Hospice Eligibility Job Aid

**Introduction/Importance**

Hospice care is a benefit under various insurance programs. Most hospice care in the United States is provided through Medicare. To be eligible to elect hospice care under Medicare (the Medicare Hospice Benefit or MHB), an individual must be entitled to Part A of Medicare, elect the benefit with the understanding that doing so waives coverage for their terminal illness through the rest of Medicare, and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual’s life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit. Hospice care covered by Medicaid generally follows Medicare coverage rules, though individual states may vary. Private insurance coverage of hospice may vary considerably, so checking individual plans is required.

The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient’s attending physician (if any).

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

- Diagnosis of the terminal condition of the patient.
- Other health conditions, whether related or unrelated to the terminal condition.
- Current clinically relevant information supporting all diagnoses.

All conditions that are contributing to the patient’s terminal prognosis are considered “related” and taken together, those diagnoses comprise the patient’s terminal illness.

Medicare makes payments to hospices through Medicare Administrative Contractors (MACs). Each MAC has developed Local Coverage Determinations (LCDs) that are guidelines for documentation of a patient’s terminal illness. While someone can be terminally ill without meeting an LCD, most patients will fall under a guideline.

The following guidelines in this document are our compilation of the information contained within the various LCDs. It may be useful to be familiar with the specific LCDs that are applicable to your given location. One can look up the actual LCD by:

- Click to: https://www.cms.gov/medicare-coverage-database/,
- Along the right side, select “Local Coverage Documents”,
- Along the right side, select the Geographic Region (usually your state),
- Along the right side, enter the keyword “hospice”, then
- Click “Search by Type”
- There may a couple of intermediate slides before the actual LCD appears. Select the blue-colored LCD number and the LCD will appear.
Four Ways to Determine and Document Hospice Eligibility

1) Patient’s illness meets one or more LCD Document how a patient fulfills all the requirements in one or more LCDs. LCD’s are guidelines only, not medical criteria.

2) Patient’s illness almost meets an LCD’s guideline and has Rapid Decline
   Patients who meet most of LCD guidelines may still be eligible for the MHB if they demonstrate a rapid decline resulting in a six months or less prognosis, as evidenced by:
   - Rapid loss of function (PPS)
   - Rapid loss of weight (typically >10% in 6-12 months)
   - Frequent office, emergency room or hospital visits
   - Rapid deterioration in laboratory values or x-ray results

3) Patient’s illness almost meets an LCD’s guideline and significant Comorbid Conditions.
   Patients who meet most of an LCD guideline may still be eligible for the MHB if they demonstrate significant life-limiting comorbid conditions resulting in a six months or less prognosis. Such comorbid conditions include, but not limited to:
   - Advanced Congestive Heart Failure
   - Advanced Chronic Obstructive Pulmonary Disease
   - Advanced Renal Failure
   - Significant Dementia

4) Physician’s Clinical Judgment
   Patients who do not meet all or for whom there is no applicable the LCD guideline, they may still be eligible for the MHB if they have a six months or less prognosis consistent with sound medical judgment which is then well-documented.
   REMEMBER: A signed certification alone is NOT sufficient.

If you are assessing a hospice-eligible patient who does not meet the specific criteria outlined within the LCDs, you must include comorbidities, and use “now and then” references regarding the deterioration in physical status/function as well as statements from the patient, caregivers, and other clinicians regarding the patient’s condition. Ask the referring physician, “Why did you refer the patient to hospice at this time” and document “triggers” that led up to the referral for hospice services. Always “paint the picture” using descriptive language so that reader can visualize the patient.

