The Four Paths to Using LCDs for Winning Documentation

MISSOURI HOSPICE AND PALLIATIVE CARE ASSN
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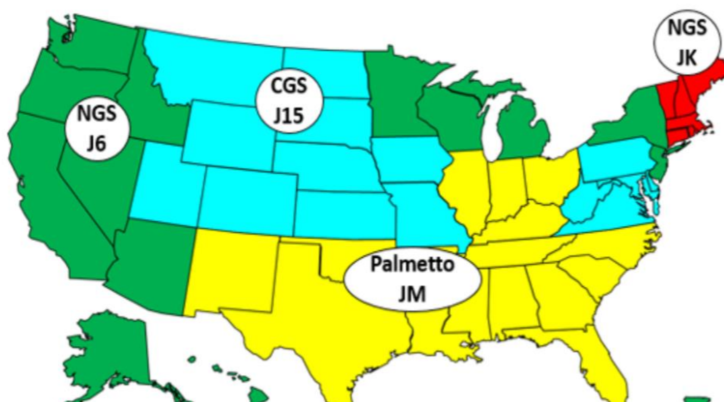
Hospice MAC Territories



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Hospice LCD Current Use

PROVIDER INSIGHTS

Provides guidelines to hospice agencies
- Admissions
- Recertifications

Used by MACs in medical review

Provides consistency

Educational for identifying hospice-eligible patients for referrals and liaisons

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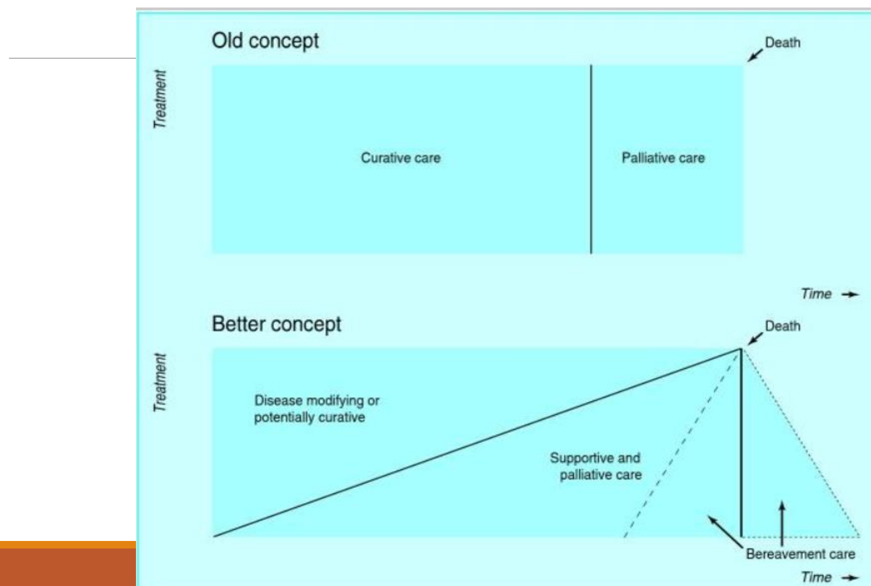
Evolution of End of Life Care

PROVIDER INSIGHTS



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The Four Paths to Eligibility

All four paths lead to the same destination: identification and support of a six-month prognosis

Path One

Meets **ALL** the Local Coverage Determination (LCD) criteria

The LCDs

- Developed by the MACs • Provide medical criteria for determining prognosis but not consistent predictors of prognosis
- Use as guidelines for documenting terminal illness
- If a patient meets certain criteria, they are deemed eligible
- If a patient doesn't meet the LCD, may still be eligible for the MHB but must document why (best done by a physician)
- Not the legal standard for hospice eligibility however, are followed by reviewers when reviewing for payment determinations

Path Two

Meets most of the LCD criteria AND has documented **rapid clinical decline** supporting a limited prognosis

Indicators of Rapid Clinical Decline

- Nutritional decline
- Functional decline
- Progressive deterioration while receiving appropriate care
- Hospital utilization
- Serial lab assessments

Path Three

Meets most of the LCD criteria AND has **significant comorbidities** that contribute to a limited prognosis

Terminal Diagnosis: The condition established after study to be chiefly responsible for the patient's admission to hospice

Related: Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and impact prognosis

Unrelated: Conditions or diagnoses that are independent of the terminal condition

