Hospice Hot Topics:

Determining Appropriate Diagnosis, Hospice Item Set (HIS), Part D Reimbursement

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Program Objectives

- Analyze clinical documentation to determine appropriate patient diagnoses
- Explain the regulatory requirements of the Hospice Item Set (HIS)
- Develop a process for compliance with Pre-Authorization of Part D prescriptions per 42 CFR § 418.202(f)
Determining Appropriate Diagnosis
Principal Illness & Terminal Condition

- The 2014 Hospice Wage Index reiterates the December 1983 final rule: “…we believe that the unique physical condition of each terminally ill patient makes it necessary for these decisions to be made on a case by case basis. It is our general view that hospices are required to provide virtually all care that is needed by terminally ill patients.”
- The hospice per diem reimbursement should provide for all of the hospice services needed to manage the patient’s care.
The Hospice Final Rule (December 1983) requires hospices to cover care for “interventions to manage pain and symptoms related to the terminal illness and related conditions (emphasis mine).” 48FR56008

COP 418.56(b) mandates a hospice provide “All services necessary for the palliation and management of the terminal illness, related conditions (emphasis mine), and interventions to manage pain and symptoms.
Principal Illness & Terminal Condition…cont.

- For example: a hospice patient with a terminal diagnosis of lung cancer might receive inhalants for the treatment of SOB related to the terminal diagnosis.
- The patient may also have bone pain associated with metastasis for which the patient receives opioids and other medications for pain relief.
- The opioids result in constipation that requires a laxative for symptom relief.
Historically, in this case scenario, hospices would admit the patient with a terminal diagnosis of lung cancer and provide interventions for symptoms related to the terminal diagnosis: medications for the relief of SOB, pain, and constipation.

The patient’s hospice Medicare benefit would cover the cost of these medical interventions.
Historically, hospices have chosen one primary diagnosis (lung cancer) and accepted responsibility for all hospice services related to that one primary diagnosis (medications for SOB, pain, and constipation).
The 2014 Wage Index states that, in light of previous statements, it is CMS’ view that “unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. ...it is the responsibility of the hospice physician to document why a patient’s medical needs would be unrelated to the terminal prognosis.”
CMS states that “it is often not a single diagnosis that represents the terminal prognosis, but the combined effects of several conditions that make the patient’s conditional terminal.”

Hospices have generally understood that it is their responsibility to provide interventions for the management of symptoms related to the terminal diagnosis, *but not necessarily to the terminal condition.*
Terminal *prognosis* is given to a patient who would be expected to die within 6 months, if their disease runs its normal course. It is a physician’s best guess of the patient’s life expectancy, given the clinical evidence for this particular patient. This takes into account everything related to the patient’s *terminal condition*.

Terminal *diagnosis* is the disease process that leads to a life expectancy of 6 months or less. This is the patient’s *principal diagnosis*. 

Principal Illness & Terminal Condition...cont.
We are seeing a shift in conversation:
- From “terminal diagnosis”
- To “terminal condition”
  - Recognizes an expanded treatment picture
- From “terminal illness,” “hospice diagnosis,” and “admission diagnosis”
- To “principal diagnosis”
  - Recognizes possibility of “other diagnoses”
Since the creation of the hospice Medicare benefit, the diagnosis patterns have dramatically changed. We have gone from predominantly cancer diagnoses to predominantly non-cancer diagnoses. In this shift, there have been significant increases in the use of non-specific, symptom-classified diagnoses. i.e. debility unspecified and Adult Failure to Thrive (AFTT)
Prevalence of Debility and AFTT

- 2002 – total hospice patients served 663,406
  #3 Debility unspecified
  #8 AFTT
- 2007 – total hospice patients served 1,039,099
  #1 Debility
  #5 AFTT
- 2012 – total hospice patients served 1,328,651
  #1 Debility
  #3 AFTT

Federal Register Volume 78, Number 91 (Friday, May 10, 2013)
Top Principal Hospice Dx FY 2012

1. Debility Unspecified – can no longer use
2. Lung Cancer
3. Adult Failure to Thrive – can no longer use
4. Congestive Heart Failure
5. COPD
6. Alzheimer’s Disease

Federal Register Volume 78, Number 91 (Friday, May 10, 2013)
ICD-9

- Reminder: Hospice benefit covers all care for the terminal illness, related conditions, and the management of pain and symptoms.
From the creation of the hospice Medicare benefit in 1983, federal regulations and the ICD–9 coding conventions have required the coding and reporting of the principal diagnosis and additional diagnoses related to the terminal condition and related conditions (i.e. co–morbid and secondary conditions)
ICD–9…cont.

