DETERMINING RELATEDNESS
to the
TERMINAL PROGNOSIS

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Goals of this Presentation:

To understand new CMS statements on Relatedness and how they relate to documentation in nurses' notes and the physician's CTI in the patient's medical record

To understand how coverage of medications and DME is related to documentation of relatedness to terminal diagnosis and prognosis

To understand the decision making process in determining relatedness of medical conditions to the terminal diagnosis and prognosis

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CMS Statements on Relatedness

"It is our (CMS') general view that … hospices are required to provide **virtually all** the care that is needed by terminally ill patients. Therefore, unless there is clear evidence that a condition is unrelated to the terminal **prognosis**, all services would be considered related.

It is also the responsibility of the hospice physician to document why a patient's medical need(s) would be unrelated to the terminal **prognosis**

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Documenting "Unrelatedness"

What Does the Hospice Physician Document?

CMS has varying guidance on this:

- **Recent NHPCO conference: should be more than "it is unrelated because it is"**
- **Recent CMS Open Door Forum call: should be a brief narrative that is reasonable in explaining why the condition is unrelated**

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Determining diagnosis and prognosis

Hospice physicians determine prognosis from:

- Records review
- IDG input
- Discussions with referral sources/attending
- Clinical judgment
- Examination of the patient (if applicable)

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When Will I Need To Be Thinking About Relatedness?

The conditions that are identified as related will be used throughout the patient's medical record as follows:

- ✓ **On admission, the related diagnoses will be used to select ICD-10 codes and to formulate the plan of care**
- ✓ **The Medical Director and admitting nurse will determine medication coverage and selection for the patient, as well as DME, etc**
- ✓ **At the IDG meeting, the Medical Director will describe in the CTI the related (Primary Diagnosis, Secondary Diagnosis, Comorbid Conditions) and unrelated conditions**
- ✓ **At the IDG meeting, the Medical Director will review the ICD-10 codes on the plan of care update with the team to determine accuracy**
- ✓ **These related diagnoses, along with their ICD-10 codes, will be used in the billing process by the business office**
- ✓ **Throughout the hospice stay, relatedness will help guide the ongoing plan of care**

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What meds should be covered under the Hospice Per Diem?

- **All medications related to the terminal diagnosis**
- **All medications related to pain and symptom control**
- **All medications related to conditions secondary to the terminal diagnosis**
- **All medications related to comorbidities that are severe enough to affect the patient's prognosis**
- **All medications for comorbidities that are physiologically related to or involving the same organ system as the primary diagnosis**

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Meds that should not be covered include:

- **Experimental medications**
- **Medications not indicated for the diagnosis/treatment of illness**
- **Medications not considered safe or effective**
- **Medications related to conditions that do not affect prognosis but are needed to maintain equilibrium (ie, synthroid, hypertensive meds in patient without significant cardiac symptoms, etc)**

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Case Study 1

Mr. G is an 89 yo male with terminal diagnosis of lung cancer, initially diagnosed two years ago. He received radiation at the time of diagnosis, but did not tolerate it well and has had no treatment since then. A repeat CT scan in December showed advancement of the cancer, including multiple masses to chest wall encasing left ribs, a new mass to the right lobe, and a left pleural effusion. Due to widespread disease and age, he was referred to hospice.

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Case Study 1, continued

The patient has a PPS of 60%, is independent with ADLs, and uses a walker for extended ambulation. He has mild dyspnea with speech, but does not want to use oxygen. Breath sounds are diminished on the left side. He is alert and oriented, but has some forgetfulness. No weight loss. Has mild chest pain to left chest wall.

Goals are to stay at home, treat pain or other symptoms, and maintain comfort.

