HOSPICE AT RISK:
WHAT HOSPICE STAFF NEED TO KNOW & DO

Objectives

- List current areas of risk in Hospice
- Describe the difference between technical and clinical eligibility
- Name three essential components for a technically compliant clinical record
- Identify four important criteria to justify clinical eligibility
On May 20, 2009, the Fraud Enforcement and Recovery Act of 2009 ("FERA") was signed into law.

Healthcare Fraud Prevention and Enforcement Action Team (HEAT)

A new effort between DOJ and DHHS with increased tools and resources to combat fraud with an emphasis on prevention.

Patient Protection & Affordable Care Act (ACA)

- Enacted March 2010
- Provides more resources and incentives for fighting fraud and abuse
- Medicare RAC (Recovery Audit Contractors) program expanded to Medicaid
- Provider Enrollment Screening
- Changes to False Claims Act
False Claims Act

- Originally passed during the Civil War during President Lincoln’s administration.
- One of the government’s most powerful enforcement tools.
- Providers must report and return overpayments (accidentally or otherwise) to Medicare/Medicaid within 60 days of identifying the overpayment.
- Under PPACA, failure to return an overpayment within 60 days exposes a provider to liability under the FCA.
Range of Program Integrity Activities

- Mistakes
- Inefficiencies
- Bending the rules
- Intentional deception

- Error
- Waste
- Abuse
- Fraud

- Incorrect coding
- Medically unnecessary service
- Improper billing practices (e.g., up-coding)
- Billing for services that were not provided

Why the Increased Scrutiny?

- Expenditures for the Medicare hospice benefit have increased approximately $1 billion per year.
- In calendar year (CY) 1998, expenditures for the Medicare hospice benefit were $2.2 billion.
- CY 2009, expenditures for the Medicare hospice benefit were $12.1 billion.
- Hospice is no longer budget dust.

Source: Health Care Information System (HCIS)
Then – How to Limit Your Citations

- Years ago our scrutiny came from the COP survey process.
- The consequences were massive plans of correction with the potential of losing Medicare Certification.
HOSPICE REGULATIONS - 42 CFR
418

- Subpart A – § 418.1 - § 418.3 General Provisions and Definitions
- Subpart B - § 418.20 - § 418.30 Eligibility, Election, Duration of Benefits
- Subpart C – § 418.52 - § 418.78 Conditions of Participation: Patient Care
- Subpart D – § 418.100 - § 418.116 Conditions of Participation - Organizational Environment
- Subpart E - Reserved
- Subpart F – § 418.200 -§ 418.205 Covered Services
- Subpart G – § 418.301 -§ 418.311 Payment for Hospice Care
- Subpart H - § 418.400 - § 418.405 Coinsurance

Now – Hit the Wallet
OIG Audits vs. Investigations

- An investigation is carried out to resolve specific allegations, complaints, or information concerning possible violations of law, regulation, or policy.

- In contrast, an OIG audit or evaluation is conducted to examine organizational program performance or financial management matters, typically of a systemic nature (e.g. Hospice care in nursing homes).
OIG’s Focus on Hospice

- Coverage requirements for hospice patients residing in nursing homes
- Medicare hospices that focus on nursing facility residents (“high percentage hospices”)
- Hospital-to-GIP transfers
- Marketing practices with nursing facilities
- Duplicate drug claims (including non-covered but hospice-related medications)
- Compliance with Medicaid reimbursement requirements
- GIP appropriateness

List of Excluded Individuals and Entities (LEIE)

- OIG has the authority to exclude individuals and entities from participation in Federally funded health care programs.

- OIG maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE).

- Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP).
EXCLUSIONS

RULE:

- Cannot hire or contract with an individual or entity you knew or should have known was excluded from participation in federally funded programs.

Check the Exclusion Lists Monthly

- Monthly & prior to:
  - Hiring employees
  - Utilizing volunteers & board members
  - Contracting for physicians, therapists, etc.
  - Working with attending physicians
  - Signing new contracts

- Service & facilities contracts should contain language stating they will check the exclusion lists for their own employees.
$3.7 Million Settlement

- Hospice X to pay **$3.7 million** to settle civil allegations that the company violated the federal False Claims Act by submitting false bills to Medicare.
- The settlement agreement resolves allegations that the hospice submitted claims for payment to Medicare for patients who were either *completely or partially hospice ineligible* or were provided a higher level of hospice care than was necessary or allowable.
- Under the settlement agreement, the owners agreed to be **excluded from Medicare, Medicaid** and all other federal health care programs for **7 years**, effective immediately.
- Special agent in charge of the OIG & DHHS region said agents used sophisticated **data mining** tools and data analysis techniques during the investigation.

Payment Related Risk Areas
### Who’s Looking at Hospices?

<table>
<thead>
<tr>
<th>Agency</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>MAC</td>
<td>FBI</td>
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<tr>
<td>RA</td>
<td>DOJ</td>
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<td>ZPIC</td>
<td>MIC</td>
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<td>OIG</td>
<td>PERM</td>
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<tr>
<td>CERT</td>
<td>Medicaid RA</td>
</tr>
</tbody>
</table>

### Medicare Contractors – CA & NV

- Medicare Administrative Contractor (MAC) – National Government Services
- Comprehensive Error Rate Testing (CERT) Review Contractor (RC) – AdvanceMed Corp.
- Recovery Auditor (RA) – HealthDataInsights – HDI
- Zone Program Integrity Contractor (ZPIC) – Safeguard Services, LLC
Medicare Contractors – CA & NV, cont’d

- State Medicaid Auditors - CA & NV DHHS
- Payment Error Rate Measurement (PERM) Review Contractor (RC) – A+ Government Solutions
- Medicaid Integrity Contractor (MIC) Review MIC – AdvanceMed

ZPIC Audits Active in Hospice

- Many hospices, across the country and recently in California, are experiencing ZPIC audits.
- Focus on:
  - ↑ Length of Stay (LOS)
  - ↑ Non-CA diagnosis
  - ↑ SNF care
  - ↑ Readmits after discharge
  - ↑ Higher Levels of Care
  - Technical & clinical compliance
How ZPIC Audits Work

- They establish a Relevant Time Frame (RTF), then request a sample of clinical records from the RTF.
- Use sophisticated data mining tools and data analysis techniques during the investigation.
- Compare to other hospice.
- All denials associated with the sample are then factored into a Charge Denial Rate (CDR).
- Denials focus on technical and clinical eligibility – e.g., certs/recerts, chronic vs. terminal.

