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## Local Coverage Determination (LCD): HOSPICE - Determining Terminal Status (L33393)

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<a href="#">National Government Services, Inc.</a>	HHH MAC	06004 - HHH MAC	J - 06	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Michigan Minnesota New Jersey Nevada New York - Entire State Oregon Puerto Rico

				Virgin Islands Washington Wisconsin Northern Mariana Islands
<u>National Government Services, Inc.</u>	A and B and HHH MAC	14014 - HHH MAC	J - K	Connecticut Massachusetts Maine New Hampshire Rhode Island Vermont

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L33393

**Original ICD-9 LCD ID**L25678**LCD Title****HOSPICE - Determining Terminal Status****Proposed LCD in Comment Period**

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**Source Proposed LCD**

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Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

### Title XVIII of the Social Security Act (SSA):

Section 1102 provides that the Secretaries of the Treasury, Labor and Health and Human Services shall make and publish such rules and regulations not inconsistent with the Social Security Act, as necessary to the efficient administration of the functions each is charged with under this Act.

Section 1812 (a)(4) and (d) provides the scope of benefits for Hospice care.

Section 1813 (a)(4) provides deductible and coinsurance information.

Section 1814 (a)(7) and (l) provides conditions of and limitations on payment for hospice care provided to an individual.

Section 1861 (dd) defines hospice care and the hospice program.

Section 1862 (a)(1), (6) and (9) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, which constitute comfort items or where such expenses are for custodial care.

Section 1871 provides that the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under the title.

### Code of Federal Regulations

42 CFR Section 418 specifies services covered as hospice care and the conditions that a hospice program must meet in order to participate in the Medicare program.

### CMS Publications:

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30:  
Financial Liability Protections

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9:  
Coverage of Hospice Services under Hospital Insurance

CMS Transmittal No. 141, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #7337, March 2, 2011, updates hospice chapter of the manual to incorporate changes implemented as a result of statutory changes, and through notice-and-comment rulemaking in 2008, 2009, and 2010. Changes include updates to the Conditions of Participation (CoP) and certification sections of the chapter.

## **Coverage Guidance**

### **Coverage Indications, Limitations, and/or Medical Necessity**

#### **Abstract**

Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This LCD describes guidelines to be used by National Government Services (NGS) in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this LCD is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein 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. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

Section 322 of BIPA amended section 1814(a) of the Social Security Act by clarifying that the certification of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The amendment clarified that the certification is based on a clinical judgment regarding the usual course of a terminal illness, and recognizes the fact that making medical prognostications of life expectancy is not always exact.

However, the amendment regarding the physician's clinical judgment does not negate the fact that there must be a basis for a certification. A hospice needs to be certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course.

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 Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

*With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS proposed and implemented policies related to this new requirement in the Home Health Prospective Payment System Rate Update for CY 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372). This new face-to-face encounter requirement became effective on January 1, 2011.*

## Indications

A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific "**Decline in clinical status**" guidelines described in Part I. Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed in Part III will establish the necessary expectancy.

### Part I. Decline in clinical status guidelines

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this

list may support a six-month or less life expectancy. These should be documented in the clinical record.

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

Clinical Status:

- a. Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;
- b. Progressive inanition as documented by:
  - 1. Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;
  - 2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
  - 3. Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;
  - 4. Decreasing serum albumin or cholesterol.
  - 5. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

- a. Dyspnea with increasing respiratory rate;
- b. Cough, intractable;
- c. Nausea/vomiting poorly responsive to treatment;
- d. Diarrhea, intractable;
- e. Pain requiring increasing doses of major analgesics more than briefly.

Signs:

- a. Decline in systolic blood pressure to below 90 or progressive postural hypotension;
- b. Ascites;
- c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease;
- d. Edema;
- e. Pleural/pericardial effusion;
- f. Weakness;
- g. Change in level of consciousness.

Laboratory (When available. Lab testing is not required to establish hospice eligibility.):

- a. Increasing pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>;
- b. Increasing calcium, creatinine or liver function studies;
- c. Increasing tumor markers (e.g. CEA, PSA);
- d. Progressively decreasing or increasing serum sodium or increasing serum potassium.

