Local Coverage Determinations for Hospice Eligibility (Determination of 6 Month Prognosis)

LCDs were conceived from guidelines developed for the National Hospice and Palliative Care Organization to help physicians determine which of their patients might qualify for hospice services. These guidelines were codified by the CMS and their fiscal intermediaries (the RHHIs) to facilitate medical review of hospice admissions. While these policies can be seen as a helpful, systematic approach to overcoming "the prognosis problem," aiding clinicians in making timely referral decisions to the proper care path, they can also be perceived as a regulatory barrier that limits access to an already underused healthcare service. Ultimately, a common-sense combination of clinical judgment and LCD guidelines may be the most useful way to proceed in prognostication.

In 2002, over 50% of hospice patients had end-stage cancer, but patients with other illnesses are increasingly using hospice as well.[4] Prognostic indicators of limited life expectancy for several common terminal illnesses need to be disease-specific, such as in end-stage heart disease, HIV/AIDS, and pulmonary diseases, as well as patients with renal failure, amyotrophic lateral sclerosis, and other progressive neurodegenerative diseases, stroke, and dementia. Nonspecific indicators, such as progressive weight loss, declining serum proteins, and loss of functional capacities, define limited life expectancy in patients with adult failure to thrive, as do other unspecified debilities that are considered untreatable and life-limiting by the patient's primary physician and the hospice medical director.

Hospice Screening Tools From the LCD

Table 4 contains a summary of some of the most current LCD prognostic tools to determine eligibility for MHB by the Palmetto RHHI. The criteria may be different with other RHHIs.

Table 4. LCD Criteria

Condition	Primary Criteria	Secondary Criteria/Notes
Heart Disease	Patient: 1. Has a poor response to (or chooses not to pursue) optimal treatment with diuretics, vasodilators, and/or ACE inhibitors; 2. Has angina pectoris, at rest, that is resistant to standard nitrate therapy; 3. Is not a candidate for or declines invasive procedures; and 4. Has significant symptoms of recurrent CHF at rest and/or refractory angina 5. Is classified as NYHA IV	Other factors supporting diagnosis of end-stage heart disease: 1. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias; 2. A history of cardiac arrest or resuscitation and unexplained syncope; 3. A brain embolism of cardiac origin; 4. An ejection fraction of 20% or less; and 5. Concomitant HIV disease.
HIV/AIDS	Patients are considered to be in the terminal stage of their disease if they have: 1. CD4+ count < 25 cells/mcL or persistent viral load > 100,000 copies/mL, plus one of the following: a. CNS lymphoma; b. Loss of 33% lean body mass; c. Mycobacterium avium complex 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; or i. Toxoplasmosis, unresponsive to therapy. 2. Decreased performance status, as measured by the Karnofsky Performance Status scale, of 50%.	Documentation of the following factors will support eligibility for hospice care: 1. Chronic persistent diarrhea for one year; 2. Persistent serum albumin < 2.5; 3. Concomitant, active substance abuse; 4. Age > 50 years; 5. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease; 6. Advanced AIDS dementia complex; 7. Toxoplasmosis; and 8. Congestive heart failure, symptomatic at rest.
Pulmonary Disease	For patients with various forms of advanced pulmonary disease who eventually follow a final common pathway to end-stage pulmonary disease: 1. Severe chronic lung disease as documented by both a and b: a. Disabling dyspnea at rest, unresponsive to bronchodilators, with decreased functional capacity; and b. Progression of end-stage pulmonary disease, evidence including prior increasing visits to the emergency department or prior hospitalizations for pulmonary infections and/or respiratory failure. 2. Hypoxemia at rest on room air; evidence: p02 </= 55 mm Hg or oxygen saturation </= 88% or hypercapnia; evidence pCO2 </= 50 mm Hg.	To lend supporting documentation: 1. Cor pulmonale and right heart failure secondary to pulmonary disease (eg, not secondary to left heart disease or valvulopathy); 2. Unintentional progressive weight loss of greater than 10% of body weight over the preceding 6 months; and 3. Resting tachycardia > 100/minute.

