**Medication Coverage:**
Relatedness, Formularies, and Documentation

**Objectives**
1. Upon completion of this session, participants will be able to describe how to determine which medications on a medication profile should be covered by hospice as a result of their relatedness to the terminal diagnosis and prognosis.
2. Attendees will leave with the ability to list three documentation elements required by CMS related to medication coverage.
3. Participants will leave the session able to describe how a formulary can simplify determination of medication coverage based on relatedness.

**Introductions**
Who am I speaking to?
- Name
- Title/Position
- Hospice

**What is the big deal about shift in determination of medication coverage?**

<table>
<thead>
<tr>
<th>Diagnosis-Driven Determination Involved:</th>
<th>Prognosis-Driven Determination Involves:</th>
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</thead>
<tbody>
<tr>
<td>Determining the primary terminal diagnosis</td>
<td>Hospice physician determining diagnoses related to the prognosis:</td>
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<tr>
<td>Determining any other diagnoses/conditions related to terminal diagnosis</td>
<td>- Medical records and laboratory reports</td>
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<td>- Input from referring clinicians</td>
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<td>- Clinical judgment</td>
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<td>- IDG discussion</td>
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<td>- Potentially examination of patient</td>
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**NHPCO Guidance**

- Identify principal hospice diagnosis
  - Diagnoses caused/exacerbated by principal hospice diagnosis
  - RELATED
- Diagnoses/symptoms contributing to prognosis of 6 months or less
  - RELATED
- Diagnoses/conditions/symptoms caused/exacerbated by treatment of any related condition
  - RELATED
- Document relatedness
  - Who: Certifying physician
  - What: Principal hospice diagnosis, diagnoses (related and unrelated), patient prognosis, and eligibility
  - When: On an ongoing basis; relatedness is a continuous process taking into account changes in patient condition
  - Where: Physician narrative and clinical record
  - Why: Compliance

Reporting of Unrelated Diagnoses

**FY 2016 Hospice Payment Rate Update**
- "We are clarifying that hospices are required to report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual. ICD-9-CM coding guidelines (and effective on October 1, 2015, ICD-10-CM) state to report all diagnoses that affect patient care. This also includes the reporting of any mental health disorders and conditions that would affect the plan of care, as hospices are to assess and provide care for identified psychosocial and emotional needs, as well as for physical and spiritual needs." (underline emphasis added)


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Key Player in Relatedness Determination: Hospice Physician

- **Role**
  - To determine the patient’s diagnoses
  - To determine any new diagnoses that have not been previously designated
  - To determine which diagnoses need not be listed due to lack of need for management
  - To determine whether treatments may no longer be beneficial in light of patient’s terminal prognosis
    - Even if they are related, they should be discontinued if no longer beneficial
  - **DOCUMENT**
    - Include a brief narrative that reasonably explains why any conditions are unrelated

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How the Hospice Nurse Assists the Hospice Physician

- **Provides clinical information to the hospice physician**
  - Comprehensive assessment
  - H&P
  - Hospital discharge summary
  - Clinical information from attending physician

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IDG and Compliance

- **Update comprehensive assessment**
  - **Update plan of care**
  - **Document**
    - Ensure hospice physician documentation in the clinical record supports why a diagnosis/medication is unrelated to terminal prognosis
    - **Update as patient’s condition changes**
    - Ensure IDG documentation supports hospice physician documentation

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Medications are either...

- **Related to terminal prognosis: hospice-paid**
  - Related but no longer effective: patient-paid (if not discontinued)
  - Related, requested by patient/family, not on formulary, and on-formulary therapeutic equivalent declined by patient/family: patient-paid
- **Unrelated to terminal prognosis: patient-paid**

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Take Note:

- Cost is **never** to be a determining factor in whether or not a medication is considered related to the terminal prognosis.
Documentation of Related Medications

- If a medication is determined to be related & covered:
  - Document in the clinical record
    - Physician narrative
    - Plan of care
    - Medication profile

- Times when a medication is determined to be related but NOT covered and therefore NOT on the plan of care:
  - Ineffective
  - Harmful
  - Duplicate medication
  - Experimental medication
  - Patient/family decline an equivalent medication that would be covered under hospice formulary or preferred med list

Documentation of Unrelated Medications

- CMS expects that review would result in another health care professional arriving at same conclusion
  - Subject to review by MAC and auditor review, as well as Part D plan sponsor review

- Documentation to appear in clinical record
  - Select a consistent, easy-to-access location

