Quick Reference Guide

For Determining Hospice Eligibility

Hospice of Palm Beach County
Hospice by the Sea
trustbridge

Hospice of Palm Beach County
Hospice by the Sea
trustbridge

Vision

To provide an unmatched healthcare experience for families in their time of need.

Mission

To provide families with access to compassionate, expert and professional healthcare services in their time of need, throughout their lifespan.

Values

- Excellence
- Integrity
- Teamwork
- Compassion
- Accountability
- Pride

When is a Patient Ready for Hospice Care?

Patients are eligible for hospice care when a physician certifies a likely prognosis of 6 months or less, based on their clinical judgment regarding the normal course of the illness. These guidelines form a reasonable approach to determining life expectancy and are based on available research and experience. Most hospice patients have a diagnosis of cancer, end-stage dementia or cardiopulmonary disease but any serious illness may contribute to a terminal prognosis.

Not every hospice-eligible patient will meet these guidelines, especially those who suffer from multiple serious chronic diseases or who are experiencing a rapid decline. A physician's professional judgment remains the ultimate standard.

Trustbridge is committed to providing hospice care to every eligible individual, regardless of their ability to pay.

What is Hospice Care?

Hospice is palliative medical and supportive care that focuses on quality of life and symptom management – the most important needs of people in the last 6 months of life. Most hospice patients receive care in their home or their place of residence, such as a nursing home or assisted-living facility. Some require short-term aggressive symptom management in one of the Trustbridge inpatient units.

Hospice is also a benefit covered by Medicare, Medicaid, and most private insurance. On admission, hospice becomes responsible for care coordination, delivery and payment for conditions contributing to the terminal prognosis. Pre-authorization is required for services outside the hospice plan of care.

Contact Trustbridge Access with any questions **844.422.3648**.

Visual Pain Scale

0-10 Escala Numérica de la Intensidad de Dolor (Spanish)

0-10 Meziré Ki Valé Doulé Ou Genyen Ak Nimébo Sw-a-yo (Creole)

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
Ningún Dolor		Dolor moderado		Dolor peor posible	
Pa gen doulé di tou		Y on doulé ki pa tro fo		Y on doulé pi fó anpil	

844.422.3648 • trustbridge.com

From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal Activity; No Evidence of Disease	Full	Normal	Full
90%	Full	Normal Activity; Some Evidence of Disease	Full	Normal	Full
80%	Full	Normal Activity with Effort; Some Evidence of Disease	Full	Normal or Reduced	Full
70%	Reduced	Unable Normal Job / Work; Some Evidence of Disease	Full	Normal or Reduced	Full
60%	Reduced	Unable Hobby / House Work; Significant Disease	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to Do Any Work; Extensive Disease	Considerable Assistance Required	Normal or Reduced	Full or Confusion
40%	Mainly in Bed	Unable to Do Any Work; Extensive Disease	Mainly Assistance	Normal or Reduced	Full or Drowsy or Confusion
30%	Totally Bed Bound	Unable to Do Any Work; Extensive Disease	Total Care	Reduced	Full or Drowsy or Confusion
20%	Totally Bed Bound	Unable to Do Any Work; Extensive Disease	Total Care	Minimal Sips	Full or Drowsy or Confusion
10%	Totally Bed Bound	Unable to Do Any Work; Extensive Disease	Total Care	Mouth Care Only	Drowsy or Coma
0%	Death	—	—	—	—

Anderson, Fern et al. (1996) *Palliative Performance Scale (PPS) a new tool*. Journal of Palliative Care 12 (1), 5-11.

ECOG Performance Status for Cancer Diagnosis

0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about > 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair > 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Oken, M.M. et al. (1982) *Toxicity and Response Criteria of the Eastern Cooperative Oncology Group*. American Journal of Clinical Oncology 5: 649-655.

FAST Scale for Alzheimer's Disease

Scale	Characteristic
1	No difficulty either subjectively or objectively
2	Complains of forgetting location of objects
3	Decreased job functioning evident to co-workers; difficulty traveling to new locations
4	Decreased ability to perform complex tasks
5	Requires assistance in choosing proper clothing for the day, season or occasion
6a	Improperly putting on clothes without assistance or cueing
6b	Unable to bathe properly
6c	Inability to handle mechanics of toileting
6d	Urinary incontinence
6e	Fecal incontinence
7 = Hospice Referral	
7a	Speaking ability limited to $\leq$ 6 intelligible words
7b	Speech ability limited to single intelligible word
7c	Cannot walk without personal assistance
7d	Cannot sit up without assistance
7e	Loss of ability to smile
7f	Unable to hold up head independently

Reisberg, B (1988) *Functional Assessment Staging*. Psychopharmacology Bulletin 24: 653-659.