- B. Decline in Karnofsky Performance Status (KPS ) or Palliative Performance Score (PPS) due to progression of disease.
- C. Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST).
- D. Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2).
- E. Progressive stage 3-4 pressure ulcers in spite of optimal care.
- F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

**Part II. Non-disease specific baseline guidelines (both A and B should be met)**

- A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or 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 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.
  1. Chronic obstructive pulmonary disease

2. Congestive heart failure
3. Ischemic heart disease
4. Diabetes mellitus
5. Neurologic disease (CVA, ALS, MS, Parkinson's)
6. Renal failure
7. Liver Disease
8. Neoplasia
9. Acquired immune deficiency syndrome
10. Dementia
11. Acquired Immune Deficiency Syndrome/HIV
12. Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)

D. See Part III for disease specific guidelines to be used with these baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

**Note:** The word "should" in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is required. The only requirement is that the documentation supports the beneficiary's prognosis of six months or less, if the illness runs its normal course.

### **Part III. Disease Specific Guidelines**

**Note:** These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines" described in Part II.

#### **Cancer Diagnoses**

- A. Disease with metastases at presentation **OR**
- B. Progression from an earlier stage of disease to metastatic disease with either:
  1. A continued decline in spite of therapy; or
  2. Patient declines further disease directed therapy.

**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.

#### **Non-Cancer Diagnoses**

##### **Amyotrophic Lateral Sclerosis**

General Considerations:

1. ALS tends to progress in a linear fashion over time. Thus the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. 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.
4. Progression of disease differs markedly from patient to patient. 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.
5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice care, the decision to institute either artificial ventilation or artificial feeding may significantly alter six month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

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 as defined by:

1. FVC < 40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs:

- Dyspnea at rest;
- Orthopnea;
- Use of accessory respiratory musculature;
- 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 confusion;
- Unexplained anxiety;
- Unexplained nausea.

2. 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 five percent of body weight with or without election for gastrostomy tube insertion.

These revised criteria rely less on the measured FVC, and as such reflect the reality that not all patients with ALS can or will undertake regular pulmonary function tests.

### **Dementia due to Alzheimer's Disease and Related Disorders**

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria.

1. Patients with dementia should show all the following characteristics:
  - a. Stage seven or beyond according to the Functional Assessment Staging Scale;
  - b. Unable to ambulate without assistance;
  - c. Unable to dress without assistance;
  - d. Unable to bathe without assistance;
  - e. Urinary and fecal incontinence, intermittent or constant;
  - f. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.
  
2. Patients should have had one of the following within the past 12 months:
  - a. Aspiration pneumonia;
  - b. Pyelonephritis;
  - c. Septicemia;
  - d. Decubitus ulcers, multiple, stage 3-4;
  - e. Fever, recurrent after antibiotics;
  - f. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

**Note:** This section is specific for Alzheimer's disease and Related Disorders, and is not appropriate for other types of dementia.

### **Heart Disease**

Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.)

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease, or are patients who are either not candidates for surgical procedures or who decline those procedures. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)

2. Patients with congestive heart failure or angina should meet the criteria for the New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an inability to carry on any physical activity. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of less than or equal to 20%, but is not required if not already available.
3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:
  - a. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;
  - b. History of cardiac arrest or resuscitation;
  - c. History of unexplained syncope;
  - d. Brain embolism of cardiac origin;
  - e. Concomitant HIV disease.

### **HIV Disease**

Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation.)

1. 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:
  - a. CNS lymphoma;
  - b. Untreated, or persistent despite treatment, wasting (loss of at least 10% 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 in the absence of dialysis;
  - h. Cryptosporidium infection;
  - i. Toxoplasmosis, unresponsive to therapy.
2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50%.
3. Documentation of the following factors 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 or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
- f. Advanced AIDS dementia complex;
- g. Toxoplasmosis;
- h. Congestive heart failure, symptomatic at rest;
- i. Advanced liver disease.

### **Liver Disease**

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present, factors from 3 will lend supporting documentation.)

1. The patient should show both a and b:
  - a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5;
  - b. Serum albumin < 2.5 gm/dl.
  
2. End stage liver disease is present and the patient shows at least one of the following:
  - a. Ascites, refractory to treatment 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 treatment, or patient non-compliant;
  - e. Recurrent variceal bleeding, despite intensive therapy.
  