Example of Determination of Medication Coverage

- **Patient:** Mrs. S.
  - 88 yo female with terminal diagnosis of lung cancer that was diagnosed 1 1/2 years ago.
  - Received radiation at time of diagnosis; unable to tolerate with no treatment since
  - Recent CT scan demonstrated cancer advancement with multiple masses to chest wall and new mass to right lobe with left pleural effusion
  - Referred to hospice due to widespread disease and age
  - PFS of 60%, independent with ADLs, uses walker outside the home, mild dyspnea with speech but refuses oxygen, diminished breath sounds on the left side
  - Alert and oriented with some forgetfulness, no weight loss, and mild chest pain to left chest wall
  - Goals: stay at home and maintain comfort
  - Other conditions: CKD 3, COPD, HTN, hyperlipidemia, osteoporosis, osteoarthritis, history of skin cancer

Example of Determination of Medication Coverage, cont.

- **Primary condition:** lung cancer, with lesions in both lungs and mets to chest wall
- **Secondary conditions (caused by the primary diagnosis):** pleural effusion and depression (recent onset after lung cancer diagnosis)
- **Comorbid conditions (contribute to poor prognosis and/or contribute to symptoms):** COPD, osteoarthritis (since causing significant pain), and CKD 3
- **Unrelated conditions (do not contribute to terminal prognosis):** HTN, osteoporosis, hyperlipidemia, history of skin cancer
  - Treatment of these conditions would be for maintenance of equilibrium only if not causing symptoms

Example of Determination of Medication Coverage, cont.

- **Medications upon admission:**
  - Acetaminophen 650 mg, two tabs po q6h
  - Vitamin B12 1000 mcg, one tab po qd
  - Calcium w/vit. D3 (600 mg/1200 IU), one tab po qd
  - Alendronate 70 mg, one tab po weekly
  - Citalopram 20 mg, one tab po qd
  - Lisinopril 20 mg, one tab po qd
  - Metoprolol succinate 50 mg, one tab po qd
  - Albuterol MDI, one puff q4h prn
  - Spiriva Handihaler, two inhalations of one capsule qd

Example of Determination of Medication Coverage, cont.

- **Medication coverage results:**
  - Acetaminophen 325 mg: related; covered
  - Vitamin B12 1000 mcg: not related; not covered (look for opportunity to discontinue)
  - Calcium w/vit. D3: not related; not covered (look for opportunity to discontinue)
  - Alendronate 70 mg: not related; not covered (look for opportunity to discontinue)
  - Citalopram 20 mg: related; covered
  - Lisinopril 20 mg: not related; not covered (may process through Part D)
  - Metoprolol succinate 50 mg: not related; not covered (may process through Part D)
  - Albuterol MDI: related; covered
  - Spiriva Handihaler: related; not on formulary (substitute and cover routine ipratropium nebulizer solution)
Example of Determination of Medication Coverage, cont.

- Physician documentation demonstrating necessary elements discussed:
  The patient is an 88 yo female admitted to hospice for end-stage lung cancer diagnosed 1 ½ years ago. The patient did not tolerate radiation at time of diagnosis and received no further treatment. A repeat CT prior to hospice admission shows multiple masses to chest wall encasing the left ribs, a new mass in the right lung, and a left plural effusion. Her PPS is 60%. She is using walker for extended ambulation, exhibits dyspnea with speech, and currently refuses oxygen. She has had no recent weight loss. Comorbid conditions include COPD, significant pain from osteoarthritis, depression, and CKD 3, all of which contribute to or are related to terminal prognosis. Her history of HTN, osteoporosis, hyperlipidemia, and skin cancer is longstanding; these conditions are unrelated to her terminal prognosis and do not affect prognosis. She desires no curative treatment for her lung cancer but does desire comfort care in her home until EOL. If the disease course follows the expected clinical trajectory, prognosis is less than six months.

Compliance Tips

- Utilize the hospice formulary or preferred medication list
  - Helpful if hospice formulary includes information on what diagnoses and/or symptoms a medication is often used for
  - Helpful if patient is on an expensive medication for which a less costly, equivalent therapeutic alternative is listed on the formulary
    - Eases burden of finding alternatives
    - Provides consistent reason for switch from a particular costly medication to the less-costly formulary medication
    - Provides consistent alternatives to offer patient/family
    - Results in non-coverage of costly med if switch is declined

Compliance Tips, cont.

- Have a process in place for determining medication relatedness
  - Hospice physician is a key player: ensure the hospice physician is adequately educated on prognosis determination and related CMS documentation requirements
- Ensure your documentation reflects your practice and vice-versa
- Ensure your clinical documentation is defensible
- Ensure all diagnoses are being reported on the claim form

QUESTIONS?