Tools and Guidelines for Determining Eligibility for Hospice

Based on Information from the

Centers for Medicare and Medicaid Services

Prepared and assembled by

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The information in this booklet may be helpful for determining hospice eligibility; however, these are guidelines only. Please contact us any time at 1-800-221-8022 for assistance with identifying your individual patient needs.

Important to note:

Patients who meet the guidelines in this booklet are expected to have a life expectancy of six months or less if the terminal illness runs its normal course.

Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Other clinical variables not on the list may support the six-month or less life expectancy. These should be documented in the clinical record.

On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve briefly while receiving hospice care, may have a reasonable expectation of continued decline for a life expectancy of less than six months, and remain eligible for hospice care.

If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status shows the life expectancy is again six months or less.

Non-Disease Specific Baseline Guidelines

A. **Physiologic impairment of functional status as demonstrated by:** Palliative Performance Score (PPS) < 70% (note that two of the disease specific guidelines (HIV, Stroke& Coma) establish a lower qualifying PPS.

B. Dependence on assistance for two or more activities of daily living (ADLs):

1. Ambulation;
2. Continence;
3. Transfer;
4. Dressing;
5. Feeding;
6. Bathing

C. Co-Morbidities—although not the primary hospice diagnosis, the presence of diseases 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:

1. COPD
2. CHF
3. Ischemic heart disease
4. Diabetes mellitus
5. Neurologic disease
6. Renal Failure
7. Liver Disease
8. Neoplasia
9. AIDS/HIV
10. Dementia
11. Refractory severe autoimmune disease (Lupus, RA)

Progression of disease *may* be supported by:

Significant decline in clinical status

- Recurrent infections (e.g. pneumonia, sepsis, pyelonephritis)
- Progressive inanition
    - weight loss (≥10% body weight in prior 6 months)
    - ↓ anthropomorphic measurements (e.g., mid-arm circ, abdominal girth)
    - Observation of ill-fitting clothes, ↓in skin turgor, ↑ skin folds
    - ↓ serum albumin or cholesterol
    - Dysphagia leading to recurrent aspiration and/or inadequate oral intake

Worsening symptoms

- Pain requiring increasing doses of major analgesics more than briefly; nausea/vomiting, poorly responsive to treatment; diarrhea, intractable; dyspnea with increasing respiratory rate; cough, intractable

Signs

- Hypotension (SBP <90mmHg or postural hypotension); edema; ascites; pleural/pericardial effusion; venous, arterial or lymphatic obstruction due to local progression or metastatic disease; weakness; change in level of consciousness, etc.

Laboratory results

- Decreasing albumin; progressively decreasing/increasing serum sodium; increasing serum potassium; increasing calcium, creatinine or liver function studies; increasing pC02, decreasing p02, or decreasing Sa02; increasing tumor markers, etc.

Change in Functional status

- Decline in PPS score; progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST); progressive stage 3-4 pressure ulcers; history of increasing

ER visits, hospitalizations or physician visits related to the hospice primary diagnosis prior to election of hospice.

Note: Debility may not be listed as a primary diagnosis, but is an accepted co-morbid condition when another primary diagnosis does not in itself meet the guidelines.

Cancer Diagnoses	
Primary Criteria	Patients are considered to be in the terminal stage of their disease if they have: 1. Disease with distant metastases at presentation; or 2. Progression from an earlier stage of disease to metastatic disease with either: a. A continued decline in spite of therapy b. Patient declines further disease directed therapy
Secondary Criteria Notes	Note: Certain cancers with poor prognoses (e.g. small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

Coma	
Primary Criteria	Patient with **any** 3 of the following on day three of coma: 1. Abnormal brain stem response 2. Absent verbal response 3. Absent withdrawal response to pain 4. Serum creatinine >1.5 mg/dL
Secondary Criteria Notes	Supporting documentation: 1. Aspiration pneumonia 2. Upper urinary tract infection (pyelonephritis) 3. Refractory stage 3-4 decubitus ulcers 4. Fever recurrent after antibiotics

Pulmonary Disease	
Primary Criteria	Patients will be considered to be in the terminal stage of pulmonary disease if they meet the following: (This refers to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway to end-stage pulmonary disease) 1. Severe chronic lung disease as documented by both a and b: a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, with decreased functional capacity (e.g., bed to chair assistance, fatigue, cough, or predicted FEV1<30% - is objective evidence of disabling dyspnea, but not necessary to obtain) b. Progression of end-stage pulmonary disease, evidence including prior increasing visits to the emergency department, hospitalizations, or increasing physician home visits for pulmonary infections and/or respiratory failure. 2. Hypoxemia at rest on room air; evidence : p02 ≤ 55 mm Hg or oxygen saturation ≤88% or hypercapnia; evidence pCO2 ≤50 mm Hg
Secondary Criteria Notes	Additional factors to assess for: 1. Right heart failure secondary to pulmonary disease (not secondary to left heart disease or valvulopathy) 2. Unintentional weigh loss of >10% body weight over past 6 months 3. Resting tachycardia of >100/min