- The ICD–9 further requires that non-specific, symptom diagnoses (and certain dementia diagnoses) may *not* be used as primary diagnoses.
- ICD–9 identifies “debility” and “AFTT” as “symptoms, signs, and ill-defined conditions” (or non-specific, symptom diagnoses)
- The ICD–9 has always prohibited the use of debility and AFTT as primary diagnoses.
The ICD–10 will follow the same coding conventions as the ICD–9. We must learn the coding conventions before ICD–10 is implemented.
Determining Diagnosis

- Determined by the Medical Director in collaboration with IDT
- Medical Director must use best clinical judgment in making diagnosis
- Physician’s clinical judgment must be supported by clinical documentation
- Based on comprehensive assessment, IDT collaboration, and review of all available clinical documentation
Determining Diagnosis...cont.

- Principal diagnosis is the diagnosis most contributing to the terminal illness.
- Related/non-related other conditions must be determined on a case by case basis.
- Other conditions (co-existing and co-morbid conditions) related to the terminal diagnosis must be reported on the billing claim.
  - Reported as additional diagnoses.
Determining Diagnosis...cont.

- Must document the co–morbids and how they are related/ not related to terminal illness
- Co–Morbid Conditions:
  - Conditions not related to the primary diagnosis
  - Based on the increasing number and age of beneficiaries, we can assume an increase in chronic (co–morbid) conditions.
  - i.e. Cardiovascular, Respiratory, Renal
- Secondary Conditions:
  - Conditions directly related to the primary diagnosis
  - i.e. Pressure Ulcers, contractures, pneumonia
Determining Diagnosis...cont.

- Secondary conditions related to the terminal illness should be reflected in the POC
  - Bone pain secondary to breast and lung Ca
  - Anxiety and delirium secondary to COPD
  - Dysphagia secondary to CVA
- Patient with “debility” or “AFTT” may have multiple co-morbid conditions, none of which by themselves rise to the level of terminal illness
Determining Diagnosis...cont.

- Physician’s narrative should reference appropriate Local Coverage Determinations (LCDs), prognostic indicators, functional ability scales, and symptom management scales that support the patient’s prognosis.
Determining Diagnosis...cont.

- If a principal diagnosis does not have a supporting LCD, the narrative should state that there is no LCD to support the diagnosis, and that the patient is eligible for hospice as evidenced by prognostic indicators, functional ability scales, and symptom management scales that support the patient’s prognosis.
Principal Diagnosis...cont.

- Physician’s narrative should document the related conditions (co-morbidities and secondary conditions) and how they contribute to terminal illness.
- To exclude hospice responsibility for care, the physician’s narrative should explain why a condition is *not* related to the terminal condition.
Debility Unspecified and AFTT

- CMS reiterates that patients with these non-specific, symptom-classified diagnoses are eligible for hospice benefit if they meet admission criteria of 6 months or less prognosis.
- Diagnosis must be consistent with ICD-9 coding conventions.
Debility and AFTT...cont.

More accurate diagnosis:

- Ensures more comprehensive description of hospice patient (“paints the picture”)
- Ensures that provider is treating all conditions contributing to the terminal illness
Debility and AFTT…cont.

- Non-specific, symptom-classified diagnoses (i.e. Debility Unspecified and AFFT) potentially mask underlying and potentially treatable diagnoses
- These underlying diagnoses may contribute to the patient’s terminal prognosis
Debility and AFTT...cont.

- Potential underlying diagnoses
  - Alzheimer’s and other dementias
  - CHF
  - COPD
  - Heart disease
  - Chronic kidney disease
  - Cancer diagnoses
  - Depression
Changing the Clinical Diagnosis

Changing the clinical diagnosis:

- New Certificate of Terminal Illness is not required
- Physician must document the change in diagnosis in the clinical record:
  - New diagnosis and why it changed
  - Why it is causing the prognosis of 6 months or less
  - Evidence of prognostic indicators (as applicable)
  - Reference to outcomes of symptom assessment scales as applicable
  - Document IDT collaboration and effect on Plan of Care
Clinical Documentation

