**CONTENTS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Introduction</td>
</tr>
<tr>
<td>II.</td>
<td>Definition</td>
</tr>
<tr>
<td>III.</td>
<td>BMI/Mid-Arm Circumference</td>
</tr>
<tr>
<td>IV.</td>
<td>PPS</td>
</tr>
<tr>
<td>V.</td>
<td>FAST</td>
</tr>
<tr>
<td>VI.</td>
<td>NYHA Classification</td>
</tr>
<tr>
<td>VII.</td>
<td>PAINAD Scale</td>
</tr>
<tr>
<td>VIII.</td>
<td>Norton Pressure Sore Risk Assessment</td>
</tr>
<tr>
<td>IX.</td>
<td>Fall Risk Assessment</td>
</tr>
<tr>
<td>X.</td>
<td>Four Ways to Document Eligibility</td>
</tr>
<tr>
<td>XI.</td>
<td>Disease-Specific Guidelines for Determining Eligibility</td>
</tr>
<tr>
<td>XI. A.</td>
<td>General Guidelines</td>
</tr>
<tr>
<td>XI. B.</td>
<td>ALS</td>
</tr>
<tr>
<td>XI. C.</td>
<td>Alzheimer’s Disease &amp; Related Disorders</td>
</tr>
<tr>
<td>XI. D.</td>
<td>Cancer</td>
</tr>
<tr>
<td>XI. E.</td>
<td>Cardiopulmonary Conditions</td>
</tr>
<tr>
<td>XI. F.</td>
<td>HIV</td>
</tr>
<tr>
<td>XI. G.</td>
<td>Liver Disease</td>
</tr>
<tr>
<td>XI. H.</td>
<td>Renal Disease</td>
</tr>
<tr>
<td>XI. I.</td>
<td>Stroke and Coma</td>
</tr>
<tr>
<td>XI. J.</td>
<td>Adult Failure to Thrive</td>
</tr>
<tr>
<td>XI. K.</td>
<td>Other Terminal Illnesses</td>
</tr>
<tr>
<td>XII.</td>
<td>Bereavement Risk Assessment</td>
</tr>
</tbody>
</table>
INTRODUCTION

WHAT THIS TOOLBOX IS:
• A collection of tools and guidelines intended to facilitate:
  ➢ Gathering of information by clinicians to improve documentation of symptoms and assessment findings that demonstrate hospice eligibility
  ➢ Providing guidance for Hospice Medical Directors/Associate Medical Directors to utilize in exercising their medical judgment in determining prognosis and documenting hospice eligibility
• An ever-evolving guide that was created and distributed by KAH and its predecessors, and will continue to be updated as guidelines and their interpretations change. This edition is felt to be current on the date it was published, subject to change with new regulations.

WHAT THIS TOOLBOX IS NOT:
• A definitive or authoritative listing of criteria for determination of prognosis and hospice eligibility

Medical judgment should always be used for each case in determining prognosis and hospice eligibility.
As part of its Conditions of Participation, CMS addresses eligibility for the Medicare Hospice Benefit in §418.20:

“In order to be eligible to elect hospice care under Medicare, an individual must be

I. Entitled to Part A Medicare; and

II. Certified as being terminally ill in accordance with §418.22”

§418.22 states:

“The certification must specify that the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.”

The above applies to Medicare patients

- Medicaid is determined by state statutes / regulations, but will generally follow this definition

- Other insurers may have their own definition of eligibility determination of who qualifies for hospice care
Measuring the Mid Arm Circumference provides an indication of skeletal muscle mass, bone and subcutaneous fat. It is used as a baseline for all patients, for future reference, and for a patient who cannot be weighed. Consistency in measurement is key.

- Position patient lying down.
- Place the non-dominant arm flat on the bed with the palm up.
- Measurement is taken on the non-dominant arm.
- Identify the acromial process (top of the shoulder) and the olecranon process (point of the elbow).
- Measure the distance between the 2 points and mark the half way point on the arm.
- Place the measuring tape perpendicular to the long axis length of the arm at the marked midpoint.
- The measurement should be in centimeters to the nearest millimeter.
- The tape must be neither too loose nor too tight.

