The LCD Roadmap to Avoid the MAC's Top Denial

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Learning Goals:

- Explain Local Coverage Determinations (LCDs) and the authorities who govern them.
- Apply the components of the CGS/NGS "unipolicy" to show how decline is a strong indicator of prognosis.
- Identify indicators in the LCD unipolicy used for guidance in determining a six-month prognosis
- Compare the specific Palmetto LCDs with the other Medicare Administrative Contractors (MACs)
- Describe how the LCD can be used throughout hospice operations to build a culture of compliance

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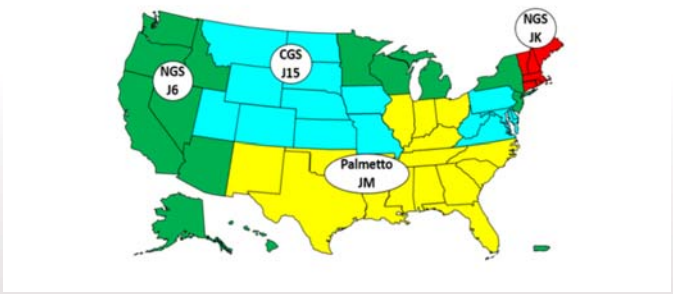
Chapter 1

What is a Local Coverage Determination (LCD)?

History of the Hospice LCD

- National Hospice Organization (NHO)
  - Preceded NHPCO of today
  - Developed guidelines for non-cancer diseases
- Office of Inspector General
  - Investigating increased abuse of hospice benefit
  - Urged Regional Home Health Intermediaries (RHHIs) to look for ways to decrease abuse
- CMDs (Chief Medical Directors) identified need for guidelines

Hospice MAC Territories



Hospice LCD Current Use

- 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

Chapter 2

The "Uni-policy" of NGS and CGS

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
- Disease-specific guidelines (Cancer and non-cancer dx)

LCD Process/Map

- 1.)Ask yourself: Is there a specific disease LCD that matches the primary diagnosis related to the six month prognosis?
- 2.) If so- review Part 2 (KPS/PPS equal or less than 70? Need assist with two or more ADLs?)
- 3.) Co morbidities from Part 3?
- 4.) Show how patient meets disease specific criteria
- 5.) Always document any changes from decline portion of policy!

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.

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

1
1

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

1
2

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:
  - pCO2
  - Calcium
  - Creatinine
  - Liver function studies
  - Tumor markers
  - Serum sodium
  - Serum potassium
- Decreasing
  - SaO2
  - 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

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

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)

LCD – Part II

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

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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Chapter 3

Disease Specific Guidelines (NGS/CGS)

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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.

Non-Cancer Diagnoses

- Amyotrophic Lateral Sclerosis
- Dementia
- Heart Disease
- HIV Disease
- Liver Disease
- Pulmonary Disease
- Renal Disease
- Stroke and Coma

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)

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

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

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

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

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

Chapter 4

Palmetto's LCDs

Palmetto's Approach to LCDs

- Palmetto has a much different approach to LCDs
- Did not adopt "uni-policy" built on the Hospice Organization guidelines
- Has multiple single diagnoses group LCDs
  - All similar to criteria in other LCDs, but less specific
- The International Classification Functioning (ICF) plays a part to show the functional decline for Palmetto providers

Alzheimer's Dementia (Palmetto)

- FAST stage 7 typically threshold for six month prognosis
- "Would also take into consideration co-morbidities and secondary conditions" to support six month prognosis

Other Palmetto LCDs

- L34566 - Hospice - HIV Disease
- L34544 - Hospice - Liver Disease
- L34547 - Hospice - Neurological Conditions
- L34559 - Hospice - Renal Care
- L34548 - Hospice Cardiopulmonary Conditions
- L34558 - Hospice The Adult Failure To Thrive Syndrome
- Palmetto also published Hospice guidance, such as "Weight Loss" which states the weight loss percentages must be supported in the documentation

The ICF and Cardiac Patients

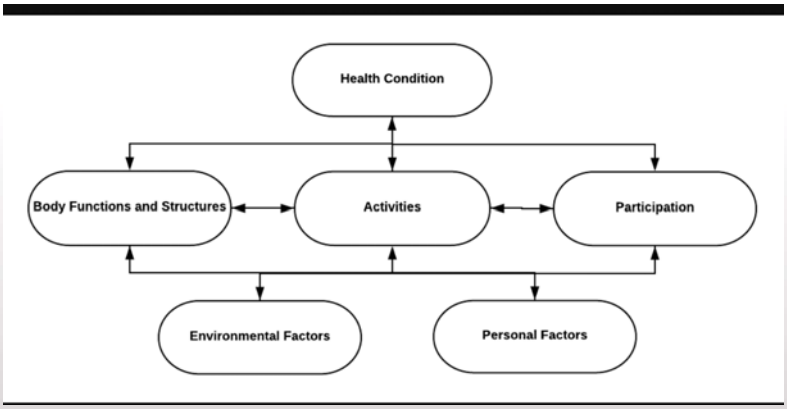
- Specifically, Palmetto cites the need to use a structured format to show the functional decline of a patient with cardiac disease
- States the ICF is an objective way to show the changes that are most indicative of terminal prognosis
- Allows the decline in function and changes in behaviors to be considered when looking at the appropriateness for hospice care

