Using the International Classification of Functioning, Disability and Health to Document Hospice Eligibility

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Feature Articles

Abstract **Author Information** **Authors** **Article Outline** **Outline** **Article Metrics** **Metrics**

Hospice documentation is an integral part of patient care as it not only paints the picture of hospice eligibility, but also tells the final chapter of a patient's life. Increasingly, hospices are under scrutiny by regulators to clearly define the admission and ongoing eligibility of the hospice patient. There is a lack of national standardization of documentation. The World Health Organization, in an effort to develop a common language among providers, developed the International Classification of Functioning, Disability and Health (ICF). Utilizing the ICF can assist with the documentation that establishes the eligibility of the hospice patient. Concepts from the ICF are applied to a case study of a patient with Parkinson's disease. The ICF has barriers and limitations for documentation of the eligibility of the hospice patient, but overall, its use is recommended by the hospice interdisciplinary team.

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Hospice documentation is all encompassing as it describes the patient's status, needs, and goals. It is inclusive of the family; it is multidimensional and must meet regulatory guidelines regarding the patient's hospice eligibility. Hospice documentation records the final chapter of a patient's life.

To be eligible for hospice, the patient must be terminally ill with a 6-month or less life expectancy should the disease run its normal course.[1] If a patient survives beyond the 6-month prognosis, the hospice medical director can recertify the patient as terminally ill, if the patient continues to meet eligibility criteria.[1(p2)] If the patient is no longer eligible, then the patient must be discharged from services. Documentation is critical in assisting the team in the decision regarding ongoing eligibility.

Hospices are facing increasing scrutiny as the Centers for Medicare & Medicaid (CMS) contracts with auditors to review hospice documentation that supports eligibility.[2] If the auditor does not find that the documentation supports eligibility, then payment is denied, and in certain instances, the hospice may be accused of fraud. The Centers for Medicare & Medicaid, along with its contractors, has the ability to perform both prepayment and postpayment audits. Hospices are often subjected to prepayment reviews that request additional information.[3] The 2017 Annual Report on Healthcare Fraud and Abuse Control reports that hundreds of millions of dollars were recovered from hospice agencies, and in some instances, hospice owners and administrators were sentenced to jail terms. False or improper billing was the primary issue.[4] Quality patient documentation by hospice staff with attention to justifying the terminal status of the patient while paying attention to regulatory issues is essential.[5] It behooves hospices to clearly document the admission and ongoing eligibility of patients.

There are general guidelines for hospice eligibility known as local coverage determinations (LCDs).[6] However, there are barriers to the documentation supporting eligibility. The LCDs have limitations. There are no national standards in regard to documentation that clearly illustrates hospice eligibility. Electronic medical record (EMR) providers vary in their substance and content and often use check boxes or charting by exception.

In 2002, the World Health Organization (WHO) proposed the International Classification of Functioning, Disability and Health (ICF)[7] as a classification of health and disease that moved health care providers toward a more common language for assessing, evaluating, and developing treatment plans for patients and for consistency in documentation. This system can be used around the world for consistency between providers.

This article discusses the importance of hospice documentation as it relates to the eligibility of the hospice patient at the time of admission and throughout the hospice stay. Barriers and challenges to meeting the Medicare Conditions of Participation are discussed. The components of the ICF and the rationale for the use of the ICF in hospice documentation are presented. The ICF is applied to a case study of a patient admitted to hospice with a diagnosis of Parkinson's disease. Conclusions and nursing implications are discussed in relation to the case study.

In 1982, CMS established the Medicare Hospice Benefit (MHB). With reimbursement, participation in hospice grew.[8] Early in the history of hospice, the majority of patients admitted to hospice services were terminally ill with a cancer diagnosis. End-stage cancer is typically associated with distant metastases and disease progression despite treatment. The trajectory of this patient was fairly predictable, and most hospice end-stage cancer patients do not survive beyond the 6-month life expectancy. Over time, other specialties began to refer patients with noncancer diagnoses to hospice. Any terminally ill patient with a 6-month prognosis, regardless of the disease process, qualifies for hospice. Noncancer diagnoses accounted for 63% of hospice patients in 2014.[9] Noncancer diagnosis trajectories are not as defined as cancer diagnosis trajectories. Patients with noncancer diagnoses may experience exacerbations and rallies, but they typically do not return to their baseline. Their decline can be characterized by ups and downs.[10] Thus, a noncancer diagnosis can be challenging for the hospice to document in terms of eligibility at admission and during their hospice stay.