**BMI Formula**

\[
\text{BMI} = \frac{\text{(weight in pounds} \times 703)}{\text{Height}^2 \text{ in inches}^2}
\]

*Maximum Adult Height is necessary to calculate BMI (Body Mass Index). If the exact height is unknown, ask for a best estimate.

**MID-ARM CIRCUMFERENCE**

Measuring the Mid Arm Circumference provides an indication of skeletal muscle mass, bone and subcutaneous fat. It is used as a baseline for all patients, for future reference, and for a patient who cannot be weighed. Consistency in measurement is key.
# Palliative Performance Scale (PPS)

(See available job aid for further instruction on appropriate usage of the PPS)

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal activity, 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, 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 to do normal work, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Unable to do hobby or housework, significant disease</td>
<td>Occasional assist necessary</td>
<td>Normal or reduced</td>
<td>Full or confusion</td>
</tr>
<tr>
<td>50</td>
<td>Mainly sit / lie</td>
<td>Unable to do any work, extensive disease</td>
<td>Considerable assist required</td>
<td>Normal or reduced</td>
<td>Full or confusion</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in bed</td>
<td>Unable to do any work, extensive disease</td>
<td>Mainly assistance</td>
<td>Normal or reduced</td>
<td>Full, drowsy, or confusion</td>
</tr>
<tr>
<td>30</td>
<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Total care</td>
<td>Reduced</td>
<td>Full, drowsy, or confusion</td>
</tr>
<tr>
<td>20</td>
<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Total care</td>
<td>Minimal sips</td>
<td>Full, drowsy, or confusion</td>
</tr>
<tr>
<td>10</td>
<td>Totally bed bound</td>
<td>Unable to do any work, extensive disease</td>
<td>Total care</td>
<td>Mouth care only</td>
<td>Drowsy or coma</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Final PPS Score: %
Functional Assessment STaging (FAST)

(See available job aid for further instruction on appropriate usage of the FAST)

FAST score is the highest consecutive level of cognitive disability:

- 1. No difficulty either subjectively or objectively.
- 2. Complains of forgetting location of objects.
   Subjective work difficulties.
- 3. Decreased job functioning evident to co-workers.
   Difficulty in traveling to new locations.
   Decreased organizational capacity.*
- 4. Decreased ability to perform complex, tasks, e.g.,
   planning dinner for guests, handling personal finances
   (such as forgetting to pay bills), difficulty marketing,
   etc.*
- 5. Requires assistance in choosing proper clothing to
   wear for the day, season, or occasion, e.g., patient
   may wear the same clothing repeatedly unless
   supervised.*
- 6. a) Improperly putting on clothes without
   assistance or cueing (e.g., may put street clothes on
   overnight clothes, put shoes on wrong feet, or have
   difficulty buttoning clothing) occasionally or more
   frequently over the past weeks.*
   
   b) Unable to bathe properly (e.g. difficulty adjusting
   the bath water temperature) occasionally or more
   frequently over the past weeks.*
c) Inability to handle mechanics of toileting (e.g. forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*

d) Urinary incontinence (occasionally or more frequently over the past weeks).*

e) Fecal incontinence (occasionally or more frequently over the past weeks).*

7. a) Ability to speak limited to approximately 1-5 intelligible different words or fewer, in the course of an average day or in the course of an intensive interview:

b) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).

c) Ambulatory ability is lost (cannot walk without personal assistance).

d) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair).

e) Loss of ability to smile.

f) Loss of ability to hold head up independently.

*Scored primarily on the basis of information obtained from knowledgeable informant and/or observation. Reisberg, B. Functional assessment staging (FAST). Psychopharmacology Bulletin 1988; 24:653-659
NEW YORK HEART ASSOCIATION (NYHA)

FUNCTIONAL CLASSIFICATION
(Class & Description)

I
Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, palpitations or anginal pain.

II
Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, dyspnea, palpitations or anginal pain.

