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Hospice - Documenting Slow Decline

Sandy Decker RN BSN
Senior Provider Education Consultant
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CMS
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Hospice Clinical Resources

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 9)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

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Documenting Terminal Status

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Effective Documentation of Terminal Status

Decisions are reliant upon documentation

Results in a **full** denial for the submission

Documentation must be **legible**

Medical necessity is always based on the patient's condition

- Is it the **patient** or the **documentation**?
- Make the reviewer **see** the patient
  - The reviewer isn't allowed to read between the lines

Effective Documentation of Terminal Status

Documentation is expected to show **significant changes** in the beneficiary's condition and plan of care

- Always include admission assessment
- Decline must be evident in documentation
- Chart or graph may be helpful

Effective Documentation of Terminal Status

Documentation must "paint the picture", especially for **long-term** hospice patients, or those with **chronic** illness and general decline

Use **quantifiable** values and measurements to show changes

Graphs can **show trends**, even though the visit to visit changes may seem minimal

Weight

Weight

- Document patient's weight **at least monthly** and more often if possible
- Take weights in **consistent** fashion
  - Time of day
  - Clothing
  - Consistency in relation to meal time
- Show **prior and current** weights
  - Don't - "loss of 4 pounds in since last weighing"
  - Do – Patient went from 132 pounds on January 17, 2018 to 128 pounds on February 20, 2018, showing a loss of 4 pounds (3%) in 34 days.

Measurements

Measurements

- **Upper arm**/girth/leg measurements **starting at admission**
  - Even if able to weigh patient
  - Shows trend if suddenly unable to weigh
- Include **policy** in documentation that shows how and where measurements are taken
  - Be consistent!

Pain

- **Level** of pain
  - 0-10 scale is preferable, but may not be workable
  - Consistent method of pain measurement is key
- Expressed in the way **patient/caregiver** understands
  - Colors
  - Small, Medium, Big
  - Wong-Baker FACES Pain Rating Scale

Pain

- Type of pain
- Body language!!!
- Document any **extenuating** circumstances
  - Examples: Wound care just completed, ready for pain meds, etc.

Responsiveness

Responsiveness

- Does the patient react to your presence?
- Is the patient frightened of you?
- Does the patient **remember** you from last visit?
- Does the patient remember why you're there?
- Unresponsive
  - Respond to touch? Smell? Light?
- Fades in and out of alertness?

ADLs

Levels of Activities of Daily Living (ADL) dependence

- What can they do **SAFELY**?
  - Examples – getting in/out of shower, ambulate while carrying food
- Are they impulsive?

Vital Signs

Vital signs

- Respiration rate, blood pressure, pulse, temperature
- **Graph** easily shows change
- Does patient have a response to the procedure?

Strength

Strength

- Ask the patient to squeeze your hands
  - Is there a difference from last visit?
  - Can the patient raise their hands to yours?
- Is the patient able to stand?
  - Assisted or unassisted
  - How **long**?
  - Safely?

Lucidity

Lucidity

- Can the patient carry on a **lucid** conversation?
  - If you change the subject abruptly can they still follow along?
- Can the patient make decisions?
  - Simple or complex
- Current events
  - Inside or outside their world

I's and O's

Intake

- Make sure the serving size is **appropriate** and **consistent**
- Check for dehydration
- Is there a system in place to measure output that is **workable** for the patient/family?
- Is the patient offered food that they like and is appropriate for them?
- Appetite persistent or changing?

I's and O's

Output

- Requests a catheter
- Incontinence

Aspiration

- Observed? By whom?
- Recurrent?
- Mild choking vs. aspiration
- Aspiration pneumonia must be confirmed by physician

Fatigue

- Meet you at the door?
- Too tired to get out of chair?
- Recurrent?
- Too tired for self grooming?
- Too tired to prepare food or eat?
- No longer does favorite tasks?

Agitation

- New
- Variable levels
- Unable to participate in conversation
- New?
- Increased?
- How easily is the patient agitated?

Tummy Trouble

GI Concerns

- Diarrhea
- Constipation
- Nausea
- Vomiting
- Persistent/changing

Skin

- Broken skin vs. fragile skin
- **Stage** wounds whenever possible
- Redness?
- Itching?
- Pale or flushed?
- Diaphoretic?

Social Status

Change in social support

Relationships

Effective Documentation of Terminal Status

Pitfalls in terminal prognosis documentation:

- Paradigm **shift** for medical professionals
  - Have been trained to show **improvement** – not **decline**
- Amount and detail dependent upon **situation**
  - Chronic, deteriorating condition vs. rapid progression
  - Chronic, deteriorating condition may depend upon small details
  - Rapid progression may be focused on only one symptom

Effective Documentation of Terminal Status

Failing to show "big picture"

- Send in relevant documentation **outside** of period requested
  - Always send in admission assessments
- Remember the reviewer can't see the person
  - Chart the obvious
  - Decrease in appetite may mean the patient's dentures no longer fit or they don't like what is being served
- Should be able to identify person from the documentation **without** seeing the name

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Effective Documentation of Terminal Status

Obtain history and physical information

- May come from **more than one** source
  - Different sources may have different focus
  - Dietician, emergency room staff
- Recent hospital stay?
- Lives or lived at facility?
- What does caregiver notice?