The year prior to hospice admissions, the course of disability has a wide variance among older patients, but the disability and declines among patients with neurodegenerative disease are particularly poor.[11] To assist with determining eligibility, the National Health Service developed LCDs with criteria for specific diseases.[6(p117)] The LCDs

are guidelines that have limitations and should be used in conjunction with clinical expertise. It is common that a patient may be terminally ill related to multiple comorbid conditions but not meet the criteria of a disease-specific LCD.

Prognostication of a terminal illness is not an exact science. Clinicians must use knowledge, expertise, and tools that predict functional decline. On average, 12% to 15% of hospice patients survive 6 months or longer.[8(p894)] Scrutiny of hospices intensifies when patients are on services beyond 180 days.[8(p895)]

Accurate, clear, concise, individualized documentation is an essential component of patient care. The nurse is responsible for much of the documentation related to patient care.[5(p335)] Medicare Conditions of Participations require documentation that is individualized and supports the eligibility of the hospice patient.[6(p117)] The documentation must also support regulatory knowledge and compliance.[5(p336)] In addition, good documentation is important in identifying effective and ineffective interventions and outcomes and in demonstrating quality and patient safety. In recent years, it has become essential that hospices pay greater attention to regulatory issues regarding documentation that justifies eligibility and ultimately affects reimbursement.[5(p336)] Medicare has fiscal intermediaries who audit and review records for compliance and payment. Palmetto GBA is one of the nation's largest processors of claims serving Medicare beneficiaries in 16 states.[12] They report the number one reason for claim denial is the lack of documentation.[12] Recovery Audit Contractors (RACs) identify claims that rise to the level of concern regarding improper payment. A RAC audit can result in hospices repaying millions of dollars if the documentation fails to support the claim.[13] Hospices are vulnerable to RAC audits as the prognosticating of a 6-month life expectancy is challenging, demanding the need for reliable tools and better eligibility criteria. Patients still alive after 6 months on hospice services are likely to undergo scrutiny.[8(898)]

In a presentation to hospice professionals in 2016, the medical director for Palmetto GBA acknowledged the challenge faced by hospices in accurate prognostication of hospice eligibility particularly for the noncancer hospice patients with a longer length of stay (>180 days).[14] In their review of hospice documentation, Palmetto is using concepts from the ICF as a framework.[15] Most people working in health care are familiar with *ICD-10*, which is the 10th revision of the *International Statistical Classification of Diseases and Related Health Problems*.[14] The *ICD-10* is a part of the WHO family of classifications, which allows a common language and framework around the globe to classify diseases and other health conditions.[7(p3)] The World Health Organization developed a framework and conceptual basis for health and disability using a universal classification intended to work hand in hand with the *ICD-10*. This framework is the ICF. Again, the goal is to develop a common language for international/universal use.[7(p4)] The ICF can be applied not only to individuals but also to populations and policies. The ICF is a validated tool.[16] It has been utilized worldwide among populations to identify disability along the continuum of care.[17-24] The ICF is relevant to all individuals. This is irrespective of the individual's environment, personal characteristics, or the presence of health conditions.[25]

The ICF is divided into internal and external contextual factors. External factors are environment factors such as the physical environment and social or legal structures. Internal factors are unique to the individual such as age, gender, experiences, character, and behaviors. The ICF is a biopsychosocial model that integrates both the social and medical, which makes it a good fit for hospice. The components of the model are health condition (disease or disorder), body functions and structures, activity, participation, and environmental, and personal factors (Figure 1). The World Health Organization provides the following definitions for the ICF components:

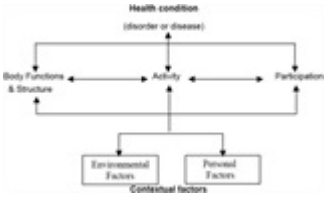

FIGURE 1

Body functions are the physiological functions of body systems (including psychological functions). Body structures are anatomical parts of the body such as organs, limbs, and their components. Impairments are problems in body functions or structure such as a significant deviation or loss. Activity is the execution of a task or action by an individual.

