Hospice Clinical Documentation

Proving Hospice Regulatory Compliance

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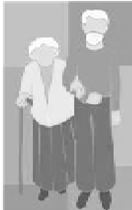
Hospice Clinical Documentation

- Course Objectives:
  - Successful course participants will learn to:
    - üRecognize common documentation errors.
    - üDiscuss the implications of erroneous, inadequate or untimely documentation.
    - üIdentify methods for improving documentation.

Hospice Clinical Documentation

- Hospice benefit available to beneficiaries who:
  - Are entitled to Part-A Medicare benefits;
  - Are certified as terminally ill;
  - Elect the hospice benefit;
  - Knowingly waive other certain Medicare benefits.



Hospice Clinical Compliance

- Hospice providers are eligible for claim payment if the patient record shows:
  - Beneficiary is eligible for hospice services;
  - Services provided were medically necessary;
  - Hospice provider met all regulatory requirements.

HOSPICE COVERAGE

Hospice Coverage

- Technical requirements for hospice coverage:
  - Notice of Election (NOE)
    - Prior to Hospice admission:
  - Certification of Terminal Illness (CTI)
    - Required for each benefit period:
  - Face-to-Face Encounter documentation
    - Required for each third and later benefit period.

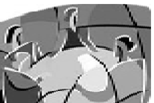
Hospice Coverage

- Clinical documentation requirement for hospice coverage:
  - Patient record must support documentation in technical elements.
    - Terminal prognosis of 6 months or less
    - LCD criteria
  - Days in any billing period without corresponding documentation showing eligibility are unpaid.

IDG, CARE PLAN, SERVICE COORDINATION

IDG, Care Plan, Service Coordination

- Approach to Service Delivery
  - IDG provides hospice care/services
  - Based on hospice patient/family needs
    - Physical
    - Medical
    - Psychosocial
    - Emotional
    - Spiritual



IDG, Care Plan, Service Coordination

- Plan of Care
  - All IDG members contribute
    - Doctor of medicine or osteopathy
    - Registered Nurse
    - Social worker
    - Pastoral or other counselor
  - Involve any attending physician

IDG, Care Plan, Service Coordination

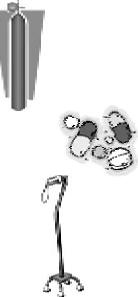
- Plan of Care
  - Based on assessment assessments
    - Initial, comprehensive, and updated
  - Individualized
  - Specifies care and services needed
    - To meet patient and family-specific needs
    - Related to the terminal illness and related conditions.

IDG, Care Plan, Service Coordination

- Needs unrelated to terminal illness
  - Hospices not required to provide these services;
  - Must acknowledge, document who is addressing;
  - Medicare considers most conditions as contributing to terminal illness;
  - Hospice physician must document why any condition is not related.

IDG, Care Plan, Service Coordination

- Hospices must provide virtually all care of terminally ill patients:
  - Most problems are related to the terminal illness.
  - All needed services are considered related.

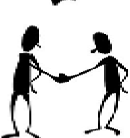


IDG, Care Plan, Service Coordination

- Care Plan Content
  - üPain and symptom management interventions;
  - üScope and frequency of needed services;
  - üMeasurable outcomes anticipated;
  - üDrugs and treatment needed;
  - üMedical supplies and appliances needed;

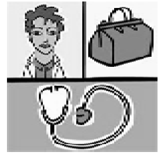
IDG, Care Plan, Service Coordination

- IDG must document patient's/representative's:
  - Level of understanding the care plan,
  - Involvement in the care plan,
  - Agreement with the care plan,
  - In accordance with the hospice's own policies.



IDG, Care Plan, Service Coordination

- IDG: review, revise, document care plan:
  - Involving any attending physician;
  - As frequently as patient condition requires;
  - At least every 15 days.



IDG, Care Plan, Service Coordination

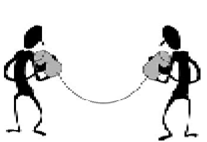
- Revised Care Plan must include:
  - Updated comprehensive assessment information;
  - Progress toward care plan outcomes and goals;
  - Documentation that assessment revealed no needed changes, if no changes are required.

IDG, Care Plan, Service Coordination

- Documentation must show that hospice care and services:
  - Are directed, coordinated, and supervised by the IDG;
  - Follow the plan of care;
  - Are based on patient and family need assessments;

IDG, Care Plan, Service Coordination

- Service coordination documentation:
  - Shows information sharing
    - Between all disciplines
    - In all settings
    - Provided directly
    - Provided under arrangement
    - With any non-hospice providers furnishing services unrelated to the terminal illness and related conditions.