3. Documentation of the following factors will support eligibility for hospice care:
  - a. Progressive malnutrition;
  - b. Muscle wasting with reduced strength and endurance;
  - c. Continued active alcoholism (> 80 gm ethanol/day);
  - d. Hepatocellular carcinoma;
  - e. HBsAg (Hepatitis B) positivity;
  - f. Hepatitis C refractory to interferon treatment.

### **Pulmonary Disease**

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation.)

1. Severe chronic lung disease as documented by both a and b:

- a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
  - b. 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 physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)
2. Hypoxemia at rest on room air, as evidenced by pO<sub>2</sub> less than or equal to 55 mmHg, or oxygen saturation less than or equal to 88%, determined either by arterial blood gases or oxygen saturation monitors, (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO<sub>2</sub> greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
  3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
  4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
  5. Resting tachycardia > 100/min.

### Renal Disease

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

**Acute Renal Failure** (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis. As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the Hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.

2. Creatinine clearance < 10 cc/min (<15 cc/min. for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.

3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).
4. Estimated glomerular filtration rate (GFR) <10 ml/min.
5. Comorbid conditions:
  - a. Mechanical ventilation;
  - b. Malignancy (other organ system);
  - c. Chronic lung disease;
  - d. Advanced cardiac disease;
  - e. Advanced liver disease;
  - f. Immunosuppression/AIDS;
  - g. Albumin < 3.5 gm/dl;
  - h. Platelet count < 25,000;
  - i. Disseminated intravascular coagulation;
  - j. Gastrointestinal bleeding.

**Chronic Kidney Disease** (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis; As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.

2. Creatinine clearance <10 cc/min (< 15 cc/min for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.
3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).
4. Signs and symptoms of renal failure:
  - a. Uremia;
  - b. Oliguria (< 400 cc/24 hours);
  - c. Intractable hyperkalemia (> 7.0) not responsive to treatment;
  - d. Uremic pericarditis;
  - e. Hepatorenal syndrome;
  - f. Intractable fluid overload, not responsive to treatment.

5. Estimated glomerular filtration rate (GFR) <10 ml/min.

### **Stroke and Coma**

Patients will be considered to be in the terminal stages of stroke or coma (life expectancy of six months or less) if they meet the following criteria:

#### **Stroke**

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

#### **Coma (any etiology):**

1. Comatose patients with any 3 of the following on day three of coma:
  - a. abnormal brain stem response;
  - b. absent verbal response;
  - c. absent withdrawal response to pain;
  - d. serum creatinine > 1.5 mg/dl.
2. Documentation of the following factors will support eligibility for hospice care:
  - a. Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:
    1. Aspiration pneumonia;
    2. Pyelonephritis;
    3. Refractory stage 3-4 decubitus ulcers;
    4. Fever recurrent after antibiotics.

3. Documentation of diagnostic imaging factors which support poor prognosis after stroke include:

## a. For non-traumatic hemorrhagic stroke:

## 1. Large-volume hemorrhage on CT:

- a. Infratentorial: greater than or equal to 20 ml.;
- b. Supratentorial: greater than or equal to 50 ml.

## 2. Ventricular extension of hemorrhage;

## 3. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;

## 4. Midline shift greater than or equal to 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;

## 4. Bilateral vertebral artery occlusion.

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Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

081x	Hospice (non-Hospital based)
082x	Hospice (hospital based)

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes

indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

0651	Hospice Service - Routine Home Care
0652	Hospice Service - Continuous Home Care
0655	Hospice Service - Inpatient Respite Care
0656	Hospice Service - General Inpatient Care Non-Respite
0657	Hospice Service - Physician Services

### CPT/HCPCS Codes

#### Group 1 Paragraph:

N/A

#### Group 1 Codes:

XX000	Not Applicable
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### ICD-10 Codes that Support Medical Necessity

#### Group 1 Paragraph:

N/A

#### Group 1 Codes:

**Show entries**

for **Group 1 ICD-10 Codes that Support Medical Necessity**

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Description ICD-10 Codes that Support Medical Necessity radio button

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ICD-10 Codes that Support Medical Necessity Clear button    **CLEAR SEARCH**

ICD-10 CODE	DESCRIPTION
XX000	Not Applicable

Showing 1 to 1 of 1 entries in Group 1

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**ICD-10 Codes that DO NOT Support Medical Necessity**