III
Patients with limitations of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitations, dyspnea or anginal pain.

IV
Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

VI. NYHA
# PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE

<table>
<thead>
<tr>
<th>Item</th>
<th>0 Points</th>
<th>1 Point</th>
<th>2 Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low-level speech with a negative or disapproving quality.</td>
<td>Repeated trouble calling out. Loud moaning or groaning. Crying.</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch.</td>
<td>Unable to console, distract or reassure.</td>
<td></td>
</tr>
</tbody>
</table>

**Total**
Breathing
1. “Normal” breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. “Occasional labored breathing” is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. “Short period of hyperventilation” is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. “Noisy labored breathing” is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling or wheezing. They appear strenuous or wearing.
5. “Long period of hyperventilation” is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. “Cheyne-Stokes respirations” are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization
1. “None” is characterized by speech or vocalization that has a neutral or pleasant quality.
2. “Occasional moan or groan” is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. “Low level speech with a negative or disapproving quality” is characterized by muttering, mumbling, whining, grumbling or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. “Repeated trouble calling out” is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness or distress.
5. “Loud moaning or groaning” is characterized by mournful or murmuring sounds, wails or laments much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. “Crying” is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression
1. “Smiling” is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to neutral, at ease, relaxed or blank look.
2. “Sad” is characterized by an unhappy, lonesome, sorrowful or dejected look. There may be tears in the eyes.
3. “Frightened” is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
Facial Expression
4. "Frown" is characterized by a downward turn of the corners of the mouth.
   Increased facial wrinkling in the forehead and around the mouth may appear.
5. "Facial grimacing" is characterized by a distorted, distressed look. The brow
   is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language
1. "Relaxed" is characterized by a calm, restful, mellow appearance. The person
   seems to be taking it easy
2. "Tense" is characterized by a strained, apprehensive or worried appearance.
   The jaw may be clenched (exclude any contractures).
3. "Distressed pacing" is characterized by activity that seems unsettled. There
   may be a fearful, worried or disturbed element present. The rate may be
   faster or slower.
4. "Fidgeting" is characterized by restless movement. Squirming about or wiggling
   in the chair may occur. The person might be hitching a chair across the room.
   Repetitive touching, tugging or rubbing body parts can also be observed.
5. "Rigid" is characterized by stiffening of the body. The arms and / or legs are
   tight and inflexible. The trunk may appear straight and unyielding (exclude
   any contractures).
6. "Fists clenched" is characterized by tightly closed hands. They may be
   opened and closed repeatedly or held tightly shut
7. "Knees pulled up" is characterized by flexing the legs and drawing the knees
   up towards the chest. An overall troubled appearance (exclude any
   contractures).
8. "Pulling or pushing away" is characterized by resistiveness upon approach or to
   care. The person is trying to escape by yanking or wrenching him or herself
   free or shoving you away.
9. "Striking out" is characterized by hitting, kicking, grabbing, punching, biting or
   other forms of personal assault.

Consolability
1. No need to console is characterized by a sense of well being. The person
   appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the
   behavior when the person is spoken to or touched. The behavior stops during
   the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterized by the inability to
   soothe the person or stop a behavior with words or actions. No amount of
   comforting (verbal or physical) will alleviate the behavior.

Warden V, Hurley AC, Volier L. Development and psychometric evaluation of the pain

Excerpted from Frampton K. "Vital Sign #5". Caring for the Ages 2004; 5(5):26-35. & copy; 2004 Lippin- cott Williams &amp Wilkins. All rights reserved. Reprinted with permission.
Norton Pressure Sore Risk Assessment Scale

Very High Risk = Score less than 10
High Risk = Score 10 – 18
Medium Risk = Score 14 – 17
Low Risk = Score 18 or higher

Physical Condition:
- Four (4) points - PPS ≥ 50%
- Three (3) points - PPS = 40%
- Two (2) points - PPS = 30%
- One (1) point - PPS ≤ 20%

