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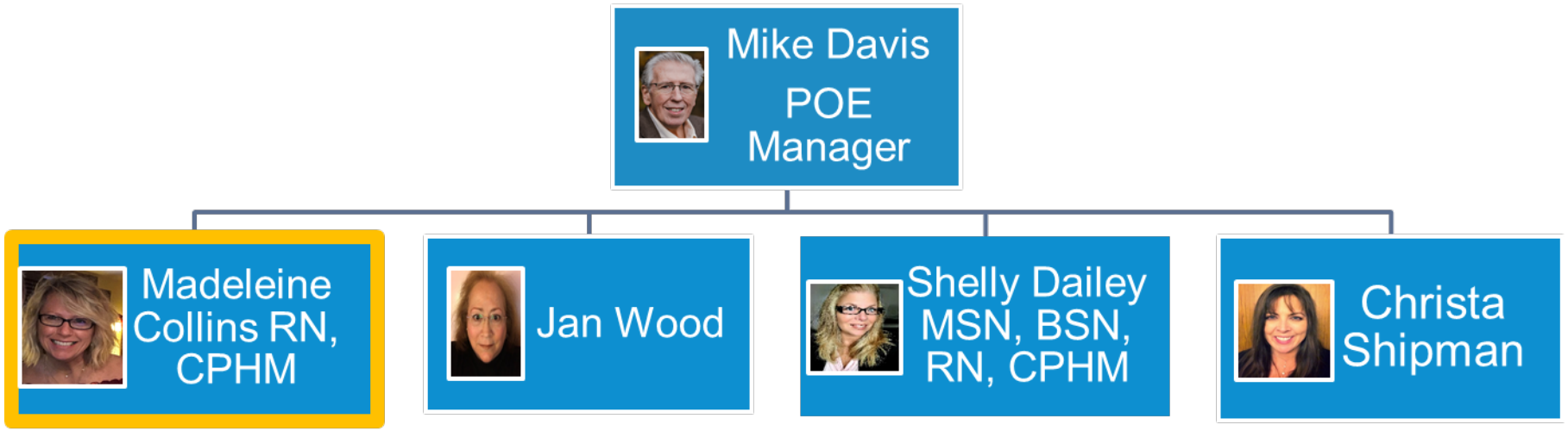
Hospice and Long Lengths of Stay

2/24/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

National Government Services Provider Outreach & Education Home Health & Hospice Team



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Objectives

- To assist providers with a greater understanding of the federal Medicare hospice benefit regulations regarding medical record documentation to support ongoing eligibility when dealing with long lengths of stay

Agenda

- Hospice Utilization-Top Diagnoses
- Eligibility, Election and Duration of Benefits
- Recertification Documentation
- Hospice Discharge

Hospice Utilization-Top Diagnoses

Hospice Utilization

- Over 1.6 million Medicare beneficiaries received hospice care in FY 2019.
- 50% of those Medicare beneficiaries who died in 2019 utilized hospice care.
- Approximately, 4,900 Medicare-certified hospices.
- $20 billion in Medicare hospice expenditures.

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Top Hospice Diagnoses, FY 2019

Rank	ICD-10/Reported Principal Diagnosis	Number of Beneficiaries	Percentage of all Reported Principal Diagnoses
1	G30.9-Alzheimer's disease, unspecified	148,890	9.2%
2	G31.1-Senile degeneration of brain, not elsewhere classified	92,931	5.8%
3	J44.9-Chronic obstructive pulmonary disease, unspecified	84,926	5.3%
4	I50.9-Heart failure, unspecified	60,383	3.7%
5	C34.90-Malignant neoplasm of unspecified part of unspecified bronchus or lung	51,927	3.2%
6	G30.1-Alzheimer's disease with late onset	47,817	3.0%
7	G20-Parkinson's disease	46,781	2.9%
8	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris	43,186	2.7%
9	I67.2-Cerebral atherosclerosis	35,355	2.2%
10	I11.0-Hypertensive heart disease with heart failure	28,657	1.8%
11	J44.1-Chronic obstructive pulmonary disease with (acute) exacerbation	28,333	1.8%
12	I63.9-Cerebral infarction, unspecified	27,405	1.7%
13	C61-Malignant neoplasm of prostate	26,652	1.7%
14	I13.0-Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	25,818	1.6%
15	I67.9-Cerebrovascular disease, unspecified	24,467	1.5%
16	N18.6-End stage renal disease	22,727	1.4%
17	C25.9-Malignant neoplasm of pancreas, unspecified	21,700	1.3%
18	C18.9-Malignant neoplasm of colon, unspecified	21,111	1.3%
19	E43-Unspecified severe protein-calorie malnutrition	20,741	1.3%
20	I51.9-Heart disease, unspecified	17,428	1.1%