Extrapolation Effect

- The CDR (% of ALL denials in sample) may be applied to all claims submitted for ALL patients during the RTF without further record review.
- E.g., 75% of denials in sample, then applied 75% to all claims in the RTF.
ZPIC Tornado Effect

- ZPICs can initiate payment suspensions, provider and supplier exclusions, overpayment recoveries, and referral of providers to law enforcement authorities.
- Potential for complete financial devastation.
- At least 3 hospices have gone out of business due to ZPIC audits.

Any Audit Creates Negative Impact

- Toll on human resources to deal with the audit complexities.
- Survival rather than growth mode
- Damage to reputation
- Loss of referral sources
- Decrease in census
- Loss of staff
- Program closure
Types of Hospice Risk

Payment - Related Risk Areas

- ADRs, ZPIC audits, fraud investigations, etc.

Technological Risks

Clinical Risks

Payment - Related Risk Areas
Major Causes of Improper Payments

- Physician orders missing (Technical)
- Illegible/missing signatures (Technical)
- National policy or Local policy requirements not met (Clinical)
- The medical record does not support medical necessity (Clinical)

CMS, Overview of Improper Payment Reviews Conducted by Medicare & Medicaid Review Contractors
Technical Risks

- Easy targets to identify and recoup money
- Missing or illegible elements on an election form voids the election
- Incorrect order of required items voids form validity
- Simple errors can invalidate the form leading to denial of payment for an entire benefit period
- Require much more intensive physician involvement without any additional reimbursement
Sad Ending to a Respected Community Hospice

- In 100% of the claims reviewed, certifications and recertifications did not contain benefit period start and end dates.
- The ZPIC extrapolated its 100% Charge Denial Rate to all claims during the review period.
- The hospice was forced to close its doors.

MAJOR CLINICAL RISKS
- ELIGIBILITY (for hospice, for higher levels of care)
- DISCHARGES and REVOCATIONS
- RELATED vs. NOT RELATED TO THE TERMINAL ILLNESS
Technical Eligibility

What Hospice Needs to Know and Do

Regulations Related Sections for Technical Eligibility

- §418.20 Eligibility Requirements
- §418.21 Duration of Hospice Care Coverage
- §418.22 Certification of Terminal Illness
- 418.24 Election of Hospice Care
Technical Requirements

- Notice of Election (NOE)
- Initial Certification of Terminal Illness
- Recertification of Terminal Illness
- Physician Narrative Statement
- Face-to-Face Encounter (F2F)
Ensure Notice of Election Validity

Each patient must have a signed NOE and the form must contain all 5 required elements:

✓ Hospice provider’s name
✓ Palliative vs. curative care
✓ Waiver language
✓ Start of care (SOC) or effective date
✓ Patient’s or representative’s signature prior to SOC

Certification of Terminal Illness (CTI)
THE ENTIRE HOSPICE STAY AND PAYMENT OF SERVICES CENTERS ON A VALID CERTIFICATION OF TERMINAL ILLNESS

Certification or Recertification of Terminal Illness

- Who signs?
- Timing of certifications
- Oral or written certification
- Physician narratives
- Attestation statements
- Face-to-face encounters
**Ensure Cert/Recert Validity**

- Be executed within the required 2-day timeframe.
- Contain a dated physician signature.
- Completed, initially, by both the hospice and attending physicians, if there is an attending

(Note: State and/or Medicaid regs. may require attending physician recerts).

**Signature Requirements**

- Valid certifications and recertifications may be signed electronically or by hand.
- Physicians must date their own signatures.
- Stamped signatures are not acceptable.
- Make sure name is printed below signature.

*Source: Medicare Program Integrity Manual, (IOM 100-09, Chapter 3), section 3.3.2.4*
Cert/Recert, cont’d.

- Specify that the prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

- Identify the start and end dates of the benefit period being certified. Be careful with Leap Years!

- Documentation of an oral cert if the written cannot be obtained within the required 2-day timeframe.

Cert/Recert, cont’d.

- Identify the hospice staff member who obtained an oral certification, the physician it was obtained from, and the date it was obtained.

- The written certification must be in the medical record prior to billing.

- Send the hospice physician or NP to perform a H&P if there is not one within the last year.
Timeframe for Completing the CTI

- Certifications can be completed no more than 15 days prior to the effective date of election.

- Recertifications can be completed no more than 15 days prior to the start of the subsequent benefit period.

Physician Narrative

- The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.
  - Physician must document clinical information that supports the medical prognosis. Initially, the clinical information may be provided verbally, as part of hospice’s eligibility assessment.
  - Include measurable data.
  - Key phrase should be used - “As evidenced by”
CTI Content - Narrative

- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain checkboxes or standard language used for all patients.
- Cannot copy & paste nurses documentation in the narrative - illegal
- The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

CTI Content - Narrative

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.

- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
Order of CTI (F2F as an Addendum)

- Verbal Order
  - Staff printed name who obtained verbal certification
  - From whom they obtained the verbal certification
  - Signature, credentials, date
- Physician Narrative
- Attestation Statement stating whether narrative was based on review of clinical record, patient exam or both
- Physician Signature and date
- Physician’s printed name

§ 418.22 Face-to-Face Encounter (F2F)

- The face-to-face encounter must be completed prior to, but no more than 30 calendar days prior to the start of the 3rd and subsequent benefit periods.

- F2F can be made on 1st day on the next benefit period.

- Under “Exceptional Circumstances” the F2F can be completed within 2 days of the start of the benefit period.
F2F & Attestation

- The physician or nurse practitioner who performs the F2F encounter with the patient, must attest in writing that he or she had a F2F encounter with the patient, including the date of that visit.
- The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.
- The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.

F2F & Narrative

- The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.
Discharge Due to Missed F2F

- The beneficiary is not considered terminally ill for Medicare purposes due to lack of recertification, and therefore is not eligible for the hospice benefit.
- CMS requires Hospice to discharge the patient from the Medicare Benefit (Not the Hospice) but can re-admit once the F2F encounter occurs.
- CMS also expects hospice to continue to care for the patient, at its own expense, until the required F2F occurs.
- Once the F2F and attestation statement is completed, the pt may then be readmitted to hospice, with the new benefit period beginning on the date of readmission.

Timing Exceptions for Face-to-Face Encounter

- When a hospice newly admits a patient who is in the 3rd or later benefit period, exceptional circumstances may prevent a timely face-to-face encounter prior to the start of the benefit period. In such documented cases, a face-to-face encounter which occurs within 2 days after admission will be considered timely.

- Clearly document timing exception reason in the medical record.
Timing Exceptions for Face-to-Face Encounter

1) Emergency weekend admission, with hospice physician or NP already booked with patients, or a major storm, etc.;

2) If CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period;

3) If the patient dies within 2 days of admission without a face to face encounter, a face to face encounter is deemed to have occurred.

Clinical Eligibility

Establishing Medical Necessity for Hospice Care
Eligibility = Coverage

If LCD criteria are not met, auditors are likely to deny the claim.