NYHA Classification

Class	Symptoms
I	Cardiac disease, but no symptoms and no limitation in ordinary physical activity; e.g., shortness of breath when walking, climbing stairs etc.
II	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
III	Marked limitation in activity due to symptoms, even during less-than-ordinary activity; e.g., walking short distances (20–100 m). Comfortable only at rest.
IV	Severe limitations. Experiences symptoms even while at rest. Mostly bed-bound patients.

The Criteria Committee for the New York Heart Association. Nomenclature and Criteria for Disease, Sixth Edition. Little, Brown and Company. 1964.

The Criteria Committee for the New York Heart Association. Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels Ninth Edition. Little, Brown and Company. 1994. Pages 253-255.

Mortality Risk Index for Nursing Home Residents

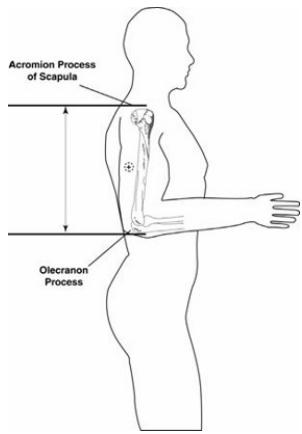
Indicator	Points
Complete dependence with ADLs	1.9
Male Gender	1.9
Cancer	1.7
CHF	1.6
O2 therapy needed within 14 days	1.6
SOB	1.5
< 25% of meals eaten at most meals	1.5
Unstable medical condition	1.5
Bowel incontinence	1.5
Bedfast	1.4
Age > 83 years	1.4
Not awake for most of day	1.4

Risk of Estimate of Death in 6 Months

% Risk	Total Points
8.9%	0
10.8%	1-2
22.2%	3-5
40.4%	6-8
57.0%	9-11
70%	≥ 12

Porock et al., (2010) The MDS Mortality Risk Index: The evolution of a method for predicting 6-month mortality in nursing home residents. BMC Research Notes 3:200.

Mid-Upper Arm Circumference Measurement Protocol (MAC)



1. Position the patient: Have the patient stand upright with the weight evenly distributed on both feet, the shoulders relaxed, and the right arm hanging loosely at the sides (flexing or tightening the arm muscles will yield an inaccurate measurement).

2. Take the measurement: Stand facing the right side of the study patient. Wrap the measuring tape around the arm at the level of the upper arm midpoint mark. Position the tape perpendicular to the long axis of the upper arm and make sure the tape is level around the circumference. Pull the two ends of the overlapping tape together so that the zero end sits below the measurement value and the result lies on the lateral aspect of the arm (not the posterior surface). Check that the tape fits snugly around the arm but does not compress the skin. Take the measurement to the nearest 0.1 cm.

Adapted from PhenX Toolkit version June 30 2010, Ver 3.3 (www.phenxtoolkit.org) is supported by NHGRI. Award No. U01 HG004597.

Model for End-Stage Liver Disease (MELD) Score

MELD uses the patient's values for serum bilirubin, serum creatinine, and the international normalized ratio for prothrombin time (INR) to predict survival. For calculating MELD Score: http://www.mayoclinic.org/meld/mayomodel6.html

In interpreting the MELD Score in hospitalized patients, the 3-month mortality is:

- 40 or more — 71.3% mortality
- 30–39 — 52.6% mortality
- 20–29 — 19.6% mortality
- 10–19 — 6.0% mortality
- <9 — 1.9% mortality

Ebell, M. (2006) *Predicting Prognosis for Patients with End Stage Liver Disease.* American Family Physician, Nov 15;74(10):1762-1763.

Activities of Daily Living (ADL)

	Independent	Moderate Impairment	Severe Impairment	Complete Impairment
Bathing				
Dressing				
Toileting				
Transfers				
Continence				
Feeding				

Mild: < 25% of time, occasionally interferes with day-to-day life
Moderate: < 50% of time or < 3X/week, interferes with day-to-day life
Severe: > 50% of time or 4-6X/week, partially disrupts day-to-day life
Complete: > 95% of time or daily, totally disrupts day-to-day life

Instrumental Activities of Daily Living (IADL)

	Independent	Moderate Impairment	Severe Impairment	Complete Impairment
Financial management				
Food preparation				
Housekeeping				
Caregiver burden				
Laundry				
Medication administration				
Transportation				
Shopping				
Telephone use				

Mild: < 25% of time, occasionally interferes with day-to-day life
Moderate: < 50% of time or < 3X/week, interferes with day-to-day life
Severe: > 50% of time or 4-6X/week, partially disrupts day-to-day life
Complete: > 95% of time or daily, totally disrupts day-to-day life