Length of Stay, FY 2019

Three ways to look at hospice length of stay:

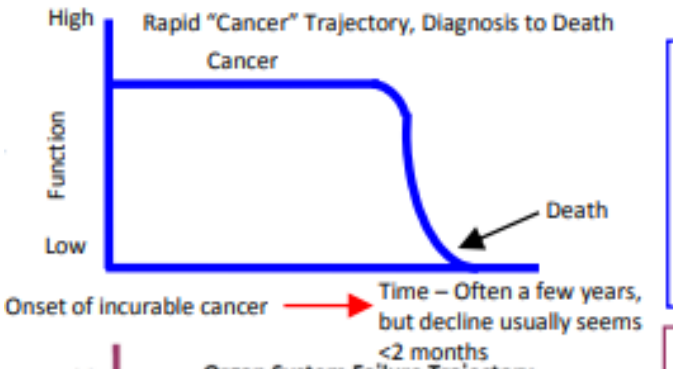
1. **Average length of election** = the number of hospice days during a single hospice election at the date of live discharge or death.
2. **Median lifetime length of stay** = half of stays are less than median and half of stays are more than median number of days.
3. **Average *lifetime* length of stay** = the sum of all days of hospice care across all hospice elections.

Average Length of Election	**77 Days**
Median Lifetime Length of Stay	**20 Days**
Average Lifetime Length of Stay	**99 Days**

Length of Stay, FY 2019

1. Alzheimer's, Dementia, and Parkinson's
2. CVA/Stroke
3. Cancers
4. Chronic Kidney Disease/Kidney Failure
5. Heart (CHF and Other Heart Disease)
6. Lung (COPD and Pneumonias)

Typical Case Histories



1) Mrs A - A 69 year old woman with cancer of the lung and known liver secondaries, with increasing breathlessness, fatigue and decreasing mobility. Concern about other metastases. Likely rapid decline

2) Mr B – An 84 year old man with heart failure and increasing breathlessness who finds activity increasingly difficult. He had 2 recent crisis hospital admissions and is worried about further admissions and coping alone in future. Decreasing recovery and likely erratic decline

3) Mrs C – A 91 year old lady with COPD, heart failure, osteoarthritis, and increasing signs of dementia, who lives in a care home. Following a fall, she grows less active, eats less, becomes easily confused and has repeated infections. She appears to be 'skating on thin ice'. Difficult to predict but likely slow decline

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Eligibility Requirements Certification and Recertification

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Medicare Hospice Coverage

42 CFR 418.20 Eligibility Requirements

- In order to be eligible to elect hospice care under Medicare, an individual must be
  a) Entitled to Part A of Medicare; and
  b) Certified as being terminally ill in accordance with Section 418.22

42 CFR 418.20

- Terminally ill means that the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course

Medicare Hospice Coverage

- Benefit is organized into two 90-day benefit periods followed by an unlimited number of 60-day periods as long as the individual remains eligible
- Terminally ill Medicare beneficiaries can receive hospice care for an unlimited time - as long as they continue to meet the eligibility criteria.

