Long Length of Stay Patients: To recertify or not? That is the question

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Disclaimer

• No conflicts of interest
• Potential off-label medication discussion
Objectives

• At the completion of this presentation, participants will be able to:
  • Describe a useful and thoughtful approach to framing LLOS patient eligibility determinations
  • Discuss and address a variety of concerns in regards to recertifying LLOS patients and how to address those concerns
  • Employ productive and organized discussions with teams and administration within one’s own hospice
Two New NGS Pre-Pay Probes Have Been Announced for Hospice Agencies

Posted on Thursday, July 27, 2017

“MPPO Edit #5A121 is a service-specific probe for hospice services provided to beneficiaries with non-cancer diagnosis(es) and LOS greater than 180 days. This is to ensure that documentation and criteria requirements are met and that the hospice services are medically reasonable and necessary”
Questions to consider re LLOS patients

• Are there victims?
• Are there wrongdoers?
## Five most common diagnoses in 2015

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9 Code</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>331.0</td>
<td>13</td>
</tr>
<tr>
<td>Congestive heart failure, unspecified</td>
<td>428.0</td>
<td>8</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>162.9</td>
<td>6</td>
</tr>
<tr>
<td>COPD</td>
<td>496</td>
<td>5</td>
</tr>
<tr>
<td>Senile degeneration of the brain</td>
<td>331.2</td>
<td>3</td>
</tr>
</tbody>
</table>

As reported by NHPCO
Days of care by principal diagnosis-2015

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Mean # Days of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>47</td>
</tr>
<tr>
<td>Cardiac and Circulatory</td>
<td>76</td>
</tr>
<tr>
<td>Dementia</td>
<td>105</td>
</tr>
<tr>
<td>Respiratory</td>
<td>69</td>
</tr>
<tr>
<td>Stroke</td>
<td>61</td>
</tr>
<tr>
<td>Other</td>
<td>29.8</td>
</tr>
</tbody>
</table>

As reported by NHPCO research team, from NHPCO Newsline, Winter 2017
Get it right at the time of admission

• Admission requirements at §418.22(b)(2) require that this clinical information and other documentation that supports the medical prognosis must accompany the certification and be filed in the medical record with the written certification.
Prognosis $\neq$ Eligibility
Prognosis and eligibility

• Prognosis
  • A range of time
    • Bell curves
  • 6-month prognosis?

• Eligibility
  • A Public Health policy
  • Qualifications physicians utilize to allow a Health Insurance recipient to receive hospice care
  • Medicare Hospice Benefit Eligibility Qualification
    • Life expectancy is 6 months or less if the terminal illness runs its normal course. (CFR 418.22 3b)
The Bell Curve

Single patient with prognosis of \( \leq 6 \) months

Modified by R. Friedman-This Photo by Unknown Author is licensed under CC BY-SA
"Just to be on the safe side, I'd like you to have an autopsy."
“I always avoid prophesying beforehand because it is much better to prophesy after the event has already taken place”

-Sir Winston Churchill
What is a prognosis of 6 months or less?

- “More likely than not”?
- A range?
- Or?
Eligibility

• Prognosis of six months or less
• Election of a course of palliative care
• No conflict with other coverage, (whether the patient is receiving other Part A benefits, Medicaid benefits, or private insurance benefits)
How do Local Coverage Determinations (LCDs) apply?

• LCDs are all about coverage and payment

• Established by Section 522 of the Benefits Improvement and Protection Act
  • Decisions by MACs whether to cover a particular service.
    • Is it reasonable and necessary?

