Please note: This is a Draft policy.
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Contractor Information

Contractor Name: Palmetto GBA
Contractor Number: 00380
Contractor Type: RHHI

LCD Information

LCD ID Number: DL30708
LCD Title: Hospice - Neurological Conditions
Contractor's Determination Number: 10HA-001-D

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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

Primary Geographic Jurisdiction

Alabama
Arkansas
Florida
Georgia
Illinois
Indiana
Kentucky
Louisiana
Mississippi
North Carolina
New Mexico
Ohio
Oklahoma
South Carolina
Tennessee
Texas

Oversight Region

Region IV

Projected Determination Effective Date

Original Determination Ending Date
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:** [back to top](#)

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.

| 81x | Special facility or ASC surgery-hospice (non-hospital based) |
| 82x | Special facility or ASC surgery-hospice (hospital based) |
Revenue Codes: back to top

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 back to top

XX000 Not Applicable

ICD-9 Codes that Support Medical Necessity back to top

While there are no specific ICD-9-CM codes for neurological 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

Diagnoses that Support Medical Necessity back to top

ICD-9 Codes that DO NOT Support Medical Necessity back to top

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation back to top

Diagnoses that DO NOT Support Medical Necessity back to top

General Information
Documentation 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  


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 Ad Hoc Advisory Committee. The Advisory Committee Meeting Date:

Start Date of Comment Period  

12/31/2009

End Date of Comment Period  

02/15/2010

Start Date of Notice Period  

Revision History Number
CP is an 82-year-old female with a terminal diagnosis of “Parkinson’s Disease”. Comorbidities identified in the medical record include the Shy-Drager Syndrome, COPD with pulmonary hypertension, Atrial Fibrillation, Aortic Stenosis with past history of Coronary Heart Disease S/P MI and Osteoarthritis. Secondary conditions include Depression and Malnutrition.

The aortic stenosis is described as “mild – moderate; associated with bilateral atrial enlargement and severe tricuspid regurgitation”. CP’s mobility is described as being limited secondary to increasing tremors, increasing shortness of breath, and increasing “weakness”. She is restricted to the “bed or couch” and requires maximum assistance - even with a walker. Records document that, in fact, CP requires maximum assistance with all Activities of Daily Living (ADLs).

History obtained from hospital records documents that one year prior to hospice admission CP was hospitalized for syncope and left hip fracture. At that time she was noted to be alert and oriented x 2, but no further information was documented regarding her past cognitive status. Following rehabilitation she was discharged using a walker for mobility and required minimal assistance with ADLs. CP complains of occasional knee pain related to osteoarthritis.

CP's son reports that over the past year his mother’s weight has decreased from 187 lbs to 102 lbs. CP is noted to be 5' 2" tall (BMI = 18.6 kg/m2). She is afebrile with a documented radial pulse rate varying from 56 – 80 beats per minute, respiratory rate of 20 – 28 breaths per minute and BP between 80/60 – 130/80. She is maintained on Florinef for hypotension. History from a recent clinic visit documented that CP had “an increased cardiac silhouette and mild vascular prominence” on chest x-ray.

CP’s appetite is described as “fair to poor” and she is noted to eat “very little”. She has temporal wasting and is “is not very talkative”. CP is maintained on a soft, puree diet supplemented by “Ensure TID”. She is now reported to be alert and oriented x 0.

Description of scenario using ICD-9-CM:

332.0 Parkinson’s Disease – Paralysis agitans
333.0 Other degenerative diseases of the basal ganglia – Shy-Drager syndrome
311 Depressive disorder, not elsewhere classified
414.0 Coronary atherosclerosis
427.31 Atrial Fibrillation
416.8 Chronic pulmonary heart disease – other (pulmonary hypertension, secondary)
424.1 Aortic valve disorders - stenosis
491.20 Obstructive chronic bronchitis – Without exacerbation
715.6 Osteoarthrosis and allied disorders – lower leg
783.2 Abnormal loss of weight

V85.0 Body Mass Index less than 19, adult

Terminal diagnosis given:
Parkinson’s disease

Comorbidities:
Shy-Drager Syndrome
COPD with pulmonary hypertension
Atrial fibrillation
Aortic stenosis with past history of coronary heart disease
Status post MI
Osteoarthritis

Secondary Conditions:
Depression
Malnutrition

Palmetto GBA instructs providers to identify and document how the impairments, activity limitations, and disability associated with the principal diagnosis (the condition impacting most acutely on the beneficiary’s clinical course) contributes to a prognosis of six months or less. In addition, where comorbid and/or secondary conditions exist, the related impairment(s), activity limitation(s), and disability should be documented—as should their impact on the beneficiary’s terminal prognosis.

