

HOSPICE GUIDELINES

Note: These are Guidelines only. The Guidelines do not replace sound clinical judgment nor are they intended to strictly apply to all patients.

The following Correctional Hospice Guidelines are based on Medicare-recognized eligibility criteria for admission to Hospice. In general, Medicare eligibility for Hospice includes a certification of terminal illness (i.e., prognosis of six months or less if the terminal illness runs its normal course) and acceptance of palliative care (for comfort) instead of care to cure the illness. However, Medicare-contracted Fiscal Intermediaries at the state level establish more specific Local Coverage Determination (LCD) guidelines for admission to Hospice. In Texas, the Medicare Hospice Fiscal Intermediary is Palmetto GBA. The following is a condensed version of the Palmetto GBA LCD guidelines for determining eligibility criteria for admission to Hospice in Texas for:

- 1) **End Stage Alzheimer's Disease and other related Dementia disorders** with structural/functional impairments and secondary conditions (e.g., delirium and pressure ulcers); and/or comorbid conditions (e.g., coronary heart disease or chronic obstructive pulmonary disease) which may not respond to or be amenable to treatment; a FAST level of 7 or greater; and the combined effects of which would support a prognosis of six months or less. The Functional Assessment Staging Test (FAST) tool can be accessed using the following website:
[http://www.mciscreen.com/pdf/fast overview.pdf](http://www.mciscreen.com/pdf/fast%20overview.pdf)
- 2) **Neurological Disease (e.g., Stroke, Parkinson's Disease, Amyotrophic Lateral Sclerosis, or other specific end-stage disease process affecting the brain)** with structural/functional impairments involving communication, mobility, and self-care; associated with secondary conditions (e.g., dysphagia, pneumonia and/or pressure ulcers; and/or comorbid conditions (e.g., Chronic Obstructive Pulmonary Disease, etc.) which may not respond to or be amenable to treatment; and the combined effects of which would support a prognosis of six months or less.
- 3) **Cardiopulmonary Disease (e.g., Heart Failure, Chronic Obstructive Pulmonary Disease, Aortic Stenosis or other specific end-stage heart and/or lung disease)** associated with structural/functional impairments, activity limitation, and/or disability from secondary conditions (e.g., delirium, pneumonia, stasis ulcers and pressure ulcers); and/or from comorbid conditions (e.g., end stage renal disease, etc.) which may not respond to or be amenable to treatment; and the combined effects of which would support a prognosis of six months or less.
- 4) **End Stage Renal Disease (ESRD) associated with specific structural/functional impairments (e.g., urinary excretory function, water, mineral and electrolyte function and endocrine gland functions);** complicated by secondary conditions (e.g., hyperkalemia, fluid overload, anorexia or secondary hyperparathyroidism); and comorbid conditions (e.g., vascular disease, coronary heart disease, peripheral vascular disease or vascular dementia) which may not respond to or be amenable to treatment; and the combined effects of which would support a prognosis of six months or less.
- 5) **End-Stage Liver Disease (Cirrhosis or Hepatitis):** (Numbers 1 and 2 must be present; factors from 3 will lend supporting documentation):
 1. Prothrombin time prolonged more than 5 seconds over control, or INR>1.5 and Serum albumin <2.5 gm/dl;
 2. ESLD diagnosis plus one of the following:
 - a) refractory ascites;
 - b) spontaneous bacterial peritonitis;
 - c) hepatorenal syndrome (elevated creatinine and BUN with oliguria <400 ml/day and urine sodium <10 mEq/l);

- d) refractory hepatic encephalopathy;
- e) recurrent variceal bleeding;
- 3. Documentation of any of the following will further support eligibility:
 - a) progressive malnutrition;
 - b) muscle wasting with reduced strength and endurance;
 - c) hepatocellular carcinoma;
 - d) HBsAg (Hepatitis B) positivity;
 - e) hepatitis C, refractory to antiviral therapy.
- 6) **HIV Disease:** (1 and 2 must be present; factors from 3 will add supporting documentation):
 - 1. CD4+ Count <25 cells/mcL or persistent viral load >100,000 copies/ml, plus one of the following:
 - a) CNS lymphoma;
 - b) refractory wasting (loss of 33% lean body mass);
 - c) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;
 - d) progressive multifocal leukoencephalopathy;
 - e) systemic lymphoma with advanced HIV disease and partial response to chemotherapy;
 - f) visceral Kaposi's sarcoma unresponsive to therapy;
 - g) renal failure without dialysis;
 - h) Cryptosporidium infection; or
 - i) refractory Toxoplasmosis.
 - 2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale of 50 or less. The Karnofsky Performance Status scale be accessed using the following website:
<http://www.pennmedicine.org/homecare/hcp/eligworksheets/Karnofsky-Performance-Status.pdf>
 - 3. Documentation of the any of the following will support eligibility for hospice care:
 - a) chronic persistent diarrhea for one year;
 - b) persistent serum albumin <2.5;
 - c) concomitant, active substance abuse;
 - d) age > 50 years;
 - e) absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related to HIV disease;
 - f) advanced AIDS dementia complex;
 - g) Toxoplasmosis; and/or
 - h) Congestive heart failure, symptomatic at rest.
- 7) **Adult Failure to Thrive (FTT):** The medical criteria listed below would support a terminal prognosis for individuals with the adult failure to thrive syndrome. Medical criteria 1 and 2 are important indicators of nutritional and functiona status respectively, and would thus support a terminal prognosis if met.

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

G-51.8 Attachment B

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$BMI (kg/m^2) = 703 \times (\text{weight in pounds}) \text{ divided by } (\text{height in inches})^2$

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

<http://www.pennmedicine.org/homecare/hcp/eligworksheets/Karnofsky-Performance-Status.pdf>

The Palliative Performance Scale (PPS) can be accessed using the following website:

<http://www.healthcare.uiowa.edu/igec/tools/function/palliativePerformance.pdf>

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

At the time of recertification recumbent measurement(s) (anthropometry) such as mid-arm muscle area in cm^2 may be substituted for BMI with documentation as to why a BMI could not be measured. This information will be subject to review on a case by case basis.

In the event a beneficiary presenting with a nutritional impairment and disability does not meet the medical criteria listed above, but is still thought to be eligible for the Medicare Hospice Benefit, an alternate diagnosis that best describes the clinical circumstances of the individual beneficiary should be selected (e.g. 783.21 "abnormal loss of weight" and 799.4 "Cachexia")

- 8) End-Stage Cancer: Evidence of disease progression, metastasis, functional decline or nutritional decline despite optimal treatment.

Reference: (1) Adapted from Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, 2nd ed. National Hospice Organization, Arlington Va., 1996