QUICK REFERENCE GUIDE

FOR DETERMINING HOSPICE ELIGIBILITY

HOSPICE OF PALM BEACH COUNTY AND BROWARD COUNTY
Your nonprofit end-of-life care provider

888.848.5200
hpbc.com / hobc.org
Vision, Mission & Values

OUR VISION
To create a world where everyone receives great service at the end of life and no one is afraid.

OUR MISSION
To provide great healthcare experience to patients and families by:

- Caring for everyone who needs and wants our services
- Establishing trust
- Empowering staff to meet the needs of our patients and families
- Focusing on compliance, education, accountability and ethics
- Operating in a fiscally responsible manner which allows us to be competitive and innovative
- Being a great place to work that fosters a passion for teamwork, flexibility, competition and service excellence

OUR VALUES
- Put patients and families first
- Do whatever it takes
- Respect each other
- Do your best every day
Coverage of hospice care depends upon a physician’s certification of an individual’s prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course. Recognizing that determination of life expectancy during terminal illness is difficult. Palmetto, the Medicare fiscal intermediary for Hospice of Palm Beach County and Broward County, has established medical criteria for determining prognosis of non-cancer diagnosis. These guidelines form a reasonable approach to the determination of life expectancy based on available research and more than 30 years of industry experience.

If a patient meets the medical guidelines, they are by definition eligible to receive hospice services. Some patients may not meet any one guideline, but may still be eligible when the combination of other secondary conditions and co-morbidities with functional and nutritional decline result in a terminal prognosis. **It is the physician’s clinical judgment regarding the normal course of the individual’s illness that determines a prognosis of 6 months or less.**

Hospice of Palm Beach County and Broward County is dedicated to providing hospice care to every individual eligible for hospice services, regardless of their ability to pay. This Quick Reference Guide for Determining Hospice Eligibility is designed to assist physicians in determining hospice eligibility. These guidelines are followed for Medicare patients, as well as all other patients.
**VISUAL PAIN SCALE**

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

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

0  No Hurt  2  Hurts Little Bit  4  Hurts Little More  6  Hurts Even More  8  Hurts Whole Lot  10  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

### Palliative Performance Scale (PPS)

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Full</td>
<td>Normal Activity; No Evidence of Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Normal Activity with Effort; Some Evidence of Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>80%</td>
<td>Reduced</td>
<td>Unable Normal Job / Work; Some Evidence of Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>70%</td>
<td>Reduced</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>60%</td>
<td>Mainly Sit/Lie</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Mainly Assistance Required</td>
<td>Total Care</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly in Bed</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Considerable Assistance Necessary</td>
<td>Reduced</td>
</tr>
<tr>
<td>40%</td>
<td>Totally Bed Bound</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Minimal Assistance Required</td>
<td>Reduced</td>
</tr>
<tr>
<td>30%</td>
<td>Totally Bed Bound</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Mouth Care Necessary</td>
<td>Reduced</td>
</tr>
<tr>
<td>20%</td>
<td>Totally Bed Bound</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Mouth Care Only</td>
<td>Reduced</td>
</tr>
<tr>
<td>10%</td>
<td>Totally Bed Bound</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Mouth Care Only</td>
<td>Reduced</td>
</tr>
<tr>
<td>0%</td>
<td>Death</td>
<td>Unable to Do Any Work; Extensive Disease</td>
<td>Full</td>
<td>Mouth Care Only</td>
<td>Reduced</td>
</tr>
</tbody>
</table>

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

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

# FAST Scale

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

*Psychopharmacology Bulletin* 24: 653-659
# NYHA Classification

<table>
<thead>
<tr>
<th>Class</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Cardiac disease, but no symptoms and no limitation in ordinary physical activity, e.g. shortness of breath when walking, climbing stairs etc.</td>
</tr>
<tr>
<td>II</td>
<td>Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.</td>
</tr>
<tr>
<td>III</td>
<td>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.</td>
</tr>
<tr>
<td>IV</td>
<td>Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients.</td>
</tr>
</tbody>
</table>


