Monday, October 14, 2019  11:30 AM

307  Hospice Long Length of Stay (LLOS) Compliance
Long Length of Stay

Objectives

The audience will understand:
• What factors contribute to Long Length of Stay (LLOS)
• The reports available to them for determining their own risk areas
• Tools and measures for tracking decline
• How to develop an action plan for LLOS cases
• How documentation reviews are completed and what is evaluated in determining ongoing decline and terminality
• How to respond to a request for additional review.
Factors contributing to LLOS

- Referral source
  - ALF vs Hospital vs Oncology
- History of Illness
- Acute illness referral vs Terminal condition
  - Exacerbation of disease
  - Hospitalization
- Diagnosis
  - See prognosis trajectory chart
  - Lack of serial measures and data or not understanding how various scales and tools should be used
  - Not emphasizing subtle changes occurring
  - Use of words like poor, better, worse, increasing, decreasing are subjective without quantitative information which would be objective
  - Inconsistent reporting of data at Interdisciplinary Group/Team meetings
- Transfer eligibility
- Lack of solid discharge plans while on service – community resources

Stats

Distribution of U.S. hospice deaths in 2017, by primary diagnosis

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Stats

Distribution of U.S. hospice patients based on length of service in 2017

Length of stay by diagnosis

Days of Care by Principal Diagnosis for 2017

- **Cancer**: Mdn: 19.0, Avg: 48.0
- **Chronic Kidney Disease**: Mdn: 8.0, Avg: 38.2
- **Circulatory/Heart**: Mdn: 30.0, Avg: 81.9
- **Dementia**: Mdn: 55.0, Avg: 110.0
- **Other**: Mdn: 19.0, Avg: 70.0
- **Respiratory**: Mdn: 20.0, Avg: 74.9
- **Stroke**: Mdn: 24.0, Avg: 82.4
Disease Trajectory CA - NIH

Disease Trajectory – Cardio/Pulmonary
Disease Trajectory - Dementias

MedPac Report Table 11-5

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Average length of stay (in days)</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
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<tbody>
<tr>
<td><strong>Beneficiary</strong></td>
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<td>Diagnosis</td>
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<tr>
<td>Cancer</td>
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<td>Neuropathological conditions</td>
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<td>8</td>
<td>33</td>
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<td>Heart/circulatory</td>
<td>89</td>
<td>2</td>
<td>5</td>
<td>14</td>
<td>79</td>
<td>262</td>
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<td>Debility or adult failure to thrive</td>
<td>102</td>
<td>3</td>
<td>6</td>
<td>20</td>
<td>99</td>
<td>307</td>
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<td>COPD</td>
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<td>5</td>
<td>25</td>
<td>129</td>
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<td>Other</td>
<td>48</td>
<td>2</td>
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<td>7</td>
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### MedPac Report Table 11-5

#### Hospice length of stay among decedents by beneficiary and hospice characteristics, 2014

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<thead>
<tr>
<th>Characteristic</th>
<th>Average length of stay (in days)</th>
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<tr>
<td><strong>Beneficiary</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Home</td>
<td>90</td>
<td>4</td>
<td>9</td>
<td>26</td>
<td>86</td>
<td>238</td>
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<td>Nursing facility</td>
<td>110</td>
<td>3</td>
<td>6</td>
<td>21</td>
<td>103</td>
<td>329</td>
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<tr>
<td>Assisted living facility</td>
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<td>5</td>
<td>12</td>
<td>51</td>
<td>187</td>
<td>441</td>
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<th>75th</th>
<th>90th</th>
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<tr>
<td><strong>Hospice</strong></td>
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<td>Hospice ownership</td>
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<tr>
<td>For profit</td>
<td>107</td>
<td>3</td>
<td>6</td>
<td>22</td>
<td>99</td>
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<td>Nonprofit</td>
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<td>5</td>
<td>13</td>
<td>55</td>
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<tr>
<td><strong>Type of hospice</strong></td>
<td></td>
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<tr>
<td>Freestanding</td>
<td>91</td>
<td>2</td>
<td>5</td>
<td>17</td>
<td>78</td>
<td>257</td>
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<tr>
<td>Home health based</td>
<td>71</td>
<td>2</td>
<td>5</td>
<td>16</td>
<td>63</td>
<td>192</td>
<td></td>
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<tr>
<td>Hospital based</td>
<td>58</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td>49</td>
<td>152</td>
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</table>
Benchmarking Risk