Effective Documentation of Terminal Status

Use functional scale, as appropriate and always **tell what changed** to make change in status

- Karnofsky Performance Scale (KPS)
  - 30%, 40%, 50%, etc.
  - Don't average numbers
- Palliative Performance Scale (PPS)
  - 30%, 40%, 50%, etc.
  - Don't average numbers

Effective Documentation of Terminal Status

Use functional scale, as appropriate and always **tell what changed** to make change in status

- Functional Assessment Staging (FAST)
- New York Heart Association (NYHA)
  - Should be determined by physician

Effective Documentation of Terminal Status

Don't forget documentation from the interdisciplinary group (IDG) meetings

- Information from **other** staff members
  - May have **different** perspectives
  - Different staff members see patient at different **times** and in different **circumstances**
  - Example – nurse compared with social worker or chaplain
  - Aides have valuable information. See patient at most vulnerable.

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Effective Documentation of Terminal Status

- Refer to Local Coverage Determination (LCD) for **guidance**
- Use numbers
- Use observations and data, **not** conclusions
- Clinical indicators of decline
  - Weight loss, infections, changes in mobility, etc.
- Review terminal **admitting** diagnosis – still appropriate?
- Reassessment is **ongoing**
- Remember **quality versus quantity**

Effective Documentation of Terminal Status

Common errors include:

- Documentation by various disciplines do not show same level of decline
- No measurable signs/symptoms presented for comparison
- Documentation does not support terminal status
- Documentation shows hospice benefit being utilized as long-term care benefit

Results in partial or full denial

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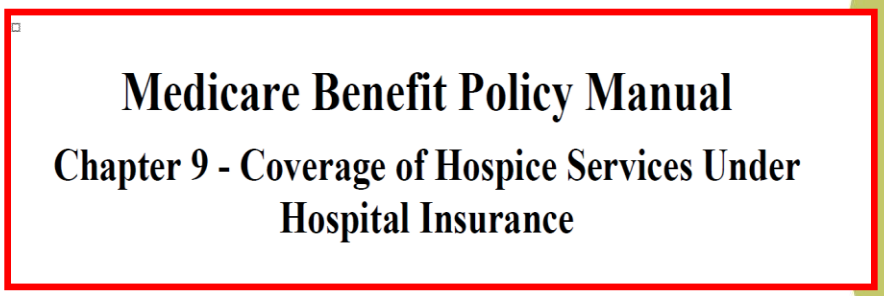


Resources

CGS HHH Medicare Bulletins

http://www.cgsmedicare.com/hhh/pubs/mb_hhh/index.html

- Published monthly (links to prior bulletins)
- Compilation of news for hospice and home health providers

CGS ListServ messages

http://www.cgsmedicare.com/hhh/pubs/news/index.html

- 'Recent News' Web page
- Timely access to current news and publications

http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp

- Join/Update Listserv

Six Months or Less Terminal Prognosis

http://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/hospice_documentation.html

Hospice Documentation

Hospice providers must establish and maintain a clinical record for every individual receiving care and services.

- The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.
- The record must include all services, whether furnished directly or under arrangements made by the hospice.
- Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy is six months or less.
- Hospice benefit periods are unlimited as long as the above remains true and documentation of disease progression is evident.
- Generally, a beneficiary will show decline from one certification period to the next; however, this may not be the case for some beneficiaries whose condition may not run the normal course of decline and remain temporarily unchanged. However, documentation in the medical record should still show that the beneficiary has a six month prognosis.
- Documentation notes from multiple disciplines involved in the care of the beneficiary should demonstrate a picture of the beneficiary's terminal progression. Avoid vague statement such as "slow decline" or "disease progressing" that do not clearly support the terminal progression requirements; the more objective the documentation, the better.
- When receiving a beneficiary as a transfer from another agency in the middle of a benefit period, obtain a copy of the signed certification for that benefit period from the transferring agency to complete that benefit period. **Remember that the benefit period does not change due to a transfer.**
- When a beneficiary's level of care changes, the documentation should show when the change occurred and the reason for the change.