- Who is the primary physician?
  - Only the Medical Director...
    - Admits the patient
    - Determines principal diagnosis
    - Determines co-morbid and secondary conditions
    - Determines related/non related conditions and medications
  - Documented evidence that Medical Director has made these determinations
Medical Director’s collaboration w/ IDT
- Complicated cases may require additional collaboration and higher level of scrutiny to determine appropriateness and diagnoses

Evidence of collaboration w/ Attending

Physician’s narrative
- Composed by Medical Director
- Contains measurable data
- Reference LCD is appropriate
- Evidence for what is related/non-related
- Co-morbidities and secondary conditions
Clinical notes

- Conversation with patient / caregiver re: what is related/not related
- Complete and thorough assessments
- Collaboration with staff (outside of IDT), vendors, NF, ALF, hospitals, in-patient units, etc.
- Differentiation in clinical notes between related/not related conditions
Patient changes are documented
  ◦ Changes in LOC
  ◦ Changes in diagnosis
  ◦ Identify new meds as related/not related

Ongoing staff education and training documented in the personnel record

Current/updated policies and procedures

Evidence that QAPI process incorporates education/training, changes to policies, PIPs as appropriate
What to Do

- Review all patients with principal diagnosis of debility or AFTT; change diagnoses
  - Contact Palmetto for procedures to change Notice of Election (NOE should match billing diagnosis)
- Review process for gathering admission clinical documentation
- Educate staff about coding multiple diagnoses
- Review POC for hospice responsibility for services
- Review cert/recert narratives for explanation of why patient’s medical need is unrelated to terminal condition
What to Do…cont.

- What do you do…
  - When there is no documented evidence of organ-based diagnosis, and
  - No clear underlying disease process, and
  - Patient is clearly hospice appropriate
What to Do…cont.

- Certifying physician must choose the condition that most contributes to the terminal prognosis (principal diagnosis)
  - Narrative must explain why this is an appropriate diagnosis (include supporting data)
  - Explain what is related/non-related and why
- Code principal diagnosis first
- Code all related conditions (dysphagia, malnutrition, decreased functional status, muscle weakness)
2014 Final Rule stated “Debility” and “Adult failure to thrive” are not acceptable as principal diagnoses and audits will be coming.
Effective October 1, 2014, claims with non-specific or ill-defined primary diagnosis (Debility and AFTT) will be returned to the provider (RTP) by MAC.
Resources

FY 2014 Hospice Wage Index:

NHPCO:
http://www.nhpco.org/

CMS:
http://www.cms.gov/Center/Provider-Type/Hospice-Center.html
Hospice Item Set (HIS)
What is Hospice Item Set Reporting

- Hospice Quality Reporting Program is mandated by the 2010 Affordable Care Act
- Currently a “pay-for-reporting” system, not a “pay-for-performance” system
- Performance level is not a factor in determining reimbursement
- HIS is a snapshot in time. It does not reflect the patient’s status throughout their hospice admission.
HIS 2014 Data Submission

- 2014 HIS submission begins July 1, 2014
- Two HIS reports for each patient: admission report and discharge report
- HIS data collection training sessions were held on February 4 & 5, and are available on CMS website (see Resources at end of slides)
- HIS technical training (with additional instruction) begins in May 2014
- Data collection and report for CY 2014 effects reimbursement for FY 2016
Penalty for Non-Report

- All Medicare hospice providers with active CNN number (provider number) must report.
- Hospices awaiting certification will be expected to have HIS processes in place at the time of their initial survey for deemed status.
- 2% reduction in market basket for FY 2016 if non-report.
- Must submit both reports (admit and discharge) for all admissions.
Hospice Item Set

- Previous HQR Structural Measure and NQF 0209 have been eliminated
- 2014 will begin collection of new data
- Need a new account for HIS; HQR account is no longer operational
- Data will be used in determining future reimbursement models
Hospice Item Set...cont.

- HIS (Hospice Item Set) *is*:
  - Set of data elements endorsed by National Quality Forum
  - Used to calculate 7 quality measures
  - A standardized mechanism for abstracting data from the medical record

- HIS is *not*:
  - A patient assessment tool
  - Will not be administered to patient/family/PCG
Submit admission and discharge data for ALL patients regardless of:
  ◦ Payor source (Medicare, Medicaid, private payor)
  ◦ Patient age
  ◦ Location where patient receives services: home, NF, ALF, in- patient
  ◦ If patient is a transfer
  ◦ Previous revocation or discharge
Required to submit two HIS records for each admission:

- HIS–Admission record (45 data elements)
  - Contains administrative data about patient
  - Contains clinical items to calculate the 7 quality measures
- HIS–Discharge record (15 data elements)
  - Contains limited set of administrative items for patient identification
  - Contains discharge information used to determine exclusions for quality measures (i.e. LOS)
HIS…cont.