Other conditions are:
COPD, CKD 3, HTN, hyperlipidemia, osteoarthritis, history of skin cancer

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Case Study 1 (continued)

MEDICATIONS:

Calcium with vitamin D3 (600 mg/1200IU) once daily
Digoxin 125 mcg, once daily
Glucosamine 2000mg once daily
Lisinopril 20 mg once daily
Metoprolol 50 mg twice daily
Simvastatin 40 mg once daily
Vitamin B12 1000 mcg, once daily
Spiriva Handihaler, one puff twice daily
Albuterol MDI, one puff q 4 hrs prn

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Relatedness Considerations:

WHAT IS THE PRIMARY CONDITION? Lung cancer, with lesions in both lungs and mets to chest wall

WHAT ARE THE SECONDARY CONDITIONS? (i.e., conditions caused by the primary diagnosis) Pleural effusion

WHAT ARE THE COMORBID CONDITIONS? Related (i.e. that contribute to the poor prognosis/eligibility): COPD, possibly arthritis if causing significant pain

WHAT ARE THE UNRELATED CONDITIONS? (not contributing to terminal prognosis): HTN, hyperlipidemia, history of skin cancer

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Case Study 1 RESULTS

Calcium with Vitamin D3 – NOT RELATED OR COVERED (supplements)

Digoxin 125 mcg – NOT RELATED, MAY BE COVERED BY PART D

Glucosamine 2000 mg- RELATED BUT NOT COVERED (supplement)

Lisinopril 20 mg –NOT RELATED, MAY BE COVERED BY PART D

Metoprolol 50 mg – NOT RELATED, MAY BE COVERED BY PART D

Simvastatin 40 mg – NOT RELATED OR COVERED

Vitamin B12, 1000 mcg – NOT RELATED OR COVERED

Spiriva Handihaler – RELATED, Nonformulary, substitute Atrovent

Albuterol MDI – RELATED AND COVERED BY HOSPICE

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The physician's CTI should contain the following elements:

The patient is an 89 yo under hospice care for end stage lung cancer, diagnosed two years ago. The patient did not tolerate radiation well at the time of diagnosis and has not received any additional treatment. A repeat CT prior to hospice admit showed multiple masses to chest wall encasing left ribs, a new mass in the right lung and a left pleural effusion. His current PPS is 60%; he uses a walker for ambulation, is dyspneic with speech but does not desire oxygen at present. He has not experienced any weight loss in recent months. The patient has comorbid COPD, chronic kidney disease stage 3 , and significant pain from his osteoarthritis, all of which contribute to his limited prognosis. He also has a history of HTN, hyperlipidemia, and skin cancer. These conditions are longstanding, unrelated to his terminal prognosis and do not affect his prognosis. The patient desires no further curative treatment for his cancer, and he desires comfort care in his home until EOL. If the disease course follows the expected clinical trajectory, prognosis is less than six months.

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Case Study 2

Mr. B is a 63 yo male with end stage liver disease secondary to hepatitis C and alcohol abuse. He has a history of hepatic encephalopathy, and was recently admitted to the hospital with ALOC, very confused, drowsy and difficult to arouse. In the hospital, his urine toxicology was positive for amphetamines, and his ammonia level was high at 95. His INR was 2.5 and albumin 1.3. He has been hospitalized multiple times this year due to encephalopathy and an episode of esophageal variceal bleed. He is not a candidate for liver transplant due to ongoing drug abuse. PPS 30%, and his po intake is approximately 25% total meals. The patient lives in a SNF and is DNR. He is dyspneic at rest with bilateral lung crackles and BLE edema.

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CASE 2, continued

Other Medical Conditions:

COPD, CKD 4 due to hepatorenal syndrome, severe aortic stenosis, CAD s/p CABG with AICD placement, CVA, CHF with EF 35%, alcohol abuse, tobacco abuse, methamphetamine abuse, DM 2

Goals of care are:
Decreased pain, anxiety, dyspnea. Safety precautions and dignity at end of life.

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MEDICATIONS:

Zocor 20 mg once daily
Amiodorone 100 mg once daily
Flomax 0.4 mg once daily
Lasix 40 mg once daily
Compazine 10 mg prn
ASA 81 mg once daily
Symbicort 160/4.5, two puffs twice daily
Albuterol 90 mcg, 2 puffs q 4 hrs prn
Norco 5/325 one q 6 hrs prn
Lactulose 30cc every 8 hours
Regular insulin, sliding scale

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Relatedness Considerations:

WHAT IS THE PRIMARY TERMINAL DIAGNOSIS? End stage liver disease

WHAT ARE THE SECONDARY CONDITIONS? hepatic encephalopathy, hepatorenal syndrome

WHAT ARE THE COMORBID CONDITIONS? Related (contributing to) terminal prognosis: congestive heart failure, COPD, tobacco abuse, methamphetamine abuse