Triggers that May Initiate a Referral to Hospice

Triggers that may initiate a referral to Hospice include (but are not limited to):
- Frequent hospital or emergency room visits
- Difficulty controlling physical or psychological symptoms
- Complex care requirements
- Decline in function, feeding intolerance unintended weight loss

Progression of Disease

Note progression of disease by worsening clinical status, symptoms, signs, and laboratory results. Examples may include (but are not limited to):
• Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis
• Recurrent fever despite antibiotics

**Clinical Status:**
Progressive lethargy as documented by:
• 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
• Decreasing mid arm circumference (MAC) or abdominal girth, not due to reversible causes such as depression or diuretics
• Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss
• Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption

**Symptoms:**
• Dyspnea with increasing respiratory rate
• Cough, intractable
• Nausea/vomiting poorly responsive to treatment
• Diarrhea, intractable
• Pain requiring increasing doses of major analgesics more than briefly

**Signs:**
• Decline in systolic blood pressure to below 90 or progressive postural hypotension
• Resting tachycardia
• Ascites
• Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
• Edema
• Pleural/pericardial effusion
• Weakness
• Change in level of consciousness

**Laboratory (when available, lab testing is not required to establish hospice eligibility):**
• Decreasing serum albumin or cholesterol
• Increasing pCO2 or decreasing pO2 or decreasing SaO2. Increasing calcium, creatinine or liver function studies
• Increasing tumor markers (e.g. CEA, PSA)
• Progressively decreasing or increasing serum sodium or increasing serum potassium
Clinical Guidelines: Disease Specific:

These Disease-Specific Guidelines are taken from the MACs’ LCDs and are to be used in conjunction with the foregoing general guidelines on clinical decline, if the terminal diagnosis is specific. Be aware that the following are disease categories, and do not necessarily represent an ICD-10 diagnosis that can be coded.

Cancer
Disease with distant metastases at presentation or Progression from an earlier stage of disease to metastatic disease with:
- PPS < 70%
- Disease with distant metastases at presentation of bone, liver, brain, other OR
- A continued decline in spite of therapy OR
- Patient declines further disease directed therapy
- Note that Palmetto does not have a cancer-specific guideline.

Amyotrophic Lateral Sclerosis
MH§ LCDs regard ALS as progressing linearly over time, with overall rate of decline “fairly constant and predictable,” though recognizes that patients vary: “Therefore, multiple clinical parameters are required to judge the progression of ALS. 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.” As an ALS patient approaches the end of life, two factors are critical prognostic elements: ability to breathe, and (to a lesser extent) ability to swallow. Inability to breathe can be managed by artificial ventilation, and inability to swallow can be managed by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. Use of such medical measures can significantly alter six-month prognosis. LCDs recommend that a neurologist evaluate the ALS patient within 3 months of considering referral to hospice, “both to confirm the diagnosis and to assist with prognosis.” In general, the presence of these elements argues for hospice eligibility: Critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months before going on hospice:
- Vital capacity (VC) less than 20% of normal (if available)
- Dyspnea at rest
- Requiring supplemental oxygen at rest
- Patient declines artificial ventilation; external ventilation used for comfort measures only

Rapid progression of ALS as demonstrated by all the following characteristics occurring within the 12 months before going on hospice:
- Progression from independent ambulation to wheelchair to bedbound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs
Critical nutritional impairment as demonstrated by all the following characteristics occurring within the 12 months before going on hospice:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeding methods, sufficient to sustain life, but not for relieving hunger

Life-threatening complications as demonstrated by all the following characteristics occurring within the 12 months before going on hospice:

- Recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infection, e.g., pyelonephritis
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

Dementia due to Alzheimer’s disease and Related Disorders

Patients with dementia should generally have all these characteristics:

- Stage seven or higher according to the Functional Assessment Staging Scale (FAST)
- Unable to ambulate without assistance
- Unable to dress without assistance
- Unable to bathe without assistance
- Urinary and fecal incontinence, intermittent or constant
- No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Note that Palmetto GBA’s applicable LCD is slightly different, so review of that LCD might be suggested for those in Palmetto’s jurisdictional area.