Mental Condition:
Definitions (score for each item):
- Oriented - Aware of person, place, time season = Four (4) points
- Inattention - Difficulty in focusing attention; easily distracted; difficulty in following conversation = Three (3) points
- Disorganized thinking - Incoherent; rambling or irrelevant to conversation; unclear; illogical flow of ideas = Two (2) points
- Altered level of consciousness - Vigilant (stirred easily to sound or touch); lethargic (repeatedly dozes off when being asked questions but responds to touch or voice); stuporous - (very difficult to arouse and keep aroused during questioning); comatose - (cannot be aroused) = One (1) point
- Psychomotor retardation - Unusually decreased level of activity (sluggishness, staring into space, sitting or lying in one position) = Zero (0) points

Activity - Degree of physical activity
- Ambulant - independent = Four (4) points
- Walks with help - limited extensive assistance = Three (3) points
- Chair-bound - no weight bearing at all = Two (2) points
- Bedfast - does not get out of bed due to physical condition, NOT due to patient’s preference = One (1) point
Norton Pressure Sore Risk Assessment Scale
(CONTINUED)

Mobility - Ability to change and control body position
- Full – independent = Four (4) points
- Slightly impaired – uses assistive devices (canes, walkers, side rails) = Three (3) points
- Very limited — devices plus physical assistance = Two (2) points
- Total dependence = One (1) point

Incontinence:
- No incontinence = Four (4) points
- Occasional = Three (3) points
- Usually, urinary = Two (2) points
- Usually, urinary and fecal = One (1) point
Fall Risk Assessment

Use when rating the patient’s Safety/Falls Risk

Fall Risk Assessment Scores:

7 points  History of fall not a slip or trip within past 12 months
8 points  Altered Elimination: incontinence/bladder and/or bowels frequency or urgency
8 points  Cognitive Impairment: inability to recall recent events, intermittent or continuous confusion, impaired judgment
4 points  Cognitive Impairment: and/or depressed
3 points  Intrinsic factors: orthostatic hypotension, syncope, cardiac arrhythmias, peripheral neuropathy, seizure history, Parkinson’s disease, CVA or neuromuscular disorder
2 points  Impaired physical mobility: unsteady gait, weakness, hemiparesis or poor muscle control
2 points  Communication/Visual Deficit: trouble, language barrier, deaf/hard of hearing
2 points  Visual impairment
2 points  Medications: diuretics/laxative
4 points  Medication - blood pressure medications
6 points  Medications - narcotics

Scale:
Very High Risk = ≥19 Points
High = 18 - 14 Points
Medium = 13 - 10 Points
Low = ≤10 Points
FOUR WAYS TO DOCUMENT ELIGIBILITY

1. Perfect Fit
   Patient meets a Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) guideline to help determine if a patient is eligible for the Hospice Medicare Benefit (HMB)

2. Close Fit – Rapid Decline
   Patients who almost meet an LCD guideline may still be eligible for the HMB if they have a six months or less prognosis and demonstrate a rapid decline as evidenced by:
   - Rapid loss of function (PPS)
   - Rapid weight loss
   - Frequent office, emergency room or hospital visits
   - Rapid deterioration in laboratory values or
   - X-ray results

3. Close Fit – Significant Related Condition
   Patients who almost meet an LCD guideline may still be eligible for the HMB if they have a six months or less prognosis and demonstrate significant life-limiting related conditions (such as, but not limited to):
   - Congestive Heart Failure
   - Chronic Obstructive Pulmonary Disease
   - Renal Failure
   - Dementia
FOUR WAYS TO DOCUMENT ELIGIBILITY

(CONTINUED)

4. Physician’s Clinical Judgment
Patients for whom there is not a disease-specific LCD guideline may be eligible for the HMB if they have a six months or less prognosis and this is documented through sound medical judgment which is based on well-documented written evidence.

*NOTE: PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.
Local Coverage Determinations (LCDs)

LCDs are published by each Medicare Administrative Contractor as guidelines to aid in the documentation of hospice eligibility.