Recertification of Terminal Illness

When recertifying the patient, the hospice medical director must consider the following information:

- ✓ Patient's end stage disease trajectory
- ✓ All important comorbid & related secondary
- ✓ conditions & impact on the terminal prognosis
- ✓ Any relevant laboratory and other test values
- ✓ Decline in performance status, amount of assistance required for ADLs
- ✓ Decline in nutritional status
- ✓ Any changes in status / condition over time

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Recertification of Terminal Illness

- Have benefit of 60-90 days of documentation
- Still compare to LCDs
- Decline
- Disease progression
- Comparison
- Hospice care is managing what symptoms

Recertification of Terminal Illness

- The recertification narrative should
  - Reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients
  - Include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (with the third benefit period recertification and every subsequent recertification)
  - Align with the local coverage determination

Recertification of Terminal Illness

The recertification narrative should not

- Have copied language from a previous recertification

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Recertification of Terminal Illness

Recertification sample one

- *100 yo woman with Alzheimer's disease. Her FAST is 7e and PPS is 30%. Weight 142 lbs from 152 lbs at admission. Sleeping 23/24 hours, up from 22/24 hours two months ago. She is dependent in all ADLs and lives at nursing home. Intake variable, from 25-75% of meals. This altogether supports a prognosis of less than six months if the disease follows its expected course. Determination of prognosis is based on review of the clinical information including the RNCM clinical summary and the face to face visit.*

Recertification of Terminal Illness

Recertification sample two:

74 y/o woman with Alzheimer's disease diagnosed 2012, with tremors and agitation. Her FAST is 7d from 7b two months ago, was 7a at time of hospice admission. PPS is 30%, from 50% 6 months prior to hospice. Weight loss from 181 3/2017 with gradual loss, 156 to 159 in the last two months. MAC has decreased from 32.75 to 29.5 cm in eight months. Sleep has increased from six to 12+ hours of sleep in 24 hours. She had had multiple falls and was hospitalized after fall in 9/16. This altogether indicates a prognosis of less than months months with her current trajectory based on review of clinical chart, face to face visit and records.

Custodial Comfort/Palliative/Terminal Care

Custodial Care

- Slowly decline disease process
- May require assistance with activities of daily living
- Can live several years as their body fails

Comfort Care

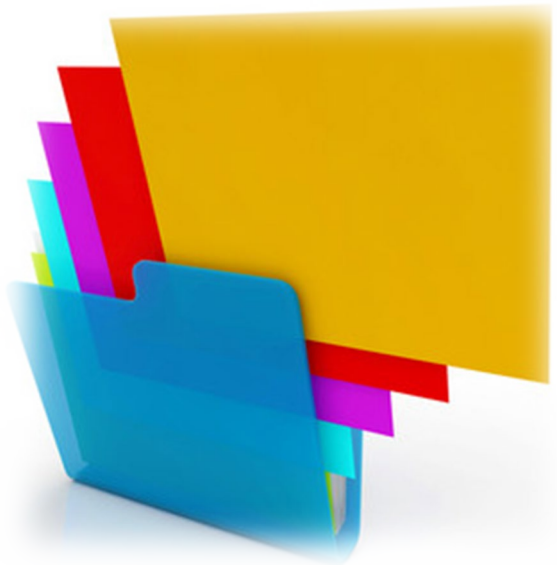
- Disease progression significantly declining
- Trajectory of progression provides prognosis of a life expectancy of less than six months

Recertification of Terminal Illness

- Are there general indicators of decline and increasing needs?
  - Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
  - Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
  - General physical decline and increasing need for support
  - Advanced disease - unstable, deteriorating complex symptom burden
  - Decreasing response to treatments, decreasing reversibility
  - Choice of no further active treatment
  - Progressive weight loss (>10%) in past six months
  - Repeated unplanned/crisis admissions
  - Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
  - Serum albumen <2.5

Determining Terminal Status: Documentation Guidelines

- Submitted documentation should always include the admission assessment, as well as any evaluations and IDT discussions used for recertification. Records that show the progression of the patient's illness are very helpful