If the diagnosis is Alzheimer’s, the eligible patient generally would have had one of the following within the past 12 months:

- Delirium
- Aspiration pneumonia
- Pyelonephritis or upper urinary tract infection
- Septicemia
- Decubitus ulcers, multiple, stage 3-4
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

Co-morbid conditions you may consider: infections, malignancies, cardiopulmonary disease, renal disease, liver disease, and/or rapid decline.
**End-stage Heart Disease**
At the time of referral for hospice, eligible end-stage heart disease patients have been already optimally treated for heart disease, or are not candidates for surgical procedures or decline them. “Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.” Eligible patients with congestive heart failure or angina should generally be classified as Class IV by New York Heart Association (NYHA) criteria – that is, they are unable to carry on almost any physical activity without their discomfort increasing. **Observe for signs/symptoms such as:** orthopnea (difficulty in breathing while lying down), Paroxysmal nocturnal dyspnea (severe sob and coughing that generally occurs at night), dependent edema (pitting), weakness, chest pain, diaphoresis, cachexia, jugular venous distention (JVD), rales and liver enlargement.

Echocardiograms aren’t required, but when they’ve already been done, a documented ejection fraction of 20% or less is supportive of the patient’s eligibility. Higher ejection fractions do not necessarily indicate lack of hospice eligibility. Other clinical elements that support a prognosis of less than six months include:

- Treatment resistant symptomatic supraventricular or ventricular arrhythmias
- History of cardiac arrest or resuscitation
- History of unexplained syncope
- Brain embolism of cardiac origin
- Concomitant HIV disease

**End-stage HIV Disease (AIDS)* - 1 & 2 are required**
The most important eligibility guidelines for HIV+ patients are these: 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:

1. **CNS lymphoma**
- Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass)
- Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
- Progressive multifocal leukoencephalopathy
- Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
- Visceral Kaposi’s sarcoma unresponsive to therapy
- Renal failure in the absence of dialysis
- Cryptosporidium infection
- Toxoplasmosis, unresponsive to therapy

2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale or Palliative Performance Scale (PPS), of 50% or less.
These factors also support an estimated life expectancy of six months or less in AIDS patients:

- Chronic persistent diarrhea for one year
- Persistent serum albumin < 2.5gm/dl
- Concomitant, active substance abuse
- Age >50 years
- Absence of or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
- Advanced AIDS dementia complex
- Toxoplasmosis
- Congestive heart failure, symptomatic at rest
- Advanced liver disease

If there are questions about use of anti-retroviral medications for HIV/AIDS patients, please discuss with your National Medical Director.

**End-stage Liver Disease**

In this case, lab values do matter. The most important eligibility guidelines for end-stage liver disease patients are these:

*Protime* > 5 seconds over control, or INR >1.5; and Serum albumin < 2.5 gm/dl.

Eligible end-stage liver disease patients also should have at least one of the following:

- Ascites, refractory to treatment or patient non-compliant
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 mEq/l)
- Hepatic encephalopathy, refractory to treatment, or patient non-compliant
- Recurrent variceal bleeding, despite intensive therapy

These factors also support an estimated life expectancy of six months or less in liver disease patients:

- Progressive malnutrition
- Muscle wasting with reduced strength and endurance
- Continued active alcoholism (>80 gm ethanol/day)
- Hepatocellular carcinoma (liver cancer)
- HBsAg (Hepatitis B) positivity
- Hepatitis C refractory to curative treatment

**End-Stage Pulmonary Disease (various types)**

The most important eligibility guidelines for end-stage pulmonary disease patients are these:
Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; and

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 provider home visits prior to initial certification.

(For obstructive pulmonary disease) Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted. This is considered to be objective evidence for disabling dyspnea.