ALS	
Primary Criteria	**In end-stage ALS, 2 factors are critical in determining prognosis; ability to breathe, and, to a lesser extent, ability to swallow.** Patients are considered eligible for Hospice care if they do not elect tracheostomy and invasive ventilation and display evidence of critically impaired respiratory function (with or without use of NIPPV) and/or severe nutritional insufficiency (with or without use of a gastrostomy tube). **Critically impaired respiratory function is defined by:** 1. FVS<40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs: • Dyspnea at rest; • Orthopnea • Use of accessory respiratory muscles; • Paradoxical abdominal motion; • Respiratory rate >20; • Reduced speech/vocal volume; • Weakened cough; • Symptoms of sleep disordered breathing; • Frequent awakening • Daytime somnolence/excessive daytime sleepiness • Unexplained headaches • Unexplained nausea • Unexplained confusion • Unexplained anxiety 2. Not all ALS patients can or will undergo regular pulmonary function tests. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the above symptoms/signs. **Severe nutritional insufficiency is defined as:** Dysphagia with progressive weight loss of at least 5% of body weight with or without election for gastrostomy tube insertion

ALS Continued	
Secondary Criteria Notes	Some general considerations: 1. ALS tends to progress in a linear fashion over time, so the overall rate of decline in each patient is fairly constant and predictable. 2. Multiple clinical parameters are required to judge the progression of ALS. 3. Although ALS usually presents in a localized anatomic area, the location of initial presentation does not correlate with survival time. 4. Progression of disease differs markedly from patient to patient. 5. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to obtain to predict prognosis

HIV Disease	
Primary Criteria	Patients are considered to be in the terminal stage of their illness if they have met the following: 1. CD4+ count < 25 cells/mcL or persistent viral load > 100,000 copies/mL, **plus** one of the following: a. CNS lymphoma; b. Untreated or persistent despite treatment, wasting (loss of at least 10% lean body mass) c. Mycobacterium avium complex bacteremia, untreated, unresponsive to treatment, or treatment refused; d. Progressive multifocal lekoencephalpathy; e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy; f. Visceral Kaposi's sarcoma unresponsive to therapy; g. Renal failure in the absence of dialysis; h. Cryptosporidium infection; or i. Toxoplasmosis, unresponsive to therapy. 2. Decreased performance status, as measured by the Palliative Performance scale, of 50%

HIV Disease Continued	
Secondary Criteria Notes	Documentation of the following factors will support eligibility for hospice care: 1. Chronic persistent diarrhea for one year; 2. Persistent serum albumin < 2.5; 3. Concomitant, active substance abuse; 4. Age > 50 years; 5. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease 6. Advanced AIDS dementia complex; 7. Toxoplasmosis; 8. Congestive heart failure, symptomatic at rest; 9. Advanced liver disease

Liver Disease	
Primary Criteria	Patients will be considered to be in the terminal stage of liver disease if they meet the following: 1. Prothrombin time prolonged more than 5 seconds over control or INR > 1.5; 2. Serum albumin < 2.5 gm/dL 3. End-stage liver disease is present and the patient shows at least one of the following: a. Ascites, refractory to TX or patient non-compliant; b. Spontaneous bacterial peritonitis; c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day and urine sodium concentration < 10 mEq/l); d. Hepatic encephalopathy, refractory to TX or patient non-compliant e. Recurrent variceal bleeding, despite intensive therapy

Liver Disease Continued	
Secondary Criteria Notes	Documentation of the following will lend support: 1. Progressive malnutrition 2. Muscle wasting with decreased strength and endurance 3. Continued active alcoholism (> 80 gm ethanol/day) 4. Hepatocellular carcinoma 5. Hep B+ 6. Hep C refractory to interferon TX Patients awaiting liver transplant who otherwise fit the criteria may be certified for Hospice, but if a donor organ is procured, the pt should be discharged.

