HOSPICE TERMINAL PROGNOSIS
Pulmonary Disease

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.

DISEASE SPECIFIC GUIDELINES

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.):

NOTE: These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines" described in Part II of the basic policy.

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) (e.g., 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/min.

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

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