Establish Baseline

Why hospice & why now?

- What prompted call today (precipitating events)?
- What changed in prior 6 - 12 months?
- What does pt need and why?
- What was pt’s prior healthcare utilization (MD/ER visits, hospitalizations, etc.)?
## Establish the Burden of Illness

- 1st diagnosed with terminal condition (date of onset)
- Current age
- Duration of illness
- Any treatments and response
- Location of care
- Functional status and time-to-task-completion
- Cognitive status
- Any current symptoms
- Goals of care (whose goals are they and appropriateness)

## Burden of Illness, cont’d.

- Degree of frailty
- Access to healthcare providers
- PCG willingness/ability
- Complications and risks
  - Secondary conditions
  - Comorbid condition
Identify the Terminal Diagnosis

- Discuss patient’s condition with the physician or medical director to determine the correct:
  - Terminal diagnosis;
  - Any secondary diagnoses; and,
  - Any co-morbidities.

Determining Related vs. Not Related

Admission nurse can make decisions that put the agency at risk by making the wrong determinations. Physician involvement is imperative!
LCD Guidelines

Local Coverage Determination (LCD)

Local Coverage Determination guidelines are the accepted industry standard for establishing medical necessity for hospice care.

- Ensure that admission notes include sufficient evidence of terminal status
- Obtain and document measurable clinical data (VS, weight, MAC, BMI, labs, ADL status, etc.)
NGS “UniPolicy”

- **Part I**: “Decline in Clinical Status Guidelines”;

  or, alternatively, Parts II & III combined

- **Part II**: “Non-Disease Specific Baseline Guidelines” (both A and B should be met) plus

- **Part III**: “Disease Specific Guidelines”

LCD - Decline in Clinical Status Guidelines

PART I
Part I – Decline in Clinical Status

□ Documented evidence of decline in clinical status over time… baseline and follow up determinations.

□ Baseline data may be established on admission by hospice or by using existing info from records.

□ Patient’s decline is not considered to be reversible.

□ Progression of disease is documented by worsening clinical status, symptoms, signs and lab results.

Clinical Status

□ Recurrent or intractable serious infections such as pneumonia, sepsis, or pyelonephritis – not UTIs

□ Progressive inanition (prolonged under- nutrition)
  1. Wt. loss of 10% or more in prior 6 mo.
  2. ↓ anthropomorphic measurements (mid-arm circumference), abdominal girth
  3. Observation (ill-fitting clothes, ↓ skin turgor)
  4. ↓ serum albumin < 2.5 gm/dl or cholesterol.
  5. Dysphasia leading to recurrent aspiration and/or inadequate oral intake
Symptoms

- Dyspnea with ↑ resp. rate
- Cough, intractable
- Nausea/vomiting, poor response to Tx.
- Diarrhea, intractable
- Pain requiring increasing doses of major analgesics more than briefly.

Signs

A. ↓ in systolic BP (<90) or progressive postural hypotension
B. Ascites
C. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
D. Edema
E. Pleural/pericardial effusion
F. Weakness
G. Change in level of consciousness.
Labs (When available)

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A. ↑ pCO2 or ↓ pO2 or ↓ SaO2
B. ↑ Calcium, creatinine, or liver functions studies
C. ↑ tumor markers (e.g. CEA, PSA)
D. Progressively ↓ or ↑ serum sodium or ↑ serum potassium

Other Supportive Information

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- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.
- Progressive decline in Functional Assessment Staging (FAST) for dementia only (7A).
- Progression to dependence on assistance with ADL.
- Progressive stage 3-4 pressure ulcers in spite of optimal care.
- Hx of ↑ ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of hospice.
½ Empty or ½ Full?

Assessment Scale Challenges

- Subjective
- Poorly predictive of prognosis
- Tendency to over-rate
- Clinician variability
- Become meaningless or moot
- Older scores get recopied
LCD - Non-Disease Specific Guidelines

PART II

Part II

Both A and B should be met:

A. Physiologic impairment of functional status as demonstrated by a KPS/PPS <70%

   HIV <= 50%
   Stroke <40% KPS/PPS
Part II, cont’d.

8. Caregiver dependence for 2 or more ADLs:
   1. Ambulation (non-purposeful = dependent)
   2. Continence (catheter, ostomy, and/or B&B program = dependent)
   3. Transfer
   4. Dressing
   5. Feeding
   6. Bathing

Part II, cont’d.

Supportive Co-morbidities

1. COPD
2. CHF
3. Ischemic heart disease
4. Diabetes mellitus
5. Neurologic disease
6. Renal failure
7. Liver disease
8. Cancer
9. HIV / AIDS
10. Dementia
11. Autoimmune
Part III

9 Disease Specific LCDs (UniPolicy)

- Cancer
- Heart disease
- Pulmonary disease
- Dementia due to Alzheimer's Disease and Related Disorders
- Renal disease
- Liver disease
- Stroke & Coma
- ALS
- HIV
Eligibility Worksheets

- Worksheets provide an excellent tool for determining eligibility.
- Always discuss why a pt is or is not appropriate with your IDG, including your attending and hospice physicians.

Progression of Terminal Illness

- The terminal prognosis of six months or less must be substantiated by documenting measurable decline and progression of illness at admission and at the end of each certification period, prior to recertification.
- Diagnosis and all other illnesses/co-morbidities affecting the terminal diagnosis & changes.
- Prior to recertification, summarize measurable decline & compare to the beginning of the last benefit period.
Progression/Measurable Decline

- Weight change (in #s or arm, leg, girth measurements)
- Food/Fluid intake %
- Cardiac/circulatory
- Respiratory (abnormal BS, O2 use)
- Edema
- Safety (DME)
- ↓ Activity tolerance (time OOB, bed bound, etc.)
- Ambulation – distance in ft.
- Recovery time after exertion – in min.
- Symptoms not alleviated by interventions
- ↑ Infections (list #/type & responses to Tx)
- Changes in sleep – in hours
- Mental/emotional changes
- Bowel/bladder changes
- Skin integrity
- ↑ Use/dose of medications for pain/symptom management (# times/day, change in dose or new medications added.)
- Diagnostic results supporting decline in condition

Managing Risks

Identify Potential Risks → Review Systems & Processes → Audit for Effectiveness → Apply Controls to Minimize Risks → Continue Assessing Risks → Identify Potential Risks
Know What Your Data States & How You Compare

- National Hospice & Palliative Care (NHPCO) Annual Statistics
- Office of Statewide Health Planning & Development (OSHPD) Data
- 2011 CMS Billing Summary
- 2012 PEPPER Report
- OSHPD Report Data
- MedPac Data

Recommendations – Be Audit Ready!