**Group 1 Paragraph:**

N/A

**Group 1 Codes:**

**Show entries**

for **Group 1 ICD-10 Codes that DO NOT Support Medical Necessity**

**Search**

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**Search Group 1 ICD-10 Codes that DO NOT Support Medical Necessity Submit button**      **SEARCH GROUP Search**

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ICD-10 CODE	DESCRIPTION
XX000	Not Applicable

Showing 1 to 1 of 1 entries in Group 1

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#### Additional ICD-10 Information

N/A

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## **General Information**

### **Associated Information**

Documentation certifying terminal status must contain enough information to support terminal status upon review. Documentation of the applicable criteria listed under the “Indications” section of this LCD would meet this requirement. If other clinical indicators of decline not listed in this LCD form the basis for certifying terminal status, they should be documented as well. Recertification for hospice care requires the same clinical standards be met as for initial certification, but they need not be reiterated. They may be incorporated by specific reference as part (or all) of the indication for recertification.

*Hospice certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less, either as part of the form or as an addendum. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The narrative must reflect the patient’s individual clinical circumstances. Narratives associated with the third and later benefit period must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)*

*For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient’s third benefit period, and prior to each subsequent benefit period. (CMS Pub 100-02. Medicare Benefit Policy Manual, Chapter 9, Section 20.1)*

*A hospice physician or hospice nurse practitioner must have a face-to-face encounter with patients prior to the third benefit period recertification and each subsequent recertification. This encounter can occur up to 30 calendar days prior to recertification, and the hospice physician or nurse practitioner must attest that the visit occurred. The certification or recertification must include the benefit period dates to which it applies, and be signed and dated by the certifying or recertifying physician. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election. Recertifications may be prepared no more than 15 calendar days prior to the start of the subsequent benefit period. (CMS Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1)*

*Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness. (CMS Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1)*

Documentation should “paint a picture” for the reviewer to clearly see why the patient is 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 should comport with normal clinical documentation practices. Unless elements in the record require explanation, such as a non-morbid diagnosis or indicators of likely greater than six month survival, as stated below, no extra or additional record entries should be needed to show hospice benefit eligibility.

The amount and detail of documentation will differ in different situations. A patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than one with chronic lung disease. 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.

If the documentation includes any findings inconsistent with or tending to disprove a less than six-month prognosis, they should be answered or refuted by other entries, or specifically addressed and explained. Most facts and observations tending to suggest a greater than six month prognosis are predictable and apparent, such as a prolonged stay in hospice or a low immediate mortality diagnosis, as stated above. But specific entries can also call for an answer, such as an opinion by one team member or recovery of ADLs when they were part of the basis for the initial declaration of eligibility. Also the lack of certain elements such as a tissue diagnosis for cancer will not negate eligibility, but does necessitate other supportive documentation.

Documentation submitted may include information from periods of time outside the billing period currently under review. Include supporting events such as a change in the level of activities of daily living, recent hospitalizations, and the known date of death (if you are billing for a period of time prior to the billing period in which death occurred).

Submitted documentation should always include the admission assessment, as well as any evaluations and Interdisciplinary Group (IDG) discussions used for recertification. Records that show the progression of the patient’s illness are very helpful.

Documentation should support the level of care being provided to the patient during the time period under review, i.e. routine or continuous home or inpatient, respite or general. The reviewer should be able to easily identify the dates and times of changes in levels of care and the reason for the change.

**The guidelines contained in this policy are intended to help providers determine when patients are appropriate for the Medicare Hospice benefit. As each patient is unique, there are patients for whom a particular guideline does not match. In such cases, it is important for providers to meticulously document the factors which specify the individual's terminal prognosis.**

**There are also patients who match a guideline at the start of hospice care, and who continue to do so for a prolonged period, e.g., greater than six months. While it is true that there is not a strict six month limit on the Hospice benefit, the underlying precept is that the beneficiary must have a prognosis of six months or less, if the illness runs its normal course. A beneficiary may match a guideline, but by virtue of that individual having lived for a significantly prolonged period thereafter, he/she has shown that guideline to be inadequate to predict the appropriate terminal prognosis.**

**ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult: Executive Summary  
A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines  
(Committee to Revise the 1995 Guidelines for the Evaluation and Management of Heart Failure)**

**Stages of Heart Failure (HF)**

**Stage A**

Patients at high risk of developing HF because of the presence of conditions that are strongly associated with the development of HF. Such patients have no identified structural or functional abnormalities of the pericardium, myocardium, or cardiac valves and have never shown signs or symptoms of HF.

