gilchrist

Hospice Care Prognostic Booklet

When is my patient eligible for hospice?

For urgent questions, call Gilchrist at 443.849.8200

Our Mission

To provide counseling, support and care to anyone with a serious illness, so they may live life to the fullest.

Our Vision

We are deeply committed to giving people the clear information and loving support they need to make informed choices about their care.

Dear Provider,

Some of the most challenging discussions a medical provider will have with a patient suffering with a serious illness is what will happen next and when. Prognostication is not an exact science and knowing when to refer to hospice can be a challenge. Gilchrist can help.

Please accept this booklet which presents some clinical guidelines that Medicare uses for disease specific prognostication. While these guidelines are not perfect and should not serve as a substitute for a physician's medical judgment regarding the normal course of the illness, we are prompted by Medicare to use these guidelines as a baseline to determine appropriateness for a hospice referral.

However, we are required to use these guidelines as a baseline to determine appropriateness for a hospice referral. The general guidelines are provided here along with the specific criteria for patients with:

Cancer	ALS	Heart Disease	HIV Disease
Liver Disease	Pulmonary Disease	Renal Disease	Stroke and Coma

Additionally, it is important to know that patients who have other disease processes or multiple medical complexities may still be eligible for hospice. Ask yourself, "Would I be surprised if this patient died in the next six months?" If the answer is "no," Gilchrist can help with the eligibility determination. Even if your patient is not eligible for hospice, they may be eligible for other Gilchrist services. We offer at-home Elder Medical Care aimed at the last three years of life (see p. 30, Other Gilchrist Services). Please call your Gilchrist representative or 443.849.8200 with any questions about a particular patient, and we will help determine the appropriate service.

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Certification/Recertification

In order for patients to be enrolled under their hospice benefit, the following criteria are required for certification:

- Patients must be considered by a physician to **have a life-limiting condition with a life expectancy of 6 months or less** if the disease were to take its normal course. **A "life-limiting condition" may be due to a specific diagnosis, a combination of diseases, or there may be no specific diagnosis defined**.
- The **patient and/or their responsible party have elected treatment goals directed towards relief of symptoms,** rather than curing the underlying terminal condition.

Paths to Eligibility

When determining and supporting a prognosis of 6 months or less, one of four possible paths to eligibility should be considered:

1. The patient meets all of the Local Coverage Determinants (LCD) criteria which are outlined in the diagnostic specific clinical variables provided in the booklet.
2. The patient meets most of the LCD criteria AND has a documented rapid decline supporting a limited prognosis which may include, but are not limited to:
   a) Progression of the terminal disease process as listed in the disease specific criteria, as documented by physician assessment, radiologic, laboratory, or other studies;
   b) Multiple emergency room visits or inpatient hospitalizations in the past six months; or
   c) Unintentional progressive weight loss or evidence of nutritional decline
3. The patient meets most of the LCD criteria and has significant comorbidities that contribute to a limited prognosis, or
4. The physician's medical judgment based on evidenced based medicine, experience with patients having a similar presentation or specific medical knowledge supports a limited prognosis.

Clinical Variables

Clinical variables provided in this booklet are general guidelines in relation to specific disease processes. In addition, information is provided on non-disease specific clinical indicators in order to support your clinical decision-making process, when referring your patient for hospice care. **Patients who meet these guidelines are expected to have a life expectancy of 6 months or less if the terminal condition follows its normal course.**

Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less. Coverage for these patients may be approved with documentation of clinical factors supporting a prognosis of less than 6 months. Please contact Gilchrist at 443.849.8200 if you have any questions related to these guidelines or would like to make a referral.

1. *Anderson F, Downing GM, Hill J. Palliative Performance Scale (PPS): a new tool. J Palliat Care. 1996; 12(1): 5-11.*
2. *Morita T, Tsunoda J, Inoue S, et al. Validity of the Palliative Performance Scale from a survival perspective. J Pain Symp Manage. 1999; 18(1):2-3.*
3. *Virik K, Glare P. Validation of the Palliative Performance Scale for inpatients admitted to a palliative care unit in Sydney, Australia. J Pain Symp Manage. 2002; 23(6):455-7.*
4. *Myers J, Kim A, Flanagan J. Palliative performance scale and survival among outpatients with advanced cancer. Supportive Care in Cancer 2015; 23.4: 913-918.*

Version History: This Fast Fact was originally edited by David E Weissman MD and published in November 2004. Version re-copy-edited in April 2009; revised again July 2015 – reference 4 added and incorporated into text.