WHAT ARE THE UNRELATED CONDITIONS? (not contributing to) terminal prognosis: AODM and BPH

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CASE 2 RESULTS:

Zocor RELATED, NOT RECOMMENDED, NOT COVERED

Amiodarone RELATED AND COVERED

Flomax NOT RELATED MAY BE COVERED BY PART D

Lasix RELATED AND COVERED

Compazine RELATED AND COVERED

ASA RELATED, NOT RECOMMENDED, NOT COVERED

Symbicort RELATED, nonformulary, substitute Advair

Albuterol RELATED AND COVERED

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CASE 2 RESULTS, continued

Norco RELATED AND COVERED

Lactulose RELATED AND COVERED

Insulin NOT RELATED, MAY BE COVERED BY PART D

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The physican narrative should contain the following elements:

The patient is a 63 yo under hospice care in a SNF for end stage liver disease secondary to hepatitis C and alcoholism. He was recently hospitalized for hepatic encephalopathy, with an ammonia level of 95, INR 2.5 and albumin 1.3. His urine toxicology was positive for amphetamines. He has a history of esophageal variceal bleeding, and he is not a candidate for liver transplant due to ongoing drug abuse. His current PPS is 30%, and he is dyspneic at rest. His po intake is reduced to approximately 25% of his total meals. The patient has secondary hepatorenal syndrome with stage 4 chronic kidney disease. He also has comorbid COPD, CAD with AICD, CHF, and CVA, and a history of tobacco and methamphetamine abuse. In addition the pt has a longstanding history of AODM type 2 and BPH which are not related to his terminal diagnosis and do not significantly affect his prognosis. The patient desires comfort care in SNF until EOL. If the disease course follows the expected clinical trajectory, prognosis is less than six months.

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Case Study 3

Mr. L is a 93 year old admitted to hospice for senile degeneration of the brain with history of a hip fracture six months ago. He has chronic afib, BPH, and abdominal aortic aneurysm. Six months ago he was eating three meals per day and was ambulating with assistance. Since his hip fracture, he has lost 22 lbs (from 145 to 123 lbs in six months) and now has a BMI of 20. He is eating approximately 15% of his meals, and ambulates with a walker. He has fallen several times in recent months, the last one resulting in a hospitalization after which he was referred to a SNF for rehab. He failed rehab due to inability to cooperate. He is incontinent of bowel and bladder with PPS 30% and Fast 6e.

Goals of care: Remain in SNF with pain and anxiety controlled. Safety precautions to avoid further falls. Maximize nutritional status (family states Megace has worked in the past and requests it be restarted)

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Medications:

Coumadin 2.5 mg daily
Digoxin 125 mcg daily
Lasix 20 mg daily
Megace 400 mg daily
Miralax 17 g in water daily
KCL 10 meq daily
Proscar 5 mg daily
Zantac 150 mg daily

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Relatedness Considerations:

WHAT IS THE PRIMARY TERMINAL DIAGNOSIS?
Senile degeneration of the brain

WHAT ARE THE SECONDARY CONDITIONS? Anorexia, weight loss, hip fx

WHAT ARE THE COMORBID CONDITIONS? Related to terminal prognosis:
Chronic afib, AAA

WHAT ARE THE UNRELATED CONDITIONS? BPH

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RESULTS:

Coumadin RELATED AND COVERED, but not recommended due to patient's history of falls

Digoxin RELATED AND COVERED

Lasix RELATED AND COVERED

Megace RELATED, NOT RECOMMENDED, NOT COVERED (hospice may choose to cover this as family states "it is the only thing that works")

Miralax RELATED AND COVERED

KCL RELATED AND COVERED

Proscar NOT RELATED, MAY BE COVERED BY PART D

Zantac RELATED, NONFORMULARY, COVERED (SUGGEST ALTERNATIVE FORMULARY MED)

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The physician CTI should include the following elements:

The pt is a 93 yo resident of a SNF under hospice care for senile degeneration of the brain, with a history of hip fracture six months ago. His Fast score is 6E, and his current PPS is 30%. Six months ago he was ambulating with assistance and eating three meals daily. Since his hip fracture, he has lost 22 lbs (15% TBW) and now has a BMI of 20. He is incontinent of bowel and bladder. He uses a walker to ambulate, and is eating only 15% of his meals. He has fallen several times during recent months, and after recent hospitalization for a fall he failed rehab in SNF due to inability to cooperate secondary to his advancing dementia. The patient has comorbid afib and abdominal aneurysm which contribute to his terminal prognosis. He also has BPH, which does not contribute to his terminal prognosis. The family desires that the patient receive comfort care in the SNF until EOL. If disease process follows expected clinical trajectory, prognosis is less than six months.