Determining Relatedness

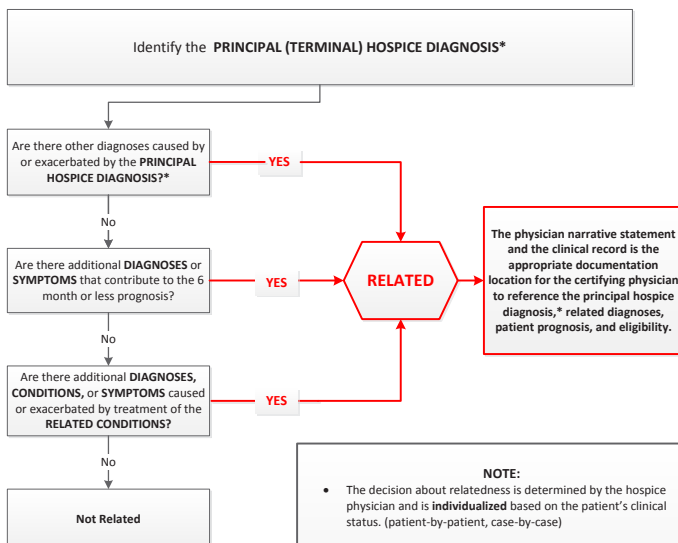
Determining Relatedness to the Terminal Prognosis Process Flow

National Hospice and Palliative Care Organization

Physician uses all available information to evaluate for:

- Terminal prognosis of 6 months or less
- Terminal and related diagnoses that contribute to the terminal prognosis
- Symptoms caused or exacerbated by terminal diagnosis, related diagnosis or treatment of terminal and related diagnoses

Note: Determining relatedness is a **continuous process** by the hospice physician which takes into account the changes in the patient's condition.



NOTE:

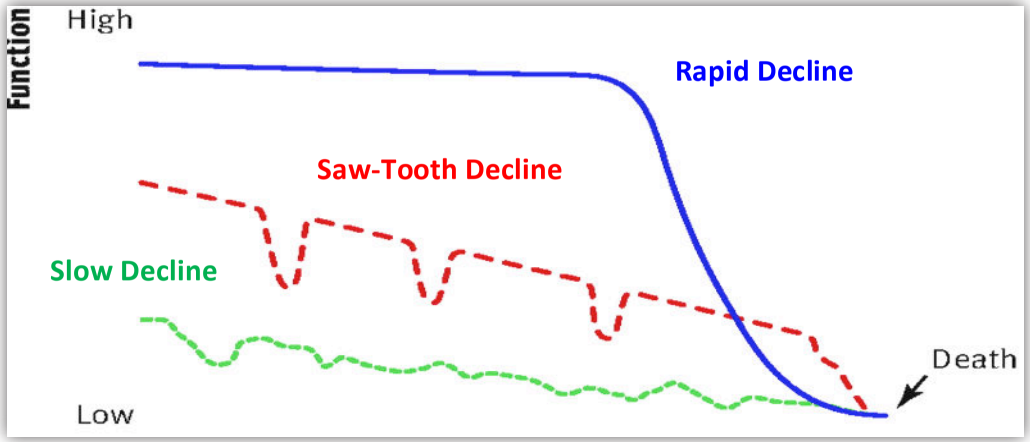
- The decision about relatedness is determined by the hospice physician and is **individualized** based on the patient's clinical status. (patient-by-patient, case-by-case)
- Decisions about relatedness change as the patient's condition changes.
- Clinical examples related to this process flow are included in the "Determining Relatedness in Hospice" resource.

The following are used as equivalent terms:
terminal hospice diagnosis = principal hospice diagnosis = primary terminal diagnosis = primary hospice condition

© National Hospice and Palliative Care Organization, December 2014, Version 1.0

National Hospice and Palliative Care Organization

Disease Trajectories



Use the following pages of Local Coverage Determination (LCD) Categories to identify the primary and any/all related diagnosis(es).

General

Many people in the last 6 months of life have multiple factors contributing to their terminal prognosis. Describe how the overall functional and nutritional decline create a disease burden and disability with prognosis of < 6 months. Include as many objective measures as possible supporting the prognosis.