Using the ICF, the relevant impairments, activity limitations, and environmental factors identified for this case are:

ICF Component: **Body Function and Structure**

**ICF Domain: Mental function**

- b114-Orientation functions-general mental functions of knowing and ascertaining one’s relationship to self, to others, to time and to ones’ surroundings
  - b1140 – Orientation to time
  - b1141 – Orientation to place
  - b1142 – Orientation to person

- b130 – Energy and drive functions
  - b1302- Appetite

**ICF Domain: Sensory functions and pain**

- b280 – Sensation of pain
  - b28016 - Pain in joints (knees)

**ICF Domain: Functions of the Cardiovascular…and Respiratory Systems**

- b410 – Heart functions
  - b4101 - Heart rhythm
  - b4103 - Blood supply to heart
  - b4108 - Heart functions, other specified (valvular)

- b420 – Blood pressure functions
  - b4201- Decreased blood pressure

- b440 – Respiratory functions
  - b4400 - Respiratory rate-tachypnea
  - b4402 - Depth of respiration

- b455 – Exercise tolerance functions
  - b4551 - Aerobic capacity

- b460-Sensations associated with cardiovascular and respiratory functions-(dyspnea)
ICF Domain: Functions of the digestive, metabolic, and endocrine systems

b530 - Weight maintenance function-functions of maintaining appropriate body weight

Inclusions: functions of maintenance of acceptable Body Mass Index (BMI); and impairments such as underweight, cachexia, wasting, overweight, emaciation and such as in primary and secondary obesity

ICF Domain: Genitourinary and reproductive functions

b620 - Urinary functions
  b6202-Urinary continence

ICF Domain: Neuromusculoskeletal and movement-related functions

b765 - Involuntary movement functions
  b7651-Tremor

ICF Domain: Structures of the Cardiovascular…and Respiratory System

s410 – Structure of the cardiovascular system
  s4100 – Atria (enlargement)
  s41008 – Structure of the heart, other specified (aortic valve)

ICF Component: Activities and Participation

ICF Domain: Mobility

d410 – Changing basic body position
  d4104 - Standing

  d420 - Transferring oneself-moving from one surface to another, such as sliding along a bench or moving from a bed to chair, without changing body position. Inclusions: transferring oneself while sitting or lying
    d4200 - Transferring oneself while sitting-moving from a sitting position on one seat to another seat on the same or different level, such as moving from chair to bed

  d450 - Walking
    d4500-Walking short distances

  d460 -Moving around in different locations
    d4600 – Moving around within the home

ICF Domain: Self-care

d510 -Washing oneself

d530 –Toileting

d540 –Dressing
d550 – Eating

d560 – Drinking

**ICF Component:** Environmental Factors

**ICF Domain:** Products and Technology

- e120 – Products and technology for personal indoor and outdoor mobility and transportation
  - e1201 - Assistive products and technology for personal indoor and outdoor mobility and transportation
<table>
<thead>
<tr>
<th>ICF Components</th>
<th>Description/Disability</th>
<th>Intervention(s)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Functions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b114 - Orientation functions</td>
<td>Initially oriented x 2; then x 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b130 - Energy and drive functions</td>
<td>Poor appetite</td>
<td></td>
<td></td>
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<tr>
<td>b280 - Sensation of pain</td>
<td>Knee pain; no chest pain reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b410 - Heart functions</td>
<td>Increased right sided pressure contributing to dyspnea; Aortic stenosis and tricuspid regurgitation also</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b420 - Blood pressure functions</td>
<td>Despite use of Florinef at times hypotensive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b440 - Respiratory functions</td>
<td>Cardiopulmonary cause of dyspnea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b455 - Exercise tolerance functions</td>
<td>Impaired due to dyspnea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b460 - Sensations associated with cardiovascular &amp; resp. functions</td>
<td>Dyspnea worsening; therapeutic options limited by hypotension</td>
<td></td>
<td></td>
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<tr>
<td>b530 - Weight maintenance functions</td>
<td>Despite use of nutritional supplement weight loss continues</td>
<td></td>
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<tr>
<td>b620 - Urination functions</td>
<td>Episodes of functional incontinence</td>
<td></td>
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<tr>
<td>b765 - Involuntary movement function</td>
<td>Anti-Parkinson's meds no longer as effective; impairment impacting ADLs</td>
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<tr>
<td><strong>Body Structures</strong></td>
<td></td>
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</tr>
<tr>
<td>s410 - Structure of heart</td>
<td>Enlarged due to pulmonary and cardiovascular</td>
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<tr>
<td><strong>Activities and Participation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d410 - Changing basic body positions</td>
<td>Severe activity limitation in mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d420 - Transferring self</td>
<td></td>
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<tr>
<td>d450 - Walking</td>
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<td>d460 - Moving around in different locations</td>
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<tr>
<td>d510 - Washing oneself</td>
<td>Severe activity limitation in self care</td>
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<tr>
<td>d530 - Toileting</td>
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<td>d540 - Dressing</td>
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<tr>
<td>d550 - Eating</td>
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<td></td>
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<tr>
<td>d560 - Drinking</td>
<td></td>
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<tr>
<td><strong>Environmental Factors</strong></td>
<td></td>
<td></td>
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<tr>
<td>e120 - Products and technology for personal indoor and outdoor mobility and transportation</td>
<td>Previously able to independently utilize walker for mobility; Currently unable.</td>
<td></td>
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</tbody>
</table>

**Medical Review Determination:**

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