

# **DRAFT POLICY**

## LCD for Draft LCD for Hospice - Determining Terminal Status

**Please note: This is a Draft policy.**

Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review. Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.

### Contractor Information

**Contractor Name-**

[National Government Services, Inc. \(formerly known as Associated Hospital Service\)](#)

**Contractor Number-**

00180

**Contractor Type-**

RHHI

### LCD Information

**LCD ID Number-**

DL25678

**LCD Title-**

Draft LCD for Hospice - Determining Terminal Status

**Contractor's Determination Number-**

Misc-AC-07-06-2

**AMA CPT / ADA CDT Copyright Statement-**

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### **CMS National Coverage Policy-**

Language quoted from Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

#### Title XVIII of the Social Security Act (SSA):

Section 1102 provides that the Secretaries of the Treasury, Labor and Health and Human Services shall make and publish such rules and regulations not inconsistent with the Social Security Act, as necessary to the efficient administration of the functions each is charged with under this Act.

Section 1812 (a)(4) and (d) provides the scope of benefits for Hospice care.

Section 1813 (a)(4) provides deductible and coinsurance information.

Section 1814 (a)(7) and (I) provides conditions of and limitations on payment for hospice care provided to an individual

Section 1862 (a)(1), (6) and (9) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, which constitute comfort items or where such expenses are for custodial care.

Section 1861 (dd) defines hospice care and the hospice program

Section 1871 provides that the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under the title.

#### Code of Federal Regulations

42 CFR Section 418 specifies services covered as hospice care and the conditions that a hospice program must meet in order to participate in the Medicare program.

#### CMS Publications:

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30:

Financial Liability Protections

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9:

## Coverage of Hospice Services under Hospital Insurance

### Primary Geographic Jurisdiction-

Connecticut  
Massachusetts  
Maine  
New Hampshire  
Rhode Island  
Vermont

### Secondary Geographic Jurisdiction-

### **Oversight Region-**

Region I

### **Projected Determination Effective Date-**

For services performed on or after 12/01/2007

### **Original Determination Ending Date-**

### **Revision Effective Date-**

### **Revision Ending Date-**

### **Indications and Limitations of Coverage and/or Medical Necessity-**

## 1. **Abstract:**

Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This LCD describes guidelines to be used by Regional Home Health Intermediaries (RHHIs) in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this LCD is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

## 2. **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 Part III 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.

- A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.
  1. Clinical Status:
    - a. Recurrent or intractable serious infections such as pneumonia, sepsis

or pyelonephritis;

- b. Progressive inanition as documented by:
  1. Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;
  2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
  3. Decreasing serum albumin or cholesterol;
- c. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

2. Symptoms:

- a. Dyspnea with increasing respiratory rate;
- b. Cough, intractable;
- c. Nausea/vomiting poorly responsive to treatment;
- d. Diarrhea, intractable;
- e. Pain requiring increasing doses of major analgesics more than briefly.

3. Signs:

- a. Decline in systolic blood pressure to below 90 or progressive postural hypotension;
- b. Ascites;
- c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease ;
- d. Edema;
- e. Pleural/pericardial effusion;
- f. Weakness;
- g. Change in level of consciousness.

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

- a. Increasing pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>;
- b. Increasing calcium, creatinine or liver function studies;
- c. Increasing tumor markers (e.g. CEA, PSA);
- d. Progressively decreasing or increasing serum sodium or increasing serum potassium;

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

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

7. Progression to dependence on assistance with additional activities of daily living See Part II, Section 2.

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

9. Increasing emergency room visits, hospitalizations, or physician's visits

related to hospice primary diagnosis.

**Part II.** Non-disease specific baseline guidelines (both of these should be met)

- A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.
- B. Dependence on assistance for two or more activities of daily living (ADLs):
  1. Ambulation;
  2. Continence;
  3. Transfer;
  4. Dressing;
  5. Feeding;
  6. Bathing.
- C. See Part III, Section II for disease specific guidelines to be used with these 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. Disease Specific Guidelines**

Note: These guidelines are to be used in conjunction with the Non-disease specific baseline guidelines described in Part II.

**Section I Cancer Diagnoses**

- 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; or
  2. Patient declines further disease directed therapy

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.

**Section II Non-Cancer Diagnoses**

**A. 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.

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:
    1. Vital capacity (VC) less than 30% of normal (if available);
    2. Dyspnea at rest;
    3. Patient declines mechanical ventilation.
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:
    1. Progression from independent ambulation to wheelchair to bed-bound status;
    2. Progression from normal to barely intelligible or unintelligible speech;
    3. Progression from normal to pureed diet;
    4. 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:
    1. Oral intake of nutrients and fluids insufficient to sustain life;
    2. Continuing weight loss;
    3. Dehydration or hypovolemia;
    4. Absence of artificial feeding methods, sufficient to sustain life, but not for relieving hunger.
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:
    1. Recurrent aspiration pneumonia (with or without tube feedings);
    2. Upper urinary tract infection, e.g., pyelonephritis;

3. Sepsis;
4. Recurrent fever after antibiotic therapy;
5. Stage 3 or 4 decubitus ulcer(s).

#### B. **Dementia due to Alzheimer's Disease and Related Disorders**

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.

1. Patients with dementia should show all the following characteristics:
  - a. Stage seven or beyond according to the Functional Assessment Staging Scale;
  - b. Unable to ambulate without assistance;
  - c. Unable to dress without assistance;
  - d. Unable to bathe without assistance;
  - e. Urinary and fecal incontinence, intermittent or constant;
  - f. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.
2. Patients should have had one of the following within the past 12 months:
  - a. Aspiration pneumonia;
  - b. Pyelonephritis;
  - c. Septicemia;
  - d. Decubitus ulcers, multiple, stage 3-4;
  - e. Fever, recurrent after antibiotics;
  - f. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

**Note:** This section is specific for Alzheimers disease and Related Disorders, and is not appropriate for other types of dementia.

#### C. **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 are patients who are either not candidates for surgical procedures or who decline those procedures. (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. Patients with congestive heart failure or angina should meet the criteria for the New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an inability to carry on any physical activity. 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 less than or equal to 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.

#### D. 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: HIV Disease (1 and 2 should be present; factors from 3 will add supporting documentation)

1. CD4+ Count < 25 cells/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 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 less than or equal to 50%
3. Documentation of the following factors will support eligibility for hospice care:
  - a. Chronic persistent diarrhea for one year; Persistent serum albumin < 2.5;
  - b. Concomitant, active substance abuse
  - c. Age > 50 years;
  - d. Absence of or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
  - e. Advanced AIDS dementia complex;
  - f. Toxoplasmosis;
  - g. Congestive heart failure, symptomatic at rest.
  - h. Advanced liver disease

#### E. Liver Disease

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 5 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 (< 400 ml/day) and urine sodium concentration < 10 mEq/l);
  - 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.

#### F. 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 pO<sub>2</sub> less than or equal to 55 mmHg; or oxygen saturation less than or equal to 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 pCO<sub>2</sub> greater than or equal to 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.

#### G. 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 < 10 cc/min (< 15 cc/min. for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure;
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. Immunosuppression/AIDS;
- g. Albumin < 3.5 gm/dl;
- h. Platelet count < 25,000;
- i. Disseminated intravascular coagulation;
- j. Gastrointestinal bleeding.

Chronic Kidney Disease: (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 <10 cc/min (< 15 cc/min for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure;
- 3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics);
- 4. Signs and symptoms of renal failure:
  - a. Uremia
  - b. Oliguria (< 400 cc/24 hours);
  - c. Intractable hyperkalemia (> 7.0) not responsive to treatment;
  - d. Uremic pericarditis;
  - e. Hepatorenal syndrome;
  - f. Intractable fluid overload, not responsive to treatment.

#### H. Stroke and Coma

Patients will be considered to be in the terminal stages 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% .
- 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 patient from continuing fluids/ foods necessary to sustain life and patient does not receive artificial nutrition and hydration.

##### Coma (any etiology):

- 1. Comatose patients with any 3 of the following on day three of coma:
  - a. abnormal brain stem response;
  - b. absent verbal response;
  - c. absent withdrawal response to pain;
  - d. serum creatinine > 1.5 mg/dl.
- 2. Documentation of the following factors will support eligibility for hospice care:
  - a. 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. Pyelonephritis;
    - 3. Refractory stage 3-4 decubitus ulcers;
    - 4. Fever recurrent after antibiotics.

3. Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
  - a. For non-traumatic hemorrhagic stroke:
    1. Large-volume hemorrhage on CT:
    2. Infratentorial: greater than or equal to 20 ml.;
    3. Supratentorial: greater than or equal to 50 ml.
  - b. Ventricular extension of hemorrhage;
  - c. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
  - d. Midline shift greater than or equal to 1.5 cm.;
  - e. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.
4. 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.

**Part IV.** 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, Parkinsons)
- F. Renal failure
- G. Liver Disease
- H. Neoplasia
- I. Acquired immune deficiency syndrome
- J. Dementia

### 3. **Other Comments:**

This Local Coverage Determination consolidates and replaces all previous policies and publications on this subject by Associated Hospital Services and United Government Services.

#### **Coverage Topic-**

Hospice Care

#### **Coding Information**



XX000

Not Applicable

**Diagnoses that Support Medical Necessity-**

**ICD-9 Codes that DO NOT Support Medical Necessity-**

**ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation-**

**Diagnoses that DO NOT Support Medical Necessity-**

## General Information

### Documentation Requirements-

Documentation certifying terminal status must contain enough information to support terminal status upon review. Documentation of the applicable criteria listed under the Indications section of this LCD would meet this requirement. If other clinical indicators of decline not listed in this LCD form the basis for certifying terminal status, they should be documented as well. Recertification for hospice care requires the same clinical standards be met as for initial certification, but they need not be reiterated. They may be incorporated by specific reference as part (or all) of the indication for recertification.

Documentation should paint a picture for the reviewer to clearly see why the patient is appropriate for hospice care and the level of care provided, i.e., routine home, continuous home, inpatient respite, or general inpatient. The records should include observations and data, not merely conclusions. However, documentation should comport with normal clinical documentation practices. Unless elements in the record require explanation, such as a non-morbid diagnosis or indicators of likely greater than six month survival, as stated below, no extra or additional record entries should be needed to show hospice benefit eligibility.

The amount and detail of documentation will differ in different situations. A patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than one with chronic lung disease. Patients with chronic lung disease, long term survival in hospice, or apparent stability can still be eligible for hospice benefits, but sufficient justification for a less than six-month prognosis should appear in the record.

If the documentation includes any findings inconsistent with or tending to disprove a less than six-month prognosis, they should be answered or refuted by other entries, or specifically addressed and explained. Most facts and observations tending to suggest a greater than six month prognosis are predictable and apparent, such as a prolonged stay in hospice or a low immediate mortality diagnosis, as stated above. But specific entries can also call for an answer, such as an opinion by one team member or recovery of ADLs when they were part of the basis for the initial declaration of eligibility. Also the lack of certain elements such as a tissue diagnosis for cancer will not negate eligibility, but does necessitate other supportive documentation.

Documentation submitted may include information from periods of time outside the billing period currently under review. Include supporting events such as a change in the level of activities of daily living, recent hospitalizations, and the known date of death (if you are billing for a period of time prior to the billing period in which death occurred).

Submitted documentation should always include the admission assessment, as well as any evaluations and Interdisciplinary Group (IDG) discussions used for recertification. Records that show the progression of the patient's illness are very helpful.

Documentation should support the level of care being provided to the patient during the time period under review, i.e. routine or continuous home or inpatient, respite or general. The reviewer should be able to easily identify the dates and times of changes in levels of care and the reason for the change.

## **Appendices-**

## **Utilization Guidelines-**

## **Sources of Information and Basis for Decision-**

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

1. All previously published UGS Local Medical Review Policies
2. Christakis N., Lamont, E., Extent and determinants of error in doctors prognoses in terminally ill patients: prospective cohort study British Medical Journal 2000; 320; 469-472
3. Friedman, B., et al, Barriers and Enablers to Hospice Referrals: An Expert Overview, J Palliative Medicine 2002;5; 73-84
4. ICD-9-CM 2003, 2002 Practice Management Information Corporation
5. Lamont, E et al, Prognostic Disclosure to Patients with Cancer near the End of Life Annals of Internal Medicine 2001; 134; 1097-1143
6. Medicare Contractor Medicare Directors Hospice Workgroup
7. Ogle, K. et al, Hospice and Primary Care Physicians: Attitudes, Knowledge, and Barriers AJ Hospice & Palliative Care 2003; 20; 41-51

8. Ogle, K et al, Physicians and Hospice Care: Attitudes, Knowledge and Referrals J Palliative Medicine 2002; 5; 85-92
9. Other Medicare contractors, specialty societies, and specialty consultants

**Advisory Committee Meeting Notes-**

This coverage determination does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this determination is undergoing development in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

**Start Date of Comment Period-**

06/01/2007

**End Date of Comment Period-**

07/16/2007

**Start Date of Notice Period-**

**Revision History Number-**

**Revision History Explanation-**

**Last Reviewed On Date-**

06/01/2007

**Related Documents-**

**Article(s)**

[A45194 - Hospice: Determining Terminal Status - Draft Supplemental Instructions Article](#)

or

[https://coverage.cms.fu.com/lcd/view\\_article\\_popup\\_front.asp?article\\_number=45194&article\\_version=2&contractor\\_id=87](https://coverage.cms.fu.com/lcd/view_article_popup_front.asp?article_number=45194&article_version=2&contractor_id=87)

**LCD Attachments**

There are no attachments for this LCD

**Draft Contact**

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