Path Four

Physician's clinical judgment is that the patient has a limited prognosis

Clinical assessment + experience + evidence based knowledge

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Four Paths of Eligibility

1	2	3	4
Meets **ALL** the Local Coverage Determination (LCD) criteria	Meets most of the LCD criteria AND has documented **rapid clinical decline**	Meets most of the LCD criteria AND has **significant comorbidities**	**Physician's clinical judgment** is that the patient has a limited prognosis
Patient presents with known diagnoses, & S/S match with LCD to support prognosis	• Nutritional decline • Functional decline • Progressive deterioration while receiving appropriate care • Hospital utilization • Serial lab assessments	Secondary conditions or related co-morbid conditions that directly emerge or result from the terminal condition or co-morbid conditions associated with the terminal illness; interconnected with the terminal condition and impact prognosis	Clinical assessment + experience + evidence-based knowledge

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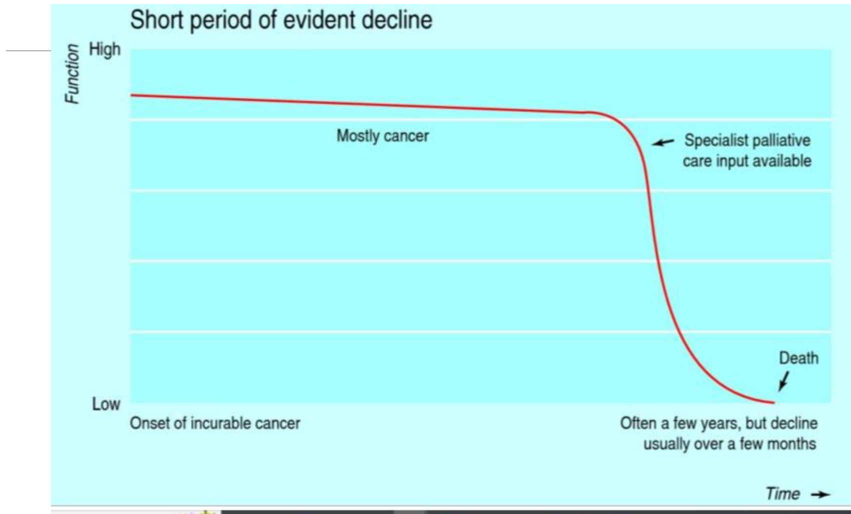
Every Path is Different… Cancer



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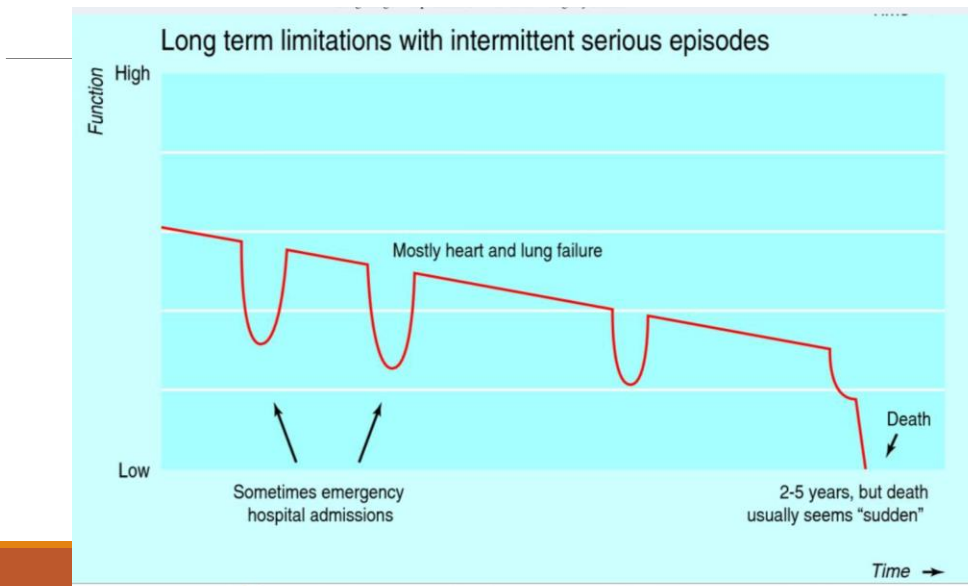
Chronic Progressive Organ Disease