Example:

Systemic hypertension; coronary artery disease; diabetes mellitus; history of cardiotoxic drug therapy or alcohol abuse; personal history of rheumatic fever; family history of cardiomyopathy.

**Stage B**

Patients who have developed structural heart disease that is strongly associated with the development of HF but who have never show signs or symptoms of HF.

Example:

Left ventricular hypertrophy or fibrosis; left ventricular dilatation or hypocontractility; asymptomatic valvular heart disease; previous myocardial infarction.

**Stage C**

Patients who have current or prior symptoms of HF associated with underlying structural heart disease.

Example:

Dyspnea or fatigue due to left ventricular systolic dysfunction; asymptomatic patients who are undergoing treatment for prior symptoms of HF.

**Stage D**

Patients with advanced structural heart disease and marked symptoms of HF at rest despite maximal medical therapy and who require specialized interventions.

**Example:**

Patients who are frequently hospitalized for HF or cannot be safely discharged from the hospital; patients in the hospital awaiting heart transplantation; patients at home receiving continuous intravenous support for symptom relief or being supported with a mechanical circulatory assist device; patients in a hospice setting for management of HF.

**Karnofsky Performance Scale (KPS)**

The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses.

**KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA**

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.

Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

### NYHA Functional Classification for Congestive Heart Failure

The New York Heart Association (NYHA) Functional Classification provides a simple way of classifying heart disease (originally cardiac failure). It places patients in one of four categories, based on how much they are limited during physical activity:

**Class I:** patients with no limitation of activities; they suffer no symptoms from ordinary activities.

**Class II:** patients with slight, mild limitation of activity; they are comfortable with rest or with mild exertion.

**Class III:** patients with marked limitation of activity; they are comfortable only at rest.

**Class IV:** patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest.

### Palliative Performance Scale

The Palliative Performance Scale (PPS) is a modification of the Karnofsky Performance Scale intended for evaluating patients requiring palliative care. The score can help determine which patients can be managed in the home and which should be admitted to a hospice unit. It was developed in British Columbia, Canada.

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<b>PPS Level</b>	<b>Ambulation</b>	<b>Activity &amp; Evidence of Disease</b>	<b>Self-Care</b>	<b>Intake</b>	<b>Conscious Level</b>
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> effort Some evidence of disease	Full	Normal or reduced	Full
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	-	-	-	-

***The Stages of Alzheimer's Disease***

At the New York University Medical Center's Aging and Dementia Research Center, Barry Reisberg, MD and colleagues have developed the Functional Assessment Staging (FAST) scale, which allows professionals and caregivers to chart the decline of people with Alzheimer's disease. The FAST scale has 16 stages and sub-stages:

<b>FAST Scale Stage</b>	<b>Characteristics</b>
1... normal adult	No functional decline.
2... normal older adult	Personal awareness of some functional decline.
3... early Alzheimer's disease	Noticeable deficits in demanding job situations.
4... mild Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.
5... moderate Alzheimer's	Requires assistance in choosing proper attire.
6... moderately severe Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.
7... severe Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of abilities to walk, sit up, smile, and hold head up.

### **Detailed Description of Each of the 7 Stages**

#### **Stage 1**

No cognitive decline. No subjective complaints of memory deficit. No memory deficit evident on clinical interviews.

**Stage2 (Forgetfulness)**

Very mild cognitive decline.

Subjective complaints of memory deficit, most frequently in the following area:

- a. forgetting where one has placed familiar objects;
- b. forgetting names on formerly knew well.

No objective evidence of memory deficit on clinical interview. No objective deficits in employment or social situations. Appropriate concern regarding symptoms.

**Stage 3 (Early Confusional)**

Mild cognitive decline. Earliest clear-cut deficits.

Manifestations in more than one of the following areas:

- a. patient may have gotten lost when traveling to an unfamiliar location;
- b. co-workers become aware of patient's relatively low performance;
- c. word and name finding deficit becomes evident to intimates;
- d. patient may read a passage of a book and retain relatively little material;
- e. patient may demonstrate decreased facility in remembering names upon introduction to new people;
- f. patient may have lost or misplaced an object of value;
- g. concentration deficit may be evident on clinical testing.