Additional Resources

"Suggestions for Improved Documentation to Support Medicare Hospice Services PDF" quick resource tool

"Appropriate Clinical Factors to Consider During Recertification of Medicare Hospice Patients PDF" quick resource tool

Six Months or Less Terminal Prognosis

https://cgsmedicare.com/hhh/education/materials/pdf/hospice_documentation_tool.pdf

SUGGESTIONS FOR IMPROVED DOCUMENTATION *to Support Medicare Hospice Services*

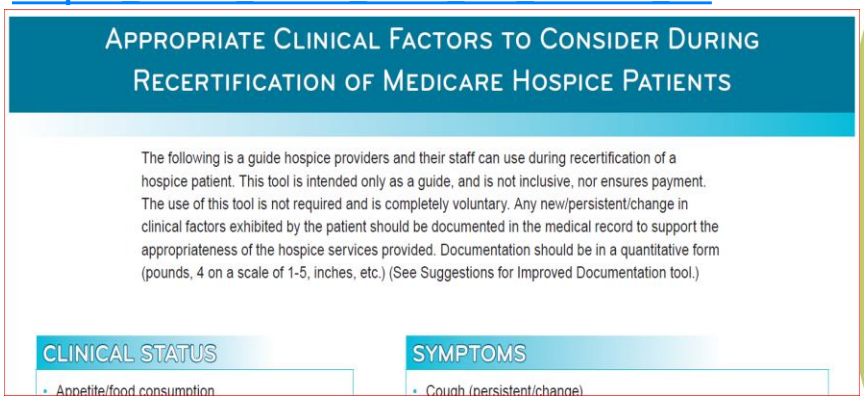
The following list is a guide for hospice providers and their staff to improve documentation of Medicare covered hospice services by including basic documentation. This list is intended only as a guide, and is not inclusive, nor ensures payment. Remember, the documentation must present a visual picture of the patient, their conditions and symptoms to support the terminal prognosis.

Documentation to Support Hospice Admission

- Change in condition to initiate hospice referral
- Diagnostic documentation to support terminal illness
- Change in anthropomorphic measures
  - Upper arm measurement (inches, centimeters)
  - Abdominal girth (inches, centimeters)
- Change in signs

Six Months or Less Terminal Prognosis

http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_clinical_factors_recert_tool_h-020-01_07-



APPROPRIATE CLINICAL FACTORS TO CONSIDER DURING RECERTIFICATION OF MEDICARE HOSPICE PATIENTS

The following is a guide hospice providers and their staff can use during recertification of a hospice patient. This tool is intended only as a guide, and is not inclusive, nor ensures payment. The use of this tool is not required and is completely voluntary. Any new/persistent/change in clinical factors exhibited by the patient should be documented in the medical record to support the appropriateness of the hospice services provided. Documentation should be in a quantitative form (pounds, 4 on a scale of 1-5, inches, etc.) (See Suggestions for Improved Documentation tool.)

CLINICAL STATUS

- Appetite/food consumption

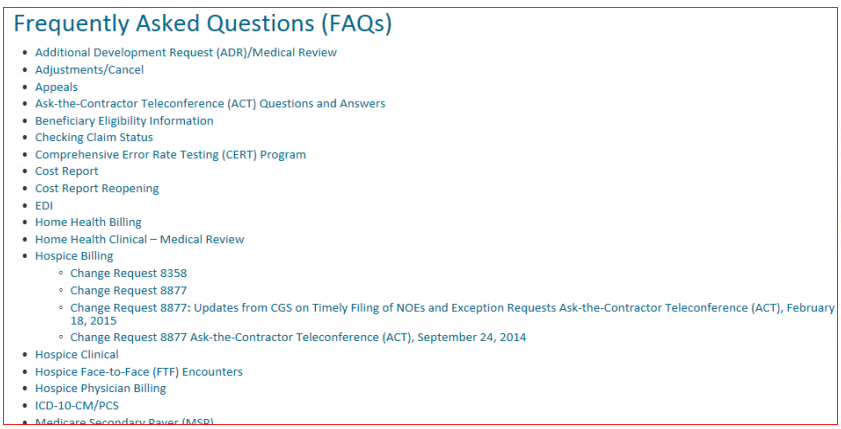
SYMPTOMS

- Cough (persistent/change)

Resources

CGS Frequently Asked Questions

http://www.cgsmedicare.com/hhh/education/faqs/index.html



Frequently Asked Questions (FAQs)

- Additional Development Request (ADR)/Medical Review
- Adjustments/Cancel
- Appeals
- Ask-the-Contractor Teleconference (ACT) Questions and Answers
- Beneficiary Eligibility Information
- Checking Claim Status
- Comprehensive Error Rate Testing (CERT) Program
- Cost Report
- Cost Report Reopening
- EDI
- Home Health Billing
- Home Health Clinical – Medical Review
- Hospice Billing
  - Change Request 8358
  - Change Request 8877
  - Change Request 8877: Updates from CGS on Timely Filing of NOEs and Exception Requests Ask-the-Contractor Teleconference (ACT), February 18, 2015
  - Change Request 8877 Ask-the-Contractor Teleconference (ACT), September 24, 2014
- Hospice Clinical
- Hospice Face-to-Face (FTF) Encounters
- Hospice Physician Billing
- ICD-10-CM/PCS
- Medicare Secondary Payer (MSP)