Participation is the involvement in a life situation. Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may experience in involvement in life situations. Environmental factors make up the physical, social, and attitudinal environment in which people live and conduct their lives.[7(p10)]

In *Going Beyond Diagnosis*, a web-based educational site for medical providers, the Palmetto medical director acknowledges there are no "magic words," but there are critical concepts that the provider must communicate in their documentation to support hospice eligibility. These concepts can be communicated by the use of the ICF.[26] Although CMS does not require the use of the ICF, the structural-functional changes and the concepts utilized by the ICF taxonomy assist in meeting the documentation required to support claim payment.

In order to implement the ICF into hospice documentation, it is important to understand the domains as defined by WHO. *Body structures* refers to the structures of the nervous system; eye, ear, and related structures; structures involved in voice and speech; structures of the cardiovascular, immunological, and respiratory systems; structures related to the digestive, metabolic, and endocrine systems; structures related to the genitourinary and reproductive systems; structures related to movement; and skin and related structures. *Body function* relates to the physiological function, which includes mental functions, sensory functions, and pain; voice and speech functions; functions of the cardiovascular, hematological, immunological, and respiratory systems; functions of the digestive, metabolic, and endocrine systems; genitourinary and reproductive functions; neuromuscular and movement-related functions; and the functions of the skin and related structures. Activities and participation refers to learning and the ability to apply knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interactions and relationships; major life areas; and community, social, and civic life. Environmental factors include products and technology; natural environmental and human-made changes to the environment; support and relationships; attitudes; and services, systems, and policies (Figure 2).[7(p16)]

FIGURE 2

The ICF does not consider diagnosis or health condition in isolation but considers environmental factors such as the increased use of health care resources, the use of durable medical equipment such as walkers or wheelchairs or a ramp to enter the home, the need for someone to assist with the activities of daily living (ADLs), and the use of support systems such as community health services. Activities and participation factors include the individual's ability to learn and retain knowledge such as the ability to learn to change an ostomy bag, learn to self-inject insulin, or learn to take medication correctly; the individual's ability to perform general chores and tasks of daily living such as shopping, chores, cooking, or managing finances; the individual's ability to communicate their wants and needs; and the individual's dependence or independence for ADLs. Other factors include the individual's relationship or participation in a family unit; the involvement in close interpersonal relationships; and the individual's involvement in the community through a place of worship, civic group, employment, or volunteerism. The International Classification of Functioning, Disability and Health considers how the health condition impairs the individual's ability to participate in family activities or participate in activities he/she previously enjoyed. Following is a case study of a patient with Parkinson's disease and application of the ICF to illustrate documentation that supports hospice eligibility.

CASE PRESENTATION

Mr Smith was a 72-year-old married, white man admitted to hospice with a diagnosis of atypical Parkinson's disease. Parkinson's disease is a progressive neurological disease characterized by changes in the neuromuscular system, resulting in the classic mask-like face, shuffling gait, stiffness, and tremors.[27] The cause of Parkinson's disease is unknown. It is a very complex disease that is difficult to diagnosis in its early stages. Dopamine replacement can assist with disease management for a period of time, but ultimately the disease will continue to progress. Parkinson's disease is a noncancer hospice diagnosis, and its trajectory can vary among individuals. The application of the ICF will clearly illustrate the eligibility of this patient. He was on hospice services for 1 year. By implementing the ICF, not only will the health condition be presented, but also the patient's activities, participation, and environment are described. The implementation of the ICF will help to paint the picture of his terminal illness.

Mr Smith was referred to hospice by his neurologist when he developed rapid declines related to his disease progression. He was experiencing impairments to his neuromuscular system that affected his activities, participation, and environment.