Why hospice coding matters

- Hospice update final rule published 08/07/13
  - Clarified hospice diagnosis reporting
    - Complete, comprehensive coding required;
    - Must follow official coding guidelines;
    - Targeted non-specific and manifestation codes used incorrectly.

Why hospice coding matters

- Hospice update final rule published 08/07/13
  - Incorrectly used diagnoses as terminal illness
    - 2002 < 10% of hospice claims
    - 2012 > 25% of hospice claims

  - Using less-specific, or catch-all codes
    - Has become more common among hospice providers;
    - In spite of prior clarifications to follow coding guidelines;
    - Has been allowed without penalty.

Why hospice coding matters

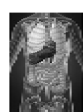
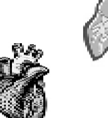
- Hospice update final rule published 08/07/13
  - Clarified that hospices must report:
    - Terminal illness diagnosis;
    - All coexisting or additional diagnoses related to the terminal illness and related conditions.
  - Data needed to evaluate hospice pay reform methods.

Why hospice coding matters

- HIPAA requires choosing the most correct, specific diagnosis codes.
- Medical record documentation must consistently support the the ICD-9-CM diagnoses documented in the CTI.

Why hospice coding matters

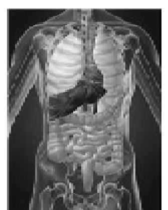
- Diagnosis-related CTI Content:
  - üPatient's name and terminal diagnosis;
  - üPrognosis: life expectancy is 6 months or less if the terminal illness runs its normal course;
  - üThe physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less;
    - Includes co-morbidities and their contribution to patient condition.

SUPPORT ICD-9 DIAGNOSES

Support ICD-9 diagnoses

- Final Rule 8/7/2013:
  - Terminal illness:
    - Advanced, progressively deteriorating illness
    - Diagnosed as incurable.



Support ICD-9 diagnoses

- Terminal illness/primary diagnosis is:
  - Identified by certifying hospice physician(s) as:
    - Chiefly responsible for the services provided;

    AND
    - Most contributory to the terminal prognosis.

Support ICD-9 diagnoses

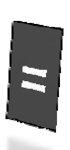
- CMS:
  - "We believe that the certifying physicians have the best clinical experience, competence and judgment to make the determination that an individual is terminally ill."
- Clinical documentation must support life expectancy of 6 months if the physician-identified terminal illness runs its normal course.

Support ICD-9 diagnoses

- Cancer diagnoses
- Amyotrophic Lateral Sclerosis
- Heart Disease
- HIV Disease
- Liver Disease
- Pulmonary Disease
- Chronic Renal Failure
- Stroke
- Coma

Support ICD-9 diagnoses

- ICD-9 diagnosis codes selected must match the primary diagnosis/terminal illness the physician identifies.
- A change in terminal illness requires documentation by the physician and a change on the next CTI, but no new mid-benefit period CTI.



NEVER-PRIMARY ICD-9 DIAGNOSES

Never-primary ICD-9 diagnoses

- HIPAA: Hospice must follow coding rules.
  - ü Assign the most specific diagnosis code available.
  - ü Code sign and symptom codes only when no related, definitive diagnosis has been confirmed.
  - ü Manifestation codes are not allowed as primary.

Never-primary ICD-10 diagnoses

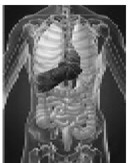
- CMS:
  - Does not require the physician to determine the actual codes for the diagnosis.
  - Expects hospices to determine to the actual codes associated with diagnoses cited by physicians.
  - Hospice must press physicians for needed specificity.

Never-primary ICD-10 diagnoses

- Debility 799.3 & Adult Failure to Thrive 783.7:
  - Not allowed as primary, as of Oct 1, 2014 :
  - Considered questionable for hospice;
  - Returned to the provider for more definitive principal diagnosis
  - OK as contributing diagnoses.

Never-primary ICD-10 diagnoses

- CMS: Don't list etiology dementia diagnoses as principal diagnosis.
  - Don't split ICD-9 etiology/manifestation pair
    - Example: Alzheimer's Dementia
      - 331.0 Alzheimer's Disease
      - 294.10 Dementia in conditions classified elsewhere

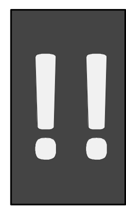


Lesson 5

RELATED ICD-9 DIAGNOSIS CODES

Related ICD-9 diagnosis codes

- The hospice claim must include:
  - All diagnoses related to the terminal illness/principal diagnosis.
  - All comorbid conditions that contribute to the prognosis of 6 months or less.
- Medicare: THIS IS NOT A NEW RULE!