The guidelines in this Toolbox are derived from the three different MAC’s LCDs, generally choosing the strictest version. Therefore, it is important to be familiar with the actual LCDs for the MAC covering your geographic practice area. At this time this Toolbox is published, there are three MACs:

- CGS Administrators LLC
- National Government Services, Inc
- Palmetto GBA
  (see next page for their geographic coverage)

The actual LCDs can be accessed online at:
www.cms.gov/medicare-coverage-database/

- Choose “Local Coverage Determinations”
- Select the geographic area (usually your state)
- Enter “hospice” as a keyword
- Click “Search by type”

LCDs are updated at irregular intervals, so it is worthwhile checking this periodically.
XI. A. GENERAL GUIDELINES

- Prognosis for a life expectancy of six months or less
- Patient/caregiver elect hospice and are in agreement with palliative care
- Physician(s) certify terminal condition (Attending, if there is one, + HMD for initial benefit period; HMD for others)
- Decline in Palliative Performance Scale (PPS) due to progression of disease (all patients should have a baseline documented PPS)
  (Actual score required is dependent on diagnosis, but except for cancer, pts with a PPS >50% are generally not eligible)
- Increasing emergency room visits, hospitalizations, or physician's visits over previous 6 months & / or last benefit period related to the hospice diagnosis

Dependence in at least 2 Activities of Daily Living -
  Evidenced by documented considerable effort required:
  - Bathing
  - Dressing
  - Feeding
  - Transfers
  - Toileting
  - Ambulation

Other indicators of decline:
- Weight loss of 10% or more in 6-12 months
- Increase in time slept (# of hours) in 24 hours
GENERAL GUIDELINES

(CONTINUED)

Recent impaired nutritional status as evidenced by (required at time of admission): Maximum Adult Height; Current Weight; BMI; Previous Weight (how long ago); Mid Arm Circumference (non-dominant arm):
- Unintentional, non-reversible progressive weight loss of 10% or more over past six months
- Decreasing Serum albumin
- Cholesterol < 150
- Dysphagia, choking, poor oral intake
- Impaired nutrition despite PEG / Tube Feeding

Co-morbidities: If not the primary hospice diagnosis, the presence of a 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:
- COPD
- CHF
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease ( □ CVA □ ALS □ MS □ Parkinson’s)
- Renal failure
- Liver Disease
- Neoplasms
- Dementia (FAST)
ALS

Terminal Stage ALS Guidelines
(Patients are considered eligible if 1, 2a & 2b or 2a & 3 are documented)

☐ (1) Critically impaired breathing capacity as evidenced by:
   ☐ Vital Capacity < 30% of normal
   ☐ Dyspnea at rest
   ☐ Declines artificial ventilation; external ventilation used for comfort measures only

☐ (2a) Rapid progression of disease as demonstrated by progression (within the 12 months preceding initial hospice certification) of:
   ☐ “ambulation” to “w/c” or “bed-bound status”
   ☐ Speech “normal” to “barely” or “unintelligible”
   ☐ Diet “normal” to “puréed”
   ☐ “Independence in ADL’s” to “needs major assistance with ADL’s”

☐ (2b) Critical nutritional impairment as demonstrated by:
   ☐ Oral intake of nutrients and fluids insufficient to sustain life
   ☐ Continued weight loss
   ☐ Dehydration or Hypovolemia
   ☐ Absence of artificial feeding methods
XI. B. ALS

- Life-threatening complications as evidenced by:
  - Recurrent Aspiration Pneumonia (with or without tube feeding)
  - Upper UTI
  - Sepsis
  - Recurrent fever after antibiotics
  - Decubitus ulcers Stage III-IV

Note: Although ALS tends to progress in a linear fashion, so the overall rate of decline in each patient is fairly constant and predictable, no single variable deteriorates at a uniform rate in all patients. Therefore, the rate of progression in individual patients is important to obtain to predict prognosis.