Palliative Performance Scale Version 2 (PPSv2)

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness
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 & work *with* effort *Some evidence of disease*	Full	Normal or Reduced	Full
70	Reduced	Unable to do normal activity & work *Significant disease*	Full	Normal or Reduced	Full
60	Reduced	Unable to do hobby/house work *Significant Disease*	Occasional Assistance	Normal or Reduced	Full or Confusion
50	Mainly sit/lie	Unable to do any work *Extensive Disease*	Considerable Assistance	Normal or Reduced	Full or Drowsy or Confusion
40	Mainly in bed	Unable to do **most** activity *Extensive Disease*	Mainly Assistance	Normal or Reduced	Full or Drowsy +/- Confusion
30	Bed Bound	Unable to do **any** activity *Extensive Disease*	Total Care	Normal or Reduced	Full or Drowsy +/- Confusion
20	Bed Bound	Unable to do **any** activity *Extensive Disease*	Total Care	Minimal Sips	Full or Drowsy +/- Confusion
10	Bed Bound	Unable to do **any** activity *Extensive Disease*	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	-	-	-	-

Pain Assessment in Advanced Dementia (PAINAD) Scale

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during ca regiving, after the administration of pain medication).

Behavior	0	1	2	Score
Independent of vocalization	Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	No need to console	• Distracted or reassured by voice or touch	• Unable to console, • distract, or reassure	
			Total	

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool. (Warden et al., 2003)

Disease Specific Guidelines

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

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 will 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.

Critically Impaired Respiratory function as defined by:

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

- Dyspnea at rest
- Unexplained sweating
- Patient declines mechanical ventilation
- External ventilation used for comfort measures
- Orthopnea
- Use of accessory respiratory musculature
- Paradoxical abdominal motion
- Respiratory rate >20
- Grunting
- Frequent awakening
- Reduced speech/vocal volume
- Chest retractions
- Weakened cough
- Daytime somnolence/excessive daytime sleepiness
- Unexplained headaches
- Unexplained anxiety
- Unexplained nausea
- Nose flaring
- Symptoms of sleep disorder breathing

If unable to perform the FVC test, patients meet these criteria if they manifest three or more of the above symptoms.

Cancer Diagnosis

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.

A. Disease with distant 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
    2. Patient declines further disease-directed therapy

Dementia Due to Alzheimer's Disease and Related Disorders

Note: This section is specific to Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia.

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. Patients with dementia should show all the following characteristics:

1. Stage seven or beyond according to the Functional Assessment Staging Scale
2. Unable to ambulate without assistance
3. Unable to dress without assistance
4. Unable to bathe without assistance
5. Urinary and fecal incontinence, intermittent or constant
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Patients 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. Decubitus ulcers, multiple, stage 3-4
5. Fever, recurrent after antibiotics
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl

Functional Assessment Staging (FAST)

The Reisberg Functional Assessment Staging (FAST) scale is a tool used to describe Medicare beneficiaries with Alzheimer's Disease with a prognosis of less than six months. The FAST scale is a 16-item scale designed to outline the progress and expected declines associated with Alzheimer's Disease. Stage 7 is aligned with the activity limitations that would support a six-month prognosis.

Stage 1	No difficulty, either subjectively or objectively
Stage 2	Complaints of forgetting location of objects; subjective work difficulties
Stage 3	Decreased job functioning evident to co-workers; difficulty traveling to new locations; decreased organizational capacity
Stage 4	Decreased ability to perform complex tasks (e.g., planning for dinner for guests, handling finances – e.g., forgetting to pay bills)
Stage 5	Requires assistance in choosing proper clothing for the season or occasion (e.g., wearing same clothes repeatedly)
Stage 6	Occasionally or more frequently decreased ability to perform ADLs (dress, bathe, and toileting independently)
Stage 7	Loss of speech, locomotion, and consciousness • Sub-stage 7a: Ability to speak limited (less than six intelligible words in the course of an average day) • Sub-stage 7b: All intelligible words are lost • Sub-stage 7c: Ambulatory ability is lost • Sub-stage 7d: Unable to sit up unassisted (e.g., would fall over without lateral arms on the chair) • Sub-stage 7e: Loss of ability to smile • Sub-stage 7f: Loss of ability to hold up head independently

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 is not a candidate for a surgical procedure or has declined a procedure. (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. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of ≤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

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Additional indicators of a poor prognosis with heart disease patients. These may be due to associated co-morbid conditions (e.g., COPD, diabetes, renal disease, anemia).