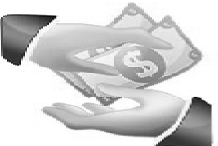


Related ICD-9 diagnosis codes

- In January-March 2013:
  - 72% of hospice providers listed only 1 diagnosis;
- Coexisting diagnoses help describe hospice patients
- Hospice data is incomplete without comorbidities.
- Incomplete data could negatively impact future hospice reimbursement.

Related ICD-9 diagnosis codes

- Hospice providers must pay for all care:
  - Related to the terminal illness;
  - Related to coexisting or contributing conditions;
  - Caused by the treatment of either.



Related ICD-9 diagnosis codes

- Hospices must provide virtually all care of terminally ill patients:
  - Most problems are related to the terminal illness
  - All needed services are considered related
- Exceptions:
  - Require documented, clear evidence that a condition is unrelated;
  - Hospice physician must document why hospice patient needs are unrelated to terminal illness.

HOSPICE LCD'S & ICD-9 DIAGNOSES

Hospice LCD's & ICD-9 diagnoses

- MAC hospice LCD:
  - Help providers determine hospice eligibility;
  - Guide MACs in reviewing claims;
  - Apply to all hospice patients.

Hospice LCD's & ICD-9 diagnoses

- Beneficiaries qualify for hospice if they meet:
  - Non-disease specific decline guidelines in part 1

OR

- Guidelines in both
  - Baseline non-disease specific guidelines in part 2

  - The applicable, disease-specific lists in the appendix

Hospice LCD's & ICD-9 diagnoses

- Part 1 - clinical status decline guidelines:
  - Decline presumes change over time;
  - Requires baseline and follow-up assessments;
    - Establish baseline on admission or from clinical record;
  - Variables other than those listed may also support 6-month life expectancy, and should be documented.

Hospice LCD's & ICD-9 diagnoses

- Part 1 - clinical status decline guidelines:
  - Apply to patients whose decline is not reversible.
  - Listed in order of their likelihood to predict poor survival:
    - Most predictive first.
    - Least predictive last.
  - No specific number of variables must be met;
  - Longevity prediction of 6 months or less requires:
    - Fewer of those listed first (more predictive);
    - More of those listed last (least predictive).

Hospice LCD's & ICD-9 diagnoses

- Disease progression, as worsening:
  - Clinical status
    - Recurrent, intractable infections
    - Progressive inanition, documented as decreasing:
      - Weight and/or anthropomorphic measurements, not due to reversible causes such as depression or diuretics
      - serum albumin or cholesterol
    - Dysphagia leading to:
      - Recurrent aspiration
      - Inadequate oral intake

Hospice LCD's & ICD-9 diagnoses

- Disease progression, as worsening:
  - Symptoms
    - Dyspnea with increasing respiratory rate
    - Cough, intractable
    - Nausea/vomiting poorly responsive to treatment
    - Diarrhea, intractable
    - Pain requiring increasing doses of major analgesics more than briefly.

Hospice LCD's & ICD-9 diagnoses

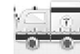
- Disease progression, as worsening:
  - Signs
    - Systolic BP decline to < 90, or progressive postural hypotension
    - Ascites
    - Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
    - Edema
    - Pleural / pericardial effusion
    - Weakness
    - Change in level of consciousness

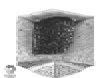
Hospice LCD's & ICD-9 diagnoses

- Disease progression, as worsening:
  - Laboratory results (If available):
    - Increasing pCO2 or decreasing pO2 or decreasing SaO2
    - Increasing calcium, creatinine or liver-function studies
    - Increasing tumor markers (e.g. CEA, PSA)
    - Progressively decreasing or increasing serum sodium or increasing serum potassium.

Hospice LCD's & ICD-9 diagnoses

- KPS or PPS decline from <70% due to disease progression;
- Increasing ER visits, hospitalizations, or physician's visits related to hospice primary diagnosis;
- Progressive
  - decline in FAST for dementia
    - From ≥7A on the FAST;
  - Dependence on assistance with additional ADLs
    - See Part II, Section 2;
  - Stage 3-4 pressure ulcers in spite of optimal care.



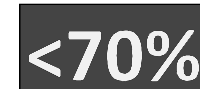


Hospice LCD's & ICD-9 diagnoses

- Part II. Non-disease specific baseline guidelines
  - Both should be met
    - Physiologic impairment of functional status;
    - Dependence on assistance for two or more ADLs.

Hospice LCD's & ICD-9 diagnoses

- Physiologic impairment of functional status:
  - KPS or PPS <70%,
    - Except when HIV Disease or Stroke and Coma is the disease-specific guideline used.