### Mortality Risk Index for Nursing Home Residents

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

### Risk of Estimate of Death in 6 Months

<table>
<thead>
<tr>
<th>% Risk</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9%</td>
<td>0</td>
</tr>
<tr>
<td>10.8%</td>
<td>1-2</td>
</tr>
<tr>
<td>22.2%</td>
<td>3-5</td>
</tr>
<tr>
<td>40.4%</td>
<td>6-8</td>
</tr>
<tr>
<td>57.0%</td>
<td>9-11</td>
</tr>
<tr>
<td>&gt; 70%</td>
<td>&gt; 12</td>
</tr>
</tbody>
</table>

1. **Position the participant:** have pt to turn so that you stand facing his or her right side. Have the participant 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:** Continue to stand facing the right side of the study participant. 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 snug around the arm but does not compress the skin. Take the measurement to the nearest 0.1 cm.

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

Conducting Assessment of Self-Care Abilities

Rate the degree of impairment of self-care activities using the definitions found under the International Classification of Functioning (ICF) Tab in this manual.

Activities of Daily Living (ADL)

1. Bathing
2. Dressing
3. Toileting
4. Transferring
5. Continence
6. Feeding


Instrumental Activities of Daily Living (IADL)

- Financial Management
- Food preparation
- Housekeeping
- Increased burden of family or caregiver(s)
- Laundry
- Medication Administration
- Mode of Transportation
- Shopping
- Telephone use

Related vs. Non-Related Diagnosis

Guidelines for determining the terminal (primary) diagnosis

1. What diagnosis is most life-limiting?
2. What symptom is most life-limiting? Work back to the diagnosis causing it
3. What was the diagnosis used in the patient’s most recent hospitalization?
4. Avoid non-specific diagnoses like failure to thrive; choose the most life-limiting or symptomatic diagnosis, even if it does not meet all LCD guidelines; look for “best fit”

Guidelines for determining related (secondary) conditions

1. A condition is **USUALLY** related to the terminal diagnosis if
   - It is a direct result of one of the most life-limiting aspects of the terminal illness
   - **OR** is a direct complication of treatment for the terminal illness
   - **OR** is more likely due to the terminal illness or its treatment complications than another cause
2. A condition **MAY** be related to the terminal illness if
   - it involves the same body part or organ system

3. Conditions that have *no more than three degrees of separation* from the terminal diagnosis are **LIKELY** to be related e.g.
   a. Cancer -> increased tendency for clotting -> leg DVT -> pulmonary embolism
   b. Dementia -> dysphagia -> aspiration pneumonia
   c. CHF -> decreased blood flow to kidneys -> renal failure
Is medication, treatment, procedure or need related to the terminal diagnosis or related conditions?

Evaluate if the medication, treatment, procedure or need is necessary & appropriate for THIS patient

Is the medication, treatment, procedure or need palliating a symptom related to the terminal condition or the dying process?

Covered vs. Non-Covered Care, Treatment or Services

Time to Benefit

Improve QOL

Symptom Control

Burden of Therapy

Primarily Life Prolonging

Curative Not Palliative

COVERED

NON-COVERED

YES

NO

YES

NO

NO

YES
“How do your patients want to live in the time they have left? When medicine can no longer cure, there is so much we still can do to help them and their families feel better. We have an obligation to manage their complex symptoms and meet their goals for life in a way that they feel protected and supported.

– Faustino Gonzalez, MD, FAAPM
Vice President of Medical Affairs
Use the following pages of Local Coverage Determination (LCD) Categories to identify the primary and any/all related diagnosis(es).
Alzheimer’s Dementia

**Criteria:** A FAST Scale Stage 7 plus the combined effects of the dementia, along with the secondary and/or co-morbid condition(s) and related structural & functional impairments and activity limitations would have a prognosis of 6 months or less.

