Eligibility for Hospice
Linda Tavel, MD MBA FAAHPM
Gentiva Hospice
Linda.tavel@gentiva.com

Objectives
- Define eligibility for hospice as outlined by Medicare CFR 418.20
- Identify times when eligibility review is required
- Discuss tools and resources that aid in determining eligibility for hospice

The Medicare Hospice Benefit
- Majority of patients are Medicare age
- Other payors and insurers often follow Medicare guidelines
- Medicare set the requirements in 1982 under Section 122 TEFRA
  - The patient elects the hospice benefit
  - The patient is certified as terminally ill
For Medicare Hospice Benefit

- The patient must be entitled to Medicare Part A
- The patient has a "terminal illness"
  - "...medical prognosis is a life expectancy of 6 months or less if the illness runs its normal course."
- But that’s not all........
  - "the total person is to be assessed, including acute and chronic conditions, as well as controlled and uncontrolled conditions, in determining an individual’s terminal prognosis."

The Total Person......

- "the presence of comorbidities is recognized as potentially contributing to the overall status of an individual and should be considered when determining the terminal prognosis.” (read: eligibility)
- NHPCO defines comorbidity: “known factors or pathological disease impacting on the primary health problem and generally attributed to increased risk for poor health status outcomes.”

What Does This Mean?

- Eligibility could encompass multiple disease processes that are contributing to the terminal prognosis.
When is Eligibility an Issue?

- At admission
- At (re)certification, the onset of:
  - Two ninety day benefit periods
  - Unlimited sixty day benefit periods
  - Throughout the benefit period
- Every team meeting, ask the question......
  - Is this patient at risk of dying within six months if the disease runs its usual course?

Where does data come from?

- Physician notes
- Clinic notes
- Hospital records
- Diagnostic studies
  - Pathology
  - Radiology
  - Labs
- Metrics: weights, functional status (distances walked, tasks accomplished)
- Mandated Face to Face per Medicare guidelines

How to determine a patient is terminally ill......

- “Prognosis”— Greek “to know before” (forecast)
- Prognostication often uses Diagnoses
  - Greek “to know thoroughly” (discerning)
- Physicians are terrible at prognostication:
  - No longer taught as skill in medical school
  - Often overestimate prognosis by factor of two or more
  - Nicholas Christakis, MD MPH
Tools for Determining Eligibility

Hospice commonly used tools:

- PPS (Palliative Performance Scale)
- FAST (Functional Assessment Staging)
- BMI (Body Mass Index)
- MAC (Mid Upper Arm Circumference)
- LCDs (Local Coverage Determination) from MAC Medicare Administrative Contractor

Palliative Performance Scale

Karnofsky/Lansky Performance Scales
ECOG/Zubrod

ECOG Performance Status

<table>
<thead>
<tr>
<th>Score</th>
<th>KPS</th>
<th>ECOG PS</th>
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<tbody>
<tr>
<td>100</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>90</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>80</td>
<td>2</td>
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<td>70</td>
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<td>10</td>
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<td>10</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>11</td>
</tr>
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</table>

The proposed conversion scale was constructed empirically from a sample of patients (~300) with advanced cancer, including different tumor types. Both ECOG PS and KPS were determined by 7 physicians for each patient. The conversion scale had the highest rate of agreement (71%) observed among all possible scales.

Lau, Downing, Lesperance. JPM 2006; 9(5):1066-1075

Karnofsky versus ECOG

Palliative Performance Scale

<table>
<thead>
<tr>
<th>Table 4. Mortality Risk Over Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death or define</td>
</tr>
<tr>
<td>% Mortality (all patients)</td>
</tr>
<tr>
<td>25% at 80%</td>
</tr>
<tr>
<td>35% at 90%</td>
</tr>
<tr>
<td>45% at 100%</td>
</tr>
<tr>
<td>60% at 200%</td>
</tr>
</tbody>
</table>

Palliative Performance Scale


Eur J Cancer 2010;45(18):3175-3183
FAST

- Developed on Alzheimer's Dementia patients
- Other types of dementia may have different trajectory
- The FAST score is the “lowest” consecutive (contiguous) score. Do NOT skip levels!!!
  - A patient who has fecal incontinence, cannot walk but can speak much more than 5-7 words per day… is NOT a 7C
  - Start at FAST score 1 and work down the scale.
- FAST 7A plus comorbidity (aspiration, upper urinary tract infection, sepsis, Stage III-IV ulcers, weight loss, persistent fever) felt to have prognosis less than 6 months