General measures of decline in terminally ill patients:

- Emergency room visits or hospitalizations (frequency, dates)
- Falls (frequency, dates, injuries)
- Infections (frequency, dates, type of infection and treatment)
- Pressure ulcers (stage, dates, response to treatment)
- Changes in diet because of impaired function (type, dates)
- Weight loss (current weight, lost weight, time frame of loss)
- Palliative performance status (current, time frame of change)
- Cognitive impairment (describe, time frame of change)
- Personal care required (ADL loss, time frame of change)

Alzheimer's, Dementia, Neurologic Diseases

End-Stage Alzheimer's Disease and Other Dementias

- Disease trajectory: Slow decline
- FAST stage 7 (Alzheimer's) or comparable impairments (other dementias)
  - Incontinent of bladder and bowels on a regular basis
  - Speech & communication diminished or absent
  - Walking requires assistance or is lost completely
- Contributing conditions
  - Impaired nutrition with dysphagia or refusal to eat
  - Aspiration pneumonia
  - Recurrent upper urinary tract infections or septicemia
  - Pressure ulcers, stage 3-4
  - Mortality risk score > 9
- ICD-10 codes commonly used
  - G30.1 Alzheimer's disease with late onset
  - G31.1 Senile degeneration of brain
  - G31.83 Dementia with Lewy Bodies
  - I69.91 Cognitive defects from CVA

Reisberg B: Dementia: A systematic approach to identifying reversible causes; Geriatrics, 41: 30, 1986.

End-Stage Neurologic Diseases

- Disease trajectory: Slow decline
- Common conditions vary depending on diagnosis but may include
  - Muscle wasting and weakness
  - Paralysis
  - Dysphagia with aspiration and/or weight loss
  - Weight loss despite nutritional support
  - Respiratory failure
  - Pressure ulcers
- ICD-10 codes commonly used
  - G20 Paralysis agitans (Parkinson's disease)
  - I63.30 Cerebral thrombosis
  - G35 Multiple sclerosis
  - G12.21 Amyotrophic lateral sclerosis (Lou Gehrig disease)

End-Stage Cancer

- Disease trajectory: Rapid decline
- Common conditions
  - Malignancy, recurrent after treatment or treatment not recommended/desired
  - Solid tumors with metastases to brain, lung, liver, abdomen or other organ
- Bone metastases with spinal cord involvement
  - Hematologic malignancy, recurrent after treatment
- Common symptoms
  - Fatigue
  - Falling performance status (PPS < 50% or ECOG 3-4)
  - Nutritional impairment and weight loss
- ICD-10 codes commonly used
  - C34.90 Lung malignancy, non-small cell
  - C50.919 Breast malignancy
  - C18.9 Colon malignancy
  - C64.9 Kidney malignancy
  - C56.9 Ovary malignancy
  - C71.9 Brain malignancy
  - C61 Prostate malignancy
  - C67.9 Bladder malignancy
  - C25.9 Pancreatic malignancy
  - C76.0 Head and neck malignancies
  - C43.0 Melanoma with metastases

Heart Disease

End-Stage Congestive Heart Failure

- Disease trajectory: Saw-toothed decline
- Common conditions
  - Left heart failure with ejection fraction < 20%
  - NYHA class IV: Shortness of breath at rest or with minimal exertion
  - Oxygen-dependent
  - Increasing dependence in daily activities
  - Optimal medical therapy ineffective or not tolerated
- ICD-10 codes commonly used
  - I42.9 Cardiomyopathy
  - I50.23 Systolic heart failure
  - I50.33 Diastolic heart failure

Pantilat, S.Z., et al.: Palliative care for patients with heart failure, JAMA 2004, May 26:291(20):2476-82.

End-Stage Coronary Disease

- Common conditions
  - NYHA class IV: Angina chest pain at rest or with minimal exertion
  - Symptomatic despite nitrate therapy
  - Invasive procedures not recommended or declined

Contributing Factors

- Symptomatic arrhythmias
- History of CPR
- History of syncope
- Cardiogenic brain embolism
- HIV disease
- Renal failure
- Other advanced chronic diseases

- ICD-10 codes commonly used
  - I25.10 Arteriosclerotic cardiovascular disease

Liver Disease

End-Stage Liver Disease

- Disease trajectory: Saw-toothed decline
- Impaired hepatic function severe enough to result in both:
  - Prothrombin time (PT) > 5 seconds over control or INR > 1.5
  - Serum albumin < 2.5 gm/d
- At least one of the following
  - Ascites, refractory to treatment
  - Spontaneous bacterial peritonitis
  - Elevated BUN/Creatinine with oliguria < 400 ml day, urine sodium < 10 mEq/L
  - Hepatic encephalopathy, refractory to treatment
  - Variceal bleeding, refractory to therapy
- Contributing conditions
  - Weight loss and malnutrition
  - Muscle wasting and weakness
  - Continued active alcoholism
  - MELD score > 30
  - Hepatocellular carcinoma
  - HbsAg positive
  - Hepatitis C refractory to treatment
- ICD-10 codes commonly used
  - K70.30 Alcoholic Cirrhosis of Liver
  - K74.60 Cirrhosis of Liver without Alcohol
  - K72.90, K72.91 Hepatic Encephalopathy