Renal Disease	Patients are considered to be in the terminal stage of renal disease if: For chronic renal failure: 1. The patient is not seeking dialysis or renal transplant; 2. Creatinine clearance < 10 cc/minute (< 15 cc/minute for diabetes); and 3. Serum creatinine > 8.0 mg/dL (> 6.0 mg/dL for diabetes) Note: see reference 12 for acute renal failure criteria.	Supporting documentation: Signs and symptoms of renal failure: 1. Uremia; 2. Oliguria (< 400 cc/day); 3. Intractable hyperkalemia (> 7.0) not responsive to treatment; 4. Uremic pericarditis; 5. Hepatorenal syndrome; and 6. Intractable fluid overload, not responsive to treatment.
ALS	Patients are considered to be in the terminal stage of ALS if 1 of the following 3 situations occurs within the 12 months preceding initial hospice certification: 1. Critically impaired breathing capacity as demonstrated by all of the following characteristics 12 months before initial hospice certification: • Vital capacity less than 30% of normal; • Significant dyspnea at rest; • Requiring supplemental oxygen at rest; and • Patient declines artificial ventilation. 2. Rapid progression of ALS and critical nutritional impairment demonstrated by all of the following characteristics: a. Rapid progression: • Progression from independent ambulation to wheelchair or bedbound status; • Progression from normal to barely intelligible or unintelligible speech; • Progression from normal to pureed diet; and • Progression from independence in most or all ADLs to major assistance by caretaker in all ADLs. b. Critical nutritional impairment: • Oral intake of nutrients and fluids insufficient to sustain life; • Continuing weight loss; • Dehydration or hypovolemia; and • Absence of artificial feeding methods. 3. Both rapid progression of ALS and life-threatening complications: a. Rapid progression of ALS, see 2.a. above; and b. Life-threatening complications: • Recurrent aspiration pneumonia (with or without tube feedings); • Upper urinary tract infection (eg, pyelonephritis); • Sepsis; and • Recurrent fever after antibiotic therapy.	Some general considerations: 1. ALS tends to progress in a linear fashion over time, so the overall rate of decline in each patient is fairly constant and predictable. 2. Multiple clinical parameters are required to judge the progression of ALS. 3. Although ALS usually presents in a localized anatomic area, the location of initial presentation does not correlate with survival time. 4. Progression of disease differs markedly from patient to patient. 5. In end-stage ALS, 2 factors are critical in determining prognosis: ability to breathe and, to a lesser extent, ability to swallow.

Stroke	The following are important indicators of functional and nutritional status, respectively, and support a terminal prognosis if met: 1. A Palliative Performance Scale score of </= 40. a. Degree of ambulation: mainly in bed b. Activity/extent of disease: unable to do work; extensive disease c. Ability to do self-care: mainly Assistance d. Food/fluid intake: normal to reduced e. State of consciousness: either fully conscious or drowsy/confused 2. Inability to maintain hydration and caloric intake with 1 of the following: a. Weight loss > 10% during previous 6 months; b. Weight loss > 7.5% in previous 3 months; c. Serum albumin < 2.5 g/dL; d. Current history of pulmonary aspiration without effective response to speech language pathology interventions; or e. Calorie counts documenting inadequate caloric/fluid intake.	If the patient does not meet both of the primary criteria, there should be documentation that describes a relevant comorbidity and/or rapid decline.
Alzheimer's Disease and Related Disorders*	For Alzheimer's disease and related disorders, the identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care planning. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by comorbid and/or secondary conditions. Comorbid conditions affecting beneficiaries with Alzheimer's Disease are by definition distinct from the Alzheimer's disease itself. Examples include coronary heart disease and chronic obstructive pulmonary disease. Secondary conditions are directly related to a primary condition. In the case of Alzheimer's disease, examples include delirium and pressure ulcers. Ultimately, the combined effects of the Alzheimer's disease (FAST stage 7) and any comorbid or secondary condition should be such that the patient with Alzheimer's disease and similar impairments would have a prognosis of 6 months or less.	The FAST Scale[11] has been used for many years to describe Medicare beneficiaries with Alzheimer's disease and a prognosis of 6 months or less. The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's disease. FAST stage 7 identifies the threshold of activity limitation that would support a 6-month prognosis. The FAST Scale does not address the impact of comorbid and secondary conditions.

LCD = local coverage determination; ACE = angiotensin-converting enzyme; CHF = congestive heart failure; NYHA = New York Heart Association; ALS = amyotrophic lateral sclerosis; ADLs = activities of daily living; FAST Scale = Reisberg Functional Assessment Staging Scale

**Some fiscal intermediaries may have a list of specific secondary conditions and comorbidities that determine eligibility. However, some RHHIs, such as Palmetto GBA, have recently changed this policy, stating that because of the complexity of the condition, they now encourage the active participation of clinical staff in the identification and documentation of relevant comorbid or secondary conditions.[12]*

Clinical Judgment and Nontraditional Patients

Some frail, elderly patients present with no specific diagnosis, yet they appear to be declining in vitality and on a seemingly predictable trajectory toward death within the next several months. For these patients, hospice care is important for their (and their family members') overall well-being at this critical life juncture, so clinical judgment must come into play even more to assure timely referral to hospice.

Nontraditional candidates for hospice include older individuals with progressive functional impairment and continuous weight loss who may have several chronic conditions (eg, hypertension, coronary artery disease, diabetes), but no single imminently fatal disease process. They may have a recent acceleration in functional or cognitive decline and have made a decision not to pursue aggressive medical evaluation or treatment due to advanced age, poor general health, cognitive impairment, or excessive opportunity costs (high burden-to-benefit determination).

In elderly patients, one of the most sensitive but nonspecific indicators of limited life expectancy is an unexplained 10% weight loss over a period of 6 months, or a body mass index (BMI) < 22 kg/m2. Patients of any age with a BMI < 20 kg/m2 who are ill enough to be hospitalized, regardless of diagnosis, have the highest mortality in the 6 months after discharge. Coupled with weight loss, progressive difficulties with the activities of daily living (ADLs) are an important predictor of 6-month mortality, generally stronger than diagnosis, mental status, or intensive care unit admission. These factors are very important to recognize, document, and consider when caring for these patients, so that realistic and truly helpful conversations and care planning can take place before crises occur.