Documentation-Recertification

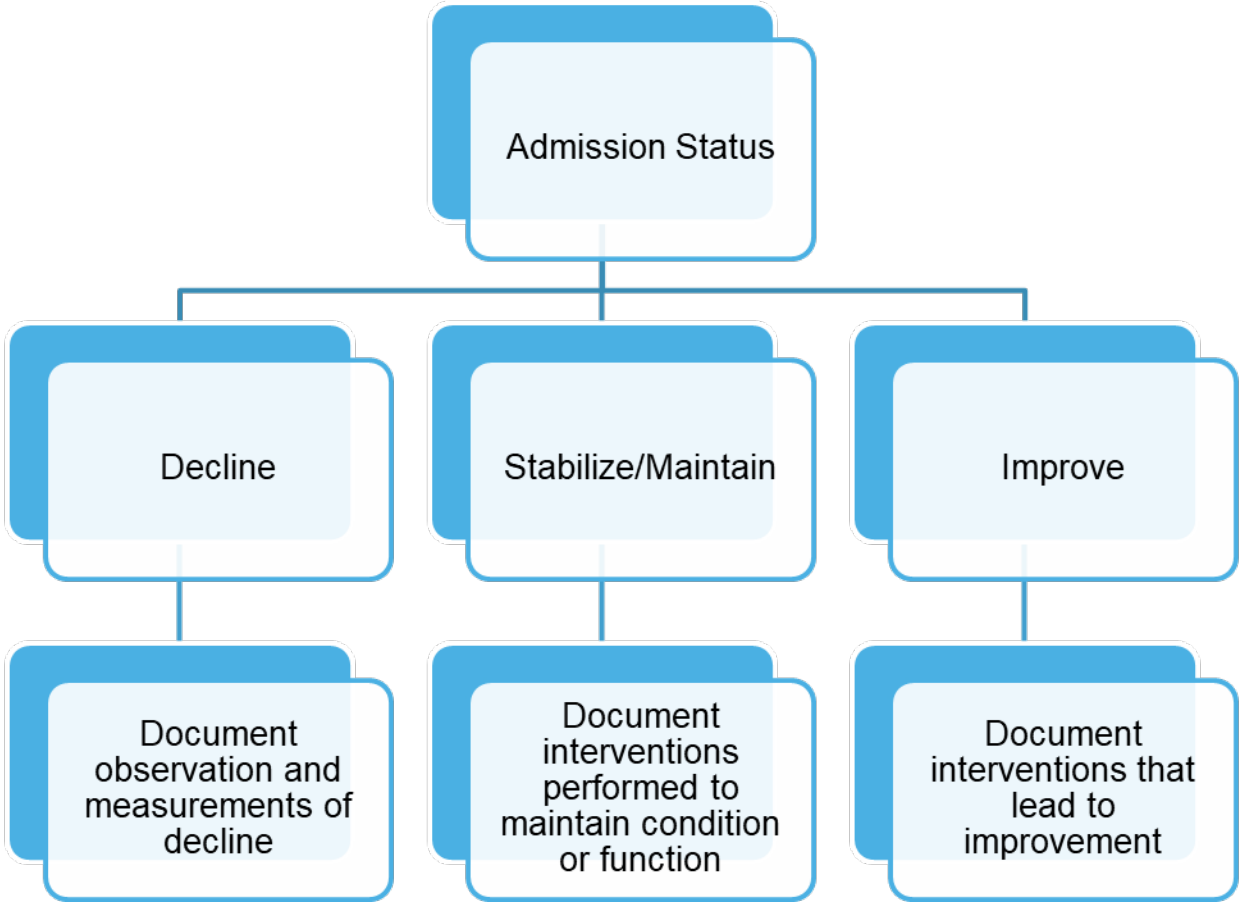
What if the patient stabilizes or plateaus??

Patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

Documentation-Recertification

- Go back to the diagnosis—why was this person admitted to hospice?
- Have you been managing the symptoms or the disease?
- What do you expect the disease process to look like?
- What are you monitoring for?
  - What secondary conditions are present?
- How does this person look compared to a well person of the same age?
- What interventions are in place that is contributing to this plateau?
- What co-morbidities are present?