- Submitted electronically (no paper transmission)
- Admit and discharge date may be the same
- Submitted on an ongoing basis
  - Have 14 calendar days from admit to complete HIS–Admit records
  - Have 7 calendar days from discharge to complete HIS–Discharge records
  - Have 30 calendar days from Admit or Discharge to submit HIS records to CMS
Administrative Information

- Admission date is date of EOB to your hospice, for this benefit period
- Discharge date is date patient leaves your hospice
- Admit and discharge can be the same day
- Leave unknown patient information blank
- Patient setting prior to admission may not change with hospice admission i.e. LTCF, home
Patient Preferences

- HIS documents discussion w/ patient, not the patient’s decision. Date of conversation is not affected by patient changing her/his mind during subsequent conversations. (Snapshot in time.)
- Initial conversation merely opens the door
- May consider conversations during a pre-admission or education visit
- Responsible party means person legally responsible
CPR Preference

- HIS: Was the patient/responsible party asked about preference regarding use of CPR?
- HIS: Date the patient was first asked...
- Must ask patient preferences even if they are recorded on referral documentation – patient may make new decision w/ hospice admit.
- Orders for “DNR” do not meet the criteria for discussion of patient preferences.
- HIS documents discussion w/ patient, not the patient’s decision. Date of conversation is not effected by patient changing her/his mind during subsequent conversations. (Snapshot in time.)
- May consider documentation from educational or pre-admit visit.
CPR Preference…cont.

- SCENARIO: patient admitted 08/01/2014. 08/01/2014 clinical note states “Talked w/ Pt about DNR status. Pt is not sure and wants to discuss this further w/ family.”
- 08/05/2014 Clinical note states “Discussed DNR status, DNR signed.”
- For HIS, what is the date the patient was first asked about CPR preferences?
  - 08/01/2014
  - Subsequent conversation does not impact the HIS
CPR Preference…cont.

- Patient admitted 08/01/2014 Clinical record documents DNR is in effect, dated 07/15/2013.
- Does this meet the burden for HIS discussion?
- What would need to be done to meet the burden? (Conversation to verify DNR status.)
Other Life-Sustaining Preferences

- HIS: Was the patient/responsible party asked about life-sustaining preferences other than CPR?
- HIS: Date the patient was first asked...
- Must ask patient preferences even if they are recorded on referral documentation.
- Conversation can be initiated by any hospice staff – who will do this for your agency?
- Where will you record this data in the patient’s record?
- CMS does not specify what “other” discussion is applicable. You will need to define this and teach your staff what and where to document. e.g. vent, dialysis, tube feedings, blood, antibiotics, IVs
- May consider information from educational or pre-admit visit.

Clinical note 06/30/2014 “Pt states she wishes to have antibiotics if needed.”

What is the date patient was first asked about antibiotics?
- 06/23/2014
- Patient’s subsequent decision does not impact HIS.
Hospitalization

- HIS: Was the patient/responsible party asked about preference regarding hospitalization?
- HIS: Date patient was first asked...
- Must ask patient preferences even if they are recorded on referral documentation.
- Does not refer to hospice respite or GIP
- Conversation may be initiated by any hospice staff.
- Who will ask, what will they ask, where will it be documented?
- May consider information from educational or pre-admit visit.
Spiritual/Existential Concerns

- HIS: Was the patient/caregiver asked about spiritual/existential concerns? HIS: Date patient was first asked...
- Documentation of evidence of a discussion. Clinical documentation of patient’s religious preference does not meet the standard.
- Caregiver may not necessarily be person legally responsible
- Patient/caregiver may refuse to discuss.
- There is no comprehensive list of existential questions/concerns. How will you define/document this?
- Note that question asks the Pt or “Caregiver.” Question may be answered by someone other than responsible party.
Active Diagnosis

- Record the patient’s principal diagnosis at the time of admission – the diagnosis that most contributes to the patient’s terminal condition.
- Determined by the Medical Director in collaboration with the IDT.
- Diagnosis code must match ICD–9/10
- Three choices:
  - Cancer
  - Dementia/Alzheimer’s
  - None of the above
Pain Screen

- HIS: Was the patient screened for pain?
- HIS: Date for screening
- HIS: Pain severity – for HIS reporting, score is converted to none, mild, moderate, severe, or not rated
- HIS: Type of standardized pain screening tool
- Must use a standardized test for screening. Reported on HIS as numeric, verbal, visual, staff observation, or none used.
Pain Screen…cont.

