HOSPICE TERMINAL PROGNOSIS

Non-Disease Specific

What is the Six-Month Terminal Prognosis?

To be eligible for the hospice benefit, the patient must be considered to be terminally ill. Terminally ill means that the patient's life expectancy is 6 months or less, if the illness runs its normal course.

As a condition of payment under the Medicare hospice benefit, the six-month terminal prognosis must be supported in the medical record. The physician's clinical judgment must be supported by clinical information and other documentation that provides a basis for the six-month prognosis. Diagnosis alone may not support terminal prognosis; therefore, documentation in the medical record must support the terminal status.

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

Part I. Decline in Clinical Status Guidelines

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

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are 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
     1) Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract
     2) 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
     3) Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption
   - B. Symptoms
     1) Dyspnea with increasing respiratory rate
     2) Cough, intractable
     3) Nausea/vomiting poorly responsive to treatment
     4) Diarrhea, intractable
     5) Pain requiring increasing doses of major analgesics more than briefly

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C. Signs

1) Decline in systolic blood pressure to below 90 or progressive postural hypotension
2) Ascites
3) Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
4) Edema
5) Pleural/pericardial effusion
6) Weakness
7) Change in level of consciousness

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

1) Increasing pCO2 or decreasing pO2 or decreasing SaO2
2) Increasing calcium, creatinine or liver function studies
3) Increasing tumor markers (e.g. CEA, PSA)
4) 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 (See Part II, Section 2)
6. Progressive stage 3-4 pressure ulcers in spite of optimal care

Part II. Non-Disease Specific Baseline Guidelines (both of these should be met)

1. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%.
2. Dependence on assistance for two or more activities of daily living (ADLs)

A. Feeding
B. Ambulation
C. Continence
D. Transfer
E. Bathing
F. Dressing

See appendix for disease specific guidelines to be used with these (Part II) baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

Note: The word "should" in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is obligatory.

Part III. Co-Morbidities

Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

A. Chronic obstructive pulmonary disease
B. Congestive heart failure
C. Ischemic heart disease
D. Diabetes mellitus
E. Neurologic disease (CVA, ALS, MS, Parkinson's)
F. Renal failure
G. Liver Disease
H. Neoplasia
I. Acquired immune deficiency syndrome
J. Dementia

Where Do I Find More Information?

- Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf
- Local Coverage Determination (LCD) L34538, "Hospice Determining Terminal Status": https://www.cgsmedicare.com/hhh/coverage/index.html