Body Mass Index

- Body Mass Index formula developed by Belgian statistician.
- BMI = weight in kg divided by height in meters squared
- “Imperial” BMI = (weight in pounds divided by height in inches squared) x 703
- BMI = weight/(height x height) or (weight/(height x height)) x 703
- BMI less than 18.5 kg/M2 is “underweight”
- BMI 18.5-25 kg/M2 is “healthy weight”
- BMI 25-30 kg/M2 is “overweight”
- BMI over 30 kg/M2 is “obese”

CDC www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html
Body Mass Index

Why is this important?
- Declining weight/BMI reflects burden of disease

What height do you use?
- Current versus peak height in adulthood
- Average person loses 2 inches over time

What if you can’t weigh the patient?
- Mid Arm Circumference

BMI in Amputees

All 4 limbs = 50%; entire arm = 5%; forearm and hand = 2.5%; hand = 0.7%; entire leg = 16%; lower leg and foot = 5.9%; foot = 1.5%


Mid Arm Circumference

1. Be consistent in technique
   - Same arm!
   - Sitting versus lying
2. Use nondominant arm unless affected by trauma/stroke/disuse
3. Measure acromion to olecranon process, then midpoint measurement
4. Do NOT measure over clothing
Mid Arm Circumference

- No good norms for adult patients
  - Average MUAC 32 +/- 5 cm men per Merck Manual
  - Average MUAC 28 +/- 6 cm in women per Merck Manual

- United Nation System Committee on Nutrition feels
  - 18.5 cm MAC moderate malnutrition
  - 16 cm MAC severe malnutrition

Elderly have “sarcopenia” with aging. Shift in body composition from limbs to trunk, so weight gain can be deceptive.
- Megace “weight gain” is primarily fat and water, and not metabolically beneficial (read: not improving muscle mass)

How else to determine weight loss

- Description of muscular wasting in face, limbs, hands
- If arms not suitable, can measure mid-thigh and keep records.
- Mid Thigh Measure:
  - Proximal edge of patella to inguinal crease, then measure midpoint.
  - Not as well studied nor validated, but a large muscle group
NYHA Classification

<table>
<thead>
<tr>
<th>Class</th>
<th>Functional Capacity during physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Cardiac disease, but no limitations of activity. Ordinary activity OK.</td>
</tr>
<tr>
<td>II</td>
<td>Cardiac disease with slight limitation of activity. Comfortable at rest. Ordinary activity causes fatigue, palpitation, dyspnea or angina.</td>
</tr>
<tr>
<td>III</td>
<td>Cardiac disease with marked limitation of activity. Comfortable at rest. Low level activity causes fatigue, palpitation, dyspnea or angina.</td>
</tr>
<tr>
<td>IV</td>
<td>Cardiac disease, unable to carry on physical activity without discomfort. Symptoms of heart failure or angina at rest. If any activity is undertaken, discomfort increases.</td>
</tr>
</tbody>
</table>

ACC/AHA Classification of CHF

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description/disease processes</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>(High risk for developing HF) Hypertension, diabetes mellitus, family history, coronary artery disease. No structural heart disease nor symptoms of HF</td>
</tr>
<tr>
<td>B</td>
<td>(Asymptomatic HF) Previous myocardial infarction (heart attack), valvular disorders, left ventricular dysfunction. Structural disease but no signs or symptoms of HF</td>
</tr>
<tr>
<td>C</td>
<td>(Symptomatic HF) Structural heart disease, fatigue, low tolerance level for physical activity. Prior or current symptoms of HF</td>
</tr>
<tr>
<td>D</td>
<td>(Refractory and stage HF) Severe limitations. Experiences symptoms even while at rest.</td>
</tr>
</tbody>
</table>
Seattle Heart Failure Model

- https://depts.washington.edu/shfm/

- Heart failure mortality ranges from 5-75%

LCDs

- Local Coverage Determinations
- Guidelines to assist the physician/hospice to determine a limited prognosis.
- They are not “absolute” but guidelines
- When multiple diseases are present, the patient could be “qualified” with less than “perfect” fit to an LCD
- Other states: [www.cms.gov](http://www.cms.gov) and search “Hospice LCD”

Palmetto GBA

- Palmetto Jurisdiction: AL, AR, FL, GA, IL, IN, KY, LA, MS, NC, NM, OH, OK, SC, TN, TX

- Three Main Medicare Administrative Contractors
Palmetto LCDs
- Current set plus LCDs that become effective 10/1/2015
  - ICD-9 versus ICD-10 codes
- HIV
- Liver Disease
- Neurological Conditions
- Renal Care
- Alzheimers Disease and Related Conditions
- Cardiopulmonary Conditions
- The Failure to Thrive Syndrome