- Orient new and re-educate current staff to laws and regulations
- Evaluate risks by benchmarking against state and national statistics
- Continue pre-billing self-audits to ensure technical and clinical eligibility
- Contract for an objective external analysis of program and/or pre-billing record review
Recommendations – Be Audit Ready! – Cont’d.

- Have a system for mail opening where time sensitive letters get immediately directed to management.
- Identify/retain a hospice audit & compliance savvy attorney prior to the need.
- Respond to audit requests with individualized cover letters summarizing patient eligibility.
- Develop and maintain a robust Corporate Compliance Program.

Questions?
Presenter

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Exclusion Lists

California & Nevada

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Contracting for physicians, therapists, etc.
Working with attending physicians
Signing new contracts

Service & facilities contracts should contain language stating they will check the exclusion lists for their own employees.

Office of Inspector General’s List of Excluded Individuals & Entities (LEIE)
Website provides for a search of 1 – 5 names
http://exclusions.oig.hhs.gov/

Website provides a database that is updated monthly & can be downloaded
http://oig.hhs.gov/exclusions/exclusions_list.asp

General Services Administration’s (GSA) Excluded Parties List System (EPLS)
http://epls.arnet.gov

Office of Foreign Assets Control (OFAC) Specially Designated Nationals & Blocked Persons (SDN)
http://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx

Medi-Cal Suspended and Ineligible Provider List (S & I List)
www.medi-cal.ca.gov

Click the “References” tab, then the “Suspended & Ineligible List” link

Nevada Excluded/Sanctioned Providers –
https://dhcfp.nv.gov/exclusions.htm
# IDG Determinations

<table>
<thead>
<tr>
<th>IDG DECISION</th>
<th>IDG ACTION</th>
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<tbody>
<tr>
<td>1) Pt fully &amp; completely <em>meets</em> LCD guidelines</td>
<td>Admit / Recert – Document how pt meets LCD and all factors contributing to limited life expectancy</td>
</tr>
<tr>
<td>2) Pt partially meets LCD guidelines <em>with</em> secondary / comorbid conditions</td>
<td>If pt has <em>symptomatic</em> secondary/co-morbid conditions sufficient to support limited life expectancy, admit / recert and document how pt does and does not meet LCD (include documentation of all contributory factors)</td>
</tr>
<tr>
<td>3) Pt partially meets LCD guidelines <em>without</em> secondary / comorbid conditions</td>
<td>If pt has <em>no</em> symptomatic secondary/co-morbid conditions sufficient to support limited life expectancy, consider physician assessment visit, DX change, deferring admission, not recertifying, etc.</td>
</tr>
<tr>
<td>4) Pt does <em>not</em> meet LCD guidelines and has <em>no</em> secondary / comorbid conditions</td>
<td>Do not admit / recertify</td>
</tr>
</tbody>
</table>
Local Coverage Determination (LCD) for HOSPICE - Determining Terminal Status (L25678)

Contractor Information

Contractor Name
National Government Services, Inc.

Contractor Number
00456

Contractor Type
RHHI

LCD Information

Document Information

LCD ID Number
L25678

LCD Title
HOSPICE - Determining Terminal Status

Contractor's Determination Number
L25678 (R6)

Primary Geographic Jurisdiction
Alaska
American Samoa
Arizona
California - Entire State
Guam
Hawaii
Idaho
Nevada
Oregon
Washington
Northern Mariana Islands

Oversight Region
Region IX

Original Determination Effective Date
For services performed on or after 12/01/2007

Original Determination Ending Date

Revision Effective Date
For services performed on or after 04/01/2011

Revision Ending Date

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1102 provides that the Secretaries of the Treasury, Labor and Health and Human Services shall make and publish such rules and regulations not inconsistent with the Social Security Act, as necessary to the efficient administration of the functions each is charged with under this Act.
Section 1812 (a)(4) and (d) provides the scope of benefits for Hospice care.

Section 1813 (a)(4) provides deductible and coinsurance information.

Section 1814 (a)(7) and (I) provides conditions of and limitations on payment for hospice care provided to an individual.

Section 1861 (dd) defines hospice care and the hospice program.

Section 1862 (a)(1), (6) and (9) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, which constitute comfort items or where such expenses are for custodial care.

Section 1871 provides that the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under the title.

Code of Federal Regulations

42 CFR Section 418 specifies services covered as hospice care and the conditions that a hospice program must meet in order to participate in the Medicare program.

CMS Publications:

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30:

Financial Liability Protections

CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 9:

Coverage of Hospice Services under Hospital Insurance

CMS Transmittal No. 141, Publication 100-02, Medicare Benefit Policy Manual, Change Request #7337, March 2, 2011, updates hospice chapter of the manual to incorporate changes implemented as a result of statutory changes, and through notice-and-comment rulemaking in 2008, 2009, and 2010. Changes include updates to the Conditions of Participation (CoP) and certification sections of the chapter.

Indications and Limitations of Coverage and/or Medical Necessity

Abstract

Medicare coverage of hospice depends on a physician’s certification that an individual’s prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This LCD describes guidelines to be used by National Government Services (NGS) in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this LCD is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

Section 322 of BIPA amended section 1814(a) of the Social Security Act by clarifying that the certification of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The amendment clarified that the certification is based on a clinical judgment regarding the usual course of a terminal illness, and recognizes the fact that making medical prognostications of life expectancy is not always exact.
However, the amendment regarding the physician’s clinical judgment does not negate the fact that there must be a basis for a certification. A hospice needs to be certain that the physician’s clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course.

If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. 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.

*With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS proposed and implemented policies related to this new requirement in the Home Health Prospective Payment System Rate Update for CY 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372). This new face-to-face encounter requirement became effective on January 1, 2011.*

**Indications**

A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific "Decline in clinical status" guidelines described in Part I. Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed in Part III will establish the necessary expectancy.

**Part I. Decline in clinical status guidelines**

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient’s status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

**Clinical Status:**

a. Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;

b. Progressive inanition as documented by:

1. Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;
2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
3. Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;
4. Decreasing serum albumin or cholesterol.
5. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

**Symptoms:**
a. Dyspnea with increasing respiratory rate;
b. Cough, intractable;
c. Nausea/vomiting poorly responsive to treatment;
d. Diarrhea, intractable;
e. Pain requiring increasing doses of major analgesics more than briefly.

Signs:
 a. Decline in systolic blood pressure to below 90 or progressive postural hypotension;
b. Ascites;
c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease;
d. Edema;
e. Pleural/pericardial effusion;
f. Weakness;
g. Change in level of consciousness.