**Disease Trajectory:** slow decline

**Common End-Stage Symptoms:** bedfast, dysphasic, cachexia, skin breakdown, frequent recurrent infections

**Supporting Diagnostics:** brain scan, Mortality Risk Score > 9 in patients residing in nursing facility

**Affected Body Structures:** brain

**ICD-9 Codes that Support Medical Necessity:**
- 290.3 Senile Dementia with Delirium
- 294.20 Dementia without Behavioral Disturbance
- 294.21 Dementia Unspecified with Behavioral Disturbance
- 331.0 Alzheimer’s Disease
- 331.2 Senile Degeneration of Brain
- 331.82 Dementia with Lewy Bodies
- 290.4 Vascular Dementia

Cancer

**Criteria:** Clinical findings of malignancy with wide spread aggressive or metastatic disease along with the secondary and/or co-morbid condition(s) related structural & functional impairments and activity limitations would have a prognosis of 6 months or less. (*Functional status not always reflective of prognosis until final weeks*)

1. Solid tumors: metastasis other than bone (specify)
2. Hematological: failed or declined treatment (specify)
3. History of treatment/therapy (specify type & timeframe)
4. Ongoing treatments/therapies (specify)
5. Other
**Disease Trajectory:** rapid decline  
**Common End-Stage Symptoms:** fatigue, pain, increased assistance with ADLs, decline in ECO6 Performance Status  
**Supporting Diagnostics:** dependant on body organ or system involvement  
**Affected Body Structures:** dependant on body organ or system involvement  
**ICD-9 Codes that Support Medical Necessity:** dependant on body organ or system involvement

**Cardiopulmonary**  
**Criteria:** Cardiopulmonary (CP) conditions are associated with the identification of specific structural/functional impairments, activity limitations and disability. Ultimately, the combined effects of the primary cardiopulmonary condition and any identified secondary/co-morbid conditions are such that support a prognosis of 6 months or less.  
**Disease Trajectory:** saw-tooth decline  
**Common End-Stage Symptoms:** periodic worsening with improvements typically not returning to baseline, NYHA Stage IV, symptomatic/disabling dyspnea at rest, symptoms uncontrolled with maximum treatment, oxygen dependency, inability to speak in full sentences, > 2 exacerbations in past 12 months, decreased ability to eat or sleep due to distress,  
**Supporting Diagnostics:** EF < 20%, FEV1 < 30% predicted, O2 saturation < 88% on room air, BNP > 1,200, pCO2 > 50 mmHg, sodium < 125 mEq/L  
**Affected Body Structures:** heart, lungs  
**ICD-9 Codes that Support Medical Necessity:** 425.4 Cardiomyopathies; 428.22 Systolic Heart Failure Chronic; 491.20 Obstructive Chronic Bronchitis
HIV

Criteria: Both 1 and 2 must be present. Factors from 3 will lend supporting documentation, plus one of the following AIDS-defining illnesses:

1. CD4+ count < 25 cells/ml or persistent viral load > 100,000 copies/ml, plus one of the following:
   a. CNS lymphoma
   b. Untreated or not responsive to treatment, wasting (loss of 33% of lean muscle 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’s sarcoma unresponsive to therapy
   g. Renal failure in the absence of dialysis
   h. Cryptosporidium infection
   i. Toxoplasmosis, unresponsive to therapy

2. Decreased Karnofsky Performance Scale of PPS < 50%

3. Documentation of the following factors will support eligibility for hospice care:
   a. Chronic persistent diarrhea for 1 year
   b. Persistent serum albumin < 2.5
   c. Concomitant, active substance abuse
   d. Age > 50 years
   e. Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specific to HIV disease
   f. Advanced AIDS dementia complex
   g. Toxoplasmosis
   h. CHF, symptomatic at rest
**Disease Trajectory:** saw-tooth decline

**Common End-Stage Symptoms:** disease progression despite treatment of infections and other complications, cachexia, failure to thrive, frequent hospitalizations

**Supporting Diagnostics:** specified in criteria

**Affected Body Structures:** immune system

**ICD-9 Codes that Support Medical Necessity:**

042 Human Immunodeficiency Virus (HIV) Disease

**Liver Disease**

**Criteria:** Both 1 and 2 must be present. Factors from 3 will lend supporting documentation.

1. *The patient should show both a and b:*
   a. Prothrombin time > 5 seconds over control; or INR > 1.5
   b. Serum albumin < 2.5 gm/d

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 < 400ml/day and urine sodium concentration of < 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. Hepatitis B positive
   f. Hepatitis C refractory to interferon treatment

