The Four Paths to Eligibility

May 2018
Subscriber Webinar

Today's Session
1. Review of the Medicare regulations related to eligibility
2. Use of the various paths to eligibility
3. Communication of eligibility at admission, recertification and on-going
4. Overview of documentation supporting eligibility

Why Do We Care?
If Someone from the OIG...

If someone from the OIG visited your hospice and asked a random IDG member to explain the process for determining eligibility at the time of admission, what would you say?

Who’s the Audience?

Governmental Entities
- Ordinary Entities
- Extraordinary Entities

Who Else?
- IDG
- Quality Reviewers
- Attorneys

What are they looking for?

The Bottom Line

Hospices without an effective mechanism and adequate clinical knowledge for evaluating eligibility at the time of admission and throughout could find themselves in some trouble.

Critical to make sure that:
1. All beneficiaries who want hospice and are eligible for hospice are admitted
2. All eligible beneficiaries (who continue to want hospice) remain on hospice

It’s your mission and the business
Eligibility

Eligibility Decisions

The ultimate decision of eligibility lies with the medical director / hospice physician (and attending, if they have one, on admission)

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

It is all about prognosis – not diagnosis!
Eligibility - Key Points

Patients must be more likely than not to die in less than six months. One does not need to be certain they will die in less than six months.

It is not necessary to know whether the individual patient will die in six months or less. The attending physician and the hospice medical director/hospice physician are asked to make a decision about whether patients who present like the patient in question have a six-month prognosis if the illness runs its normal course.

Research has shown that physicians are reluctant to share prognosis with patients (particularly limited prognoses) and are often over-optimistic when developing prognoses.

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)

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 many die without a clear terminal period

Lunne, et al
JAMA, May 2003
**Disease Trajectory**

![Graph showing disease trajectory with legend: Mostly CA, Mostly heart & lung, Mostly dementia and frailty.]

**Probability of Death within Six Months**

<table>
<thead>
<tr>
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<th>PPS 30</th>
<th>PPS 40</th>
<th>PPS 50</th>
<th>PPS &gt;60</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>98.3%</td>
<td>95.5%</td>
<td>92.8%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>89.8%</td>
<td>74.2%</td>
<td>65.3%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Dementia</td>
<td>73.6%</td>
<td>54.9%</td>
<td>51.4%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>92.4%</td>
<td>79.9%</td>
<td>71.6%</td>
<td>63.8%</td>
</tr>
<tr>
<td>Stroke</td>
<td>67.4%</td>
<td>48.4%</td>
<td>39.4%</td>
<td>32.6%</td>
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*Source: Harris, et al. Can Hospices Predict which Patients Will Die within Six Months? Journal of Palliative Medicine; Vol 17, Number 8, 2014*

**4 Paths to Hospice Eligibility**

*Admission and On-Going*
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

Local Coverage Determination

- Developed by the MACs
- Provide medical criteria for determining prognosis
  - But not consistent predictors of prognosis
- Use as guidelines for documenting terminal illness
- If a patient meets certain criteria, they are deemed eligible
  - If a patient doesn't meet the LCD,
    - May still be eligible for the MHB,
    - But must document why (best done by a physician)
- Not the legal standard for hospice eligibility
  - However, are followed by reviewers when reviewing for payment determinations

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 be at a FAST 7A and 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.

CGS & NGS

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.

Palmetto GBA

Four Paths to Eligibility

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Indicators of Rapid Clinical Decline

- Nutritional decline
  - Weight loss greater than 10% in prior 6 months
  - Significant decrease in MAC
- Functional decline
  - Changes in ability to do own ADLS
  - ADL deficits are the most important predictor of 6-month mortality
  - Stronger than diagnosis, mental status, or ICU admission
- Progressive deterioration while receiving appropriate care
- Hospital Utilization
- Serial Lab Assessments

Four Paths to Eligibility

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Defining the Terms

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<tr>
<td><strong>Terminal Diagnosis</strong></td>
<td>The condition established after study to be chiefly responsible for the patient’s admission to hospice</td>
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<tr>
<td><strong>Related</strong></td>
<td>Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and impact prognosis</td>
</tr>
<tr>
<td><strong>Unrelated</strong></td>
<td>Conditions or diagnoses that are independent of the terminal condition</td>
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Physician's Clinical Judgment

What happens when there is no clear diagnosis or LCD to follow?