Laboratory (When available. Lab testing is not required to establish hospice eligibility.):
 a. Increasing pCO2 or decreasing pO2 or decreasing SaO2;
b. Increasing calcium, creatinine or liver function studies;
c. Increasing tumor markers (e.g. CEA, PSA);
d. Progressively decreasing or increasing serum sodium or increasing serum potassium.

B. Decline in Karnofsky Performance Status (KPS ) or Palliative Performance Score (PPS) due to progression of disease.

C. Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST).

D. Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2).

E. Progressive stage 3-4 pressure ulcers in spite of optimal care.

F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

**Part II. Non-disease specific baseline guidelines (both A and B should be met)**

A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

B. Dependence on assistance for two or more activities of daily living (ADLs):

1. Ambulation;
2. Continence;
3. Transfer;
4. Dressing;
5. Feeding;

C. Co-morbidities – although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.
1. Chronic obstructive pulmonary disease
2. Congestive heart failure
3. Ischemic heart disease
4. Diabetes mellitus
5. Neurologic disease (CVA, ALS, MS, Parkinson’s)
6. Renal failure
7. Liver Disease
8. Neoplasia
9. Acquired immune deficiency syndrome
10. Dementia
11. Acquired Immune Deficiency Syndrome/HIV
12. Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)

D. See Part III for disease specific guidelines to be used with these baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

**Note:** The word “should” in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is required. The only requirement is that the documentation supports the beneficiary’s prognosis of six months or less, if the illness runs its normal course.

### Part III. Disease Specific Guidelines

**Note:** These guidelines are to be used in conjunction with the “Non-disease specific baseline guidelines” described in Part II.

#### Cancer Diagnoses

A. Disease with metastases at presentation **OR**
B. Progression from an earlier stage of disease to metastatic disease with either:
   1. A continued decline in spite of therapy; or
   2. Patient declines further disease directed therapy.

**Note:** Certain cancers with poor prognoses (e.g., small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

#### Non-Cancer Diagnoses

##### Amyotrophic Lateral Sclerosis

**General Considerations:**

1. ALS tends to progress in a linear fashion over time. Thus the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to obtain to predict prognosis.
5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice care, the decision to institute either artificial ventilation or artificial feeding may significantly alter six month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.
Patients are considered eligible for Hospice care if they do not elect tracheostomy and invasive ventilation and display evidence of critically impaired respiratory function (with or without use of NIPPV) and / or severe nutritional insufficiency (with or without use of a gastrostomy tube).

Critically impaired respiratory function is as defined by:

1. FVC < 40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs:
   - Dyspnea at rest;
   - Orthopnea;
   - Use of accessory respiratory musculature;
   - Paradoxical abdominal motion;
   - Respiratory rate > 20;
   - Reduced speech / vocal volume;
   - Weakened cough;
   - Symptoms of sleep disordered breathing;
   - Frequent awakening;
   - Daytime somnolence / excessive daytime sleepiness;
   - Unexplained headaches;
   - Unexplained confusion;
   - Unexplained anxiety;
   - Unexplained nausea.

2. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the above symptoms/signs.

Severe nutritional insufficiency is defined as:

Dysphagia with progressive weight loss of at least five percent of body weight with or without election for gastrostomy tube insertion.

These revised criteria rely less on the measured FVC, and as such reflect the reality that not all patients with ALS can or will undertake regular pulmonary function tests.

**Dementia due to Alzheimer’s Disease and Related Disorders**

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria.

1. Patients with dementia should show all the following characteristics:
   a. Stage seven or beyond according to the Functional Assessment Staging Scale;
   b. Unable to ambulate without assistance;
   c. Unable to dress without assistance;
   d. Unable to bathe without assistance;
   e. Urinary and fecal incontinence, intermittent or constant;
   f. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

2. Patients should have had one of the following within the past 12 months:
   a. Aspiration pneumonia;
   b. Pyelonephritis;
   c. Septicemia;
   d. Decubitus ulcers, multiple, stage 3-4;
   e. Fever, recurrent after antibiotics;
   f. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

**Note:** This section is specific for Alzheimer’s disease and Related Disorders, and is not appropriate for other types of dementia.

**Heart Disease**
Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.)

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease, or are patients who are either not candidates for surgical procedures or who decline those procedures. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)

2. Patients with congestive heart failure or angina should meet the criteria for the New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an inability to carry on any physical activity. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of less than or equal to 20%, but is not required if not already available.

3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:
   a. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;
   b. History of cardiac arrest or resuscitation;
   c. History of unexplained syncope;
   d. Brain embolism of cardiac origin;
   e. Concomitant HIV disease.

**HIV Disease**

Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation.)

1. CD4+ Count < 25 cells/mcl or persistent (2 or more assays at least one month apart) viral load >100,000 copies/ml, plus one of the following:
   a. CNS lymphoma;
   b. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass);
   c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;
   d. Progressive multifocal leukoencephalopathy;
   e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy;
   f. Visceral Kaposi’s sarcoma unresponsive to therapy;
   g. Renal failure in the absence of dialysis;
   h. Cryptosporidium infection;
   i. Toxoplasmosis, unresponsive to therapy.

2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50%.

3. Documentation of the following factors will support eligibility for hospice care:
   a. Chronic persistent diarrhea for one year;
   b. Persistent serum albumin < 2.5;
   c. Concomitant, active substance abuse;
   d. Age > 50 years;
   e. Absence of or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
   f. Advanced AIDS dementia complex;
   g. Toxoplasmosis;
   h. Congestive heart failure, symptomatic at rest;
   i. Advanced liver disease.

**Liver Disease**

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present, factors from 3 will lend supporting documentation.)
1. The patient should show both a and b:
   a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5;
   b. Serum albumin < 2.5 gm/dl.

2. End stage liver disease is present and the patient shows at least one of the following:
   a. Ascites, refractory to treatment or patient non-compliant;
   b. Spontaneous bacterial peritonitis;
   c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 mEq/l);
   d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
   e. Recurrent variceal bleeding, despite intensive therapy.

3. Documentation of the following factors will support eligibility for hospice care:
   a. Progressive malnutrition;
   b. Muscle wasting with reduced strength and endurance;
   c. Continued active alcoholism (> 80 gm ethanol/day);
   d. Hepatocellular carcinoma;
   e. HBsAg (Hepatitis B) positivity;
   f. Hepatitis C refractory to interferon treatment.

**Pulmonary Disease**

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation.)

1. Severe chronic lung disease as documented by both a and b:
   a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
   b. Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)

2. Hypoxemia at rest on room air, as evidenced by pO2 less than or equal to 55 mmHg, or oxygen saturation less than or equal to 88%, determined either by arterial blood gases or oxygen saturation monitors, (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO2 greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)

3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).

4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

5. Resting tachycardia > 100/min.

**Renal Disease**

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

**Acute Renal Failure** (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)
1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis. As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient’s prognosis, and thus potentially impact that individual’s eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the Hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient’s terminal illness.

