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Live Every Moment

Hospice Care Eligibility Guide

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For urgent questions, call:

Gilchrist	**443.849.8200**
The Lifecare Institute	**443.332.5800**
Hospice of Washington County	**301.791.6360**
Franklin Hospice	**717.504.3465**
Gilchrist Inova	**844.774.0242**

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,

One 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. We 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. We can assist and support you in providing the needed perspective on your patients clinical status when you feel adequate or sufficient data are lacking to align with these guidelines.

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, patients who have other disease processes or multiple medical complexities may still be eligible for hospice. Asking yourself, "*Would I be surprised if this patient died in the next six months?*" can trigger your consideration for a hospice eligibility determination referral if the answer is "no." If your patient is not eligible for hospice, they may be eligible for one of our other services. **Please call us with any questions about a particular patient, and we will help determine the appropriate service.**

The Role of the Hospice Attending

Upon electing hospice, the patient or their representative must include their choice of an attending provider who they identify as the one who would have the most impact on their plan of care under hospice.

When that attending provider agrees, their role will include:

- If a physician, provide a one time verbal certification of terminal illness (CTI) and communicate that directly to a hospice staff member per regulation 42 CFR 418.22(a)(3)(i).
- If a physician, sign and return the CTI order when received on paper or electronically per regulation 42 CFR 418.22(c)(1)(ii).
- Communicate with the hospice nurse(s) about patient care needs when available.
- Sign the plan of care (POC) when updates are sent on paper or electronically.
- Choose to complete the death certificate upon patient's death, or defer that to the hospice physician.

Hospice's responsibilities toward the hospice attending:

- Keep the hospice attending appraised of patient status and any changes in clinical condition.
- Provide 24/7 hospice provider back-up when the hospice attending is not available for any needs.
- Collaborate with the hospice attending on the plan of care (POC).

Deferring the role of the hospice attending upon patient enrollment in hospice is also acceptable, and in this case the hospice physician will assume the role of managing all aspects of your patient's care.

Hospice and Provider Billing

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

Absolutely! A primary care provider not affiliated or under contract with the hospice may bill Medicare for services provided to a hospice patient if they are chosen as the attending physician by the patient when they enroll in hospice.

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

For questions regarding billing, please contact the billing department at 443-849-8390 for assistance.

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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 clinical variables sections of this 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 us if you have any questions related to these guidelines or would like to make a referral.

Right (page 11):
© Copyright Notice. The Palliative Performance Scale version 2 (PPSv2) tool is copyright to Victoria Hospice Society and replaces the first PPS published in 1996 [J Pall Care 9(4): 26-32].

For instructions on using the PPS, scan this QR code or visit:
victoriahospice.org/wp-content/uploads/2020/08/PPSv2-QA-Instructions-and-Definitions-updated-July-2020.pdf

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	-	-	-	-

Decline in Clinical Status Guidelines

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are listed in order of their likelihood to predict poor survival, the most predictive first and the least predictive last. No specific number of variables must be met, but fewer of those listed first (more predictive) and more of those listed last (least predictive) would be expected to predict longevity of six months or less.

1. **Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results**
   a. Clinical Status
      i. Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.
      ii. Progressive inanition as documented by:
         a) Weight loss not due to reversible causes such as depression or use of diuretics
         b) Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
         c) Decreasing serum albumin or cholesterol
      iii. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

   b. Symptoms
      i. Dyspnea with increasing respiratory rate
      ii. Cough, intractable
      iii. Nausea/vomiting poorly responsive to treatment
      iv. Diarrhea, intractablectable
      v. Pain requiring increasing doses of major analgesics more than briefly

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c. Signs
   i. Decline in systolic blood pressure to below 90 or progressive postural hypotension
   ii. Ascites
   iii. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
   iv. Edema
   v. Pleural / pericardial effusion
   vi. Weakness
   vii. Change in level of consciousness

d. Laboratory (When available. Lab testing is not required to establish hospice eligibility.)
   i. Increasing pCO2 or decreasing pO2 or decreasing SaO2
   ii. Increasing calcium, creatinine or liver function studies
   iii. Increasing tumor markers (e.g. CEA, PSA)
   iv. Progressively decreasing or increasing serum sodium or increasing serum potassium

2. **Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.**

3. **Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis**

4. **Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST)**

5. **Progression to dependence on assistance with additional activities of daily living**

6. **Progressive stage 3-4 pressure ulcers in spite of optimal care**

Disease Specific Guidelines

Note: These guidelines are to be used in conjunction with the "Decline in Clinical Status 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.

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Criteria:

Patients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria. (Should fulfill 1, 2, or 3):

1. **Patient should demonstrate critically impaired breathing capacity.**
   a. Critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
      i. Vital capacity (VC) less than 30% of normal (if available);
      ii. Dyspnea at rest;
      iii. Patient declines mechanical ventilation; external ventilation used for comfort measures only.

2. **Patient should demonstrate both rapid progression of ALS and critical nutritional impairment.**
   a. Rapid progression of ALS as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
      i. Progression from independent ambulation to wheelchair to bed bound status;
      ii. Progression from normal to barely intelligible or unintelligible speech;
      iii. Progression from normal to pureed diet;
      iv. Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs.
   b. Critical nutritional impairment as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
      i. Oral intake of nutrients and fluids insufficient to sustain life;
      ii. Continuing weight loss;
      iii. Dehydration or hypovolemia;
      iv. Absence of artificial feeding methods, sufficient to sustain life, but not for relieving hunger.

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3. Patient should demonstrate both rapid progression of ALS and life-threatening complications.

a. Rapid progression of ALS, see 2.a above.

b. Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months preceding initial hospice certification:

i. Recurrent aspiration pneumonia (with or without tube feedings);

ii. Upper urinary tract infection, e.g., pyelonephritis;

iii. Sepsis;

iv. Recurrent fever after antibiotic therapy;

v. Stage 3 or 4 decubitus ulcer(s).

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

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	• Nocturia
• Exercise intolerance	• Ascites
• Wheezing	• Peripheral edema
• Dizziness, confusion	• Congestive hepatomegaly
• Cool extremities at rest	

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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 are present even at rest or minimal exertion. If any physical activity is undertaken, discomfort is increased.

[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 cell/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 ≤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 above 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. Immunosuppression/AIDS
   h. Albumin
   i. Cachexia
   j. Platelet count <25,000
   k. Disseminated intravascular coagulation
   l. Gastrointestinal bleeding

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 and 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:

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

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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

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

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

Sources, References and Web Versions

- **Clinical Variables, Certification/Recertification, and Hospice Eligibility:**
  https://www.cms.gov/medicare-coverage-database/view/lcd.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
- **Prognostication in Dementia:**
  https://www.mypcnow.org/fast-fact/prognostication-in-dementia/
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2981683/pdf/nihms232449.pdf
- **Hospice & Physician Billing:**
  https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00003600

Live Every Moment

We are honored to help patients and their loved ones navigate the complexities of advancing age, serious illness, and end-of-life care with a comprehensive array of services that meet life's ever-changing physical, psychological, spiritual, and emotional needs. Because no two journeys are the same, our integrated care model brings the highest quality clinical and compassionate care wherever it is needed most—across care settings, private residences, and senior living communities.

Whether time with us is measured in years, months, days, or hours, our mission remains the same: ensuring our patients **live every moment** to the fullest.

To learn more about Gilchrist and it's affiliates, visit gilchristcares.org/partner or call 443.849.8200.

For urgent questions, call 443.849.8200

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