These factors also support an estimated life expectancy of six months or less in pulmonary disease patients:

- Hypoxemia at rest on room air, as evidenced by pO2 ≤55 mmHg; or oxygen saturation ≤88% on room air; (These values may be obtained from recent hospital records.) or
- Supplemental oxygen
- Hypercapnia, as evidenced by pCO2 ≥50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
- Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy)
- Resting tachycardia >100/min
- Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months

**End-Stage Renal Failure**
The most important usual eligibility guidelines for terminal renal failure patients are these:
The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis; and
Creatinine clearance < 10 cc/min (<15 cc/min. for diabetics); or < 15cc/min (< 20cc/min for diabetics) with co-morbidity of congestive heart failure; or
Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)

One of these *co-morbid conditions or clinical factors* is generally present in the eligible patient with acute renal failure:

- Mechanical ventilation
- Cancer or metastasis or advanced disease of cardiac, liver or lung
- Sepsis
- Immunosuppression/AIDS
- Cachexia
- Albumin < 3.5 gm/dl
- Platelet count < 25,000
- Disseminated intravascular coagulation (DIC)
- Gastrointestinal bleeding
- Uremia
- GFR (Glomerular filtration rate) < 10ml/min
- Oliguria (< 400 cc/24 hours)
- Intractable hyperkalemia (>7.0) not responsive to treatment
- Uremic pericarditis
- Hepatorenal syndrome
- Intractable fluid overload, not responsive to treatment

**End-Stage Stroke and Coma of any Etiology**

**End-Stage Coma** - The most important usual eligibility guidelines for patients are these: Generally, comatose patients are hospice-eligible if they have any 3 of the following on day three of coma:
- abnormal brain stem response
- absent verbal response
- absent withdrawal response to pain
- serum creatinine > 1.5 mg/dl
- post-anoxic stroke

**Stroke:**
Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of ≤40%
Inability to maintain hydration and caloric intake with one of the following:
- Weight loss >10% in the last 6 months or >7.5% in the last 3 months
- Serum albumin < 2.5 gm/dl
- Current history of pulmonary aspiration not responsive to speech language pathology intervention
- Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration
- Sequential calorie counts documenting inadequate caloric/fluid intake

**Diagnostic imaging** factors which support poor prognosis after stroke include: For non-traumatic hemorrhagic stroke:
- Large-volume hemorrhage on CT (Infratentorial: ≥20 ml; Supratentorial: ≥50 ml.)
- Ventricular extension of hemorrhage
- Surface area of involvement of hemorrhage =30% of cerebrum
- Midline shift ≥1.5 cm.
- Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt

**For thrombotic/embolic stroke:**
- Large anterior infarcts with both cortical and subcortical involvement
- Large bihemispheric infarcts
- Basilar artery occlusion
- Bilateral vertebral artery occlusion
In **either stroke or coma** patients, documented medical complications, in the context of progressive clinical decline, within the previous 12 months, support the prediction of life expectancy < 6 months. Among them are often:

- Aspiration pneumonia
- Upper urinary tract infection (pyelonephritis)
- Sepsis
- Refractory stage 3-4 decubitus ulcers
- Fever recurrent after antibiotics

**Adult Failure to Thrive Syndrome**

Note that while Adult Failure to Thrive (AFTT) Syndrome can no longer be used as a primary hospice diagnosis, it remains an appropriate secondary or related diagnosis. Palmetto GBA continues to support this syndrome as a descriptor of one way a patient may manifest a terminal illness:

The medical criteria listed below would support a terminal prognosis for individuals with the adult failure to thrive syndrome. Medical criteria 1 and 2 are important indicators of nutritional and functional status respectively, and would thus support a terminal prognosis if met.

1. The nutritional impairment associated with the adult failure to thrive syndrome should be severe enough to impact a beneficiary's weight. It is expected that the Body Mass Index (BMI) of beneficiaries electing the Medicare Hospice Benefit for the adult failure to thrive syndrome will be below 22 kg/m² and that the patient is either declining enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.

   **BMI (kg/m²) =** 703 x (weight in pounds) divided by (height in inches)²

2. The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability would be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%.

Both the beneficiary's BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to the election of the Hospice Medicare Benefit and will be continued, the BMI and level of disability should be determined using measurements/observations made at the time of the initial certification and at each subsequent recertification.

At the time of recertification recumbent measurement(s) (anthropometry) such as mid-arm muscle area in cm² may be substituted for BMI with documentation as to why a BMI could not be measured. This information will be subject to review on a case by case basis.

**Resources:**