"REMINDER: PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

Remember to document your clinical judgment!
ALZHEIMER’S & RELATED DISEASES

FAST Scale

☑ 6a: unable to dress without assistance
☑ 6b: unable to bathe without assistance
☑ 6c: unable to handle mechanics of toileting
☑ 6d: urinary incontinence, intermittent or constant
☑ 6e: fecal incontinence, intermittent or constant
☑ 7a: ability to speak limited (1 to 5 words a day)
  ☐ 7b: all intelligible vocabulary is lost
  ☐ 7c: unable to ambulate without assistance
  ☐ 7d: unable to sit up independently
  ☐ 7e: unable to smile
  ☐ 7f: unable to hold head up

Patients will be considered to be in the terminal stage of dementia if they have a FAST of 7 and one of the following (should have been within the past 12 months):

☐ Delirium
☐ Aspiration pneumonia Pyelonephritis (or other upper UTI) Septicemia
☐ Decubitus ulcers, multiple, Stage III-IV
☐ 10% weight loss or albumin < 2.5 gm/dl

Co-morbid conditions sufficiently severe to lead to a terminal prognosis:
☐ Infections
☐ Malignancies
☐ Fever recurrent after antibiotics

XI C. ALZHEIMER’S & RELATED DISEASES
Co-morbid conditions (cont’d):

- Cardiopulmonary disease
- Renal disease
- Liver disease
- Rapid decline

REMEMBER: PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!*
CANCER

“General Guidelines” plus:

- **PPS < 70%**
  - Disease with distant metastases at presentation of:
    - bone
    - liver
    - brain
    - other
  
  OR

- Progression from an earlier stage of disease to metastatic disease with either:
  - Continued decline in spite of therapy
  - Patient declines further disease-directed therapy

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

**Reminder:** PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!"
XI. E. CARDIOPULMONARY CONDITIONS

Cardiac Disease (1 & 2 should be present; 3 is supportive)
- (1) Already optimally treated with diuretics & vasodilators (ACE inhibitors); if not, explain why (i.e., hypotension or renal disease)
- (2) Class IV of NYHA (physical activity causes discomfort, symptoms present at rest)
- (3) Angina at rest, resistant to nitrates therapy or declines invasive procedures

Signs / Symptoms / Supporting Factors
- Orthopnea
- Paroxysmal Nocturnal Dyspnea
- Dependent Edema (pitting)
- Syncope
- Weakness
- Chest Pain
- Diaphoresis
- Cachexia
- Jugular Venous Distension
- Rales
- Liver Enlargement
- Hx of cardiac arrest or resuscitation
- Hx of unexplained syncope
- Treatment-resistant symptomatic Arrhythmias
- Brain embolism of cardiac origin (stroke / CVA)
Concomitant HIV disease

- Ejection fraction of ≤ 20% (not required if not available)

- Dyspnea at rest

**Pulmonary Disease** (ALL are required)

- (1) Disabling dyspnea at rest; poor or unresponsive to bronchodilators resulting in decreased functional capacity (bed to chair existence, fatigue, cough) [FEV1 <80% if available]

- (2) Increasing visits to ER or current or prior hospitalizations over previous 6 months &/or last benefit period for respiratory infections &/or respiratory failure

- (3) Hypoxemia at rest, pO2 ≤ 55mmHg or O2 sat ≤ 88% on room air or at rest on O2

- Hypercapnia with CO2 ≥ 50mm Hg

**Supplemental:**

- Cor-pulmonale & right heart failure secondary to pulmonary disease

- Resting tachycardia > 100

- Unintentional, progressive weight loss of >10% of body weight over prior 6 months

**Reminder:** PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!*
HIV

HIV Disease Guidelines
(Patients are considered to be eligible if 1 & 2 are present)

- **(1)** CD4 + count <25 cells/mL or persistent (tested twice, at least one month apart) viral load >100,000 copies/mL, plus one of the following:
  - CNS Lymphoma
  - Untreated/unresponsive wasting (loss of lean body mass = 10% - 33%)
  - MAC infection (untreated/unresponsive to treatment, or treatment refused)
  - Progressive multifocal leukoencephalopathy
  - Systemic lymphoma
  - Visceral Kaposi’s Sarcoma, unresponsive to tx
  - Renal failure without dialysis
  - Cryptosporidium infection
  - Toxoplasmosis, unresponsive to tx