Renal Disease: Acute Renal Failure	
Primary Criteria	Patients will be considered to be in the terminal stage of renal disease if they meet the following. Patients terminal due to **acute renal disease** should have 1 **and** 2, 3, or 4: 1. The patient is not seeking dialysis or renal transplant; or is discontinuing dialysis; 2. Creatinine clearance <10 cc/min (<15 cc/min for diabetics and <20 cc/min for diabetics with CHF) 3. Serum creatinine >8.0 mg/dL (> 6.0 mg/dL for diabetics) 4. Estimated glomerular filtration rate (GFR) < 10ml/min
Secondary Criteria Notes	Documentation of the following will lend support: Co-morbid conditions: 1. Mechanical ventilation 2. Malignancy in another organ system 3. Chronic lung disease 4. Advanced cardiac disease 5. Advanced liver disease 6. Immunosuppression/AIDS 7. Albumin < 3.5 gm/dL 8. Platelet count < 25,000 9. Disseminated intravascular coagulation 10. GI bleeding

Renal Disease: Chronic Renal Failure	
Primary Criteria	Patients will be considered to be in the terminal stage of renal disease if they meet the following. Patients terminal due to **chronic renal disease** should have 1 **and** 2, 3, or 4: 1. The patient is not seeking dialysis or renal transplant; or is discontinuing dialysis; 2. Creatinine clearance <10 cc/min (<15 cc/min for diabetics and <20 cc/min for diabetics with CHF) 3. Serum creatinine >8.0 mg/dL (> 6.0 mg/dL for diabetics) 4. Signs & symptoms of renal failure: Uremia Oliguria (<400cc/day) Intractable hyperkalemia (> 7.0) not responsive to treatment Uremic pericarditis Hepatorenal syndrome Intractable fluid overload, not responsive to treatment.
Secondary Criteria Notes	Documentation of the following will lend support: 1. Estimated glomerular filtration rate (GFR) <10ml/min **Dialysis—may continue after careful goals clarification & contract in place** Goal: reduce discomfort associated with excess fluid and toxins buildup such as dyspnea, disorientation, itching, nausea Planned Short term/allow pt and family to plan for EOL Pt likely not to be able to continue soon – goal for comfort care at home following that Death soon expected despite dialysis and choice not to hospitalize

Heart Disease	
Primary Criteria	Patients will be considered to be in the terminal stage of heart disease if they meet the following: 1. Pt is or has been optimally treated for heart disease or are not eligible or have declined surgical procedures (optimally treated means if not on vasodilators, have a medical reason) 2. Pts with CHF or angina should meet criteria for the NYHA class IV 3. Significant congestive heart failure may be documented by an EF of ≤ 20% but it is not required if not already available.
Secondary Criteria Notes	Documentation of the following factors will support but is not required to establish eligibility for hospice care: 1. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias; 2. History of cardiac arrest or resuscitation; 3. History of unexplained syncope; 4. Brain embolism of cardiac origin 5. Concomitant HIV Disease
Class	**New York Heart Association Functional Classification**
I	Patients have cardiac disease but *without* the resulting *limitations* of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
II	Patients have cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain
III	Patients have cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.
IV	Patients have cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Stroke	
Primary Criteria Note: the diagnosis of CVA, Late Effects is used once a patient has left the hospital following an Acute Stroke. The diagnosis of Acute CVA can only be used in Inpatient Hospice when a patient is admitted to a GIP level of care prior to going home.	Patients will be considered to be in the terminal stages of stroke or coma if they meet the following: 1. A Palliative Performance Scale score of < 40 %. 2. Inability to maintain hydration and caloric intake with 1 of the following: a. Weight loss > 10% during previous 6 months or > 7.5% in previous 3 months; b. Serum albumin < 2.5 g/dL; c. Current history of pulmonary aspiration without effective response to speech language pathology interventions; d. Sequential calorie counts documenting inadequate caloric/fluid intake; e. Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, and patient does not receive artificial nutrition and hydration.
Secondary Criteria Notes	Documentation of the following will lend support: **Diagnostic Imaging** For non-traumatic, hemorrhagic: -large volume hemorrhage -extension into ventricles -midline shift -obstructive hydrocephalus For thrombotic /embolic: -large bi-hemispheric infarcts -basilar artery occlusion -bilateral vertebral artery occlusion -large anterior infarcts **Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months.** Aspiration pneumonia; Pyelonephritis; Refractory stage 3-4 decubitus ulcers; Fever recurrent after antibiotics