Just prior to his hospice admission, Mr Smith and his wife moved into their daughter's home because of his increased care needs. On admission, Mr Smith was ambulatory with the use of wheeled walker. A ramp had been installed for ease of access to the home as Mr Smith was no longer able to navigate steps. Mr Smith still enjoyed going out to eat occasionally. He was able to sit at the dining table and participate in meals with his family. Mr Smith was alert, oriented, and fully participatory in the discussion and decision-making process of the hospice admission. He was aware of his prognosis and elected comfort-focused care and a do-not-resuscitate status. His primary concern was his increasing weakness, his inability to enjoy previous pastimes, and the increasing caregiving burden on his wife. He was very independent in the past and hated having to dependent on others. He was aware of fall risks and the potential for serious injury. Mr Smith experienced structural-functional impairments related to his neuromuscular system. He reported that he thinks and speaks slowly, which he finds very frustrating. He has to chew carefully, stating that he occasionally experiences "strangling." He was on a regular diet, but foods are finely chopped. He was able to feed himself, but does drop some foods secondary to tremors. He reported food just did not taste good. He tried high-calorie supplements but did not like them.

His family reported that Mr Smith's decline had been fairly rapid, as he was diagnosed with Parkinson's disease only 6 months ago. At that time, he was totally independent for all ADLs, but he was experiencing increasing weakness and falls. Mr Smith experienced a 20-lb weight loss in the 3 months prior to his hospice admission. At the time of admission, his weight was 123 lb with a body mass index of 19.3 kg/m^2. Mr Smith had experienced depression and anxiety related to his declining physical condition. He had significant heart disease, but he denied chest pain, chest tightening, pressure, or dyspnea. The admission care plans developed for Mr Smith focused on safety issues related to his high fall risk, his nutritional risk, and his anxiety and depression. The admission note included the ICF concepts of structural-functional changes, that is, changes in his neuromuscular system (thinking, speaking, swallowing, gait, tremors, weakness, falls), and described changes in his ability to participate in activities and changes in his environment necessary to support him.

Mr Smith survived his initial 6-month prognosis. Mr Smith experienced worsening structural-functional impairments affecting his neuromuscular system including thought, cognition, voice, swallowing, and movement. He experienced associated declines in his ability to interact and participate with his family. His physical environment was now limited to 1 room. Based on these declines, the interdisciplinary team and the hospice medical director found Mr Smith to continue to be hospice eligible. He was recertified as terminally ill, and services continued.

As Mr Smith approached 1 year of hospice service, he had experienced significant changes in his environment, participation, and activities. He was confined to a hospital bed for ease of caregiving. He was unable to turn or reposition in bed without assistance. He experienced stiffness of his lower extremities, making turning challenging. He was totally dependent for all ADLs with maximum assistance. He was fed a mechanical soft diet with aspiration

precautions and increased time to task. He had no interest in food, and his family coaxed him to eat. He experienced urinary retention requiring the use of a Foley catheter. He was incontinent of bowel. Mr Smith experienced frequent hallucinations, which were anxiety producing for him and his family and required the use of haloperidol (Haldol) 1 mg twice daily and as needed every 4 hours to manage restlessness and agitation. He developed severe headaches and back and leg pain that required extended-release morphine 15 mg in the morning and 30 mg at night. He was treated with ciprofloxacin (Cipro) and phenazopyridine hydrochloride (Pyridium) for a urinary tract infection and later amoxicillin and Pyridium for a second urinary tract infection. Mrs Smith's health declined as she experienced increased stress and anxiety related to increasing caregiving burden. Mr Smith's daughter took time off work to assist with caregiving. Mr Smith no longer participated in activities or pastimes that previously brought enjoyment. He was increasingly withdrawn and less interactive with his family. He was sleeping 20 to 22 hours a day. This certification period, Mr Smith experienced significant declines characterized by further changes in his neuromuscular system as he was no longer able to assist in his care, he was unable to participate in family activities/interactions, and his environment now required the use of a hospital bed, Foley catheter, and medication changes. Mr Smith died at the end of this certification period. He was surrounded by his wife and daughter who expressed their relief that his journey was finished. They were very appreciative of the support provided by hospice. Using the components of the ICF in documentation helped to clearly paint the picture of this patient's hospice eligibility during every certification period.