• Guidelines
  • Yet frequently referred to as criteria
What do we know about the LCDs in regards to prognostication

- Never intended to be used as public policy
- Never validated
- Ineffective at predicting prognosis
  - “The predictive ability of hospice guidelines, simulated with MDS data, was poor.” SL Mitchell MD MPH, SC Miller PhD, JM Teno, MD MSc, RB Davis ScD, and ML Shaffer, PhD. The Advanced Dementia Prognostic Tool (ADEPT): A Risk Score to Estimate Survival in Nursing Home Residents with Advanced Dementia. *J Pain Symptom Manage*. 2010;40:639e651.
- Are checklists useful for prognostication?
### LOS Graph Analysis for Dementia and Related Diagnoses

Single Hospice agency: 11/01/2015 - 08/31/2017

<table>
<thead>
<tr>
<th>LOS-Days</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-14</td>
<td>117</td>
</tr>
<tr>
<td>15-30</td>
<td>44</td>
</tr>
<tr>
<td>31-60</td>
<td>42</td>
</tr>
<tr>
<td>61-90</td>
<td>27</td>
</tr>
<tr>
<td>91-180</td>
<td>69</td>
</tr>
<tr>
<td>181-360</td>
<td>60</td>
</tr>
<tr>
<td>&gt; 360</td>
<td>40</td>
</tr>
</tbody>
</table>

#### Pie Chart

- **1-14 days**: 117 patients (29%)
- **15-30 days**: 44 patients (15%)
- **31-60 days**: 42 patients (10%)
- **61-90 days**: 27 patients (7%)
- **91-180 days**: 69 patients (17%)
- **181-360 days**: 60 patients (11%)
- **> 360 days**: 40 patients (10%)

**Legend**
- Blue: 1-14 days
- Orange: 15-30 days
- Green: 31-60 days
- Purple: 61-90 days
- Red: 91-180 days
- Light Green: 181-360 days
- Pink: > 360 days
Patient LOS on Hospice-Dementia and related (deceased patients)

<table>
<thead>
<tr>
<th>LOS-Days</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-14</td>
<td>109</td>
</tr>
<tr>
<td>15-30</td>
<td>31</td>
</tr>
<tr>
<td>31-60</td>
<td>29</td>
</tr>
<tr>
<td>61-90</td>
<td>16</td>
</tr>
<tr>
<td>91-180</td>
<td>32</td>
</tr>
<tr>
<td>181-360</td>
<td>24</td>
</tr>
<tr>
<td>&gt;360</td>
<td>20</td>
</tr>
</tbody>
</table>
Patients discharged for extended prognosis

<table>
<thead>
<tr>
<th>LOS-Days</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-14</td>
<td>0</td>
</tr>
<tr>
<td>15-30</td>
<td>0</td>
</tr>
<tr>
<td>31-60</td>
<td>0</td>
</tr>
<tr>
<td>61-90</td>
<td>1</td>
</tr>
<tr>
<td>91-180</td>
<td>12</td>
</tr>
<tr>
<td>181-360</td>
<td>10</td>
</tr>
<tr>
<td>&gt;360</td>
<td>7</td>
</tr>
</tbody>
</table>
How does one prognosticate?

- Patient history, principle diagnosis/diagnoses, co-morbidities
- Patient examination
- Discussion with attending and consulting physicians, as indicated
- Psycho-social, emotional, and spiritual considerations
- Functional, nutritional, cognitive status
- Expected disease progression
- General prognostic tools
- Disease-specific prognostic tools
- Evidence-based studies and research
- Other-genotypes, life-style, age, gender, lab/studies/markers, previous treatment
- The Surprise Question
- Physician judgement
- Other
Prognostication in LLOS patients

General

• Tools/studies/articles
• Examples
  • PPS
    • “Using the Palliative Performance Scale to Provide Meaningful Survival Estimates”
    • Nomogram using points-includes PPS score, age, gender, locations, diagnosis
  • PaP
  • Pps
  • ADLs-reflects ↑hospitalizations, LTCF placement, and one of several 2-yr mortality rate predictors
  • MMRI-R
  • Surprise question-identifying older patients with high risk of death
  • BMI
# PaP - Palliative Prognostic Score

