HOSPICE of The Gorge
With love, since 1981

For Our Community Medical Providers

Is Your Patient Ready for Hospice?

Hospice Admission Guidelines

This is the principal tool we at Hospice of The Gorge use for determining if a patient is eligible for hospice care.

Your Use of this Tool.

This tool is designed for use by medical providers. We are pleased to offer you this tool for use in your own practice, but please do not violate our copyright by altering this document, by using it beyond your own practice, or by selling it to others. Please call us for additional information, in Hood River, Oregon at 541-387-6449.

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Introduction

It can be difficult to know when a patient is eligible for hospice, from the point of view of meeting prognostic criteria. This document is intended to help you make that determination.

The guidelines below are paraphrased from an official document created by the Centers for Medicare and Medicaid Services (CMS) and utilized by the Medicare fiscal intermediaries who, in turn, oversee the application of "hospice benefit" for Medicare beneficiaries.

The original document is entitled "Indications and Limitations of Coverage and/or Medical Necessity" and is sometimes called "Local Coverage Determinations" (or LCDs). Medicaid and most commercial insurers refer to these or similar guidelines.

We at Hospice of The Gorge, as well as hospices throughout the nation, study the CMS guidelines carefully. When patients are referred to us for hospice care, we must feel confident that the prognostic criteria implied in these guidelines are met, or else that there are exceptional circumstances, comorbidities, caretaker issues, or other factors to take into account.

We also utilize these guidelines at "recertification" time, when deciding whether hospice patients remain eligible -- in other words, are likely to die within the next six months.

I've tried here to make the guidelines more "user friendly" to our community colleagues. Please let me know if you find them useful or not, or if you have questions. Our Medical Director staff is always honored to speak with you directly, and the Hospice of The Gorge staff know how to reach us when we're not present in the office.

—Tina Castañares, MD, Medical Director, Hospice of The Gorge

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General Eligibility Guidelines

Who certifies eligibility, and on what grounds?

Only physicians (MD and DO) and nurse practitioners may certify eligibility of a patient, and this means the clinician believes the patient to have a life expectancy of six months or less if the terminal condition runs its usual course. It may be a specific disease that is expected to take the patient's life, or (in many cases) a combination of illnesses, general frailty or failure to thrive.

The referring provider must certify initial eligibility, along with the hospice Medical Director. Your certification statement has been combined by Hospice of The Gorge with your admitting order form, for your convenience. For recertification later, only the hospice Medical Director must officially sign.

Are the eligibility guidelines below iron-clad? What happens if Medicare disagrees about the patient's eligibility?

No. They are held as a standard, in general, by Medicare and other payors, but coverage is often approved even when the implied criteria are not met. "Documentation of clinical factors supporting a less than six-month life expectancy" is always required for certifying initial and continuing eligibility. If Medicare or another payor reviews the case of a hospice patient and elects to deny coverage or even require payback of past coverage, on the basis of insufficient evidence of eligibility, the hospice may be penalized, but the referring provider is not held liable for any prognostic error. Some community clinicians have felt some fear of making the prognostic determination, but for many years Medicare has articulated a very respectful attitude about providers' clinical judgment in these matters.

What happens if the patient actually improves and is likely to live beyond the next six months?

Often hospice care does help patients to stabilize or even to significantly improve, and sometimes this means a revision to their estimated life expectancy. Hospices must discharge patients who are no longer likely to die within the next six months. They can be re-enrolled later, without any waiting or penalty, whenever they decline and, once again, are judged to be within six months remaining life expectancy. At Hospice of The Gorge, hospice discharge and later re-enrollment is not a rare phenomenon, and we work with you, your staff, the patient and family, and any residential facility or other caregivers involved to make smooth transitions.

How do we document eligibility at Hospice of The Gorge?

The expectations of Medicare and other payors with respect to our records are very reasonable in this respect. Accountability is required, but varying clinical situations are respected. The following quote from the official CMS document says it well: "Documentation certifying terminal status must contain enough information to support terminal status upon review... Documentation should "paint a picture" for the reviewer to clearly see why the patient is

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appropriate for hospice care and the level of care provided, i.e., routine home, continuous home, inpatient respite, or general inpatient. The records should include observations and data, not merely conclusions. However, documentation expectations should comport with normal clinical documentation practices....The amount and detail of documentation will differ in different situations. Thus a patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than a chronic lung disease patient. These situations are obvious. Patients with chronic lung disease, long term survival in hospice, or apparent stability can still be eligible for hospice benefits, but sufficient justification for a less than six-month prognosis should appear in the record."

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Part 1
Clinical Guidelines: Non-Disease Specific

Establishing a decline in clinical status

"Decline in clinical status" is established and documented, using baseline information available in your records or upon hospice admission, with certain clinical elements highlighted.

Decline, in general, is considered to be mostly irreversible. The clinical elements most often used are listed below, in order of their likelihood to predict poor survival (the most predictive first and the least predictive last) in each section. "No specific number of variables must be met, but fewer of those listed first (more predictive) and more of those listed last (least predictive) would be expected to predict longevity of six months or less."

Worsening Clinical Status

- Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract
- Weight loss not due to reversible causes such as depression or use of diuretics
- Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
- Decreasing serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption
- Increasing emergency room visits, hospitalizations, or provider visits related to hospice primary diagnosis

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
- Ascites
- Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
- Edema

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- Pleural/pericardial effusion
- Weakness
- Change in level of consciousness
- Progressive stage 3-4 pressure ulcers in spite of optimal care

Laboratory

(When available; lab testing is not required to establish hospice eligibility.)

- 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

Functional status, scores on standardized tests

(When available; not required. Hospice of The Gorge is happy to do such assessments for you.)

- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from < 70% due to progression of disease (50% for HIV disease; 40% for stroke)
- Progressive decline in Functional Assessment Staging (FAST) for dementia (from =7A on the FAST)
- Dependence on assistance for two or more activities of daily living (ADLs): ambulation, continence, transfer, dressing, feeding, bathing

Co-morbidities:

When one or more of the following is present, even though it is not the terminal diagnosis, it should be taken into account as likely to predict poorer survival:

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson's)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired immune deficiency syndrome
- Dementia

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Part 2
Clinical Guidelines: Disease Specific

These Disease-Specific Guidelines are to be used *in conjunction with* the foregoing general guidelines on clinical decline, *if the terminal diagnosis is specific*. Don't forget that some patients will be hospice-eligible on the basis of general frailty, failure to thrive, etc. Such a "hospice diagnosis" may be appropriate in a patient in multiple medical conditions, where it's hard to predict just which one will take the patient's life.

Cancers

Disease with distant metastases at presentation *or*

Progression from an earlier stage of disease to metastatic disease with either;

- A continued decline in spite of therapy
- Patient declines further disease directed therapy

Certain cancers with especially poor prognoses (e.g. small cell lung cancer, brain cancer and pancreatic cancer) may represent hospice eligibility without use of the above brief guidelines.

Amyotrophic Lateral Sclerosis

Medicare regards 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.

Medicare recommends 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."

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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 30% 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).

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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 *(Hospice of The Gorge can help you by scoring this, if you wish)*;
- 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.

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

- 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.

End-stage Heart Disease

At the time of referral and also recertification for hospice, eligible end-stage heart disease patients have been already optimally treated for heart disease, or either 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. 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.

Other clinical elements that support a prognosis of less than six months include:

- Treatment resistant symptomatic supraventricular or ventricular arrhythmias; k
- History of cardiac arrest or resuscitation;

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- History of unexplained syncope;
- Brain embolism of cardiac origin;
- Concomitant HIV disease.

End-stage HIV Disease (AIDS)

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:

- 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.
- Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of 50% or less *(Hospice of The Gorge will be happy to score this for you if you wish).*

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 < 2.5;
- 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.

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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;
- HBsAg (Hepatitis B) positivity;
- Hepatitis C refractory to interferon 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.

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Some diagnostic studies can support the prognosis in end-stage pulmonary disease patients, although those studies are *not required:*

- Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted. This is considered to be objective evidence for disabling dyspnea.
- Serial decrease of FEV1>40 ml/year. This is considered to be objective evidence for disease progression.

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 supplemental oxygen determined either by arterial blood gases or oxygen saturation monitors; (These values may be obtained from recent hospital records.) *or*
- 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 comorbidity of congestive heart failure; *or*
- Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics);

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

- Mechanical ventilation;
- Malignancy (other organ system);
- Chronic lung disease;
- Advanced cardiac disease;
- Advanced liver disease;
- Immunosuppression/AIDS;

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- Albumin < 3.5 gm/dl;
- Platelet count < 25,000;
- Disseminated intravascular coagulation;
- Gastrointestinal bleeding.

One of these clinical factors or co-morbidities is generally present in the eligible patient with chronic renal failure

- Uremia;
- 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

The most important usual eligibility guidelines for **end-stage stroke** patients are these:

- 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;
  - Sequential calorie counts documenting inadequate caloric/fluid intake.
- Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration.

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.

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For thrombotic/embolic stroke:

- Large anterior infarcts with both cortical and subcortical involvement;
- Large bihemispheric infarcts;
- Basilar artery occlusion;
- Bilateral vertebral artery occlusion.

The most important usual eligibility guidelines for **end-stage coma** 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.

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);
- Refractory stage 3-4 decubitus ulcers;
- Fever recurrent after antibiotics.

(Continued on next page)

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Closing Remarks

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Though based on Medicare guidelines, the information I provided in this document is more of an overview than a complete guide to prognostication. It does not cover all possible diagnoses – much less all possible individual variations in patients' lives and circumstances.

Still, I hope you find it to be an easy-to-use reference in determining prognosis and hospice eligibility in your patients … and possibly even in having discussions with patients and families.

To help you further, elsewhere on our Hospice of The Gorge website, you will find reference to additional tools created by scholars and medical centers, intended to assist in prognostication.

Please don't hesitate to ask me if you'd like to see the original document Medicare document I based this material on, and/or its bibliography and resources,

This section of our website was developed specifically at the request of my medical colleagues in the Mid-Columbia. As always, feedback and suggestions are welcome.

Best Regards,

—Tina Castañares, MD, Medical Director, Hospice of The Gorge

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About Hospice of The Gorge

Hospice of The Gorge is a non-profit organization that has been helping people with end-of-life needs and related challenges since 1981. We are a skilled and compassionate team of people, with a goal to bring help and hope to people suffering from the changes in life that matter most.

- We are the oldest and largest hospice in the Mid-Columbia region of the Pacific Northwest
- We serve eight counties. In Oregon we serve: Hood River, Wasco, Sherman, Gilliam, Morrow, and Wheeler counties, in Washington we serve Skamania, and Klickitat counties.
- We are certified by Medicare and the State of Oregon. We are licensed in Washington. We are also members in good standing with state and national hospice associations.

Hospice of The Gorge tailors what we do to meet the specific needs of each individual. We determine those needs by working in close partnership with the patient's physician, other care provides, and family members.

Give Us a Call

We can help; all you need to do is call.

- In Hood River: 541-387-6449
- In The Dalles: 541-296-3228

To learn more about us, please visit our website at http://www.hospiceofthegorge.org

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