- Report score at the time of the assessment.
- If a range is given during the screen, document the highest level of pain.
- Clinical judgment can be used to document severity of pain if screening tool does not provide.
- Screen tool may not be required if patient reports she/he is not in pain and appears to be comfortable.
Pain Screen...cont.

- SCENARIO: Clinical note states “Pt drowsy, appears comfortable.”
- Is this a pain screen? Yes.
  - Although there is no standardized tool, it is clear the clinician did an assessment.
Pain Screen...cont.

- SCENARIO: Clinical record states “Pt pain free now, reports abdominal pain rated 4–5 through the night.”
- What is the pain screen for this screen?
  - 4–5 (reported in HIS as “moderate”)
  - HIS records the greater pain when a range is reported
Comprehensive Pain Assessment

- HIS: Was a comprehensive pain assessment done?
- HIS: Date of pain assessment.
- Documentation of the following is acceptable evidence of pain assessment:
  - Caregiver report of pain
  - Non-verbal indicators of pain
  - Documentation of the clinician’s attempt to gather information about pain
Comprehensive Pain Assessment…cont.

- A comprehensive pain assessment consists of seven elements.
  - Location
  - Severity
  - Character
  - Duration
  - Frequency
  - What relieves/worsens pain
  - Effect on function or quality of life
**SOB Screen**

- HIS: Was the patient screened for shortness of breath?
- HIS: Date of screen.
- No standardized assessment tool is required for assessment of SOB
- If SOB present, screen must include documentation of severity
- Documentation of a positive screen may include Patient’s verbal statements, caregiver reports, clinician’s observations
- Changes in patient status over time do not impact the HIS. (Snapshot in time.)
Treatment for SOB

- HIS: Was treatment of shortness of breath initiated?
- HIS: Date treatment was initiated.
- HIS: Types of treatment initiated:
  - Opioids
  - Other medication
  - Oxygen
  - Non-medication
- Consider both scheduled and PRN meds
- Include standing orders only if they are initiated
- For this question, include only those treatments specifically ordered in response to this positive SOB screen. Meds may be ordered for multiple purposes. i.e. pain or SOB
Treatment for SOB…cont.

- Non-medications interventions (other than O2) may include:
  - Repositioning
  - Fans
  - HOB elevated
  - Relaxation techniques
  - Breathing exercises
  - Patient education about energy conservation
Treatment for SOB…cont.

SCENARIO: 08/17/2014  Clinical note states “Pt reports SOB at rest.” Clinical assessment of dyspnea, rapid and shallow respirations. Instructed PCG in use of fan and elevated HOB. 08/15/2014 order for PRN morphine. What is date treatment was initiated? What treatment?

- Treatment date 08/17 (fan and HOB). Cannot use MS order because it does not state intended use for SOB.
- Treatments: fan, HOB
SCENARIO: “08/19/2014 Clinical assessment of SOB, discussion with PCG on use of fan and elevated HOB. 08/20/2014 O2 ordered.”
What is date of initiation of treatment?
  ◦ Treatment date 08/19/2014 for patient instruction.
  ◦ Treatments: instruction and O2.
NOTE: Next HIS section on medications is not specific to treatment for dyspnea!
Medications – Scheduled Opioid

- HIS: Was a scheduled opioid initiated or continued?
- HIS: Date opioid initiated or continued.
- If patient received several different opioids in sequence over time, record the date the first opioid was initiated.
- Date is defined as the date the order was received not date first dose was taken.
- Order may be written or verbal.
- Answer “yes” if regularly scheduled opioid is initiated, regardless of reason.
Medications – PRN Opioid

- HIS: Was a PRN opioid initiated or continued?
- HIS: Date opioid initiated or continued.
- If patient received several different PRN opioids in sequence over time, record the date the first PRN opioid was initiated.
- Date is defined as the date the order was received not date the first dose was taken.
- Order may be written or verbal.
- Answer “yes” if PRN opioid is initiated, regardless of reason.
Bowel Regimen

- HIS: Was a bowel regimen initiated or continued?  N  No, but…  Y
- HIS: Date bowel regimen was initiated or continued.
- Orders may include regularly scheduled treatments/med or PRN.
- Physician’s order may not be present for nursing instruction. i.e. prune juice or high fiber diet
- Bowel regimen may include:
  ◦ Laxatives or stool softeners
  ◦ High fiber supplements
  ◦ Enemas
  ◦ Suppositories
  ◦ Non-pharmacologic regimen (prune juice, high fiber diet)
Bowel Regimen...cont.