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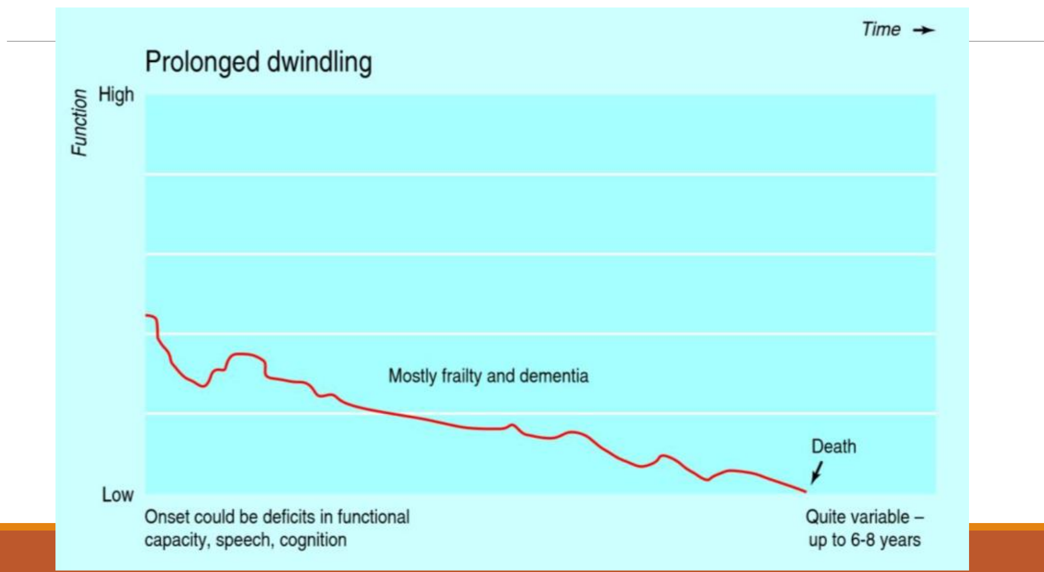
Dementia/Frailty



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Structure of the LCD

The LCD for hospices used by CGS and NGS is sometimes called the "uni-policy" because it is all gathered into one LCD

Part I is the "Decline Policy" where the patient's functional decline and other symptoms can stand alone to show terminal trajectory

Part II is a gateway of minimal functional limitations, which opens the door to diagnosis specific guidelines

Comorbidities are also listed that would supply extra support

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LCD – Part I: The Decline Policy

- Decline in clinical status guidelines.
  - Listed in order of their likelihood to predict poor survival – the most predictive first and least predictive last.
  - Progression of disease as evidenced by worsening:
    - Clinical status.
    - Symptoms.
    - Signs.
    - Laboratory results.

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LCD Part I- Clinical Status

1. Recurrent or intractable infections
   - Such as pneumonia, sepsis or upper UTIs
2. Progressive inanition
   - Weight loss
   - Decreasing MAC
   - Decreasing serum albumin or cholesterol
3. Dysphagia leading to recurrent aspiration
   - And/or inadequate oral intake- documented consumption

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LCD Part I- Clinical Symptoms

1. Dyspnea with increasing respiratory rate
2. Cough- intractable
3. Nausea/vomiting- poorly responsive to treatment
4. Diarrhea- intractable
5. Pain requiring increasing doses of major analgesics
   - More than just briefly

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LCD Part I- Clinical Signs

1. Decline in systolic blood pressure
   - Below 90
   - Progressive postural hypotension
2. Ascites
3. Obstruction of venous, arterial or lymphatic systems due to metastatic disease
4. Edema
5. Pleural/pericardial effusion
6. Weakness
7. Change in level of consciousness

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LCD Part I- Labs (when available)

- Increasing:
  - pCO_2
  - Calcium
  - Creatinine
  - Liver function studies
  - Tumor markers
  - Serum sodium
  - Serum potassium
- Decreasing
  - SaO_2
  - Serum sodium
  - Serum potassium

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LCD – Part I

Decline in clinical status guidelines (cont.)

- Decline in Karnofsky performance studies (KPS) or palliative performance score (PPS) from ≤70% due to progression of disease
- Increase in:
  - ED visits
  - Hospitalizations
  - Physician's visits related to hospice primary diagnosis

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LCD – Part I

- Decline in clinical status guidelines (cont.)
  - Progressive decline in functional assessment staging (FAST) for dementia (from ≥7A on the FAST)
  - Progression to dependence on assistance with additional ADLs (see part II, section 2)
  - Progressive stage 3-4 pressure ulcers despite optimal care

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LCD – Part II: The Gateway

- Non-disease specific baseline guidelines (both must be met)
  - Physiologic impairment of functional status as demonstrated by: KPS or PPS ≤70
  - Dependence on assistance for two or more ADLs (feeding, ambulation, continence, transfer, bathing and dressing)