- Advanced Age
- Hemoglobin <10 g/dl
- Hypotension
- Serum Sodium < 136 mEq/L
- Serum Creatinine >2.0 mg/dl
- Cardiac Cachexia: Nonintentional nonedema loss of >7.5% of body weight over the previous 6 months

Signs and Symptoms of Heart Failure:

Left Sided Heart Failure	Right Sided Heart Failure
• Dyspnea • Exercise intolerance • Wheezing • Dizziness, confusion • Cool extremities at rest	• Nocturia • Ascites • Peripheral edema • Congestive hepatomegaly

Classes of Heart Failure (NYHA)

Doctors usually classify patients' heart failure according to the severity of their symptoms. The table below describes the most commonly used classification system, the New York Heart Association (NYHA) Functional Classification[1]. It places patients in one of four categories based on how much they are limited during physical activity.

Class	Patient Symptoms
I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

Class	Objective Assessment
A	No objective evidence of cardiovascular disease. No symptoms and no limitation in ordinary physical activity.
B	Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
C	Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
D	Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.

For Example:

A patient with minimal or no symptoms but a large pressure gradient across the aortic valve or severe obstruction of the left main coronary artery is classified: ***Function Capacity I, Objective Assessment D***

A patient with severe anginal syndrome but angiographically normal coronary arteries is classified: ***Functional Capacity IV, Objective Assessment A***

[1] Adapted from Dolgin M, Association NYH, Fox AC, Gorlin R, Levin RI, New York Heart Association. Criteria Committee. Nomenclature and criteria for diagnosis of diseases of the heart and great vessels. 9th ed. Boston, MA: Lippincott Williams and Wilkins; March 1, 1994.

Original source: Criteria Committee, New York Heart Association, Inc. Diseases of the Heart and Blood Vessels. Nomenclature and Criteria for diagnosis, 6th edition Boston, Little, Brown and Co. 1964, p 114.

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 (two 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 ≤50% or Palliative Performance Scale (PPS), of ≤50%

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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 gm/dl
    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

Note: Patients awaiting liver transplant who otherwise fit the below criteria may be certified for the Medicare hospice benefit, but if a donor organ is procured, the patient should be discharged from hospice.

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 five 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)
    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 pO2 ≤55 mmHg; or oxygen saturation ≤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 pCO2 ≥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) (i.e., 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/minute

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 or 3 should be present. Factors from 4 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
2. Creatinine clearance GFR <15 ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
4. Comorbid conditions:
   a. Mechanical ventilation
   b. Malignancy (other organ system)
   c. Chronic lung disease
   d. Advanced cardiac disease
   e. Advanced liver disease
   f. Sepsis
   g. Gastrointestinal bleeding
   h. Disseminated intravascular coagulation
   i. Platelet count <25,000
   j. Cachexia
   k. Serum albumin <2.5 gm/dl
   l. Immunosuppression/AIDS

Chronic renal failure:

(1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
2. Creatinine clearance GFR <15ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
4. Signs and symptoms of renal failure:
   a. Uremia
   b. Oliguria
   c. Intractable hyperkalemia (>7.0) not responsive to treatment
   d. Uremic pericarditis
   e. Hepatorenal syndrome
   f. Intractable fluid overload, not responsive to treatment

Stroke & Coma

Patients will be considered to be in the terminal stage 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% or less
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
    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, in a patient who declines or does not receive artificial nutrition and hydration

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

Coma (any etiology):

Comatose patients with any three 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

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For non-traumatic hemorrhagic stroke:

1. Large-volume hemorrhage on CT:
    a. Infratentorial: ≥20 ml
    b. Supratentorial: ≥50 ml
2. Ventricular extension of hemorrhage
3. Surface area of involvement of hemorrhage ≥30% of cerebrum
4. Midline shift ≥1.5 cm
5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt

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

Documentation of the following factors will support eligibility for hospice care:

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. Upper urinary tract infection (pyelonephritis)
3. Sepsis
4. Refractory stage 3-4 decubitus ulcers
5. Fever recurrent after antibiotics

Opioid Analgesic Equivalences

It is often necessary to switch from one opioid to a different opioid, a different formulation, or a different route of administration.