Hospice LCD's & ICD-9 diagnoses

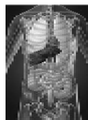
- Dependence on assistance for two or more ADLs:
  - Feeding
  - Ambulation
  - Continence
  - Transfer
  - Bathing
  - Dressing

Hospice LCD's & ICD-9 diagnoses

- Use baseline guidelines with disease-specific guidelines in appendix
  - Meeting part II criteria alone does not qualify a patient for hospice coverage.

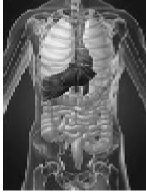
Hospice LCD's & ICD-9 diagnoses

- Disease-specific guidelines include:
  - Cancer Diagnoses
    - With distant metastases at presentation OR
    - Progression to metastatic disease with either:
      - Continued decline in spite of therapy, or
      - Patient declines further disease-directed therapy.
    - Certain cancers with poor prognoses may be hospice eligible without fulfilling the other cancer criteria.



Hospice LCD's & ICD-9 diagnoses

- Non-cancer, disease-specific diagnoses:
  - Amyotrophic Lateral Sclerosis,
  - Dementia due to Alzheimer's Disease & Related Disorders,
  - Heart Disease,
  - HIV Disease,
  - Liver Disease,
  - Pulmonary Disease,
  - Renal Disease,
  - Stroke & Coma

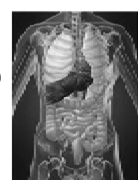


Hospice LCD's & ICD-9 diagnoses

- Non-cancer, disease-specific diagnoses:
  - ü Includes criteria specific to diagnoses;
  - ü Facilitate coverage determination;
  - ü Considered greatly during medical review;
  - ü Meeting the specific guideline is not obligatory.

Hospice LCD's & ICD-9 diagnoses

- Part III. Co-morbidities
- These diagnoses, when present, are likely to contribute to a life expectancy of six months or less:
  - Chronic obstructive pulmonary disease
  - Congestive heart failure
  - Ischemic heart disease
  - Diabetes mellitus
  - Neurologic disease (CVA, ALS, MS, Parkinson's)
  - Renal failure
  - Liver Disease
  - Neoplasia
  - Acquired immune deficiency syndrome
  - Dementia



DOCUMENTING MEDICAL NECESSITY

Documenting medical necessity

- Level of care must match patient need:
  - Routine home care
  - Continuous home care
  - Inpatient respite care
  - General inpatient care

Documenting medical necessity

- Routine home care – appropriate for:
  - Most common hospice level of care;
  - Fewer than 8 hours of nursing care required/day;
  - In the patient's residence;
  - Includes all services, supplies, and medications
    - Indicated in the plan of care as developed from the comprehensive assessment;
    - Necessary for the palliation and management of the terminal illness and related conditions.

Documenting medical necessity

- Continuous home care – appropriate for:
  - Period of crisis needing skilled nursing care
    - Palliation or management of acute medical symptoms;
    - Caregiver unable or unwilling to perform needed care;
  - Home setting or long-term care facility;
  - Primarily nursing care totaling 8 of each 24 hours;
    - At least half of the hours must be provided by a nurse;
    - Aide and homemaker services may supplement care.
  - All care/services needed during the crisis period.

Documenting medical necessity

- Inpatient respite care – appropriate for:
  - Relief for patient's caregivers;
  - Documentation must clearly show the reason for the inpatient stay.

Documenting medical necessity

- General inpatient care – appropriate for:
  - Pain and other symptom management not feasibly done at home;
  - Skilled nursing care when home support breaks down;
  - Medication adjustment, observation;
  - Stabilizing treatment, psycho-social monitoring;
  - Needed care that family refuses to allow at home.

Documenting medical necessity

- The hospice must provide all services
  - Indicated in the plan of care as
  - Necessary for the palliation and management of
    - The terminal illness and
    - Related conditions.
- Documentation must show that services are consistent with the plan of care.

Documenting medical necessity

- If documentation contradicts terminal prognosis:
  - Other documentation in the record must explain;
  - Requires documentation of re-examination of hospice eligibility.
  - If the patient is no longer terminally ill, the hospice must discharge a patient.

Documenting medical necessity

- If a hospice patient's condition improves:
  - Document process of patient re-evaluation;
  - Discharge the patient if no loner terminally ill
  - Document reasonable expectation of continued decline if improvement is expected to be brief or temporary;
    - Care can continue if decline is expected;
    - Hospice physician's verifying documentation is valuable.

Documenting medical necessity

- If MAC medical review finds that a patient record doesn't meet hospice guidelines, payment for the claim is decreased or denied.

References

- CMS Coverage Manual Chapter 09 Hospice
- MM7337
- State Operations Manual Appendix M - Hospice Interpretive Guidelines
- Hospice LCD via CGS Medicare

Thank You!

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