HIV
1. CD4+ Count <25 cells/mcL or viral load>100,000
   a. CNS lymphoma
   b. Untreated/not responding wasting (loss 33% lean mass)
   c. Mycobacterium avium complex bacteremia
   d. Progressive multifocal leukoencephalopathy
   e. Systemic lymphoma, advanced HIV dz, -ctx response
   f. Visceral Kaposi’s sarcoma not responding
   g. Renal failure without dialysis
   h. Cryptosporidium infection
   i. Toxoplasmosis, not responding

HIV continued
2. Decreased performance status (KPS < 50%)
3. Documentation:
   a. Chronic persistent diarrhea > 1 year
   b. Persistent serum albumin <2.5
   c. Concomitant substance abuse
   d. Age > 50 years
   e. Absence of specific anti-HIV drug therapy
   f. Advanced AIDS dementia complex
   g. Toxoplasmosis
   h. Congestive heart failure, symptomatic at rest
Liver Disease

1. Patient shows a and b:
   a. Prothrombin time >5 seconds over control or INR>1.5
   b. Serum albumin <2.5 gm/dl

2. ES Liver disease and patient shows at least one:
   a. Ascites, refractory or patient noncompliant
   b. Spontaneous bacterial peritonitis
   c. Hepatorenal syndrome (creatinine/BUN/oliguria)
   d. Hepatic encephalopathy, refractory or pt noncompliant
   e. Recurrent variceal bleeding

Liver Disease

3. Documentation of following items are supportive:
   a. Progressive malnutrition
   b. Muscle wasting with reduced strength and endurance
   c. Continued alcoholism (> 80 gm etOH per day)
   d. Hepatocellular carcinoma
   e. HBsAg (Hepatitis B) positivity
   f. Hepatitis C refractory to interferon

Patients awaiting liver transplant OK, but must be discharged once organ procured.

Neurologic Conditions

- Fairly nonspecific
- Functional impairments
- Activity limitations
- Secondary conditions: dysphagia, pneumonia, pressure ulcers
- Comorbidities help with eligibility
- Example: Amyotrophic Lateral Sclerosis, Multiple Sclerosis, other degenerative neurological condition
End Stage Renal Disease

- Fairly nonspecific: functional impairments
- Comorbidities such as cardiac disease, peripheral vascular disease, and "vascular dementia".
- Secondary conditions such as hyperparathyroidism, calciphylaxis, electrolyte abnormalities, anorexia, hyperkalemia, edema/fluid overload, urinary function
- Hypertensive chronic kidney disease, CKD V or ESRD
- Acute kidney failure (with specified site of lesion)
- Renal failure unspecified
- ESRD

Alzheimers Dementia

- FAST 7 PLUS:
  - Secondary conditions related to Alzheimers:
    - Delirium
    - Pressure ulcers
    - Impairments of mental function and movement can lead to pneumonia/infections
    - Remember the restrictions on ICD-9 codes: no 290-294 series diagnoses
    - 331.x Alzheimer’s disease, Pick’s disease, Senile degeneration of brain, Corticobasal Degeneration as examples
  - Comorbidities help!

Adult Failure to Thrive*****

- No longer a PRIMARY hospice diagnosis, but can be a secondary condition or comorbidity
- Unexplained weight loss, malnutrition, disability
- BMI < 22 kg/m² and not responding to nutritional tx
- PPS or KPS < or = to 40%
- If no weight—Mid arm measurements but documentation regards why BMI cannot be obtained
- ICD-9 codes: 783.41, 783.7, 799.3, 799.89, 799.9 cannot be primary hospice diagnoses!
**CardioPulmonary Conditions**

- Nonspecific but discusses functional impairments and activity limitations. Recommends using ICF: International Classification of Functioning, Disability and Health to identify cardiopulmonary status.
- Secondary conditions such as delirium, pneumonia, stasis ulcers and pressures, as well as arrhythmias, Ejection Fraction, sleep dysfunctions, and respiratory insufficiency.
- Comorbidities can help.

**All Palmetto LCDs state:**

- Documentation certifying terminal status must contain enough information to confirm terminal status upon review. Documentation meeting the criteria listed under the *Indications and Limitations of Coverage and/or Medical Necessity* section of this LCD would contribute to this requirement. Recertification for hospice care requires that the same standards be met as for the *initial certification* (my italics).

**Missing the more specific guidelines?**

- National Government Services has some of the more specific measures in its LCD: “Determining Terminal Status.”
- *NGS Jurisdiction:* AK, AZ, CA, HI, ID, MI, MN, NJ, NY, OR, WA, WI, Guam, Puerto Rico, Virgin Islands, Northern Mariana Islands, American Samoa
- Other NGS Jurisdictions: CT, ME, MA, NH, RI, VT
- CGS has some of the more specific measures in its LCD: “Determining Terminal Status”
- *CGS Jurisdiction:* CO, DC, DE, IA, KS, MO, MT, ND, NE, PA, SD, UT, VA, WV, WI
Is this patient eligible?