DISCUSSION

The ICF goes beyond the patient's terminal diagnosis. It is all encompassing, looking at not only the health condition but also the impairments associated with that condition and the impact on the patient's activities, participation, and environment. Based on the literature review, the ICF is more widely used in Europe than in the United States. There appears to be a lack of knowledge among US health care providers about the ICF, although it has been in existence since 2002. The use of the ICF has been recently recommended for use among health care providers by Palmetto.

Using the ICF to document the admission narrative and the recertification narratives of hospice patients clearly shows the declines that support the terminal status of the patient. The reader or auditor can quickly compare the changes that occurred leading up to the hospice admission and, once admitted, the changes that have occurred that support hospice eligibility. Noncancer diagnoses can be challenging to document, especially to support eligibility. The ICF addresses all aspects of the health condition and how much work/effort is required to support the patient.

A major barrier to the use of the ICF is the lack of knowledge among health care providers of the ICF, its components, and how to implement it. In addition, using the ICF can be time consuming as it is typically best or more clearly understood in narrative form rather than EMR check boxes. Busy providers have difficulty finding the time to document to this degree and may be distracted by other tasks at hand and not focus on all the components of the ICF.

In summary, Mr Smith was a 72-year-old married, white man with a hospice diagnosis of Parkinson's disease. He had multiple significant comorbid conditions. His Parkinson's disease progressed rapidly after his diagnosis, and he was admitted to hospice services. He experienced structural-functional impairments that would be anticipated with his neuromuscular disease. Parkinson's disease impacted his activity, participation, and environment. Mr Smith survived his initial 6-month prognosis. By using the components of the ICF, his ongoing hospice eligibility was clearly documented, thus allowing him to continue to access his MHB.

CONCLUSION

Hospice documentation is essential to guiding the patient's care, facilitating communication among interdisciplinary team members, and painting the picture of hospice eligibility, in evaluating outcomes and meeting regulatory criteria. There are no national standards for hospice documentation. Electronic medical records often rely on check boxes, and some use charting by exception. To meet CMS's clearly stated need of documentation that supports a 6-month life expectancy, Palmetto has recommended using the concepts from the ICF. The ICF is used internationally and has

validity. It can be used with any individual. Therefore, the conclusion drawn by this author after applying the ICF to a case study is that the ICF does meet the challenge and criteria for documentation that supports hospice eligibility and recommends the use of the ICF in hospice documentation. The previously identified barriers will need to be addressed by providing education to health care providers and the realization that, although this method of documentation may initially be time consuming, avoiding costly audits and reimbursement to CMS may save money in the long run. Nurses have a primary role in patient documentation. Ongoing education regarding regulatory requirements and feedback from audits is an important aspect of providing quality care. By providing the documentation that paints the picture of hospice eligibility, the nurse helps to ensure that the patient will be able to continue to access his/her MHB.

After researching the ICF, education was presented to the interdisciplinary team. The concepts of the ICF were not well conveyed by lecture alone. However, after discussions in combination with a PowerPoint presentation that included conceptual diagrams and visuals of each domain, the team was successful in grasping the key points. Discussions on structural-functional impairments centered on “Back to Basics.” Basic anatomy and the function of various body systems were reviewed. The team was asked, “If there are impairments to the structure of the heart, what functional impairments would you anticipate?” As the discussion progressed, the team acknowledged that frequently there were many physical changes that were often subtle but that they had never thought about documenting, such as changes in voice (hypophonia) in Parkinson’s disease. In addition to education on the concepts of structural-functional changes, the team was presented with definitions and examples of activity, participation, and environment. The examples were very important in assisting the team to recognize the broader concept of environment beyond the immediate physical location of the patient. It is important to document environmental factors such as the increased use of health care resources in the year prior to the hospice admission, the accommodation and changes required in the physical environment (including durable medical equipment) needed to support the patient, and the impact of the health condition on the caregiving situation as well as the impact on the caregiver.

To assist the team with the inclusion of the domains of the ICF in their documentation, admission and recertification templates were developed. These templates are Word documents that are copied into the EMR. The use of the templates resulted in uniformity, consistency, and use of the ICF domains (Figure 3). Ongoing internal audits have been set up to assist the staff in review and feedback on their goal of documenting hospice eligibility. The ICF is challenging but rewarding, and it is anticipated that its use in health care documentation will grow.

FIGURE 3

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