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Assessment</th>
<th>Partial Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyspnea</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Anorexia</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>Karnofsky Performance Status</td>
<td>≥ 30</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>≤ 20</td>
<td>2.5</td>
</tr>
<tr>
<td>Clinical Prediction of Survival (weeks)</td>
<td>&gt;12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>11-12</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>7-10</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>5-6</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>3-4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>8.5</td>
</tr>
<tr>
<td>Total WBC (x10 9/L)</td>
<td>&lt;8.5</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>8.6-11</td>
<td>0.5</td>
</tr>
<tr>
<td>Lymphocyte Percentage</td>
<td>20-40%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>12-19.9%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>&lt;12%</td>
<td>2.5</td>
</tr>
<tr>
<td>RISK GROUP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>&gt;70%</td>
<td>0-5.5</td>
</tr>
<tr>
<td>B</td>
<td>30-70 %</td>
<td>5.6-11</td>
</tr>
<tr>
<td>C</td>
<td>&lt;30%</td>
<td>11.1-17.5</td>
</tr>
</tbody>
</table>
# Palliative Prognostic Index (PPI)

<table>
<thead>
<tr>
<th>Palliative Prognostic Index (PPI)</th>
<th>Max Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Palliative Performance Scale</strong></td>
<td></td>
</tr>
<tr>
<td>10-20</td>
<td>4.0</td>
</tr>
<tr>
<td>30-50</td>
<td>2.5</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>0</td>
</tr>
<tr>
<td><strong>Oral Intake</strong></td>
<td></td>
</tr>
<tr>
<td>Severely Reduced (&lt; mouthfuls)</td>
<td>2.5</td>
</tr>
<tr>
<td>Mod. Reduced (&gt; mouthfuls)</td>
<td>1.0</td>
</tr>
<tr>
<td>Normal</td>
<td>0</td>
</tr>
<tr>
<td><strong>Edema</strong></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>1.0</td>
</tr>
<tr>
<td>Absent</td>
<td>0</td>
</tr>
<tr>
<td><strong>Dyspnea at rest</strong></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>3.5</td>
</tr>
<tr>
<td>Absent</td>
<td>0</td>
</tr>
<tr>
<td><strong>Delirium</strong></td>
<td></td>
</tr>
<tr>
<td>Present</td>
<td>4.0</td>
</tr>
<tr>
<td>Absent</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15</td>
</tr>
</tbody>
</table>

If the PPI is greater than 6.0, survival is less than three weeks (Sensitivity - 80%; Specificity - 85%).
Prognostication in LLOS patients

Disease specific

- Tools/studies/articles
- Examples
  - EFFECT HF mortality prediction 30-day and 1 year mortality predictor
  - ID of Older Pts w Heart Failure...JGS: BUN >29 mg/dl, SBP <120, PAD, serum Na <135 mEq/L
  - Seattle Heart Failure Model
  - ADEPT
  - MELD- various versions
  - CLIP Scoring System- HCC patients, using Child-Pugh stage, tumor presentation, AFP, portal vein thrombosis
  - Others
Seattle Heart Failure Model
Certification and recertification narratives should
  • Paint the picture
  • Be consistent with available outside records
  • Incorporate appropriate tools when indicated
  • Be supported by/consistent with documentation by other disciplines

Visit and phone call documentation for any discipline
  • Should capture relevant information
    • SBAR approach
  • Avoid EHR pitfalls of canned/pasted appearance of relevant findings
  • Inconsistencies of findings within a discipline and from discipline to discipline should be addressed in the record
The value of internal audits

• Be proactive........
Recertification

• What a hospice might face if a LLOS patient is
  • Recertified
  • Discharged for extended prognosis
What goes into a recert narrative

• IDT role
  • In person assessment
    • What if out of area admission/transfer?
  • IDT discussion
  • Documentation in the record

• Hospice Physician role
  • Review and synthesize available information in order to determine prognosis and eligibility
  • Speak with involved health care providers, as indicated
  • Request additional information, as indicated, as needed
  • Include conditions/symptoms/findings “related” to the terminal prognosis
  • Give verbal/sign written certification, including certification narrative
Recert narrative format

• Many variations
• Key components
  • Identification of the patient
  • Principal diagnosis
  • Related diagnoses/symptoms
  • Relevant supportive information
    • See previous slide: How does one prognosticate?
• Conclusion
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 2 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 6 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.
Recert narrative for LLOS patient-Case 2