2. Creatinine clearance < 10 cc/min (<15 cc/min for diabetics); or < 15 cc/min (< 20 cc/min for diabetics) with comorbidity of congestive heart failure.

3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).

4. Estimated glomerular filtration rate (GFR) < 10 ml/min.

5. Comorbid conditions:
   a. Mechanical ventilation;
   b. Malignancy (other organ system);
   c. Chronic lung disease;
   d. Advanced cardiac disease;
   e. Advanced liver disease;
   f. Immunosuppression/AIDS;
   g. Albumin < 3.5 gm/dl;
   h. Platelet count < 25,000;
   i. Disseminated intravascular coagulation;
   j. Gastrointestinal bleeding.

**Chronic Kidney Disease** (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis; As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient’s prognosis, and thus potentially impact that individual’s eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient’s terminal illness.

2. Creatinine clearance <10 cc/min (<15 cc/min for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.

3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).

4. Signs and symptoms of renal failure:
   a. Uremia;
   b. Oliguria (< 400 cc/24 hours);
   c. Intractable hyperkalemia (> 7.0) not responsive to treatment;
   d. Uremic pericarditis;
   e. Hepatorenal syndrome;
   f. Intractable fluid overload, not responsive to treatment.

5. Estimated glomerular filtration rate (GFR) <10 ml/min.

**Stroke and Coma**
Patients will be considered to be in the terminal stages of stroke or coma (life expectancy of six months or less) if they meet the following criteria:

**Stroke**

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40%.

2. Inability to maintain hydration and caloric intake with one of the following:
   a. Weight loss > 10% in the last 6 months or > 7.5% in the last 3 months;
   b. Serum albumin < 2.5 gm/dl;
   c. Current history of pulmonary aspiration not responsive to speech language pathology intervention; Sequential calorie counts documenting inadequate caloric/fluid intake;
   d. Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration.

**Coma (any etiology):**

1. Comatose patients with any 3 of the following on day three of coma:
   a. abnormal brain stem response;
   b. absent verbal response;
   c. absent withdrawal response to pain;
   d. serum creatinine > 1.5 mg/dl.

2. Documentation of the following factors will support eligibility for hospice care:
   a. Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:
      1. Aspiration pneumonia;
      2. Pyelonephritis;
      3. Refractory stage 3-4 decubitus ulcers;
      4. Fever recurrent after antibiotics.

3. Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
   a. For non-traumatic hemorrhagic stroke:
      1. Large-volume hemorrhage on CT:
         a. Infratentorial: greater than or equal to 20 ml.;
         b. Supratentorial: greater than or equal to 50 ml.
      2. Ventricular extension of hemorrhage;
      3. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
      4. Midline shift greater than or equal to 1.5 cm.;
      5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.
   b. For thrombotic/embolic stroke:
      1. Large anterior infarcts with both cortical and subcortical involvement;
      2. Large bihemispheric infarcts;
      3. Basilar artery occlusion;

**Other Comments**

For claims submitted to the fiscal intermediary or Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.
Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

081x Hospice (non-Hospital based)
082x Hospice (hospital based)

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

0651 Hospice Service - Routine Home Care
0652 Hospice Service - Continuous Home Care
0655 Hospice Service - Inpatient Respite Care
0656 Hospice Service - General Inpatient Care Non-Respite
0657 Hospice Service - Physician Services

CPT/HCPCS Codes

ICD-9 Codes that Support Medical Necessity
It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

XX000 Not Applicable

Diagnoses that Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity
Not applicable
General Information

Documentations Requirements

Documentation certifying terminal status must contain enough information to support terminal status upon review. Documentation of the applicable criteria listed under the “Indications” section of this LCD would meet this requirement. If other clinical indicators of decline not listed in this LCD form the basis for certifying terminal status, they should be documented as well. Recertification for hospice care requires the same clinical standards be met as for initial certification, but they need not be reiterated. They may be incorporated by specific reference as part (or all) of the indication for recertification.

Hospice certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less, either as part of the form or as an addendum. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The narrative must reflect the patient’s individual clinical circumstances. Narratives associated with the third and later benefit period must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient’s third benefit period, and prior to each subsequent benefit period. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with patients prior to the third benefit period recertification and each subsequent recertification. This encounter can occur up to 30 calendar days prior to recertification, and the hospice physician or nurse practitioner must attest that the visit occurred. The certification or recertification must include the benefit period dates to which it applies, and be signed and dated by the certifying or recertifying physician. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election. Recertifications may be prepared no more than 15 calendar days prior to the start of the subsequent benefit period. (CMS Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

Documentation should “paint a picture” for the reviewer to clearly see why the patient is appropriate for hospice care and the level of care provided, i.e., routine home, continuous home, inpatient respite, or general inpatient. The records should include observations and data, not merely conclusions. However, documentation should comport with normal clinical documentation practices. Unless elements in the record require explanation, such as a non-morbid diagnosis or indicators of likely greater than six month survival, as stated above, no extra or additional record entries should be needed to show hospice benefit eligibility.

The amount and detail of documentation will differ in different situations. A patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than one with chronic lung disease. Patients with chronic lung disease, long term survival in hospice, or apparent stability can still be eligible for hospice benefits, but sufficient justification for a less than six-month prognosis should appear in the record.

If the documentation includes any findings inconsistent with or tending to disprove a less than six-month prognosis, they should be answered or refuted by other entries, or specifically addressed and explained. Most facts and observations tending to suggest a greater than six month prognosis are predictable and apparent, such as a prolonged stay in hospice or a low immediate mortality diagnosis, as stated above. But specific entries can also call for an answer, such as an opinion by one team member or recovery of ADLs when they were part of the basis for the initial declaration of eligibility. Also the lack of certain elements such as a tissue diagnosis for cancer will not negate eligibility, but does necessitate other supportive documentation.
Documentation submitted may include information from periods of time outside the billing period currently under review. Include supporting events such as a change in the level of activities of daily living, recent hospitalizations, and the known date of death (if you are billing for a period of time prior to the billing period in which death occurred).

Submitted documentation should always include the admission assessment, as well as any evaluations and Interdisciplinary Group (IDG) discussions used for recertification. Records that show the progression of the patient’s illness are very helpful.

Documentation should support the level of care being provided to the patient during the time period under review, i.e. routine or continuous home or inpatient, respite or general. The reviewer should be able to easily identify the dates and times of changes in levels of care and the reason for the change.

The guidelines contained in this policy are intended to help providers determine when patients are appropriate for the Medicare Hospice benefit. As each patient is unique, there are patients for whom a particular guideline does not match. In such cases, it is important for providers to meticulously document the factors which specify the individual’s terminal prognosis.