Equianalgesic Equivalence Formula

Total Daily Dose **(TTD)**

Current equianalgesic equivalence * **new** equianalgesic equivalence = new total Daily Dose **(tDD)**

Calculating Breakthrough Dose:

New **tDD** X .15 = PRN dose to be administered

	Equianalgesic Equivalences (mg)	
Opioid	**Parenteral**	**Oral**
Morphine	10	30
Fentanyl	.1	N/A
Hydrocodone	N/A	30
Hydromorphone	1.5	7.5
Oxycodone	N/A	20

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1) Calculate the current Total Daily Dose for the last 24 hours of scheduled opioids.
2) Calculate the Total Daily Dose for the last 24 hours of PRN opioids.
3) Add scheduled and PRN opioid totals for the last 24 hrs for the Total Daily Dose (TTD).
4) Divide TTD by the patient's ***current*** equianalgesic equivalence, then multiply the **new** equianalgesic equivalence for the **new total Daily Dose (tDD)** administered over the next 24 hrs.
5) Divide the **new total Daily Dose (tDD)** administered over the next 24hrs by the desired frequency (q1hr, q2hrs, q3hrs, q4hrs, q6hrs, q8hrs, q12hrs).
6) Multiply the **new total Daily Dose (tDD) by 15%** (.15) for the breakthrough opioid dose that will be administered on a PRN schedule.

Calculating current Total Daily Dose (TTD) (Oxycodone to Morphine PO)

1) Oxycodone (2) 5mg tabs q6hrs (4) [2 * 5 = 10 * 4 = 40mgs]

2) Oxycodone 5mg tabs q4hrs/PRN and (4) 5mg doses administered in the last 24hrs [4 * 5 = 20mgs]

3) [40mgs + 20mgs = **60mgs current TDD**]

4) Equianalgesic Equivalence Calculation (*table left*):
   [60mgs current **TDD** / 20 = 2 * 30 = **90mgs new tDD**] for Morphine PO

5) Calculating frequency to be administered:
   90mgs / q4hr (6) [90 / 6 = 15mgs] Morphine PO administered every 4hrs

6) Calculating Breakthrough Dose:
   90mgs **new tDD** * .15 = 13.5mgs dose rounded to 10mgs or 15mgs
   a. Morphine 15mgs q2hrs/PRN

Hospice & Physician Billing

Can physician visits be billed once my patient elects hospice care?

Absolutely! A primary care physician not affiliated or under contract with the hospice may bill Medicare for services provided to a hospice patient.

How do I bill?

Using the correct modifier codes is key. See the examples below:

Scenario	Modifier to use:
Primary physician visit is related to the patient's terminal diagnosis	GV
Primary physician visit is not related to the patient's terminal diagnosis	GW
Covering physician is a member of the primary physician's practice	Q5 & GV or GW
Covering physician is not a member of the primary physician's practice	Q6 & GV or GW

If you have questions regarding billing, please contact Gilchrist for assistance.

Sources, References and Web Versions

- **Clinical Certification/Recertification, Hospice Eligibility:**
  https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538
- **Clinical Variables:**
  https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538
- **Palliative Performance Scale:**
  https://www.mypcnow.org/fast-fact/the-palliative-performance-scale-pps/
  Online Palliative Performance Scale Score Sheet located at https://eprognosis.ucsf.edu/pps.php
- **Pain Assessment in Advanced Dementia Scale (PAINAD):**
  Pain Assessment Scales/Tools > Pain Assessment in Advanced Dementia Scale (PAINAD)
  https://pami.emergency.med.jax.ufl.edu/wordpress/files/2019/10/Pain-Assessment-in-Advanced-Dementia.pdf
- **Karnofsky Performance Stats Scale**
  Oxford Textbook of Palliative Medicine, Oxford University Press. 1993;109.
  http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf
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- **Opioid Analgesic Equivalences:**
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- **Hospice & Physician Billing:**
  https://ngsmedicare.com/ngs/wcm/connect/ngsmedicare/e2a938ad-dc7b-4bde-aceb-755704bd00ee/1484_0913_Hospice_Physician_Nurse_Practitioner_Billing_Job_Aid%28CorrectedCMSLink%29.pdf?MOD=AJPERES&CVID=lfDnAYx

Other Gilchrist Services

If your patient is not eligible for hospice, Gilchrist may still be able to help. We offer a comprehensive continuum of care for people with serious illness aimed at the last three years of life.

Gilchrist's Elder Medical Care program offers home-based medical care and support for aging adults with chronic and progressive serious illness who have difficulty traveling to medical appointments. Nurse practitioners provide at-home primary care, medication and symptom management, and coordination of care to help seniors age in place. Social workers are available to provide emotional support and connect patients with community resources. Elder Medical Care services are also provided to elders in residential care communities (assisted living, long-term care or skilled nursing facilities).

As a person's illness progresses, **they can seamlessly transition to hospice**. In addition, Gilchrist offers counseling and bereavement services for families after the death of a loved one.

To learn more and discover how Gilchrist can help, call 443.849.8200.

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