• 74 y/o woman with Alzheimer’s disease diagnosed 2012, with tremors and agitation. Her FAST is 7d from 7b 2 m 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 2 months. MAC has decreased from 32.75 to 29.5 cm in 8 months. Sleep has increased from 6 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 6 months with her current trajectory based on review of clinical chart, face to face visit and records.
“On the other hand, 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. The hospice medical director must assess and evaluate the full clinical picture of the Medicare hospice beneficiary to make the determination whether the beneficiary still has a medical prognosis of 6 months or less, regardless of whether the beneficiary has stabilized or improved. There are prognostication tools available for hospices to assist in thoughtful evaluation...”.
The Social Security Act

• Disagreements about medical necessity – CMS and its contractors should follow the established waiver of liability provisions for audit findings that the patient is not “terminally ill.”
  
  • While done under the auspices of "fraud", the majority of these audit findings reflect only disagreement between the clinical judgment of the hospice medical director and the audit agency regarding medical necessity. Congress has established an applicable waiver of liability provision, which is consistently disregarded.
  
  • Section 1879(g) of the Social Security Act requires Medicare to pay for hospice services despite a determination that a patient is not “terminally ill” when both the individual and the hospice "did not know, and could not reasonably have been expected to know, that payment would not be made...."[5] Congress specifically added section 1879(g) to the Act to extend this waiver protection to determinations that a patient is not terminally ill.
Regulatory review/scrutiny

• What can a hospice expect?
Case presentation 3-JW

• JW is an 86 y.o. man with Advanced Dementia
  • Resides in a personal care home
  • FAST score is 7c and PPS score is 30%.
  • Has mild dyspnea secondary to chronic obstructive pulmonary disease.
  • Is in bed most of the day and has bowel incontinence.
  • BMI is 18.4
  • He is total care, but can still move around in bed.
  • His ADEPT score is 16.8, which predicts a 62% six-month mortality risk.
JW is due for recertification

- Has been on service for almost 14 months
- Time spent sleeping has increased over the last 6 weeks, from 10-12 hours per day to 14-16 hours per day
- He was treated for a possible urinary tract infection 5 weeks ago, at the insistence of the patient’s family
- Nothing else has changed
- Is this, overall, a change in condition?
- If this is a change, does it impact prognosis
- Should JW be recertified?
The ADEPT score v Alzheimer LCD


How should JW’s recertification narrative be worded?
Case 4-COPD new admit, recert in 10th period

88 y/o man with COPD x 3 years and has been on O2 that whole time prn and now continuously. He has h/o hypoxia with chronic respiratory failure. Fell and sustained vertebral fx 3 months ago treated with kyphoplasty. 1 week ago he went to the ER for pneumonia. He is on O2 5L nc. Off O2 for 30 seconds, O2 saturation dropped from 93% to 88% and HR went from 96 to 100. He is dyspneic at rest. He has lost 15 lbs in the past month (12%) and BMI 15. C/w AFTT. PPS 50% from 60% 6 months ago. He can walk 10-15 feet, limited by dyspnea. He has h/o pulmonary granulomatous disease (denies h/o TB). He was on hospice about 2 years ago and improved so was discharged. His goal is to avoid hospitalization. This altogether supports a prognosis of less than 6 months if the disease follows its expected course. Determination of prognosis is based on review of medical records and discussion with the admission nurse.
89 yo male with COPD diagnosed 3 1/2 years ago, now on O2 continuously and steroid dependent. He also gives a h/o of nontubercular granulomatous lung disease. He has h/o hypoxia with chronic respiratory failure, with ER visit 3/2017 with venous blood gas PCO2 64 and pO2 of 23 and CXR showing severe bullous emphysema. He has had repeated exacerbations requiring antibiotics and steroid burst most recently in the last week. O2 sat on 4 lpm is 92% which drops to 82% on ra, and with O2 drops to 88% with minimal exertion. He has resting tachycardia and tachypnea. PPS is 50% from 60% 6 m prior to admission. This altogether presents a trajectory of illness with likely prognosis of less than 6 months based on review of available records, clinical chart and face to face encounter.
91 y/o man with HF rEF, EF on 3/7/17 was <20%, along with valvular disease. He has NYHA Class III symptoms, with dyspnea after ambulating 10 feet. He has lost 25 pound in the past 6 months. His PPS is 50% from 60% 6 months ago. His prognosis is less than six months, based on discussion with admission nurse and records.