- Documentation of why a bowel regimen was not initiated (No, but...), may include:
  - Bowel obstruction, ileus
  - Diarrhea
  - No bowel function
  - Colostomy/ileostomy
  - Nausea/vomiting
  - Recent abdominal surgery
  - NPO
  - Bowel regimen offered and refused by patient
Bowel Regimen…cont.

- HIS record of bowel regimen is linked to relief of constipation from any cause and not exclusively linked to opioid prescription.
- It may be necessary to review other parts of the clinical record to find documented evidence of bowel regimen or contraindications. e.g.:
  - In the GI assessment
  - In nutritional assessment
Record Administration – Section Z

- Any staff may complete the HIS report.
- Clinician who does screens and assessments may not be the person completing the HIS.
- Multiple staff may make entries in the HIS.
- Administrative signatures must include everyone who recorded data in the HIS report.
- Each person signs the report and records which sections of the report they completed.
Record Administration – Section Z…cont.

- Signature on the HIS record does not attest to the accuracy of the assessments in the clinical record.
- Signature on the HIS record certifies only that the HIS record itself is complete.
- If EMR extracts data for HIS, signature page must still be signed.
Capturing the HQR Data

- Analyze your existing forms for presence/absence of each of the HIS measures (mapping)
- Review clinical forms
  - Comprehensive Assessment, including Initial Nursing Assessment, SW Assessment, and Spiritual Assessment
  - Nursing Visit Note
  - QAPI Chart Audit Tool – for ongoing monitoring of HIS process
Capturing Data...cont.

- Data elements to find in current forms:
  - CPR preferences
  - Other life-sustaining treatment preferences
  - Hospitalization preferences
  - Spiritual/existential concerns
  - Pain screening on admit
  - Comprehensive pain assessment
  - SOB assessment
  - SOB treatment
  - Scheduled and PRN opioids
  - Bowel regimen
Capturing Data…cont.

- Can you find all of the HIS measures in your assessments and audit tools?
- Identify presence or absence of specific measures; revise forms accordingly
- Educate staff to observe and record data in a systematic way
Creating a HIS process to:
- Screen and assess
- Document in the clinical record
- Locate appropriate data in the clinical record
- Process for extracting data from the clinical record
Capturing Data…cont.

- Where in the clinical record are each of the data elements documented?
  - One place?
  - Multiple places?
  - Where???

- Identify staff who will:
  - Ask HIS questions, do screens and assessments
  - Collect data from patient records
  - Report data on the HIS
  - These may be different people
Reporting Data

- Only data available in the patient’s clinical record may be used for HIS.
- Evidence found in referral documentation does not apply.
- Retain a copy of the HIS and signature page.

Appendix C of HIS manual gives guidance on how to use the HIS data to calculate the NQF (National Quality Forum) measures. This is not a requirement, but may be used in your QAPI process.
Time/Cost Burdens*

- **Time Estimate:**
  - Average admissions per hospice/mo = 24
  - Estimated # of HIS records/mo = 49

- **Cost Estimate**
  - $3,818.26 annual cost per hospice
    - Includes clinical and admin/clerical time to abstract and upload assessment data for admission reports, and abstract and upload data for discharge reports
    - Cost to provider per patient = $13.11

*Based on 2011 statistics from Medicare and US Bureau of Labor Statistics
See Paper Reduction Act (PRA) CMS 10390
Documenting the HIS: Clinical Review
Review of HIS Data Elements

- Data elements to find in forms:
  - CPR preferences
  - Other life-sustaining treatment preferences
  - Hospitalization preferences
  - Spiritual/existential concerns
  - Pain screening on admit
  - Comprehensive pain assessment
  - SOB assessment
  - SOB treatment
  - Scheduled and PRN opioids
  - Bowel regimen
HIS Resources

- Hospice Item Set (HIS)

- HIS Data collection training video:

- National Quality Forum measure search:
  [http://www.qualityforum.org/Home.aspx](http://www.qualityforum.org/Home.aspx)
Part D Prescription Reimbursement
2014 Part D Final Guidance

- Each April, CMS issues Call Letters in anticipation of needs for following year.
  - Call Letter was issued in April 2013 for CY 2014
- After the April 2013 Call Letter was issued, CMS became aware of need to clarify
  - Request sent to hospices for feedback; 130 responses received
  - Clarification memorandum issued December 2013
- Final guidance issued March 10, 2014
In 2013, CMS’ Center for Program Integrity reviewed data for reported prescriptions for analgesics paid under Part D during a hospice election

- Part D sponsors were ordered to recover payment from hospices

The 2013 Call Letter strongly encouraged Part D sponsors to place pre-authorization requirements for four categories of drugs: analgesics, anti-emetics, laxatives, and anti-anxiety medications
2014 Final Part D Guidance…cont.

- 2014 Final Guidance directs Part D sponsors to place pre-authorization requirements on all drugs for beneficiaries who have elected hospice to determine if drugs are coverable under Part D
- Prevents duplicate payments for medications
  - That should be covered under the hospice benefit
  - That are waived through the hospice election
- Final guidance requires explanation of all medications unrelated to the patient's terminal illness and related conditions. This is called “Rationale for Treatment.”
Prior to admission, many hospice patients receive medications through their Medicare Part D prescription plans.

Pre-authorization will now be required in order for the patient to fill those non-related prescriptions,

- *If* patient continues on those medications, and
- *If* those medications will not be part of the Hospice Plan of Care (there could be several reasons for this)
Each Part D sponsor will initiate the pre-authorization, by verifying with the patient and prescribing physician/s whether the medications are related to the hospice diagnosis or related conditions.

Hospices must provide an explanation of why medication should not be covered under the hospice EOB

Hospices can facilitate the process of pre-authorization:
  ◦ By being proactive in gathering patient medication data
  ◦ By supplying information to Part D sponsors and pharmacies
  ◦ By advocating for patients.
2014 Final Guidance...cont.

- CMS has stated it will not issue further guidance in 2014 for Part D Pre-Authorization.
- CMS has issued no standard forms for Pre-Authorization and will consider issuing one in 2015.
- 2014 policy will be effective May 1, 2014 (though some denials have already started, esp. for patients residing in NF)
CMS has not issued a specific hospice–sponsor communication process

Hospice may initiate communication with Part D sponsor; this is not required

Each Part D sponsor will have its own process

Each Part D sponsor is at a different point of readiness

If there is a dispute over who will cover meds, patient/hospice/Part D will have to negotiate
  ◦ This is a CMS expectation, but is not enforceable

CMS will issue no dispute resolution process for 2014
CMS states, “Hospices should use thoughtful clinical judgment, with a patient–centered focus, when developing the hospice plan of care, including the recommendations for medication management.”
Facilitating Pre-Authorization

- Patient Admit Pack – Include language in your hospice Admit Pack:
  - Hospice is required to review all medications to determine relatedness to the patient's terminal diagnosis or related conditions
  - Letter should be a simple explanation. Medicare language can be confusing
  - Describe your process, and the potential impact to patient
Facilitating Pre-Authorization…cont.

- Determine whether or not the patient is enrolled in a Part D Prescription Plan: identify the Plan
  - *PREFERRED Method – Review the patient's Part D identification card; contact info and fax number to send pre-authorization information
  - Check HIPPA Eligibility Transaction System (HETS)
  - Contact pre-hospice pharmacy provider for information
  - Hospice pharmacy may initiate an electronic eligibility (EI) query
Facilitating Pre-Authorization…cont.

- Describe the new Pre-Authorization process to patient/responsible party
  - Review all medications with patient/responsible party
  - Verify non-relatedness of medications that will continue to be covered under Part D
  - Explain the possibility of patient liability to pay out of pocket for medications not included in the patient's hospice Plan of Care; medications that are not medically necessary; or medications not on the hospice formulary
Facilitating Pre-Authorization…cont.

- File the patient's Notice of Election of Benefits as soon as possible
- Pro-actively gather and communicate patient medication information to the patient's Plan D sponsor
  - Create a form for systematically gathering data
- Communicate with pharmacies and NF
Facilitating Pre-Authorization…cont.