Objective evidence of memory deficit obtained only with an intensive interview. Denial begins to become manifest in patient. Mild to moderate anxiety accompanies symptoms.

**Stage 4 (Late Confusional)**Moderate cognitive decline. Clear-cut deficit on careful clinical interview.

Deficit manifest in following areas:

- a. decreased knowledge of current and recent events;
- b. may exhibit some deficit in memory of one's personal history;
- c. concentration deficit elicited on serial subtractions;
- d. decreased ability to travel, handle finances, etc.

Frequently no deficit in the following areas:

- a. orientation to time and person;
- b. recognition of familiar persons and faces;
- c. ability to travel to familiar locations.

Inability to perform complex tasks. Denial is dominant defense mechanism. Flattening of affect and withdrawal from challenging situations occur.

**Stage 5 (Early Dementia)** Moderately severe cognitive decline.

Patient can no longer survive without some assistance. Patient is unable during interview to recall a major relevant aspect of their current lives, e.g., an address or telephone number of many years, the names of close family members (such as grandchildren), the name of the high school or college from which they graduated. Frequently some disorientation to time (date, day of week, season, etc.) or to place. An educated person may have difficulty counting back from 40 by 4s or from 20 by 2s. Persons at this stage retain knowledge of many major facts regarding themselves and others. They invariably know their own names and generally know their spouse's and children's names. They require no assistance with toileting and eating, but may have some difficulty choosing the proper clothing to wear.

**Stage 6 (Middle Dementia)** Severe cognitive decline.

May occasionally forget the name of the spouse upon whom they are entirely dependent for survival. Will be largely unaware of all recent events and experiences in their lives. Retain some knowledge of their past lives but this is very sketchy. Generally unaware of their surroundings, the year, the season, etc. May have difficulty counting from 10, both backward and sometimes forward. Will require some assistance with activities of daily living, e.g., may become incontinent, will require travel assistance but occasionally will display ability to familiar locations. Diurnal rhythm frequently disturbed. Almost always recall their own name. Frequently continue to be able to distinguish familiar from unfamiliar persons in their environment.

Personality and emotional changes occur. These are quite variable and include:

- a. delusional behavior, e.g., patients may accuse their spouse of being an impostor, may talk to imaginary figures in the environment, or to their own reflection in the mirror;
- b. obsessive symptoms, e.g., person may continually repeat simple cleaning activities;

- c. anxiety agitation, and even previously nonexistent violent behavior may occur;
- d. cognitive abulia, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.

**Stage 7 (Late Dementia)** Very severe cognitive decline. All verbal abilities are lost.

Frequently there is no speech at all - only grunting. Incontinent of urine, requires assistance toileting and feeding. Lose basic psychomotor skills, e.g., ability to walk, sitting and head control. The brain appears to no longer be able to tell the body what to do. Generalized and cortical neurologic signs and symptoms are frequently present.

**Dr Reisberg has also shown that the decline typical of Alzheimer's disease is the flip side of normal skill acquisition by infants, children, and young adults:**

<b>Ability</b>	<b>Age of acquisition during normal development</b>	<b>Alzheimer's stage at which ability is lost</b>
<b>Hold a job. Function independently in the world.</b>	<b>12 years and older</b>	<b>3... early Alzheimer's disease</b>
<b>Handle simple finances.</b>	<b>8-12 years</b>	<b>4... mild Alzheimer's</b>
<b>Select proper clothing.</b>	<b>5-7 years</b>	<b>5... moderate Alzheimer's</b>

Available from ElderCare Online™ <http://www.ec-online.net/> ©Barry Reisberg, MD 1984

Not applicable

### **Sources of Information and Basis for Decision**

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

All previously published UGS Local Medical Review Policies (LMRP)/Local Coverage Determinations (LCD).

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## - **Revision History Information**

N/A

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## - **Associated Documents**

### **Attachments**

N/A

### **Related Local Coverage Documents**

Article(s)

[A52830 - Hospice: Determining Terminal Status - Supplemental Instructions Article](#)

### **Related National Coverage Documents**

N/A

### **Public Version(s)**

Updated on 04/02/2014 with effective dates 10/01/2015 - N/A

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– **Keywords**

N/A

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