{But also has cardiomyopathy, atrial fibrillation, hx of syncope, and paroxysmal dyspnea. He has no appetite. His functional decline necessitated a move to an ALF one month ago.}
Case presentation 5-CHF recert 10 months

92 y/o man with CHF, EF <20%. His PPS is 50%. He has dyspnea with minimal exertion, can only walk about 10 feet with assistive device. His prognosis is less than six months.
Case 5-F2F visit note for entering 5th BP

92 y/o man with ES systolic HF. LVEF <20% (per echo 3/7/2017) along with valvular disease. Pt declined further cardiac intervention including ICD. He has NYHA Class III symptoms, with dyspnea after ambulating 10 feet. In six months prior to admission, he lost 25 pounds and PPS went down from 60 to 50% after wife passed away and pt was living alone. Pt resides in an ALF past 10 months and has gained some of that wt back. Pt denies any sx of fatigue, dyspnea or chest pain. Denies BLE edema. No pain, no discomfort. Pt saw cardiologist yesterday and will be scheduling echo with next visit. On admission EF was <20%. He is currently on cardiac meds including carvedilol, enalapril, furosemide and finesteride.

Functional: PPS 50%. Independent in all ADLs with exception of needing some assist with bathing(this has improved some) and meal prep. Continent of bowel/bladder. Ambulates independently with cane or walker, denies being unsteady + dyspnea with walking more than 10-15 feet. He declines to use a walker but uses cane for short distances, such as when in the home, but will use it when out walking in community settings.

Nutritional: Staff report that he typically eats 75-100% of meals. 6lb weight increase, per facility, over last 8 weeks. Wt has been going up since ALF placement. MAC unchanged at 18.5cm since last 2 months was 16.5 on admission to Hospice.

Other: No injuries, falls or life threatening illnesses since hospice admission.

Exam: Thin elderly WM sitting in common area, conversing with a fellow resident. awake alert, Oriented x 4, cooperative, friendly. NAD. VS: T 98.2, BP=90/65, P=57, SPO2=99%, Resp=18. C/V: Normal S1, S2. RRR. No pedal edema. Lungs: CTA, no wheezing, rhonchi or rales.
Case 6-Alcoholic Cirrhosis initial cert (1/2017)

52 y/o female with alcoholic cirrhosis diagnosed April 2015 was hospitalized 1/10/17 for incarcerated umbilical hernia, s/p surgery with small bowel resection and had complications postoperatively with hepatic encephalopathy and acute kidney injury. She developed spontaneous bacterial peritonitis as well. By EGD has been found to have esophageal varices. She has also been diagnosed with tonsillar cancer 11/2016 though has not been eligible for surgery due to general health status. INR is 1.55, last Hgb 8.6. PPS is now 30% from 50% 6 m ago. With natural progression of her disease process she has a prognosis is less than 6 months based on discussion with admissions and review of available records.
Case 6-Alcoholic Cirrhosis, 1 year recert

53 y/o woman with alcoholic cirrhosis diagnosed April 2015. Hospitalized 1/10/17 for incarcerated umbilical hernia, s/p surgery with small bowel resection who had complications postoperatively with hepatic encephalopathy and acute kidney injury. She developed spontaneous bacterial peritonitis as well. By EGD she was found to have esophageal varices. She has also been diagnosed with tonsillar cancer (in situ) 11/2016 though has not been eligible for surgery due to general health status. INR at was 1.55, last Hgb 8.6. Repeat lab 1/22/18 indicates Cr 1.22, PT 17.2/INR 1.3 and Hgb of 4.0. She is suspected to have continued slow GI bleed. She has developed new fecal incontinence. Her PPS initially improved on hospice from 30 to 60% but has since decreased from 60 to 50%. She is lately sleeping up to 20 hours a day. She is having increased edema and ascites with poor response to diuretics. With continued progression of her disease process she has a likely prognosis of less than 6 m based on review of clinical chart, records and face to face visit.

