Hospice Clinical Documentation

Proving Hospice Regulatory Compliance

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

- 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

• 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.

• 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
  • Pain and symptom management interventions;
  • Scope and frequency of needed services;
  • Measurable outcomes anticipated;
  • Drugs and treatment needed;
  • Medical 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.

- 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 payment reform methods.

Why hospice coding matters

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

Why hospice coding matters

- Diagnosis-related CTI Content:
  - Patient's name and terminal diagnosis;
  - Prognosis: life expectancy is 6 months or less if the terminal illness runs its normal course;
  - The 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;
    - 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.
  - Assign the most specific diagnosis code available.
  - Code sign and symptom codes only when no related, definitive diagnosis has been confirmed.
  - 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:
  • Includes criteria specific to diagnoses;
  • Facilitate coverage determination;
  • Considered greatly during medical review;
  • 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 longer 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.

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

Questions?
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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