- Know your potential risk areas by utilizing reports to evaluate your agency
- Payment Patterns Electronic Report (PEPPER)
- Certification And Survey Provider Enhanced Reports (CASPER)
- OIG Workplan
- Targeted Probe and Educate (TPE) Results
- Office of the Inspector General (OIG) Corporate Integrity Agreement (CIA) website
- Comparative reports within multi-site agencies
- Work to minimize risks

PEPPER Retrieval Map

Percent of hospices that accessed PEPPER in the state:

- 80-100%
- 60-79%
- 40-59%
- 20-39%
- 0-19%
Tools and Measures for tracking decline

- 4D’s – Diagnosis, Doctor, Decision, Decline
- Start serial measures at hospice admission
  - FAST – Cognitive Scale for Alzheimer’s
    - When used
    - How used

FAST Scale for Alzheimer’s Dementia

<table>
<thead>
<tr>
<th>Stage</th>
<th>Stage Name</th>
<th>Characteristic</th>
<th>Expected Untreated AD Duration (months)</th>
<th>Mental Age (years)</th>
<th>MMSE (score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal Aging</td>
<td>No deficits whatsoever</td>
<td>--</td>
<td>Adult</td>
<td>29-30</td>
</tr>
<tr>
<td>2</td>
<td>Possible Mild Cognitive Impairment</td>
<td>Subjective functional deficit</td>
<td>--</td>
<td>28-29</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mild Cognitive Impairment</td>
<td>Objective functional deficit interferes with a person’s most complex tasks</td>
<td>84</td>
<td>12+</td>
<td>24-28</td>
</tr>
<tr>
<td>4</td>
<td>Mild Dementia</td>
<td>IADLs become affected, such as bill paying, cooking, cleaning, traveling</td>
<td>24</td>
<td>8-12</td>
<td>19-20</td>
</tr>
<tr>
<td>5</td>
<td>Moderate Dementia</td>
<td>Needs help selecting proper attire</td>
<td>18</td>
<td>5-7</td>
<td>15</td>
</tr>
<tr>
<td>6a</td>
<td>Moderately Severe Dementia</td>
<td>Needs help putting on clothes</td>
<td>4.8</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6b</td>
<td>Moderately Severe Dementia</td>
<td>Needs help bathing</td>
<td>4.8</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>6c</td>
<td>Moderately Severe Dementia</td>
<td>Needs help toileting</td>
<td>4.8</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6d</td>
<td>Moderately Severe Dementia</td>
<td>Urinary incontinence</td>
<td>3.6</td>
<td>3-4</td>
<td>3</td>
</tr>
<tr>
<td>6e</td>
<td>Moderately Severe Dementia</td>
<td>Fecal incontinence</td>
<td>9.6</td>
<td>2-3</td>
<td>1</td>
</tr>
<tr>
<td>7a</td>
<td>Severe Dementia</td>
<td>Speaks 5-6 words during day</td>
<td>12</td>
<td>1.25</td>
<td>0</td>
</tr>
<tr>
<td>7b</td>
<td>Severe Dementia</td>
<td>Speaks only 1 word clearly</td>
<td>18</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7c</td>
<td>Severe Dementia</td>
<td>Can no longer walk</td>
<td>12</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7d</td>
<td>Severe Dementia</td>
<td>Can no longer sit up</td>
<td>12</td>
<td>0.5-0.8</td>
<td>0</td>
</tr>
<tr>
<td>7e</td>
<td>Severe Dementia</td>
<td>Can no longer smile</td>
<td>18</td>
<td>0.2-0.4</td>
<td>0</td>
</tr>
<tr>
<td>7f</td>
<td>Severe Dementia</td>
<td>Can no longer hold up head</td>
<td>12+</td>
<td>0-2</td>
<td>0</td>
</tr>
</tbody>
</table>
Tools and Measures for tracking decline