Serum sodium 131 mEq/L
Case 7-Cerebral Vascular Disease
initial certification 12/2013

82 yo woman admitted to hospice with dx of Alzheimer's dementia dx'd 2006 with decline in FAST score from 6c to 7c in the past 2 years. PPS has gone from 60% to 50% in that time. She was treated for pneumonia this week, and it is unclear if it is aspiration pneumonia or bacterial pneumonia. She was treated for pneumonia in January, 2013. She had a UTI 2 months ago. No recent hospitalization. She is sleeping 20 hours/day, up from 16-17 hours 6 months ago. She is eating ok and has not lost weight. BMI is 26.4. No albumin available. No pressure ulcer. PMH significant for h/o TIA, seizure disorder. Prognosis is less than 6 months if the disease follows its expected course.
Case 7-Cerebral Vascular Disease recert
1/2018, for 25\textsuperscript{th} benefit period

86 yo woman w/ cerebrovascular disease. She has cognitive deficits that have advanced over last 2 years and are part of vascular dementia. She has had CVA bilat in late 2015 with new deficits on right side and 2-3 months prior developed deficits on left side which remain. She is sleeping 23/24 hours, up from 20/24 9/16. Weight 163 lbs 7/17 (up 21 lbs due to fluid), from 135.8 9/16, from 132.4 lbs 5/16, from 129 lbs 4/16 from 132 lbs 1/16 from 125 ls 9/15 from 131 lbs 9/15 from 135 lbs 3/15 from 150 lbs 4/14 from 154 lbs 12/13. Can no longer be weighed. Now difficult to obtain MAC due to contracture. MAC 22.5 cm, from 23.7 cm 7/16 from 22 cm 4/16, from 22.5 9/16 from 24 cm 5/15 from 25.5 cm 6/14. FAST 7f from 7e 5/15 from 7c 12/13. PPS remains 30\% with a brief dip to 20\%. She has 4+ BLE/BUE weeping edema. This altogether supports a prognosis of less than 6 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.
Case 8-Parkinson’s Disease
readmission cert 4/2017, 3rd BP

85 yo woman with Parkinson's disease diagnosed 10/15. She was on hospice 12/16-3/17 and revoked to pursue kyphoplasty after fall with vertebral fxs. She continues to aspirate while eating. PPS 40%. She has had aspiration pneumonia 3 times in 2016 and h/o recurrent UTI. Her family’s goal is no further hospitalization. She has Parkinson's dementia FAST 6e. Her PPS is 40%. She has h/o depression and has new anxiety/restlessness. This altogether supports a prognosis of less than 6 months if the disease follows its expected course. Determination of prognosis is based on review of the clinical information including the RNCM clinical summary.
85 yo woman with Parkinson's disease diagnosed 10/15. She was on hospice 12/16-3/17 and revoked to pursue kyphoplasty after fall with vertebral fxs. She continues to cough/aspirate while eating. PPS 40%. She had aspiration pneumonia 3 times in 2016 and has h/o recurrent UTI, last treated 11/17. Her family's goal is no further hospitalization. She has Parkinson's dementia FAST 6e. She has seemed more confused than usual. Has been hypoxic O2 sat 88-92%. She has decreased vocal volume. Denies dyspnea. Using O2 prn. No fever. Some hallucinations. She has h/o depression. She is sleeping 10-12/24 hours. MAC 32 cm, from 33 cm 10/17, from 34 cm 6/17, from 34.7 cm 5/17, from 35.5 cm 2/17. This altogether supports a prognosis of less than 6 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.
62 yo woman w/ primary biliary cirrhosis dx'd 11/2011. Has not sought medical care since that time until she was hospitalized yesterday with n/v, coffee ground emesis. Found to have bleeding gastric ulcers (likely due to portal gastropathy) and ESLD. PPS 50% from 70% PTA. She holds on to furniture while walking. She is eating 25% of prior intake--usually just 1/2 sandwich per day. INR 1.1, alb 2.4, Hb 4.2 on admission and has received 3U prbcs. She has been more forgetful for the past 6 months. She has h/o previous GI bleed in 2011 and also 11/2016. She declines disease-directed therapy including liver transplant. She declines future hospitalization. This altogether supports a prognosis of less than 6 months if the disease follows its expected course. Determination of prognosis is based on review of medical records and discussion with the admission nurse.
Case 9-Primary Biliary Cirrhosis recert
entering 6\textsuperscript{th} benefit period