- **(2)** PPS ≤ 50%

**Supplemental:**
- Chronic, persistent diarrhea for 1 year
- Persistent serum albumin <2.5gm/dL
- Concomitant active substance abuse
- Age > 50 years
- Absence/resistance of antiretroviral, chemotherapeutic or prophylactic HIV tx
- Advanced AIDS dementia complex
- CHF, symptomatic at rest
- Toxoplasmosis
- Advanced liver disease
**REMINDER:** PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!*
LIVER DISEASES

Liver Disease Guidelines
(Patients will be considered to be eligible if 1 & 2 are present)

1. Documented Lab Values:
   - Prothrombin time prolonged more than 5 sec over control or International Normalized Ratio (INR) > 1.5
   - Serum albumin < 2.5 gm / dl

2. At least one of the following:
   - Ascites refractory to treatment or patient non-compliant (baseline girth vs. current)
   - Hepatorenal syndrome (elevated Creatinine & BUN with oliguria < 400 cc / day and urine sodium < 10 mEq)
   - Spontaneous bacterial peritonitis
   - Hepatic encephalopathy (decreased awareness, disturbed sleep, depressed, emotionally labile, somnolence, slurred speech) refractory to treatment
   - Recurrent variceal bleeding despite therapy

Supporting Factors:
   - Progressive malnutrition
   - Muscle wasting with reduced strength and endurance
• Continued active alcoholism (> 80 gm ethanol [approx 4 cans beer]/day)
• Liver Cancer
• Hepatitis B or C refractory to interferon treatment

**Note:** Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare Hospice Benefit, but if a donor organ is procured, the patient must be discharged from hospice.

**REMINDER:** PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if *documentation of clinical factors* supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!*
Patients will be considered to be in the terminal stage of renal disease if 1 & 2 are present or 1 & 3 are present.

- (1) Discontinues or refuses dialysis
- (2) Creatinine clearance < 10 cc/min (<15 cc/min for diabetics) or < 15 cc/min (<20 cc/min for diabetics) with co-morbidity of CHF
- (3) Serum Creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics)

**Supporting Factors:**

- Co-morbid conditions:
  - Cancer or metastasis or advanced disease of cardiac, liver or lung
  - Sepsis
  - Immunosuppression / AIDS
  - Cachexia
  - Albumin < 3.5 gm/dl
  - GI Bleeding
  - S/S of renal failure
  - Oliguria (<400 cc/24 hrs)
  - Uremia
  - Uremic Pericarditis
  - Intractable hyperkalemia (>7.0) unresponsive to treatment
  - Hepatorenal syndrome
  - Platelets < 25,000
  - GFR < 10 ml/min
- Intractable fluid overload, not responsive to treatment
- Mechanical ventilation
- DIC

**REMINDER:** PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

*Remember to document your clinical judgment!*
STROKE AND COMA

Coma – any etiology (ANY 3 of the following on day 3):
- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum Creatinine > 1.5 mg/dl
- Post-anoxic stroke

Stroke – 1 & 2 should be present
- (1) PPS ≤ 40%
- (2) Inability to maintain hydration and caloric intake with one of the following:
  - Weight loss > 10% during previous 6 months or 7.5% in the last 8 months
  - Serum albumin < 2.5 gm/dl
  - Current history of pulmonary aspiration not responsive to speech language pathology intervention
  - Dysphagia severe enough to prevent the pt from receiving food & fluids necessary to sustain life in a pt who declines or does not receive artificial nutrition and hydration
  - Sequential caloric counts documenting inadequate caloric/ fluid intake

Supporting Factors:
- Aspiration Pneumonia
- Upper UTI (pyelonephritis)
Sepsis
- Refractory decubitis ulcers Stage III-IV
- Recurrent fever after antibiotic

Note: Documented diagnostic imaging factors which support poor prognosis after stroke include:

A. For non-traumatic hemorrhagic stroke:
1. Large-volume hemorrhage on CT:
   - Infratentorial: ≥20 ml
   - Supratentorial: ≥50 ml
2. Ventricular extension of hemorrhage;
3. Surface area of involvement of hemorrhage ≥30% of cerebrum;
4. Midline shift ≥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;

*Reminder: PER CMS, patients may not meet the LCD guidelines, yet still have a life expectancy of 6 months or less. Coverage of these patients may be approved if documentation of clinical factors supporting a less-than-6-month life expectancy, that is not included in these guidelines, is included.