Ms. H is an 84 year old woman with advanced ASCVD. She has been hospitalized 3 times in the last 12 months. She was recently discharged from hospital. Her PPS is 50%, but she becomes very short of breath walking through her apartment and takes several minutes to recover. She wears O2 mostly at night, but does use O2 when short of breath. She has lost 20 pounds in the last year. She has an EF 42%, diagnosis of diastolic heart failure. She also has Chronic Kidney Disease stage 3, diabetes type II and hypertension. 5’4”, 160 pounds, MAC 27

- Her meds: lisinopril, metoprolol, metformin, HCTZ, simvastatin, isosorbide, tramadol
- Is she eligible?
- What meds will you cover? Which will you recommend d/c?

Is this patient eligible?

Dr. D is a 66 year old veterinarian with cortico basal degeneration for 8 years. He has frequent falls, often with minor injury. He is said to be 50% PPS, and his wife shadows behind him when he walks. He sits in recliner most of the day. He sleeps 9 hours at night. He mumbles, so no distinct words, other than occasional “thank you”. He is cognitively very slow and doesn’t follow many verbal commands. His wife has started chopping his food, as he has difficulty chewing and eating. He has problems with constipation. He has lost 35# in a year. He becomes agitated in the evenings. His wife does not wish him to go to hospital, ER, or clinic again.

- His meds: seroquel, advil, tylenol, fibercon, centrum vitamins.
- Is he eligible for hospice? What else would you like to know?
- What meds will you cover and what might you add?

Is this patient eligible?

Mrs. P is a 78 year old “doctor’s widow” with ovarian cancer, metastatic to peritoneum, adrenals, liver. Her cancer was discovered after her husband’s death 2 years ago. Her cancer initially responded to debulking surgery and chemotherapy but returned. She also has irritable bowel syndrome and depression. Her three sons (two of whom are attorneys) are very involved in her care. She declines to take opiates for pain so she can drive to her duplicate bridge matches weekly. She has problems with constipation and has to disimpact herself once to twice a week. She is losing weight, eats fairly. Pain is 6-8/10 at worst, 2/10 best. Occasional nausea and vomiting.

- Her meds: flurazepam, omeprazole, hydrocodone/apap, zofran, zyrtec, nasocort, miralax (dislikes due to too much liquid)
- Is she eligible for hospice? What else would you like to know?
- What meds will you be covering?
Is this patient eligible?

- Mr. M is a 86 year old man with hospice diagnosis of dementia. He had multiple hospitalizations, last stay it was determined he had dysphagia; family refused PEG. Pt also received diagnosis of PD recently. He has lost weight—10#. PPS has declined from 60% to 40%. Gait unsteady. Diet changed to pureed. He requires assistance in all ADLs—feeding assisted. He has history of TIA, and recently has had 2 bouts post prandial nonresponsiveness. One morning was unresponsive for several hours prior to meal. FAST 7a-b. Recent CAT scan showed cerebral ischemia. History of facial shingles and pain syndrome. Hypertension and prostate cancer also in history. Meds are: seroquel, flomax, amlodipine, aricept, namenda, lyrice, tylenol. Wife is worried that seroquel will cause him to stop breathing.

- Is he eligible for hospice? What diagnoses? What else do you wish to know?
- Which medications will you cover?

Eligibility

- At admission and at every recertification, the question must be asked: “is this patient likely to die within 6 months if the disease runs its usual course?”
- Due to the “rolling” recertification, the question is always “is this patient likely to die within 6 months?” but the trajectory must be towards death.
- Documentation must be present in the medical record to substantiate the assertion that the patient is terminally ill.
- Eligibility is based upon Prognosis, not “need” for the services!!!
Eligibility

- Statements regards “decline” should be specific, measurable, and should convey a trajectory towards death.
- If one measurement improves (yikes!), the patient can remain on service if he/she remains likely to die within 6 months if the disease process(es) continue the usual course.
- “Stable” should probably not be in your vocabulary when describing an eligible hospice patient.

Bibliography

- Palmetto Workshop for Hospice 2013
  - [Link](http://www.palmettogba.com/event/pgbaevent NSF/NEU/ARCH/9AALR35211/324/file/2013_Hospice_Workshop_Handou t_Appendix_rev07292013.pdf)
- CDC National Health and Nutrition Examination Survey Anthropometry Procedures Manual
  - [Link](http://www.cdc.gov/nchs/data/nhanes/nhanes_03_04/ BM...pdf)
  - [Link](http://jama.jamanetwork.com/article.aspx?articleid=198894)