There are also patients who match a guideline at the start of hospice care, and who continue to do so for a prolonged period, e.g., greater than six months. While it is true that there is not a strict six month limit on the Hospice benefit, the underlying precept is that the beneficiary must have a prognosis of six months or less, if the illness runs its normal course. A beneficiary may match a guideline, but by virtue of that individual having lived for a significantly prolonged period thereafter, he/she has shown that guideline to be inadequate to predict the appropriate terminal prognosis.

Appendices ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult: Executive Summary A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1995 Guidelines for the Evaluation and Management of Heart Failure)

Stages of Heart Failure (HF)

Stage A
Patients at high risk of developing HF because of the presence of conditions that are strongly associated with the development of HF. Such patients have no identified structural or functional abnormalities of the pericardium, myocardium, or cardiac valves and have never shown signs or symptoms of HF.

Example:
Systemic hypertension; coronary artery disease; diabetes mellitus; history of cardiotoxic drug therapy or alcohol abuse; personal history of rheumatic fever; family history of cardiomyopathy.

Stage B
Patients who have developed structural heart disease that is strongly associated with the development of HF but who have never show signs or symptoms of HF.

Example:
Left ventricular hypertrophy or fibrosis; left ventricular dilatation or hypocontractility; asymptomatic valvular heart disease; previous myocardial infarction.

Stage C
Patients who have current or prior symptoms of HF associated with underlying structural heart disease.

Example:
Dyspnea or fatigue due to left ventricular systolic dysfunction; asymptomatic patients who are undergoing treatment for prior symptoms of HF.

Stage D
Patients with advanced structural heart disease and marked symptoms of HF at rest despite maximal medical therapy and who require specialized interventions.

Example:
Patients who are frequently hospitalized for HF or cannot be safely discharged from the hospital; patients in the hospital awaiting heart transplantation; patients at home receiving continuous intravenous support for symptom relief or being supported with a mechanical circulatory assist device; patients in a hospice setting for management of HF.

Karnofsky Performance Scale (KPS)
The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses.

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

<table>
<thead>
<tr>
<th>Rating</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Normal no complaints; no evidence of disease. Able to carry on normal activity; minor signs or symptoms of disease.</td>
</tr>
<tr>
<td>90</td>
<td>Normal activity with effort; some signs or symptoms of disease. Cares for self; unable to carry on normal activity or to do active work. Requires occasional assistance, but is able to care for most of his personal needs.</td>
</tr>
<tr>
<td>80</td>
<td>Requires considerable assistance and frequent medical care. Disabled; requires special care and assistance. Severely disabled; hospital admission is indicated although death not imminent.</td>
</tr>
<tr>
<td>70</td>
<td>Very sick; hospital admission necessary; active supportive treatment necessary. Moribund; fatal processes progressing rapidly.</td>
</tr>
<tr>
<td>60</td>
<td>Requires considerable assistance and frequent medical care. Disabled; requires special care and assistance. Severely disabled; hospital admission is indicated although death not imminent.</td>
</tr>
<tr>
<td>50</td>
<td>Requires considerable assistance and frequent medical care. Disabled; requires special care and assistance. Severely disabled; hospital admission is indicated although death not imminent.</td>
</tr>
<tr>
<td>40</td>
<td>Severely disabled; hospital admission is indicated although death not imminent.</td>
</tr>
<tr>
<td>30</td>
<td>Very sick; hospital admission necessary; active supportive treatment necessary. Moribund; fatal processes progressing rapidly.</td>
</tr>
<tr>
<td>20</td>
<td>Moribund; fatal processes progressing rapidly.</td>
</tr>
<tr>
<td>10</td>
<td>Moribund; fatal processes progressing rapidly.</td>
</tr>
<tr>
<td>0</td>
<td>Dead</td>
</tr>
</tbody>
</table>

NYHA Functional Classification for Congestive Heart Failure

The New York Heart Association (NYHA) Functional Classification provides a simple way of classifying heart disease (originally cardiac failure). It places patients in one of four categories, based on how much they are limited during physical activity:

**Class I**: patients with no limitation of activities; they suffer no symptoms from ordinary activities.

**Class II**: patients with slight, mild limitation of activity; they are comfortable with rest or with mild exertion.

**Class III**: patients with marked limitation of activity; they are comfortable only at rest.

**Class IV**: patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest.

Palliative Performance Scale

The Palliative Performance Scale (PPS) is a modification of the Karnofsky Performance Scale intended for evaluating patients requiring palliative care. The score can help determine which patients can be managed in the home and which should be admitted to a hospice unit. It was developed in British Columbia, Canada.

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Full</td>
<td>Normal activity &amp; work No evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Normal activity &amp; work Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80%</td>
<td>Full</td>
<td>Normal activity with effort Some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70%</td>
<td>Reduced</td>
<td>Unable Normal Job/Work Significant disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
</tbody>
</table>
### The Stages of Alzheimer's Disease

At the New York University Medical Center's Aging and Dementia Research Center, Barry Reisberg, MD and colleagues have developed the Functional Assessment Staging (FAST) scale, which allows professionals and caregivers to chart the decline of people with Alzheimer's disease. The FAST scale has 16 stages and sub-stages:

<table>
<thead>
<tr>
<th>FAST Scale Stage</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Normal adult</td>
</tr>
<tr>
<td>Stage 2 (Forgetfulness)</td>
<td>No cognitive decline.</td>
</tr>
<tr>
<td>Stage 3 (Early Confusional)</td>
<td>Noticeable deficits in demanding job situations.</td>
</tr>
</tbody>
</table>

#### Detailed Description of Each of the 7 Stages

**Stage 1**

No cognitive decline. No subjective complaints of memory deficit. No memory deficit evident on clinical interviews.

**Stage 2 (Forgetfulness)**

Very mild cognitive decline.

Subjective complaints of memory deficit, most frequently in the following area:

- a. Forgetting where one has placed familiar objects;
- b. Forgetting names on formerly knew well.

No objective evidence of memory deficit on clinical interview. No objective deficits in employment or social situations. Appropriate concern regarding symptoms.

**Stage 3 (Early Confusional)**

Mild cognitive decline. Earliest clear-cut deficits.

Manifestations in more than one of the following areas:
a. patient may have gotten lost when traveling to an unfamiliar location;
b. co-workers become aware of patient's relatively low performance;
c. word and name finding deficit becomes evident to intimates;
d. patient may read a passage of a book and retain relatively little material;
e. patient may demonstrate decreased facility in remembering names upon introduction to new people;
f. patient may have lost or misplaced an object of value;
g. concentration deficit may be evident on clinical testing.

Objective evidence of memory deficit obtained only with an intensive interview. Denial begins to become manifest in patient. Mild to moderate anxiety accompanies symptoms.