Documentation-Recertification



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Documentation-Recertification

Documentation should always:

- Be specific to that individual patient
- Document what distinguishes the patient as terminal and not chronic
- Have narrative notes to explain information noted on a checklist - use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Compare current to previous
- Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments

Hospice Discharge

Hospice Discharge

- Discharge from Hospice Care
  - Reason for discharge
    I. Patient moves out of the area/Transfer to another hospice
    II. Hospice determines that the patient is no longer terminally ill
    III. Discharge for cause
  - Discharge order
  - Effect of the discharge
  - **Discharge Planning**
  - Filing a notice of termination of election within five days after the effective date of the discharge unless it has already filed a final claim for that beneficiary

Hospice Live Discharges

FY 2014 through FY 2019 → 17% per year

FY 2019

- 37.5% Revocations
- 37.2% no longer terminally ill
- 10.7% moved out of service area
- 12.9% transferred hospices
- 1.6% d/c for cause

Hospice Resources

CMS Hospice Resources

- Hospice Center Webpage
- Hospice Code of Federal Regulations
- Medicare Contractor Beneficiary and Provider Communications Manual
- Medicare Benefit Policy Manual-Hospice
- Medicare Claims Processing Manual-Hospice
- Fiscal Year (FY) 2022 Hospice Payment Rate Update Final Rule (CMS-1754-F)
- Hospice Payment Rate Update: FY 2022 Final Rule

National Government Services Website Hospice Resources

Accessing Webinar Materials/Presentations

Available on our website

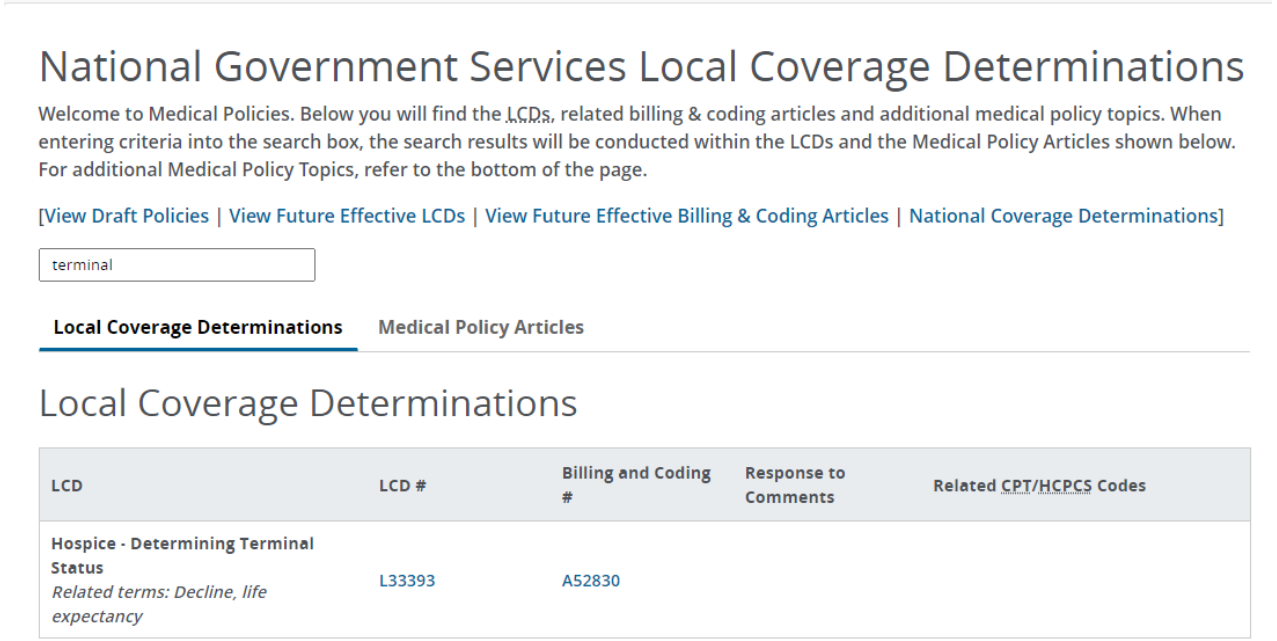
- Select your provider type and applicable state, click on enter.
- From the drop down menu, click on **Education** for manuals, job aids and to access Medicare University.
- From the drop down menu, click **Events** to view and register for upcoming webinars.