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Case Study 4

Mrs. N is a 68 year old residing at a SNF, with COPD and multiple hospitalizations over the past year. She is dyspneic at rest on 3 liters oxygen per nasal cannula. She also has significant cardiac disease with history of CHF, chronic afib, NIDDM, renal failure, schizophrenia, history of GI bleed, chronic back pain, hypothyroidism, and gout.

Goals of care: relief of dyspnea and pain, control of schizophrenia with psychotic symptoms.

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Case Study 4 Medications:

Cymbalta 30 mg daily
Spiriva two oral inhalations of 18 mcg capsule daily
Synthroid 0.1 mg daily
Zoloft 150 mg daily
Betapace 40 mg daily
Klor Con 40 mg twice daily
Senna Plus 2 twice daily
Spironolactone 100 mg twice daily
Symbicort 2 puffs twice daily
Oxycontin 60 mg three times daily
Albuterol nebs four times daily
Ipratropium nebs four times daily
Neurontin 100 mg four times daily
Xanax 1 mg every 6 hours
Zyprexa 5 mg every 6 hours

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Case Study 4 Medications, Continued

Requip 0.5 mg daily
Nitrostat 0.4 mg q 5 min x 3
Hydroxyzine 10 mg daily as needed
Temazepam 15 mg daily as needed
Coumadin 2 mg daily
Bumex 4 mg daily

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Relatedness Considerations:

WHAT IS THE PRIMARY TERMINAL DIAGNOSIS? COPD

WHAT ARE THE SECONDARY CONDITIONS? dyspnea, frequent respiratory infections

WHAT ARE THE COMORBID CONDITIONS? Related (contributing to terminal prognosis): CHF, afib, renal failure and GI Bleed

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WHAT ARE UNRELATED CONDITIONS? (not contributing to terminal prognosis): schizophrenia, gout, chronic back pain, and hypothyroidism

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Case Study 4 RESULTS

Cymbalta NOT RELATED, MAY BE COVERED BY PART D

Spiriva RELATED, nonformulatry, Substitute Atrovent

Synthroid NOT RELATED, MAY BE COVERED BY PART D

Zoloft NOT RELATED (LONG STANDING USE), MAY BE COVERED BY PART D

Betapace RELATED AND COVERED

Klor Con RELATED AND COVERED

Senna plus RELATED AND COVERED

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Case Study 4 Results, continued

Spironolactone RELATED AND COVERED

Symbicort RELATED, nonformulary, substitute Advair

Oxycontin RELATED, NONFORMULARY, COVERED, prohibitively expensive; use alternative narcotic

Albuterol RELATED AND COVERED

Ipratropium RELATED AND COVERED

Neurontin RELATED AND COVERED

Xanax RELATED AND COVERED

Zyprexa NOT RELATED, MAY BE COVERED BY PART D

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Case Study 4 Results, Continued

Requip DEBATABLE – in this patient being used for restless legs. Would recommend trial off med. Restart and cover if symptoms recur.

Nitrostat RELATED AND COVERED

Hydroxyzine RELATED AND COVERED

Temazepam RELATED AND COVERED

Coumadin RELATED AND COVERED

Bumex RELATED AND COVERED

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The physician CTI should contain the following elements:

The pt is a 68 yo under hospice care in SNF for end stage COPD. She has had multiple hospitalizations over the past year, and continues to be dyspneic at rest on 3 liters oxygen per NC. She has comorbid cardiac disease with a history of chronic afib and CHF, and she also has a history of renal failure and GI bleed. The patient has longstanding schizophrenia, chronic back pain and gout which are not related to her terminal prognosis. The patient desires no further hospitalization and elects comfort care in SNF until EOL. If the disease process follows the expected clinical trajectory,prognosis is less than six months.

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Questions?

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