The ICF Worksheet

https://www.who.int/classifications/icf/icfchecklist.pdf?ua=1

Short List of Body Functions	*Qualifier*
b1. MENTAL FUNCTIONS	
b110 Consciousness	
b114 Orientation *(time, place, person)*	
b117 Intellectual *(incl. Retardation, dementia)*	
b130 Energy and drive functions	
b134 Sleep	
b140 Attention	
b144 Memory	
b152 Emotional functions	
b156 Perceptual functions	
b164 Higher level cognitive functions	
b167 Language	
b2. SENSORY FUNCTIONS AND PAIN	
b210 Seeing	
b230 Hearing	
b235 Vestibular *(incl. Balance functions)*	
b280 Pain	
b3. VOICE AND SPEECH FUNCTIONS	
b310 Voice	
b4. FUNCTIONS OF THE CARDIOVASCULAR, HAEMATOLOGICAL, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS	
b410 Heart	
b420 Blood pressure	
b430 Haematological *(blood)*	
b435 Immunological *(allergies, hypersensitivity)*	
b440 Respiration *(breathing)*	

What are the Components in ICF?



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Palmetto Example of ICF Blend

ICD-10-CM Primary Condition

- Parkinson's disease

Secondary Conditions

- Dysphagia
- Weight loss
- Neuropsychiatric disorders secondary to Parkinson's
- Falls

39 Relevant ICF categories

- 17 impaired body functions
- 17 activity limitations
- 2 participation restrictions
- 3 environmental factors

Chapter 5

Using the LCD from Admission to Discharge

How Can Our Hospice Use LCDs?

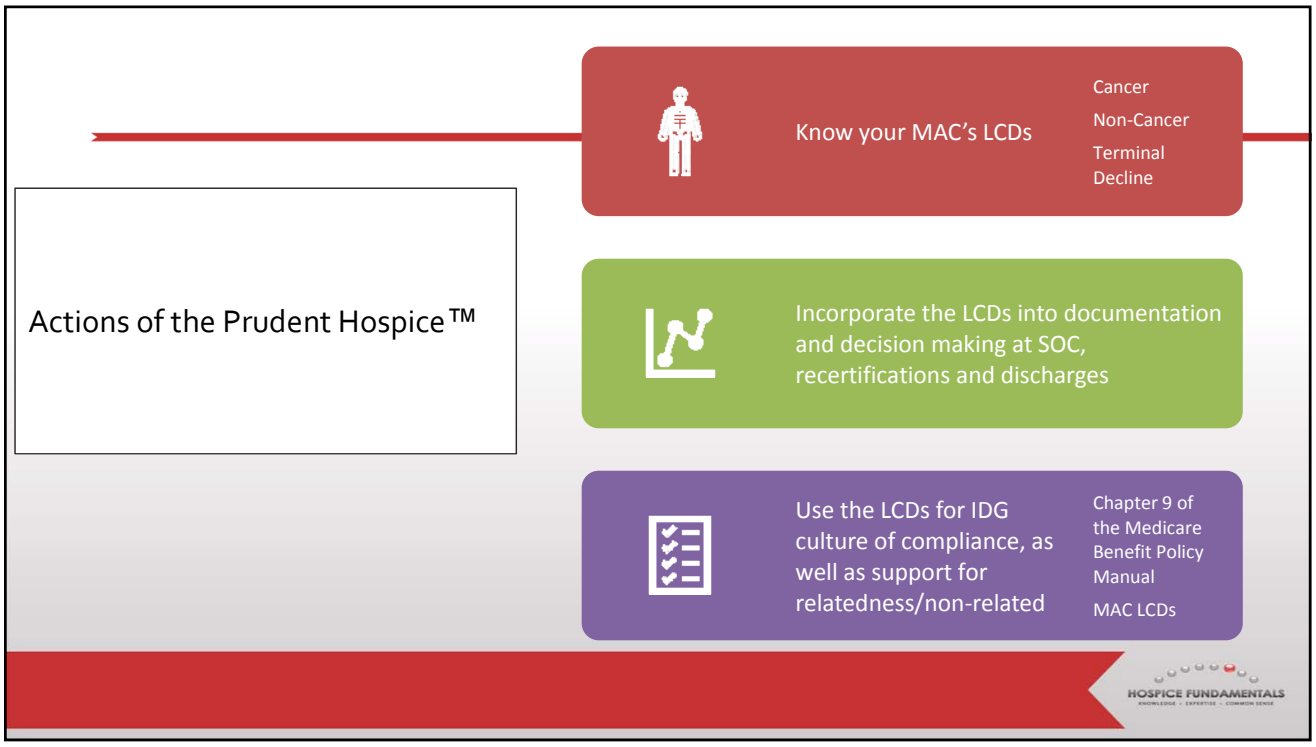
- Provides guidelines
  - Admissions
  - Recertifications/ ongoing care
- Provides consistency
- Educational for identifying hospice-eligible patients= Referral sources
- IDT Format

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.

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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Questions????

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