

Centers for Medicare & Medicaid Services

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Local Coverage Determination (LCD) for Hospice - Neurological Conditions (L31537)

Contractor Information

Contractor Name
Palmetto GBA

Contractor Number
11004

Contractor Type
HHH MAC

LCD Information

Document Information

LCD ID Number
L31537

LCD Title
Hospice - Neurological Conditions

Contractor's Determination Number
J11AH-11-008-L

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Oversight Region

Region IV

Original Determination Effective Date

For services performed on or after 01/24/2011

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

CMS National Coverage Policy

Title XVIII of the Social Security Act, §§1812(a)(4), 1813(a)(4), 1814(a)(7) and (i), 1862(a)(1)(A), (6) and (9), 1861(dd)

42 CFR Chapter IV, Part 418

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, §§10, 20, 30, 40, 50, 60, 70 and 80

CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1, §10.1

CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, §§60 and 80

CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §§60.1 and 60.2

Indications and Limitations of Coverage and/or Medical Necessity

Neurological conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual's over-all health status. Health status mediates the much studied relationship between ICD-9-CM diagnosis and care outcomes. Health status includes environmental factors, such as the availability of palliative care services. The objective of this policy is to present a framework for identifying, documenting, and communicating the unique health care needs of individuals with neurological conditions and thus promote the over-all goal of the right care for every person, every time.

Neurological conditions may support a prognosis of six months or less under many clinical scenarios. Medicare rules and regulations addressing hospice services require the documentation of sufficient "clinical information and other documentation" to support the certification of individuals as having a terminal illness with a life expectancy of 6 or fewer months, if the illness runs its normal course. The identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care-planning. Use of the International Classification of Functioning, Disability and Health (ICF) to help identify and document the unique service needs of individuals with neurological conditions is suggested, but not required.

The health status changes associated with neurological conditions can be characterized using categories contained in the ICF. The ICF contains domains and categories (e.g., structures of the nervous system, mental functions, sensory functions and pain, neuromusculoskeletal and movement related functions, communication, mobility, and self-care) that allow for a comprehensive description of an individual's health status and service needs. Information addressing relevant ICF categories, defined within each of these domains and categories, should form the core of the clinical record and be incorporated into the care plan, as appropriate.

Additionally the care plan may be impacted by relevant secondary and/or comorbid conditions. Secondary conditions are directly related to a primary condition. In the case of neurological conditions, examples of secondary conditions could include dysphagia, pneumonia, and pressure ulcers. Comorbid conditions affecting beneficiaries with neurological conditions are, by definition, distinct from the primary condition itself, however, services aimed at the comorbid condition may indeed be related to the palliation and or management of the terminal condition. An example of a comorbid condition would be Chronic Obstructive Pulmonary Disease (COPD).

The important roles of secondary and comorbid conditions are described below in order to facilitate their recognition and assist providers in documenting their impact. The identification and documentation of relevant secondary and comorbid conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors would help establish hospice eligibility and maintain a beneficiary-centered plan of care.

Secondary Conditions:

Neurological conditions may be complicated by secondary conditions. The significance of a given secondary condition is best described by defining the structural/functional impairments - together with any limitation in activity and restriction in participation - related to the secondary condition. The occurrence of secondary conditions in beneficiaries with neurological conditions results from the

presence of impairments in such body functions as consciousness, attention, sequencing complex movements, ingestion (which includes chewing, manipulation of food in the mouth, and swallowing), muscle power, tone, and endurance. These impairments contribute to the increased incidence of secondary conditions such as dysphagia, pneumonia, and pressure ulcers observed in Medicare beneficiaries with neurological conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.

Ultimately, in order to support a hospice plan of care, the combined effects of the primary neurological condition and any identified secondary condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

Comorbid Conditions:

The significance of a given comorbid condition is best described by defining the structural/functional impairments - together with any limitation in activity and restriction in participation - related to the comorbid condition. For example a beneficiary with a primary neurological condition such as Amyotrophic Lateral Sclerosis (ALS) and a comorbidity of COPD could have specific COPD-related structural and functional impairments of respiration (e.g., structural impairments of the bronchoalveolar tree resulting in increased respiratory rate, cough and impaired gas exchange) that contribute to the activity limitations and participation restrictions already present due to the respiratory muscle weakness often observed with ALS.

Such a combination could affect the palliative care-plan by contributing to the individual's dyspnea and impaired exercise tolerance. Further description/documentation using the activities and participation component of the ICF (e.g., mobility, self-care, and interpersonal interactions and relationships), would help complete the clinical picture. Palliative care aimed at relieving the dyspnea and improving the individual's health status would be the goal.

Ultimately, in order to support a hospice plan of care, the combined effects of the primary neurologic condition and any identified comorbid condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

The documentation of structural/functional impairments, together with the observed activity limitations, facilitate the selection of the most appropriate intervention strategies (palliative/hospice vs. long-term disease management) and provide objective criteria for determining the effects of such interventions. The documentation of these variables is thus essential in the determination of reasonable and necessary Medicare Hospice Services.

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.

0651
0652
0655
0656
0657

CPT/HCPCS Codes**GroupName**

XX000	Not Applicable
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ICD-9 Codes that Support Medical Necessity

While there are no specific ICD-9-CM codes for neurological conditions conditions, the ICD-9-CM code describing the most relevant illness, disorder, or injury contributing to the prognosis of six months or less should be coded.

XX000	Not Applicable
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Diagnoses that Support Medical Necessity**ICD-9 Codes that DO NOT Support Medical Necessity****ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation****Diagnoses that DO NOT Support Medical Necessity**

General Information

Documentations Requirements

Documentation certifying terminal status must contain enough information to confirm terminal status upon review. Documentation meeting the criteria listed under the **Indications and Limitations of Coverage and/or Medical Necessity** section of this LCD would contribute to this requirement. Recertification for hospice care requires that the same standards be met as for the initial certification.

Appendices

N/A

Utilization Guidelines

N/A

Sources of Information and Basis for Decision

World Health Organization (WHO). International Classification of Functioning, Disability and Health. Geneva: World Health Organization, 2001.

Stier-Jarmer M, Grill, E, Ewert T, et al. ICF Core Set for patients with neurological conditions in early post-acute rehabilitation facilities. Dis Rehab 2005; 27(7/8):389-395.

Ewert T, Grill E, Sabine B, et al. ICF Core Set for patients with neurological conditions in the acute hospital. Dis Rehab 2005; (7/8): 367-373.

Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the Intermediary, this policy was developed in cooperation with advisory groups, which include representatives from the Hospice providers. The Advisory Committee Meeting Date:

Start Date of Comment Period**End Date of Comment Period**

Start Date of Notice Period

12/09/2010

Revision History Number**Revision History Explanation**

01/24/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Palmetto GBA Title 18 RHHI (00380) was removed from this LCD and implemented to Palmetto GBA J11 HH and H MAC (11004). Effective date of this Implementation is January 24, 2011.

Reason for Change**Related Documents**

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

 All Versions

Updated on 11/30/2010 with effective dates 01/24/2011 - N/A

Read the **LCD Disclaimer**