63 yo woman w/ primary biliary cirrhosis dx'd 11/2011. Has not sought medical care since that time until she was hospitalized just prior to hospice admission with n/v, coffee ground emesis. Found to have bleeding gastric ulcers (likely due to portal gastropathy) and ESLD. INR 1.1, alb 2.4, Hb 4.2 on admission and has received 3U prbcs. She has been more forgetful for the past 11 months. She has h/o previous GI bleed in 2011 and also 11/2016. She declines disease-directed therapy including liver transplant. She declines future hospitalization. \textbf{PPS 40\% most days} though 50\% today, from 50\% 4 months ago, from 70\% prior to hospitalization. She holds on to furniture while walking. She is \textbf{eating 2 small snacks/day}. She has chronic back pain with LLE weakness. She is \textbf{sleeping 12/24 hours}. MAC \textbf{22.8 cm}, from 24.5 cm 7/17, from 25.5 cm 5/17, from 27.4 cm 3/17, from \textbf{28 cm 1/17}. Weight 125 lbs from 165 lbs at admission. She has had \textbf{multiple falls and near falls in the past few weeks}. This altogether supports a prognosis of less than 6
24 years old with principal diagnosis end-stage juvenile rheumatoid arthritis. She has a complex connective tissue disorder, which also includes juvenile dermatomyositis and probable myopathy. She now requires a Trilogy and uses the vent setting at night, and has a feeding tube in place for dysphagia and gastroparesis. In spite of tube feedings, she continues to lose 7-10 pounds per month. Although she probably weighs around or under 200 pounds, (she can no longer be weighed), she has lost more than 100 pounds in the last few years, with 38 lb documented weight loss over since 12/16. She had issues with respiratory tract infections for several weeks earlier this year. She has ongoing significant bilateral LE edema. Her PPS is 30% and she is bedbound. She is now sleeping 16/24 hours. She has had troubles with aspiration recently. She desires not to go back to the hospital. This altogether supports a prognosis of less than 6 months if the disease follows its expected course. Determination of prognosis is based on review of medical records and discussion with the admission nurse.
Case 10-Limb Girdle Muscular Dystrophy recert for benefit period 4, 1/2018

24 years old with principal diagnosis limb girdle muscular dystrophy diagnosed 8/2017 based on genetic testing. She has a complex connective tissue disorder, which also includes juvenile rheumatoid arthritis and dermatomyositis. She now requires a Trilogy and uses the vent setting at night, and has a feeding tube in place for dysphagia and gastroparesis. In spite of tube feedings, she was losing 7-10 pounds per month prior to hospice admission. Although she probably weighs around or under 200 pounds, (she can no longer be weighed), she has lost more than 100 pounds in the last few years, with 38 lb documented weight loss between 12/16 and 5/17 hospice admission. She had issues with respiratory tract infections treated with abx 10/17 and 12/17. She has had increased difficulty with mucous plugs. She has ongoing significant bilateral LE edema. Her PPS is 40%. She requires assistance with all ADLs and transfers as well as with TF. She is now sleeping 12-14/24 hours. She has had troubles with aspiration. She desires not to go back to the hospital. This altogether supports a prognosis of less than 6 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.
Questions

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References


• C Woelk, M Harlos. Guidelines for Estimating Length of Survival in Palliative Patients. [http://palliative.info](http://palliative.info). Date unknown, but references are from 2001 or earlier.