Dementia due to Alzheimer's and Other Causes	
Primary Criteria	For Alzheimer's disease and related disorders, the identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care planning. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co-morbid and/or secondary conditions. Co-morbid conditions affecting beneficiaries with Dementia are by definition distinct from Dementia itself. Examples include coronary heart disease and chronic obstructive pulmonary disease. Secondary conditions are directly related to a primary condition. In the case of Alzheimer's disease, examples include delirium and pressure ulcers. Ultimately, the combined effects of the Alzheimer's disease (FAST stage 7) and any co-morbid or secondary condition should be such that the patient with Alzheimer's disease and similar impairments would have a prognosis of 6 months or less.
Secondary Criteria Notes	Patients will be considered to be in the terminal stage of dementia if they meet the following: Stage 7 or beyond according to the Functional Assessment Staging Tool (FAST) Scale: • Unable to ambulate without assistance • Unable to dress without assistance • Unable to bathe without assistance • Urinary & 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

Dementia due to Alzheimer's and Other Causes Continued	
Secondary Criteria Notes (cont.)	Should have had one of the following within the past 12 months**:** 1. Aspiration pneumonia 2. Pyelonephritis or other upper urinary tract infection 3. Septicemia 4. Pressure ulcers, stage 3 – 4 5. Fever, recurrent after antibiotics 6. Inability to maintain sufficient fluid and caloric intake with 10% weight loss during the previous six months **<u>or</u>** serum albumin < 2.5 gm/dL

FUNCTIONAL ASSESSMENT STAGING TOOL (for Alzheimer's Disease)	
Stage	**Assessment** (***score is highest consecutive level of disability)***
1	No difficulties, either subjectively or objectively.
2	Complains of forgetting location of objects; subjective word finding difficulties only.
3	Decreased job functioning evident to coworkers; difficulty in traveling to new locations.
4	Decreased ability to perform complex tasks (e.g. planning dinner for guests; handling finances; marketing).
5	Requires assistance in choosing proper clothing for the season or occasion.
6a	Difficulty putting clothing on properly without assistance
6b	Unable to bathe properly; may develop fear of bathing. Will usually require assistance adjusting bath water temperature.
6c	Inability to handle mechanics of toileting (i.e. forgets to flush; doesn't wipe properly).
6d	Urinary incontinence, occasional or more frequent.
6e	Fecal incontinence, occasional or more frequent.
7a	Ability to speak limited to about half a dozen words in an average day.
7b	Intelligible vocabulary limited to a single word in an average day.
7c	Non-ambulatory (unable to walk without assistance).
7d	Unable to sit up independently.

FUNCTIONAL ASSESSMENT STAGING TOOL CONTINUED (for Alzheimer's Disease)	
Stage	**Assessment** (***score is highest consecutive level of disability)***
7e	Unable to smile.
7f	Unable to hold head up.

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also Definition of Terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient, which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column are 'stronger' determinants and generally take precedence over the others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for a short distance but who is otherwise fully conscious level with good intake would be scored at PPS 50%

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and be bound but still able to do some self-care such as feed themselves then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes there are several columns easily placed at one level but one or two which seem better at higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the most accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall 'best fit' using all five columns.

1. **Ambulation**
   The items 'mainly sit/lie' and 'totally bed bound' are clearly similar. The subtle differences are related to items in the self-care column. For example, 'totally bed bound' at PPS 30% is due whether to profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between 'sit/lie' and 'bed' is proportionate to the amount of time the patient is able to sit up vs. need to lie down.

   Reduced ambulation' is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. **Activity & extent of disease**
   'Some,' 'significant,' 'extensive' disease refer to physical and investigative evidence which shows degrees of progression. For example in breast cancer, a local recurrence would imply 'some' disease, one or two metastases in the lung or bone would imply 'significant' disease, whereas multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be 'extensive' disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, 'some' may mean the shift from HIV to AIDS, 'significant' implies progression in physical decline, new or difficult symptoms and laboratory findings with low counts. 'Extensive' refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

   The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (e.g. trying to walk the halls).

3. **Self-Care**
   'Occasional assistance' means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

'Considerable assistance' means that regularly every day the patient needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes but the patient is then able to eat of his or her own accord.

'Mainly assistance' is a further extension of 'considerable.' Using the above example, the patient now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.

'Total care' means that the patient is completely unable to eat without help, toilet, or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him or her.

4. **Intake**

   Changes in intake are quite obvious with 'normal intake' referring to the person's usual eating habits while healthy. 'Reduced' means any reduction from that and is highly variable according to the unique individual circumstances. 'Minimal' refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. **Conscious Level**

   'Full consciousness' implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. 'Confusion' is used to denote either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple etiologies. 'Drowsiness' implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor. 'Coma' in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.

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