

# Local Coverage Determination (LCD): Hospice Determining Terminal Status (L34538)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	HHH MAC	15004 - HHH MAC	J - 15	Colorado District of Columbia Delaware Iowa Kansas Maryland Missouri - Entire State Montana North Dakota Nebraska Pennsylvania South Dakota Utah Virginia West Virginia Wyoming

## LCD Information

### Document Information

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L34538

**Original Effective Date**

For services performed on or after 10/01/2015

**Original ICD-9 LCD ID**

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**Revision Effective Date**

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**LCD Title**

Hospice Determining Terminal Status

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N/A

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N/A

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**Notice Period Start Date**

N/A

**AMA CPT / ADA CDT / AHA NUBC Copyright****Notice Period End Date**

## Statement

N/A

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## CMS National Coverage Policy

- Social Security Act, Sections 1102, 1812 (a)(4) and (d); 1813 (a) (4); 1814 (a)(7) and (I); 1862 (a)(1), (6), and (9); 1861 (dd), 1871
- 42 CFR Part 418
- CMS Publication 100-02, Medicare Benefit Policy, Chapter 9.
- CMS Publication 100-04, Medicare Claims Processing, Chapter 30.

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

#### GENERAL INDICATIONS:

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 policy describes guidelines to be used by

Home Health & Hospice (HH&H) MAC 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 policy 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 6 months or less. Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy not included in these guidelines is provided.

If a patient improves 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.

## **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.

#### 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 pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>
- 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  $\geq 7A$  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%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

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

### **LIMITATIONS:**

Medical review of records of hospice patients that do not document that patients meet the guidelines set forth herein may result in denial of coverage unless other clinical circumstances reasonably predictive of a life expectancy of six months or less are provided.

The condition of some patients receiving hospice care may stabilize or improve during or due to that care, with the expectation that the stabilization or improvement will not be brief and temporary. In such circumstances, if the patient's condition changes such that he or she no longer has a prognosis of life expectancy of six months or less, and that improvement can be expected to continue outside the hospice setting, then that patient should be discharged from hospice.

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.

### **Summary of Evidence**

N/A

### **Analysis of Evidence (Rationale for Determination)**

# Coding Information

## Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

## Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

## CPT/HCPCS Codes

### Group 1 Paragraph:

N/A

### Group 1 Codes:

CODE	DESCRIPTION
XX000	Not Applicable

## ICD-10 Codes that Support Medical Necessity

### Group 1 Paragraph:

N/A

### Group 1 Codes:

ICD-10 CODE	DESCRIPTION
XX000	Not Applicable

## ICD-10 Codes that DO NOT Support Medical Necessity

**Additional ICD-10 Information**

N/A

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# General Information

**Associated Information****General Guidelines:**

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 policy would meet this requirement. If other clinical indicators of decline not listed in this policy such as psychological and spiritual factors 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. Note, however, paragraph 3 of 'General Indications' under "Indications and Limitations of Coverage and/or Medical Necessity" regarding patients who improve or stabilize.

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 expectations 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 6-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. Thus a patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than a chronic lung disease patient. These situations are obvious. 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 6-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 6 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 documentation elements such as a tissue diagnosis for cancer will not create non-eligibility for the hospice benefit, but does necessitate other supportive documentation.

Documentation submitted may include information from periods of time that fall 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.)

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.

In addition the documentation must comply with the requirements found in accordance with CMS IOM 100-02 Chapter 9 Section 20.

### **Disease Specific Guidelines**

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

### **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
  - 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:
    - i. Vital capacity (VC) less than 30% of normal (if available);
    - ii. Dyspnea at rest;
    - iii. Patient declines mechanical ventilation; external ventilation used for comfort measures only.
- 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:
    - i. Progression from independent ambulation to wheelchair to bed bound status;



- ii. Progression from normal to barely intelligible or unintelligible speech;
  - iii. Progression from normal to pureed diet;
  - iv. 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:
- i. Oral intake of nutrients and fluids insufficient to sustain life;
  - ii. Continuing weight loss;
  - iii. Dehydration or hypovolemia;
  - iv. 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:
    - i. Recurrent aspiration pneumonia (with or without tube feedings);
    - ii. Upper urinary tract infection, e.g., pyelonephritis;
    - iii. Sepsis;
    - iv. Recurrent fever after antibiotic therapy;
    - v. 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. Patients with dementia should show all the following characteristics:

1. Stage seven or beyond according to the Functional Assessment Staging Scale;
2. Unable to ambulate without assistance;
3. Unable to dress without assistance;
4. Unable to bathe without assistance;
5. Urinary and fecal incontinence, intermittent or constant;
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia;
2. Pyelonephritis or other upper urinary tract infection;
3. Septicemia;
4. Decubitus ulcers, multiple, stage 3-4;
5. Fever, recurrent after antibiotics;
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin Note: This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct 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 is not a candidate for a surgical procedure or has declined a procedure. (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. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an inability to carry on any physical activity without discomfort. 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  $\leq 20\%$ , 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. (1 and 2 should be present; factors from 3 will add supporting documentation):

1. CD4+ Count 100,000 copies/ml, plus one of the following:

- CNS lymphoma;
- Untreated, or persistent despite treatment, wasting (loss of at least 10% 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 the Karnofsky Performance Status (KPS) scale, of  $\leq 50\%$

3. Documentation of the following factors will support eligibility for hospice care:

- Chronic persistent diarrhea for one year;
- Persistent serum albumin  $< 2.5$ ;
- Concomitant, active substance abuse;
- Age  $> 50$  years;
- Absence of, or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
- Advanced AIDS dementia complex;
- Toxoplasmosis;
- Congestive heart failure, symptomatic at rest;
- 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. 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 (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.

Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare hospice

benefit, but if a donor organ is procured, the patient should be discharged from hospice.

## **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  $pO_2 \leq 55$  mmHg; or oxygen saturation  $\leq 88\%$ , determined either by arterial blood gases or oxygen saturation monitors; (These values may be obtained from recent hospital records.) OR Hypercapnia, as evidenced by  $pCO_2 \geq 50$  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 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. Sepsis;
  - g. Immunosuppression/AIDS;
  - h. Albumin i. Cachexia;
  - j. Platelet count <25,000;
  - k. Disseminated intravascular coagulation;
  - l. Gastrointestinal bleeding.

### **Chronic 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 3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics);
4. Signs and symptoms of renal failure:
  - a. Uremia;

- b. Oliguria (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 & Coma**

Patients will be considered to be in the terminal stage 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% or less;
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 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 the patient from receiving food and fluids necessary to sustain life, in a patient who declines or does not receive artificial nutrition and hydration.

### **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:

Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:

- a. Aspiration pneumonia;
- b. Upper urinary tract infection (pyelonephritis);
- c. Sepsis;
- d. Refractory stage 3-4 decubitus ulcers;
- e. Fever recurrent after antibiotics.

Documentation of diagnostic imaging factors which support poor prognosis after stroke include:

A. For non-traumatic hemorrhagic stroke:

1. Large-volume hemorrhage on CT:
  - a. Infratentorial:  $\geq 20$  ml.;
  - b. Supratentorial:  $\geq 50$  ml.
2. Ventricular extension of hemorrhage;
3. Surface area of involvement of hemorrhage  $\geq 30\%$  of cerebrum;
4. Midline shift  $\geq 1.5$  cm.;
5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.

B. 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.

## Sources of Information

Medicare Contractor Medical Directors' Hospice Workgroup

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N. Christakis, E. Lamont. Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. British Medical Journal 2000; 320; 469-472.

E. Lamont, N. Christakis. Prognostic disclosure to patients with cancer near end of life. Annals of Internal Medicine 2001; 134; 1097-1143.

This policy consolidates, simplifies and supercedes the several current hospice local medical review policies on determining terminal status previously implemented by this contractor whose references are incorporated herewith.

## Bibliography

N/A

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## Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2015	R2	R3  Revision Effective:N/A  Revision Explanation: Annual review no changes made.	<ul style="list-style-type: none"><li>Other (Annual Review)</li></ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>DATE (05/31/2018): At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>R2 Revision Effective: N/A Revision Explanation: Annual review no changes made.</p>	
10/01/2015	R1	<p>R1 Revision Effective: N/A Revision Explanation: Annual review no changes made.</p>	<ul style="list-style-type: none"> <li>Other (Annual Review)</li> </ul>

## Associated Documents

### Attachments

N/A

### Related Local Coverage Documents

N/A

### Related National Coverage Documents

N/A

### Public Version(s)

Updated on 05/31/2018 with effective dates 10/01/2015 - N/A

Updated on 04/27/2016 with effective dates 10/01/2015 - N/A

Updated on 03/13/2014 with effective dates 10/01/2015 - N/A

# Keywords

N/A