Clinical Assessment  →  Experience  →  Evidence Based Knowledge

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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 [HCFA] 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 Tom Hoyer
Former Director, Chronic Care and Insurance Policy, HCFA
~ 2000

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Factors Impacting All Paths to Eligibility

Effects on Prognosis

Primary condition
– Sometimes is automatically terminal; e.g. Stage IV lung cancer no longer seeking treatment

Secondary conditions
– Directly related to the terminal illness
– Examples
  • Dementia: aspiration pneumonia, pressure ulcers, delirium, sepsis
  • Neuromuscular diseases: contractures, pressure ulcers

Co-morbid conditions — can be distinct from the primary or related to the primary

Effects on Prognosis

Function
– Seriousness of disease (terminal diagnosis, secondary and co-morbid conditions) is reflected by the degree of lost function
– Decreased function is related to increased mortality

Nutrition
– Extremes of nutritional status are associated with increased mortality
Effects on Prognosis

Younger
– Need more things “wrong” (i.e. co-morbid diagnoses)

Older
– Usually already have more things “wrong”

Centenarians
– Almost automatically eligible, based on statistics
– However they still need to have a terminal illness & prognosis of 6 months or less

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 on-going 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.

NGS/CGS Hospice Determining Terminal Status
October 2015
The interaction of these factors plays an important role in supporting eligibility.

Eligibility
Communication

Documentation = Communication
Effective Communication

- Nursing admission assessments/summaries
- Nursing recertification assessments/summaries
- Measurable data
- Comparison
  - Last period to this period & over the prior 3–6 months
  - Trending reports
- IDG meetings/presentations
  - “I think they are eligible as evidenced by...”
- F2F

Face to Face Encounter

Purpose “to gather clinical findings to determine continued hospice eligibility”
- Increase physician accountability
- F2F by itself is not intended to determine eligibility or non-eligibility
- Findings are provided to the certifying physician for use in determining continued eligibility for hospice care

The Physician Narrative

INGREDIENT ONE
Solid clinical information on which to base narrative

INGREDIENT TWO
Solid narrative writing skills

THE FINAL PRODUCT
A strong physician narrative

Review March 2018 Subscriber Webinar: The Face-to-Face Encounter & Brief Physician Narrative with presenter Joan Harrold, MD
Physician Narrative

Purpose
- Explains the rationale used by the physician to determine that the patient has a terminal prognosis
- Context is matter of eligibility
- Focuses on prognosis
- Addresses the terminal condition and related conditions
- Includes prognostic indicators and explanation of the patient specific clinical findings that supports terminal prognosis

If condition is not related or supportive of eligibility, do not put into narrative
Information in narrative should be available in the record
When don’t meet the LCD, say it “although they do not meet all the LCD criteria here is why they have a 6 month prognosis…”
Since purpose of narrative is to support eligibility for the next benefit period, no need for one when patient will not be recertified

Evaluate and Admit: Admission Visit

Be careful of short cuts – don’t lose admission of eligible patients based on
- Incomplete information
- Unilateral decision making
- Poor process
Focus on what makes the patient appear eligible not the normal
Which “Path” are they taking?

Outside Clinical Data

Data collection before, during and after
- Information from referral source
- Records from other providers
- Family reports

Gathering
- Hospital referral
- Nursing facility referral
- Community referral
From the past 6 – 12 months
- Hospital records
- Physician notes (office visits)
- Labs
- Weight records for NF and ALF
- Medication and diet changes for NF and ALF

Reviewing
- Hospice physician
- Admission nurse
- Team
Incorporating into physician narrative and nursing admission summary
Availability in the clinical record
**Nursing Admission Documentation**

Includes:
- Age, reason for admission, i.e., terminal and related conditions
- Why hospice, why now, i.e., what led to the hospice referral
- Past and current treatments, test results, surgeries and therapies related to terminal and related conditions
- Mental and functional status prior to decline and how long ago that status was
- Describe any decline over the prior 3–12 months before admission
- Describe current status this allows you to compare and contrast in future documentation

Make sure the summary is consistent with data in the nursing assessment and ICDs/Clinical Indicators/Worksheets for Eligibility

Describe in detail the path to eligibility the patient took.

