DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1470

In the case of	**Claim for**
Covenant VNA Hospice (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
National Government Services, Inc. (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 11, 2011, which concerned hospice services rendered to the beneficiary from April 1 through 30, 2009, and June 1 through 30, 2009. The ALJ's partially favorable decision allowed coverage for the services furnished in April 2009, but denied coverage for the services furnished in June 2009, on the grounds that the documentation did not substantiate terminal illness for the month of June 2009. The ALJ found the appellant-provider liable for the non-covered costs. The appellant has asked the Medicare Appeals Council (Council) to review the ALJ's decision as to the June 2009 services.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The appellant's request for review and supporting letter are admitted into the record as exhibit (Exh.) MAC-1.

As set forth below, the Council reverses the ALJ's denial of coverage for the hospice services furnished in June 2009. The services are covered.

BACKGROUND

The issue on appeal is whether Medicare covers the hospice services furnished to the beneficiary from June 1 through 30, 2009. During the dates of service at issue the beneficiary was 81 years old with a primary diagnosis of debility. Her comorbidities included atrial fibrillation, chronic obstructive pulmonary disease, and advanced dementia. Exh. 2 at 238. The beneficiary elected hospice care and was admitted to the hospice facility on March 2, 2009. Exh. 2 at 36, 233.

The appellant submitted a claim to National Government Services, the Medicare contractor (contractor), and Medicare denied coverage for the services initially and upon redetermination. Exh. 3; Exh. 1. The appellant then requested reconsideration by a Qualified Independent Contractor (QIC), which affirmed the contractor's denial of coverage. The QIC stated:

> Medicare coverage criteria are no longer met for the continuation of hospice care services. The beneficiary was chronically ill, but medically stable with no continuum of decline of their status. The beneficiary had no recent hospitalization or acute changes. The documentation submitted does not support a terminal prognosis of six months or less as required to meet Medicare coverage criteria for hospice care services.

Exh. 4 at 273-74.

The ALJ conducted a hearing by telephone on March 8, 2011, and found that the beneficiary was terminally ill for the month of April 2009, and, accordingly, allowed for coverage for the services furnished in April. Dec. at 5. However, the ALJ denied coverage for the services furnished in June 2009, and found the provider liable for the non-covered costs. *Id.* at 6.

APPLICABLE LEGAL AUTHORITY

Section 1812(a)(4) of the Social Security Act (Act) provides that an individual may elect to receive hospice, in lieu of

certain other benefits "during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each." Section 1861(dd) of the Act defines what services constitute hospice care to a "terminally ill individual", and states that an individual is considered to be terminally ill if "the individual has a medical prognosis that the individual's life expectancy is 6 months or less." Section 1861(dd)(3)(A) of the Act. Medicare regulations applicable to payment and coverage requirements can be found at part 418 of title 42 of the Code of Federal Regulations (C.F.R.). A beneficiary must be certified as terminally ill by the medical director or the physician member of the hospice's interdisciplinary group, as well as the individual's attending physician if the patient has one. 42 C.F.R. §§ 418.20, 418.22.

Local and regional Medicare contractors issue local coverage determinations (LCDs) to implement hospice and other coverage provisions. The Council is not bound by LCDs; however the Council must explain its reasoning when it declines to follow a local policy in any particular case. 42 C.F.R. § 405.1062.

The contractor has issued LCD L25678, *LCD for Hospice – Determining Terminal Illness*, which outlines criteria for determining Medicare coverage for hospice care.[1] In the LCD the contractor establishes criteria to support a terminal prognosis for beneficiaries who meet the non-disease specific "Decline in clinical status" guidelines:

> ***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.

[1] A copy of LCD L25678 is entered into the record as Exh. MAC-2.

These changes in clinical variables apply to patients whose decline is not considered to be reversible....

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.
    1. 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....
            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.

    2. 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.

    3. 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.

4. Laboratory
   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.

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

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

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

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

9. 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 Pallative Performance Score (PPS) < 70%....

B. Dependence on assistance for two or more activities of daily living (ADLs):
   1. Ambulation;
   2. Continence;
   3. Transfer;

4. Dressing;
5. Feeding;
6. Bathing.

C. Co-morbidities....
   a. Chronic obstructive pulmonary disease
   b. Congestive heart failure
   c. Ischemic heart disease
   d. Diabetes mellitus
   e. Neurologic disease (CVA, ALS, MS, Parkinson's)
   f. Renal failure
   g. Liver Disease
   h. Neoplasia
   i. Acquired immune deficiency syndrome
   j. Dementia
   k. Aquired Immune Deficiency Syndrome/HIV
   l. 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....

Part III. Disease specific guidelines Note: These guidelines are to be used in conjunction with the [guidelines set forth in Part II]

* * *

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.

See LCD L25678.

DISCUSSION

Evidence submitted with the Request for Review

As a general rule an appellant must submit all the relevant evidence in a case at the QIC reconsideration level of appeal. 42 C.F.R. §§ 405.966(a)(2), 405.1018, 405.1122(c). When an appellant submits new evidence to the Council that relates to an issue the QIC or ALJ already considered, the Council must determine if it is new evidence. The appellant must show good cause for submitting evidence for the first time at this level.