**Stage 4 (Late Confusional)** Moderate cognitive decline. Clear-cut deficit on careful clinical interview.

Deficit manifest in following areas:

a. decreased knowledge of current and recent events;
b. may exhibit some deficit in memory of one's personal history;
c. concentration deficit elicited on serial subtractions;
d. decreased ability to travel, handle finances, etc.

Frequently no deficit in the following areas:

a. orientation to time and person;
b. recognition of familiar persons and faces;
c. ability to travel to familiar locations.

Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations occur.

**Stage 5 (Early Dementia)** Moderately severe cognitive decline.

Patient can no longer survive without some assistance. Patient is unable during interview to recall a major relevant aspect of their current lives, e.g., an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouse's and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.

**Stage 6 (Middle Dementia)** Severe cognitive decline.

May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season, etc. May have difficulty counting from 10, both backward and sometimes forward. Will require some assistance with activities of daily living, e.g., may become incontinent, will require travel assistance but occasionally will display ability to familiar locations. Diurnal rhythm frequently disturbed. Almost always recall their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment.

Personality and emotional changes occur. These are quite variable and include:

a. delusional behavior, e.g., patients may accuse their spouse of being an impostor, may talk to imaginary figures in the environment, or to their own reflection in the mirror;
b. obsessive symptoms, e.g., person may continually repeat simple cleaning activities;
c. anxiety agitation, and even previously nonexistent violent behavior may occur;
d. cognitive abulia, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.

**Stage 7 (Late Dementia)** Very severe cognitive decline. All verbal abilities are lost.
Frequently there is no speech at all - only grunting. Incontinent of urine, requires assistance toileting and feeding. Lose basic psychomotor skills, e.g., ability to walk, sitting and head control. The brain appears to no longer be able to tell the body what to do. Generalized and cortical neurologic signs and symptoms are frequently present.

Dr Reisberg has also shown that the decline typical of Alzheimer's disease is the flip side of normal skill acquisition by infants, children, and young adults:

<table>
<thead>
<tr>
<th>Ability</th>
<th>Age of acquisition during normal development</th>
<th>Alzheimer's stage at which ability is lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold a job. Function independently in the world.</td>
<td>12 years and older</td>
<td>3... early Alzheimer's disease</td>
</tr>
<tr>
<td>Handle simple finances.</td>
<td>8-12 years</td>
<td>4... mild Alzheimer's</td>
</tr>
<tr>
<td>Select proper clothing.</td>
<td>5-7 years</td>
<td>5... moderate Alzheimer's</td>
</tr>
</tbody>
</table>

Available from ElderCare Online™ [http://www.ec-online.net](http://www.ec-online.net) ©Barry Reisberg, MD 1984

Utilization Guidelines Not applicable

Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

All previously published UGS Local Medical Review Policies (LMRP)/Local Coverage Determinations (LCD).


Medicare Contractor Medical Directors Hospice Workgroup.
Advisory Committee Meeting Notes

This coverage determination does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this determination is developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period 06/01/2007

End Date of Comment Period 07/16/2007

Start Date of Notice Period 04/01/2011

Revision History Number R6

Revision History Explanation R6 (effective 04/01/2011): The CMS National Policy Coverage section was updated to include CMS Transmittal No. 141, Publication 100-02, Medicare Benefit Policy Manual, Change Request #7337, March 2, 2011 which updates hospice chapter of the manual to incorporate changes implemented as a result of statutory changes, and through notice-and-comment rulemaking in 2008, 2009, and 2010. Changes include updates to the Conditions of Participation (CoP) and certification sections of the chapter. The abstract was updated specify reason for current policy update.

The Documentation section updated certification/recertification requirements as follows:

Hospice certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less, either as part of the form or as an addendum. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The narrative must reflect the patient’s individual clinical circumstances. Narratives associated with the third and later benefit period must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less. (CMS Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient’s third benefit period, and prior to each subsequent benefit period. (CMS Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with patients prior to the third benefit period recertification and each subsequent recertification. This encounter can occur up to 30 calendar days prior to recertification, and the hospice physician or nurse practitioner must attest that the visit occurred. The certification or recertification must include the benefit period dates to which it applies, and be signed and dated by the certifying or recertifying physician. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election. Recertifications may be prepared no more than 15 calendar days prior to the start of the subsequent benefit period. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)

No notice given, none required.
R5 (effective 06/01/2010): Annual LCD review per CMS Program Integrity Manual, Chapter 13, Section 13.4[C]. The entire policy was reviewed. A number of minor changes were made to reflect current CMS and National Government Services current policy formats. No comment and notice periods required and none given. The Supplemental Instructions Article associated with this policy was similarly updated.

R4 (effective 06/05/2009): Source of revision-Internal. Bibliography section revised to reflect current template format. Bill type codes 81X and 82X added to the “Bill Type Codes” Section of the LCD.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, RHHI number 00180 was removed from this LCD as the RHHI claims processing for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont was transitioned to NHIC, the RHHI contractor in these states.

R3 (effective 04/01/2009): Source of revision- Internal. Minor changes made to reflect current template language and minor typos corrected. Contractor jurisdictions have been clarified.

R2 (effective 01/01/2009) Annual review. Minor changes were made to reflect current template language.

R1 (effective 02/01/2008):

Non-disease specific baseline guidelines (both A and B should be met)

A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

B. Dependence on assistance for two or more activities of daily living (ADLs):

1. Ambulation;
2. Continence;
3. Transfer;
4. Dressing;
5. Feeding;

Inserted Functional Assessment Staging (FAST) scale.

08/18/2008 - In accordance with Section 911 of the Medicare Modernization Act of 2003, RHHI Contractor Number (00454) was replaced by RHHI Contractor number (00456) in this LCD as the claims processing for the states of Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Nevada, Oregon, Washington, and Northern Mariana Islands.

8/1/2010 - The description for Bill Type Code 81 was changed
8/1/2010 - The description for Bill Type Code 82 was changed

8/1/2010 - The description for Revenue code 0651 was changed
8/1/2010 - The description for Revenue code 0652 was changed
8/1/2010 - The description for Revenue code 0655 was changed
8/1/2010 - The description for Revenue code 0656 was changed
8/1/2010 - The description for Revenue code 0657 was changed

Reason for Change

Related Documents
Article(s)
A45194 - Hospice: Determining Terminal Status - Supplemental Instructions Article opens in new window

LCD Attachments
There are no attachments for this LCD.

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All Versions
Updated on 03/21/2011 with effective dates 04/01/2011 - N/A
Updated on 08/01/2010 with effective dates 06/01/2010 - 03/31/2011
Updated on 08/01/2010 with effective dates 06/01/2010 - N/A
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