Materials from prior webinars are available on our website:

- Click on **Events** from the drop down, scroll towards the bottom of the page for past events.

NGS Local Coverage Determinations

- NGS Website
  - Medical Policies tab
    - LCD: Hospice – Determining Terminal Status (L33393)



National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

terminal

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

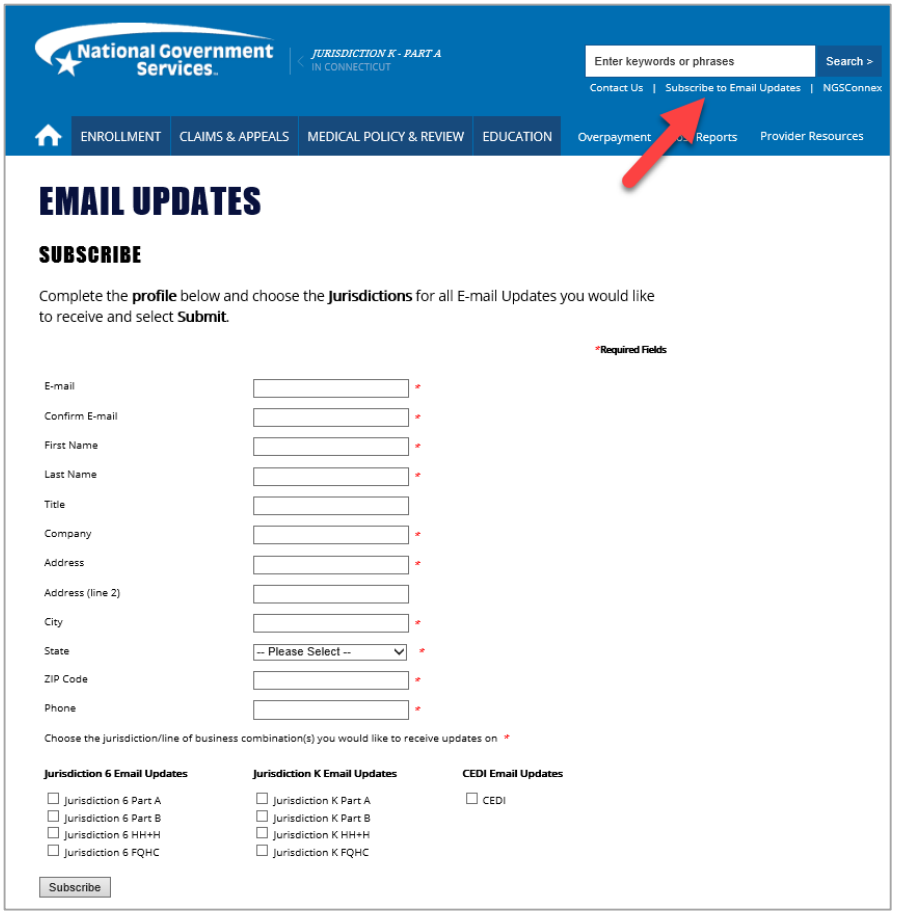
LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Hospice - Determining Terminal Status *Related terms: Decline, life expectancy*	L33393	A52830		

NGS Jurisdiction K

- NGS Website
- IVR Unit – 866-275-7396
- Provider Contact Center – 866-289-0423
- LCDs and Policy Articles – See website home page, Medical Policies – Find LCDs and related billing and coding articles card

NGS Email Updates

- Subscribe to receive the latest Medicare information



Contact Us

- For future hospice questions or issues
  - Email: J6.provider.training@anthem.com

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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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