliation, not life prolongation

...the Bad...

• 84 year old with advanced dementia, wt loss, decline, pneumonia. Pt appropriate.
  • How advanced is dementia (FAST)?
  • Timing and continuation of wt loss?
  • When was pneumonia?
  • What kind of decline?
  • Probably supported in the record, but does not stand alone.

...and the Ugly

• Pt died.
  • Insufficient
  • No justification of hospice eligibility.
  • No stand-alone defense of prognosis
    – And what does that suggest to a reviewer if pt didn’t die in 6 months or was discharged.
  • Need a supported px—won’t always be right.
Also ... Ugly

- “ES disease with decline—eligible for hospice”
- “Next decline will be death”
- “Pt with ESRD does not want dialysis.”
- What about:
  - Pt meets LCD with BMI < 22 and PPS 40.
  - Pt with DM and dementia is certified based on hospitalization last month for L BKA, hospital-acquired UTI (requiring IV abx), and 10% TBW loss (112# to 100#) within the past 6 months.

Also ... Ugly

- Copy and paste
  - No copying and pasting from someone else’s visit, FTF, IDT, or summary notes
    - The information—and even the words—may be similar.
    - But a physician note should read like a physician note.
  - No copying and pasting of last narrative with date change.
  - Worse: your copying makes the narrative WRONG!
    - Records can't support.
    - Integrity of judgement and record are now questionable.

Physician Narrative: Success

- Admission and IDG staff have the forms and training to document pertinent information
- Physician narratives
  - Composed by physician
  - Focused on prognosis
  - Well-written
  - Reviewed with feedback
Physician Narrative: Success

• Have a consistent order, such as:
  – age, primary diagnosis, other diagnoses affecting px
  – recent events, infections, new or worsening symptoms
  – changes in nutritional, physical, and functional assessment
  – Pulse oximetry, labs, imaging
  – F2F findings: name of provider and date of visit
  – Interpretive conclusions about findings
  – Desire for palliative plan of care

Physician Narrative: Success

• Presence of the narrative = compliance
• Content of the narrative = eligibility
• Exercise of physician’s clinical judgement per the CoPs
  – A persuasive, stand-alone justification of prognosis of < 6 months for an individual patient
  – Supported by the record
• Written for the reviewers who determine coverage

A GIFT to hospices to support care delivery & reimbursement

Resources

• Prediction of 6-month survival of nursing home residents with advanced dementia using ADEPT vs hospice eligibility guidelines. www.ncbi.nlm.nih.gov/pubmed/21045099
• Can hospices predict which patients will die within six months? www.ncbi.nlm.nih.gov/pubmed/24922330
• Estimating prognosis for nursing home residents with advanced dementia. www.ncbi.nlm.nih.gov/pubmed/15187055
Resources

• Systematic review of cancer presentations with a median survival of six months or less. www.ncbi.nlm.nih.gov/pubmed/22023378


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