- Review all patient medications to determine:
  - Whether they are related to the patient's terminal diagnosis or related conditions
  - Whether medications will be covered under the Hospice benefit or Part D Plan
  - Physician documentation (physician narrative) of clinical reason why each medication is unrelated to the terminal diagnosis or related conditions
  - Discuss determinations with patient/responsible party
Facilitating Pre-Authorization…cont.

- Review medications that are:
  - Related to patient’s terminal condition
  - Related but no longer medically necessary
  - Unrelated to terminal condition and eligible under Part D
  - Unrelated and no longer medically necessary
Facilitating Pre-Authorization…cont.

Discuss with your Medical Director the continuing medical necessity of:

- Warfarin
- Statins
- Clopidogrel
- Furosemide (long term use)
- Bisphosphonates
- Donepezil (and others used to treat dementia)
- Sulfonylureas and insulin
- Vitamins E, A, D
- Antihypertensives
- Psychogenics
Facilitating Pre-Authorization…cont.

- Review medical necessity…cont.
  - Beta-agonists anticholinergics, and other inhalers
- May need to taper:
  - Anti-depressants
  - Anti-psychotics
  - Anti-epileptics
  - Cardiac meds
  - Anti-hypertensives
  - Muscle relaxants
  - Corticosteroids
Facilitating Pre–Authorization…cont.

Work with your Medical Director and pharmacist to appropriate medications for end–of–life palliative care.

- Review
- Change
- Taper
- Continue
Facilitating Pre-Authorization…cont.

- Inform patient/responsible party of potential liability for payment of medications and ABN
- Inform patient/responsible party of patient's right to appeal a denial of Part D claim for reimbursement
Facilitating Pre–Authorization…cont.

- Contact the patient's attending physician or other physicians who prescribe patient medications
  - Physicians may be required to complete Pre–Authorization forms
  - Physician must attest that medications have been reviewed with hospice
Part D Preparation

- Consider writing a letter to your patients to include in your Admit Pack, highlighting:
  - The new CMS requirement for pre-authorization
  - Hospice’s responsibility to provide and pay for medications related to the principal diagnosis and any related conditions that are reasonable and necessary for the treatment of the terminal diagnosis and related conditions
Part D Preparation...cont.

- Letter to patients...
  - Your agency’s process for determining related/unrelated medications
  - Situations in which the patient might anticipate having to pay for medications out of pocket (ABN)
  - The appeals process for denials of claims submitted to Part D prescription plans
Advanced Beneficiary Notice – (ABN)

- Purpose:
  - To inform the patient, before they receive items or services, that Medicare probably will not pay for them on that particular occasion.
- Use CMS form: ABN (CMS–R–131)
- Agency staff are required to explain entire notice and its content and answer patient questions.
The situations that would require mandatory issuance of the ABN to a hospice patient are:

- Patient wants to continue taking medications for treatment of terminal illness and/or related conditions when those medications have been discontinued upon hospice election
  - i.e. Medications determined by the IDT to be no longer effective for the intended treatment
  - Medications that cause additional negative symptoms in the patient
Situations…cont.

- Patient requests a medication for treatment of the terminal illness or related conditions that is not on the hospice formulary and patient refuses to try a formulary equivalent first.
- Patient wants to continue a medication the IDT determines is unreasonable and unnecessary for the palliation of pain/symptom management.
To date, CMS has given no guidance about providing either the Notice of Medicare Non-Coverage (NOMNC) or the Detailed Explanation of Non-Coverage (DENC)
Patient Appeals

- To date, there are no processes in place to mediate disputes over Part D reimbursement
- Patient should be directed to Plan D sponsor
- Patient may appeal the hospice decision to not include a drug on the Plan of Care
- Patient may submit a claim directly to Medicare on form CMS–1490S
Patient may submit quality of care complaints to the OIG
- i.e. when patient believes a non-formulary drug is more efficacious than formulary drug prescribed by hospice
- Texas QIO is TMF Health Quality Institute
Review Pre-authorization
Part D Resources

- Part D Payment for Drugs for Beneficiaries Enrolled in Hospice – CMS 2014 Final Guidance (March 10, 2014)

- To download ABN notice, and Generic Notice for Expedited Determination:
  http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
Part D Resources…cont.

- Notice of Medicare Non-Coverage

- From CMS-1490S – Patient’s request for medical payment
Part D Resources…cont.

CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 2864


Palmetto Hospice Coalition Q&A, March 6, 2014: