LOCAL COVERAGE DETERMINATION
LCD PACKET

Bear Valley Hospice LLC

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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 National Government Services (NGS) 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.

LOCAL COVERAGE DETERMINATION (LCD)
OVERVIEW 10-18-2013

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 National Government Services (NGS) 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.

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 these guidelines. 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 examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

OR

PART II. NON-DISEASE SPECIFIC BASELINE GUIDELINES

AND

PART III. DISEASE SPECIFIC GUIDELINES

Bear Valley Hospice LLC

Local Coverage Determination/Part of RN Assessment Upon Admission

DECLINE IN CLINICAL STATUS

DX:_____

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

Clinical Status:

- ☐ Recurrent or intractable serious infections such as pneumonia, sepsis, or pyelonephritis;

Progressive inanition as documented by:

- ☐ 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;
- ☐ Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
- ☐ Observation of ill-fitting cloths, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented and weight;
- ☐ Decreasing serum albumin or cholesterol.
- ☐ Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

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

Signs:

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

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

- ☐ Increasing pC02 or decreasing p02 or decreasing Sa02
- ☐ Increasing, calcium, creatinine, or liver function studies;
- ☐ Increasing tumor markers (e.g. CEA, PSA);
- ☐ Progressively decreasing or increasing serum sodium or increasing serum potassium.

B. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.

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

D. Progression to dependence on assistance with additional activities of daily living (see part II, Section 2).

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

F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

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Local Coverage Determination/Part of RN Assessment Upon Admission

NON-DISEASE SPECIFIC BASELINE

DX:_____

QUALIFYING CONDITIONS

Both A and B should be met.

A. PHYSIOLOGIC IMPAIRMENT OF FUNCTIONAL STATUS:
☐ Palliative Performance Score (PPS) below 70%

B. DEPENDENCE ON ASSISTANCE FOR TWO OR MORE ACTIVITES OF DAILY LIVING (ADLs):
☐ Ambulation
☐ Continence
☐ Transfer
☐ Dressing
☐ Feeding
☐ Bathing

C. 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.
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure (CHF)
☐ Ischemic Heart Disease
☐ Diabetes Mellitus
☐ Neurological Disease (CVA, ALS, MS, Parkinson's)
☐ Renal Failure
☐ Liver Disease
☐ Neoplasia
☐ Acquired Immune Deficiency Syndrome/HIV
☐ Dementia
☐ Refractory Severe Autoimmune Disease (Lupus or Rheumatoid Arthritis)

D. DISEASE SPECIFIC GUIDELINES
☐ See the disease specific guidelines to be used with these baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

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Local Coverage Determination/Part of RN Assessment Upon Admission

CANCER DIAGNOSIS

DX:_____

(Qualifying Conditions as check)

Either A or B should be present.

☐ A. Disease with metastases at presentation

☐ 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.

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____I have educated the family and or PCG and or staff in the facility of patient's disease progression, normal changes that will appear worsening of condition as part of the disease progression.

___ I have educated the family/PT and or PCG on general interventions for comfort once symptoms of worsening condition seen and to call hospice 24-hour number for any concern or questions.

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Bear Valley Hospice LLC

Local Coverage Determination Upon Admission

NON-CANCER DIAGNOSIS

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 may 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.

Patients are considered eligible for Hospice care if they do not elect tracheostomy and invasive ventilation and display evidence of critically impaired respiratory function (with or without use of NIPPV) and / or severe nutritional insufficiency (with or without use of a gastrostomy tube).

Critically impaired respiratory function is as defined by:

1. FVC < 40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs: Dyspnea at rest; Orthopnea; Use of accessory respiratory musculature; Paradoxical abdominal motion; Respiratory rate > 20; Reduced speech / vocal volume; Weakened cough; Symptoms of sleep disordered breathing; Frequent awakening; Daytime somnolence / excessive daytime sleepiness; Unexplained headaches; Unexplained confusion; Unexplained anxiety; Unexplained nausea.
2. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the above symptoms/signs.

Severe nutritional insufficiency is defined as:

1. Dysphagia with progressive weight loss of at least five percent of body weight with or without election for gastrostomy tube insertion.

_____ _____

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NON-CANCER DIAGNOSIS

DEMENTIA

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.

CHARACTERISTICS FOUND UPON VISIT:

- ☐ Stage 7 or beyond according to Functional Assessment Staging Scale
- ☐ Unable to ambulate without assistance
- ☐ Unable to dress without assistance
- ☐ Unable to bathe without assistance
- ☐ Urinary and fecal incontinence, intermittent or constant
- ☐ No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to 6 or fewer intelligible words

HAVE HAD ONE OF THE FOLLOWING WITHIN THE PAST 12 MONTHS:

- ☐ Aspiration Pneumonia
- ☐ Pyelonephritis
- ☐ Septicemia
- ☐ Decubitus ulcers, multiple, stage 3-4
- ☐ Fever, recurrent after antibiotics
- ☐ Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin<2.5 gm/dl

_____ _____

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NON-CANCER DIAGNOSIS

ES HEART DISEASE

(Please check signs and symptoms per assessment)

QUALIFYING CONDITIONS

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.

OTHER FINDINGS NOT LISTED AS FOLLOW:

____ I have seen the above patient in the location where patient resides and have checked qualifications for Diagnosis and Symptoms underlying worsening of clinical status and worsening symptoms in addition to underlying diagnosis.

____I have educated the family and or PCG and or staff in the facility of patient's disease progression, normal changes that will appear worsening of condition as part of the disease progression.

___ I have educated the family/PT and or PCG on general interventions for comfort once symptoms of worsening condition seen and to call hospice 24-hour number for any concern or questions.

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NON-CANCER DIAGNOSIS

HIV

QUALIFYING CONDITIONS

BOTH 1 and 2 should be present

1. CD4+count<25 cells/mcl or persistent (2 or more assays at least 1month apart) viral load > 100,000 copies/ml, plus one of the following:

- ☐ CNS lymphoma
- ☐ Untreated, or persistent despite treatment, wasting (loss of at least 10% of lean body mass)
- ☐ Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment or treatment refused
- ☐ Progressive multifocal leukoencephalopathy
- ☐ Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
- ☐ Visceral Kaposi's sarcoma unresponsive to therapy
- ☐ Renal failure in the absence of dialysis
- ☐ Cryptosporidium infection
- ☐ Toxoplasmosis, unresponsive to therapy

2. Decreased performance status, as measured by a Karnofsky Performance Scale value of 50% or less

ADDITIONAL FACTORS:

- ☐ Chronic persistent diarrhea for one year
- ☐ Persistent serum albumin<2.5 gm/dl
- ☐ Concomitant, active substance abuse
- ☐ Age > 50 years
- ☐ Advanced AIDS dementia complex
- ☐ Congestive heart failure, symptoms at rest
- ☐ Toxoplasmosis
- ☐ Advanced liver disease
- ☐ Absence of or resistance to effective antiretroviral, chemotherapeutic, and prophylactic drug therapy related to HIV disease

OTHER FIINDINGS:

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NON-CANCER DIAGNOSIS

LIVER DISEASE

(Qualifying Conditions as check)

BOTH 1 and 2 should be present

1.The patient should show both:

☐ Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5 and

☐ Serum Albumin < 2.5 gm/dl

2. End stage liver disease is present and the patient shows at least one of the following:

☐ Ascites, refractory to treatment or patient non-compliant

☐ Spontaneous bacterial peritonitis

☐ Hepatorenal syndrome: elevated creatinine and BUN with oliguria < 400ml/day and urine sodium concentration < 10meq/l

☐ Recurrent variceal bleeding, despite intensive therapy

ANY OF THE OTHER FACTORS AS FOLLOWS:

☐ Progressive malnutrition

☐ Muscle wasting with reduced strength and endurance

☐ Continued active alcoholism (>80 gm ethanol/day)

☐ Hepatocellular carcinoma

☐ Hepatitis B positive

☐ Hepatitis C refractory to interferon treatment

OTHER FINDINGS NOT LISTED AS FOLLOW:

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NON-CANCER DIAGNOSIS

PULMONARY DISEASE

(Qualifying Conditions as check)

BOTH 1 and 2 should be present

1. Severe chronic lung disease as evidence by:

☐ Disabling dyspnea at rest, poor 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.)

☐ Progression of end stage pulmonary disease, as evidenced by increasing ER visits or hospitalizations for pulmonary infection and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40ml/year is objective evidence for disease progression, but is not necessary to obtain.)

2. Hypoxemia at rest on room air, as evidenced by pO2<=55mmHg; or O2 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>50mmHg. (This value may be obtained from recent [within 3 months] hospital records.)

The following factors also lend support to terminal diagnosis of pulmonary disease.

☐ Right heart failure (RHF) secondary to pulmonary disease (cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).

☐ Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months

☐ Resting tachycardia>100/min

OTHER FINDINGS NOT LISTED AS FOLLOW:

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Local Coverage Determination/Part of RN Assessment Upon Admission

NON-CANCER DIAGNOSIS

ACUTE RENAL FAILURE

(Qualifying Conditions as check)

BOTH 1 and EITHER 2,3, or 4 should be present.

☐ 1. **Patient not pursuing dialysis or renal transplant, or is discontinuing dialysis.** As with any other condition, an individual with renal disease is eligible for the Hospice Benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.
When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the Hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.
☐ 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. Estimated **glomerular filtration rate** (GFR) < 10 ml/min.

Additional Comorbid Factors:
☐ Mechanical ventilation
☐ Malignancy (other organ system)
☐ Chronic lung disease
☐ Advanced liver disease
☐ Immunosuppression/AIDS
☐ Albumin < 3.5 gm/dl
☐ Platelet count < 25,000
☐ Disseminated intravascular coagulation
☐ Gastrointestinal bleeding

OTHER FINDINGS NOT LISTED AS FOLLOW:

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NON-CANCER DIAGNOSIS

CHRONIC KIDNEY DISEASE

(Please check signs and symptoms per assessment)

QUALIFYING CONDITIONS

Chronic Kidney Disease (**1 and either 2, 3, or 4 should be present**. Factors from 5 will lend supporting documentation.)

☐ 1. **The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis**; As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.

☐ 2. **Creatinine clearance** < 10 cc/min (<15 cc/min for diabetics); or < 15 cc/min (< 20 cc/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:
Uremia;
Oliguria (< 400 cc/24 hours);
Intractable hyperkalemia (> 7.0) not responsive to treatment;
Uremic pericarditis;
Hepatorenal syndrome;
Intractable fluid overload, not responsive to treatment.

☐ 5. Estimated glomerular filtration rate (GFR) < 10 ml/min.

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Local Coverage Determination/Part of RN Assessment Upon Admission

NON-CANCER DIAGNOSIS

STROKE AND COMA

(Qualifying Conditions as check)

Patients will be considered to be in the terminal stages of stroke or coma (life expectancy of six month or less) if they meet the following criteria:

STROKE:

- ❑ Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40%.
- ❑ 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.

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COMA (any etiology):

- ❑ 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.
- ❑ 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:
    i. Aspiration pneumonia;
    ii. Pyelonephritis;
    iii. Refractory stage 3-4 decubitus ulcers;
    iv. Fever recurrent after antibiotics.
- ❑ Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
  a. For non-traumatic hemorrhagic stroke:
    i. Large-volume hemorrhage on CT:
      1. Infratentorial: greater than or equal to 20 ml.;
      2. Supratentorial: greater than or equal to 50 ml.;
    ii. Ventricular extension of hemorrhage;
    iii. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
    iv. Midline shift greater than or equal to 1.5 cm;
    v. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.
  b. For thrombotic/embolic stroke:
    i. Large anterior infarcts with both cortical and subcortical involvement;
    ii. Large bihemispheric infarcts;
    iii. Basilar artery occlusion;
    iv. Bilateral vertebral artery occlusion.

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