- Palliative Performance Scale (PPS) / Karnofsky Performance Scale (KPS) – no halflies
  - 50% -
  - 40% - Mostly bed existence – someone assists to w/c
  - 30% - Not feeding self, totally bedbound – months
  - 20% - Weeks
  - 10% - Days
- MAC / Girth at admission
  - Consistent location
  - Compared by who performed the MAC – differs between clinicians
- Weight
  - Gain vs edema;
  - Weight loss 7.5% in 3 months or 10% in 6 months with BMI <22
- NYHA – I-IV (IV – unable to perform any activity without discomfort)
- Vital signs and interventions
- Medication changes and use of PRN interventions
- Updating symptom and diagnosis codes as they become relevant to the terminal condition

Tools and Measures for tracking decline

- Timed get up and go - TUG
- Tinetti – balance and gait – Max 28, >24 Low risk, 19-23 Mod Risk, 18 or less – High risk
- MAHC – fall risk – 4 or greater are at risk for falls (can use this backwards as well)
- Parkinson’s Scale – Stages 1-5 (5 mostly bed/chair unless aided)
- Amyotrophic Lateral Sclerosis Functional Rating Scale (ALSFRS) 0-40 - The lower the score the less function is retained.
- Mini Mental Status Exam (MMSE) – usually performed by social work
- Chronic Renal Failure Stages – Lab based – BUN, CREAT, GFR
Develop an action plan for LLOS cases

- View agency LOS tracking reports
- Auto review of any LOS >180 days
  - Monthly with complete assessment and serial measures
  - 2nd “eye” – have a different RN do the re-assessment
  - Establish an agency parameter for when discharge should be indicated
    - How many weeks without documented decline?
    - How many weeks without symptoms?
- Increase frequency of F2F visits or perform well in advance of recert
- Having a different practitioner do F2F – different NP or the hospice physician
- Quality review of documentation – assessment, F2F, narrative summary
- Ask yourself if you would you admit them today?

How documentation reviews are completed

- H&P – history and progression of illness
- F2F
  - Comparative information between 60day intervals
- Certification Narrative Summary
  - Physician prognostication
- IDG/IDT notes
  - Events occurring between IDG/IDT’s
- Medication changes
  - Infections
  - Symptom management
  - Co-morbidity medication adjustments
- Plan of Care Changes – HHA as well
  - Change in frequency
  - Change in needs
- Clinical documentation
  - Cognitive decline
  - Functional decline
  - Wounds and measurements
  - Symptoms
  - Equipment needs/changes
- Non-clinical documentation
  - Family/caregiver response to decline
  - Psychosocial issues related to decline
  - Spiritual issues related to decline
Targeted Probe and Educate (TPE) Denials

- **Top Denial Reasons January 1, 2019 – March 31, 2019**
  - *Terminal prognosis not supported* accounted for approximately 47% of the total Targeted Probe and Educate denials.
  - *Physician narrative missing/invalid* accounted for approximately 17% of the total Targeted Probe and Educate denials.
  - *Notice of Election is invalid* accounted for approximately 11% of the total Targeted Probe and Educate denials

Responding to a Request for Additional Review

- **Educate staff on the use of comparative measurable data**
- Perform Quality Review of printed records to evaluate forms, ease of finding information and how that information is translated to paper.
- **ALWAYS RESPOND**
- **Always Submit Timely**
- Include significant information prior to and after claim month requested
  - *Ie: Additional Documentation Request (ADR)* for September 2018 claim – also submit events in July, August or October, November if they assist in supporting the September Claim
  - Put a star, underline or bracket items you don’t want the reviewer to miss
- Engage additional experienced resources within or outside of your organization to review information prior to submission
- **ALWAYS APPEAL**
- Don’t give up!
Questions:

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