**When Eligibility Is Not So Clear at Admission**

After nurse completes assessment:
- Discussion with clinical leader
- Talk to the doctor(s):
  - Attending is the expert on the patient
  - Medical director is the expert on eligibility
- Verbal certifications can be given pending more information
  - Can’t bill until written certification is received & eligibility is determined and documented
- Detective Work:
  - Seek out more information—labs, hospital records, call other physicians and health professionals involved in the patient’s care
  - Comparison of past to current
    - Weight
    - Functional ability
    - O2 utilization

**Any Time Eligibility Is Unclear**

It means there is not clear evidence of a terminal prognosis supported by documentation

One or both of the following options must occur:
- Obtain more clinical information to determine eligibility, and/or
- Begin formulating a plan for discharge from hospice

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Remember this Equation

Evaluation of results of supporting data gathering ≠ Need to treat

Recertification Process

Why Hospice? Why Still?

Supporting Eligibility

Status at Admission

DECLINE Document measurements and observations of decline
MAINTAIN Document interventions in place to maintain function or condition
IMPROVE Document interventions in place leading to improvement
Nursing Documentation Needs to Contain

Recertification
- Age, reason for continued hospice eligibility, i.e., terminal, secondary and co-morbid conditions
- Why hospice, why still, i.e., what demonstrates person remains eligible
- Describe any decline over past 3 – 6 months
- Mental and functional status prior to admission or last 4 to 6 months compared to now
- Describe current status as compared to 4 – 6 months ago
- Medication changes
- Plan of care changes

Make sure the summary is consistent with data in the nursing assessment and LCDs/Clinical Indicators/Worksheets for Eligibility

Is the patient still on the same path of eligibility?

Long Length of Stays - Key Question

Knowing what we know about this patient, what will look different the next 6 months from the last 6 months?

Documentation

Painting the Picture
The Major Concept

We are looking for why they are getting worse
- Context of a good day
- Context of a good meal
- Context of a good conversation
  - Word salad
  - Number of words

Painting the Picture

- Comparison charting
- Subjective writing
- Use of comment boxes
- Clear and detailed descriptions
- Specific discipline’s documentation
- Changing plan of care
- Illustrate why beneficiary is considered terminally ill

The Documentation Should

- Be specific to that individual patient
- Have narrative notes to explain information noted on a checklist
  - Use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Illustrate progression of terminal condition
- Purpose and need for aggressive palliative treatment
**IDG Documentation**

Social worker, 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, it’s because they are too loose
  - Sitting in a wheelchair with head hanging down and leaning to one side

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**Dangers**

LCD worksheets or clinical indicator worksheets regardless if paper or EMR
- If you “check” it off, it has to be true
  - Ex: Inability to maintain sufficient fluid and calorie intake with 10% weight loss during previous six months or serum albumin < 2.5 gm/dl.
  - Ex: Is or has been already optimally treated for heart disease, or are patients who are either not candidates for surgical procedures or who decline those procedures. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)

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**EMR Dangers**

- Click and close without quantifying
- Not capturing trackable longitudinal measures
- Copy and paste
- Cloning
- Depending on EMR, IDG updates are historical and difficult to differentiate what is current and what is not
  - “recent hospitalization”
  - “Respiratory infection last month”

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Eligibility Documentation

Even if the patient is absolutely clinically eligible:
– If the chart doesn’t document the eligibility
  • On admission
  • At recertification
  • Ongoing basis during the cert period
– If the staff don’t document eligibility in their notes
  • All the staff (Chaplains and Social Workers included)
– If we can’t prove they are/were eligible

Medicare will say they are not eligible

Remember the Four Paths to Eligibility

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How well does the clinical record support which Path they patient is taking?

Actions of a Prudent Hospice

Evaluate your practices related to
1. Admission
2. Gathering outside clinical documentation
3. Communicating admission findings
4. Recertification
5. F2F Understanding, assessing for and communicating eligibility helps ensure all hospice eligible patients who want your care, get your care
  • Improve your eligibility assessment skills
  • Comprehensive and ongoing eligibility education program
6. Narrative
7. When eligibility not clear
8. IDG’s role in eligibility
9. Eligibility education
10. Auditing process

Comprehensive and ongoing eligibility education program
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