Lung Disease

End-Stage Lung Disease

- Disease trajectory: Saw-toothed decline
- Common conditions
  - Dyspnea at rest or with minimal exertion
  - Poor response to bronchodilator therapy
  - FEV1 < 30% predicted post-bronchodilator
  - O2 saturation < 88% on room air or PCO2 > 50 mmHg
  - Progressive disease
  - Frequent hospitalization or emergency department visits
  - Frequent bronchitis or pneumonia
  - Unintentional weight loss > 10% body weight over 6 months
  - Increasing need for assistance in daily activity
- Contributing factors
  - Right heart failure, cor pulmonale
  - Continuous oxygen therapy
  - Resting tachycardia > 100 bpm
  - Steroid dependence
  - Cyanosis
- ICD-10 codes commonly used
  - J44.1, J44.9 COPD
  - J69.0 Aspiration pneumonia with T17.218 Gastric contents in pharynx
  - J18.9 Pneumonia

Renal Disease

End-Stage Renal Disease

- Disease trajectory: Saw-toothed decline
- Common conditions
  - Dialysis needed but not recommended or not desired
  - Oliguria < 400 ml/day
  - Potassium > 7 mg/dl
  - Volume overload, recurrent despite treatment
  - Creatinine > 8 mg/dl (> 6 mg/dl for diabetic nephropathy)
  - Platelets < 25,000
- Contributing factors
  - Delirium
  - Edema
  - Anorexia
  - Myoclonus or seizures
- ICD-10 codes commonly used
  - N18.9 End-stage renal disease
  - Code first cause, if known

HIV

- Disease trajectory: Saw-toothed decline
- Common conditions
  - o CD4+ count < 25 cells/mcL
  - o Viral load > 100,000 copies/ml
  - o Significant infectious or malignant complications, not responding to treatment
    - Mycobacterium avium complex (MAC) infection
    - Cryptosporidium infection
    - Toxoplasmosis infection
    - Systemic lymphoma
    - Visceral Kaposi's sarcoma
  - o End-stage renal failure
  - o Progressive multifocal leukoencephalopathy (PML)
  - o Weight loss
  - o PPS < 50%
- Contributing factors
  - o Chronic persistent diarrhea
  - o Persistent serum albumin < 2.5 gm/dL
  - o Active substance abuse
  - o Age > 50 years
  - o Advanced AIDS dementia
  - o Congestive heart failure
- ICD-10 codes commonly used
  - o B20

Building Blocks for ***Compassionate Care***

Physician Billing for Medicare Hospice Patients

Hospice attending physician services:

Bill Medicare Part B

- If you are the hospice attending physician chosen by the patient, you may continue to bill Medicare B as usual, adding a modifier:
    - o GV = care related to the terminal prognosis
    - o GW = care NOT related to the terminal prognosis

All other physician services for care related to the terminal prognosis:

Bill Trustbridge

- Obtain pre-authorization from the Care Team
- Have a "Physician Consulting Agreement" with Trustbridge. Contact contractadmin@Trustbridge.com or call 561-227-5188
- Submit itemized bill to Trustbridge using CMS 1500 form
    - o Receive payment from Trustbridge at agreed-upon rate

Medications, diagnostic testing or procedures related to the terminal prognosis:

Bill Trustbridge

- Obtain pre-authorization from the Care Team
- Have a "Billing Agreement" with Trustbridge. Contact contractadmin@Trustbridge.com or call 561-227-5188
- Submit itemized bill to Trustbridge
    - o Receive payment from Trustbridge at agreed-upon rate

To submit a claim:
ATTN: Accounting Department
Trustbridge Health
5300 East Avenue
West Palm Beach, FL 33407

Contact Trustbridge for assistance:
Contact your Trustbridge representative
or call 561-227-5294

Email to accountspayable@Trustbridge.com

One team, one goal to continually embrace each patient and family through the journey no one wants to walk.

844.422.3648 | trustbridge.com

Licensed since 1981. Accredited by The Joint Commission.
501(c)(3) not-for-profit organization.
Jewish Accreditation by The Palm Beach County Board of Rabbis, Inc.

Copyright © 2021 Trustbridge, Inc.
No reproduction allowed without expressed, written permission. All rights reserved. Direct inquiries to Senior Director of Marketing at 561.848.5200

03/2021