Remember to document your clinical judgment!
ADULT FAILURE TO THRIVE*
(NOT to be used as a principal diagnosis)

Essential:
- Palliative Performance Scale (PPS) ≤ 40%
- BMI < 22
- Unresponsive to enteral/parenteral nutrition
- Declined enteral/parenteral nutritional support

Supporting Factors:
- Worsening in FAST
- Scale UTI
- Sepsis
- Aspiration
- Decubitus ulcer Stage III-IV (in spite of optimal care)
- Failure of therapies to reverse impairment & disability
- Recurrent fever

*NOTE: ADULT FAILURE TO THRIVE MAY NOT BE USED AS A PRINCIPAL DIAGNOSIS, but continues to be an active guideline describing a trajectory towards death.

Remember to document your clinical judgment!
OTHER TERMINAL ILLNESSES*

Observable and documented deterioration in overall clinical condition in the past 6 months as evidenced by any of the following:

- Serial physician assessments
- Multiple hospital / ER visits
- Progressive pressure ulcers
- Decline in functional status with a PPS of ≤40%
- Systolic BP <90
- Progressive dependence in ADL's
- Persistent nausea and vomiting
- Recent impaired nutritional status
- Weight loss
- Decreasing serum albumin <2.5 gm/dl
- Malnutrition with BMI <22 kg/m^2
- Combination of disease processes which, viewed together, present a picture of structural and functional impairment
- Requires O_2 at rest
- Declines artificial ventilation

*‘Other Terminal Illness’ is NOT a diagnosis. Use the patient’s actual diagnosis that is leading to their terminal prognosis. This page is just to suggest what might be documented to support a patient with a terminal illness for which there is no applicable LCD. For a patient to be considered eligible there must be sufficient documentation in support of a prognosis for a life expectancy of six months or less, if the terminal illness runs its normal course.

Remember to document your clinical judgment!
Bereavement Risk Assessment

The strengths & complicators listed below will help determine potential for grief complication(s) or will identify the presence of current complications

**STRENGTHS**
- Life is meaningful/purposeful
- Is able to express feelings/thoughts/hopefulness
- Has supportive family and/or friends available
- Has environmental support network available
- Current environment is congruent to overall well-being/needs
- Has/had a healthy relationship with patient
- Has healthy relationships with others
- Spiritual well-being
- Financially stable
- Reactions are congruent to imminent death/dying process
- A process of functional coping/grief is occurring
- Other: __________
- Other: __________
- Total # of items that apply

**COMPLICATORS**
- Self-worth is tied to patient
- Lack of functional self expressions
- Devaluation of life/living
- No hope
- Extreme anger
- Extreme hopelessness/meaninglessness/despair
- Depression/extreme sadness
- Is not consistently recognizing dying process/imminent death
- Has experienced multiple losses
- Has experienced sudden/violent deaths
- Has weak support system
- Social isolation
- Cultural isolation
XII. BEREAVENTMENT RISK ASSESSMENT

Family discord
Experiencing spiritual distress/lack of faith
Experiencing feelings of abandonment (by God, friends, family)
Experiencing financial problems
Suicide ideation/suicide plan/hx of past attempt(s)
Current abuse of a chemical (drug/alcohol/past hx)
Homicidal ideation
Other: ______________________
Other: ______________________
____ Total # of items that apply

RISK RATING LEVEL
Low Risk: # of complicators is less than # of strengths
(complicators < strengths)

Moderate Risk: # of complicators are greater than or equal to # of strengths
(complicators ≥ strengths)

High Risk: # of complicators is at least twice the # of strengths
(complicators ≥ 2x strengths)