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LCD – Part II

- Part II must be used in conjunction with LCD appendix
- Part II guidelines alone do not qualify a beneficiary for hospice

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LCD – Part III/ Comorbidities

- Co-morbidities (Not the primary diagnosis, but help support prognosis of < 6 months.)
  - CHF
  - COPD
  - Ischemic heart disease
  - DM
  - Neurological disease (CVA, ALS, MS, Parkinson’s)
  - Renal failure
  - Liver disease
  - Neoplastic Disease
  - AIDS
  - Dementia

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Appendices: Disease Specific Guidelines

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Cancer Diagnoses

Disease with distant metastases at presentation -or-

Progression from an earlier stage with either:

1. a continued decline in spite of therapy.
2. patient declines further therapy.

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Non-Cancer Diagnoses

Amyotrophic Lateral Sclerosis

Dementia

Heart Disease

HIV Disease

Liver Disease

Pulmonary Disease

Renal Disease

Stroke and Coma

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Example of LCD Usage: Heart Disease

Must start with “Part II” of LCD (as a ‘gateway’)

- Non-disease specific baseline guidelines (both must be met)
  - Physiologic impairment of functional status as demonstrated by: KPS or PPS ≤70
  - Dependence on assistance for two or more ADLs (feeding, ambulation, continence, transfer, bathing and dressing)

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Example of LCD Usage: Heart Disease

Appendix: Heart Disease:

1 and 2 should be present. Factors from 3 add supportive documentation:

1. At initial or recertification, must show optimal treatment for heart disease or not a candidate for surgical procedures, or declines these procedures
2. New York Heart Association (NYHA) Class IV and significant symptoms of heart failure or angina *at rest.* Significant CHF with ejection fraction of ≤20% - EF is not required if not already available

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Example of LCD Usage: Heart Disease

3. The following factors support the eligibility for hospice, but are not required.
   a. Treatment resistant symptomatic SVT or ventricular arrythmias
   b. History of cardiac arrest or resuscitation
   c. History of unexplained syncope
   d. Brain embolism of cardiac origin
   e. Concomitant HIV

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Alzheimer's Example

92 year old- Long history AD, FAST 7f

Referred after weight loss and aspiration pneumonia

SLP initially recommended pureed and thick liquids

On service one year, and now:

Remains non-ambulatory, dependent in all ADLs and non-verbal, except a few words

No further aspiration

Weight gain +10 pounds to 120# since admit

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Alzheimer’s and other related Dementia LCD Guidance

1. Stage seven or beyond according to the Functional Assessment Staging Scale;
2. Unable to ambulate without assistance;
3. Unable to dress without assistance;
4. Unable to bathe without assistance;
5. Urinary and fecal incontinence, intermittent or constant;
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

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Alzheimer's and other related Dementia LCD Guidance (continued)

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia;
2. Pyelonephritis or other upper urinary tract infection;
3. Septicemia;
4. Decubitus ulcers, multiple, stage 3-4;
5. Fever, recurrent after antibiotics;
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin Note: This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia

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Mel- with the Best Wife

Mel was a 97 year old gentleman in a NF with long term Alzheimer's dementia.

Mel's wife, Alice, was the most sincere, doting caregiver- showing up to feed him all three meals every day.

Mel was mostly bedbound, but did get up by hoyer into a reclined Geri-chair for periods of time

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Mel's Disease

Mel only had left his ability to smile- 7F Fast

Mel had no functional ability, nor vocabulary

Mel had no weight loss, no infections, no skin breakdown- all due to the incredible level of care provided for the two years I knew him in a NF

Did he qualify for hospice?

At dinner one day, he coughed and sputtered when he swallowed. Mel developed aspiration pneumonia. Now did he qualify?

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Creating a "Culture of Eligibility" in Your IDT Meeting

Be sure every clinician in your organization has a current copy of the LCD guidelines.

Keep a copy in IDT, and review one at the beginning of every meeting; "LCD of the Week."

Use LCD-specific worksheets for admissions and recertifications.

Review the LCD guidelines for every admission and recertification before it is presented.

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Your Agency Actions!

Know your MAC's LCDs

- Cancer
- Non-Cancer
- Terminal Decline

Incorporate the LCDs into documentation and decision making at SOC, recertifications and discharges

Use the LCDs for IDG culture of compliance, as well as support for relatedness/non-related

- Chapter 9 of the Medicare Benefit Policy Manual
- MAC LCDs

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Questions?

PLEASE CONTACT US ANYTIME:

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