The appellant submitted additional medical records for the months before and after the denied coverage period. No explanation of good cause was offered by the appellant to submit these records for the first time to the Council. Therefore, the Council excludes the evidence from the record and has not considered it in making this determination. *See* 42 C.F.R. § 405.1122(c).

Coverage

The LCD requires that the criteria in Part I, or, alternatively, the criteria in Parts II and III be met. Part I of the LCD

requires that the medical documentation show the beneficiary's decline in clinical status. *See* LCD L25678, Exh. MAC-2.

The ALJ found the patient was terminally ill in April, 2009, but that,

> The evidence in the record does not support a determination the beneficiary was terminally ill during the month of June, 2009. She did have more behaviors, but she was up in her wheelchair almost every day. It was stated that she was more active and her PPS increased to 50%. The records clearly demonstrate an improvement. Inasmuch as the evidence in the record did not support a decline in June, 2009, the hospice services are not covered under Medicare.

Dec. at 6.

The appellant counters that periods of increased quality of life is a hospice goal and that it is simply not feasible to discharge and readmit a hospice patient for every period of increased quality of life. Exh. MAC-1. The appellant also argues the patient remained confused and wholly dependent on care for daily living, had an inability to stay awake during visits, and exhibited continued weight loss. *Id*.

The record indicates beneficiary was admitted to hospice in March 2009, with a primary diagnosis of debility and co-morbidities of chronic obstructive pulmonary disease and dementia. *See generally* Exh. 2. The initial PPS score was 40 percent, which remained constant through June 5, 2009, and increased to 50 percent on June 16, 2009. Exh. 3 at 217, 221. A score of 40 percent indicates the patient is: mainly in bed, unable to do most activities and exhibits extensive disease, requires mainly assisted self-care, has normal or reduced food intake, has full or drowsy consciousness with or without confusion. Exh. MAC-2 at 13.

A PPS score of 50 percent indicates the patient is: mainly sit or lie, unable to do any work and exhibits extensive disease, requires considerable assistance for self-care, has normal or reduced food intake, and has full or confused consciousness. *Id*. A 30 percent PPS requires the patient to be totally bed bound and to require total care. *Id*.

The record shows the patient was receiving total care for her daily self-care, had full or drowsy consciousness with confusion, had nurses assist her with all activities of daily living (ADLs), and was most often found in bed or sitting in her wheelchair. *See generally* Exh. 2 at 129-228. The record supports a conclusion that the beneficiary's condition varied, such that PPS scores ranging between 30 percent to 50 percent would have been appropriate during the time period at issue.

The medical documents indicate the beneficiary required total care for bathing, hygiene, total incontinence of bladder and bowel, and all other ADLs. *Id*. The beneficiary had poor appetite and was fed daily by a home health aide. Exh. 2 at 217. The patient was often up in her wheelchair and talked non-stop; however, her speech mostly consisted of shouting at the nurses, "rambling nonsense", and irrational demands for someone to "butter her socks." *Id.* at 221. The record reflects the beneficiary's level of consciousness varied from an inability to maintain full consciousness, to severe confusion, and short periods of clarity. *See generally* Exh. 2.

The records following the month of June show a PPS score of 40 percent. The beneficiary experienced progressive weight loss, required total care for all ADLs, and began sleeping more during the day. *See* Exh. 2 at 27-31. At the end of June the beneficiary was more "demanding" and a psychological follow up was initiated. Exh. 2 at 225. The record reveals that the patient was "more demanding" in the sense that her deteriorating psychological state required more attention due to increased agitation and outbursts. *Id*. The beneficiary has since expired. Exh. MAC-1.

The ALJ, in finding hospice care covered for the month of April 2009 opined:

> Pursuant to the relevant LCD, the beneficiary should show progression of disease evidenced by recurrent infections; progressive inanition; dysphagia; dyspnea; cough; nausea and vomiting; diarrhea; pain; decline in blood pressure; ascites; edema; weakness; a Karnofsky Performance Status or Palliative Performance Score below 70%; dependence on more activities for daily living; and increasing emergency room visits. The evidence in the record for the month of April, 2009 showed the beneficiary's Palliative Performance Score was 40% (Ex. 2, p. 205). She was confused and

> suffered a few falls (Ex. 2, p. 205). She was incontinent of bowel and bladder and had poor appetite (Ex. 2, p. 205). She was lethargic and slept during visits (Ex. 2, p. 175. She required total care (Ex. 2, p. 175). The beneficiary wanted to sleep and was more confused (Ex. 2, p. 209).

Dec. at 5.

The beneficiary's condition in June 2009 was substantially similar to that in April 2009, and, at times, declined. *See generally* Exh. 2. It also appears from the record that the beneficiary's mental state and level of function gradually declined in June 2009 and thereafter. *Id*. The Council finds that the medical documentation, overall, indicates a gradual decline such that the criteria in Part II and Part III of the LCD were substantially met.

DECISION

The Council reverses the ALJ's decision denying coverage for the hospice services furnished from June 1 through 30, 2009. Medicare shall cover these services.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: July 29, 2011