**Disease Trajectory:** saw-tooth decline

**Affected Body Structures:** liver

**Common End-Stage Symptoms:** ascites, jaundice, delirium, coma

**Supporting Diagnostics:** elevated MELD score

**ICD-9 Codes that Support Medical Necessity:**
571.2 Alcoholic Cirrhosis of Liver; 571.40 Chronic Hepatitis Unspecified; 571.5 Cirrhosis of Liver Without Alcohol; 571.6 Biliary Cirrhosis; 572.2 Hepatic Encephalopathy; 573.3 Hepatitis Unspecified

**Neurological Disease**

**Criteria:** Neurological conditions are associated with the identification of specific structural/functional impairments, activity limitations and disability. Ultimately, the combined effects of the primary neurological condition and any identified secondary/co-morbid conditions are such that support a prognosis of 6 months or less.

**Disease Trajectory:** slow decline

**Common End-Stage Symptoms:** ataxia, muscle wasting, paralysis, dysphagia, cachexia, respiratory failure

**Supporting Diagnostics:** vital capacity > 30%, O2 saturation < 88% on room air
**Affected Body Structures:** brain, spinal cord & peripheral nerves

**ICD-9 Codes that Support Medical Necessity:**
332.0 Paralysis Agitans; 434.0 Cerebral Thrombosis; 340 Multiple Sclerosis; 335.20 Amyotrophic Sclerosis

**Renal Disease**

**Criteria:** ESRD conditions are associated with the identification of specific structural/functional impairments, activity limitations and disability. Ultimately, the combined effects of the primary renal condition and any identified secondary/co-morbid conditions are such that support a prognosis of 6 months or less. *(Severe enough that dialysis would have been discontinued or recommended)*

**Disease Trajectory:** saw-tooth decline

**Common End-Stage Symptoms:** generalized weakness, edema, muscle twitches, confusion, irritability, loss of appetite, coma, seizures

**Supporting Diagnostics:** serum creatinine > 8.0 mg/dl, creatinine clearance 10 ml/min, potassium level > 7.0 mmol/L, platelet count < 25,000, GFR < 15%

**Affected Body Structures:** kidney

**ICD-9 Codes that Support Medical Necessity:**
403.11 Hypertensive Chronic Kidney Disease With Stage V End Stage Renal Disease; 585.5 End Stage Renal Disease; 586 Renal Failure Unspecified
Other Diseases

Criteria: For end stage diseases that do not fall under any of the disease specific diagnostic guidelines, the identification of specific structural/functional impairments, activity limitations and disability of the primary and identified secondary/co morbid conditions support a prognosis of 6 months or less. Disease Trajectory: dependant on body organ or system involvement

Common End-Stage Symptoms: describe how the overall functional and nutritional decline affects an increased disease burden and rate of decline
**International Classification of Functioning (ICF)**

**What is ICF?**
- Developed by the World Health Organization (WHO)
- A unified, standardized language & framework for the classification of health and disability

**What is the Purpose for Hospice?**
- Describes the impact the terminal disease has on all aspects of the patient’s life, sometimes referred to as the burden of illness
- Enables all team members to quantify the extent of impairment, especially for interdisciplinary teams where the picture of the whole person needs to be illustrated
- This is the format adopted by Palmetto in developing the LCD’s

**Definitions**
- **Body functions:** physiological, how the body works
- **Body structures:** anatomical parts of the body such as organs, limbs, and their components
- **Activity:** the execution of a task or action by an individual
- **Participation:** involvement in a life situation
- **Environmental factors:** make up the physical, social, and attitudinal environment
The degree of impairment, difficulty or barrier is defined in the following manner:

**Moderate (M):** problem is present < 50% of the time with an intensity interfering with day-to-day life and happens occasionally (<3x/wk) over past 30 days

**Severe (S):** problem is present > 50% of the time with an intensity partially disrupting day-to-day life and happens frequently (4-6x/wk) over past 30 days

**Complete (C):** problem is present > 95% of the time with an intensity totally disrupting day-to-day life and happens daily (7x/wk) over past 30 days

Adapted from International Classification of Functioning, Disability and Health; World Health Organization, 2001
FUNCTIONAL ASSESSMENT

Indicators of General Decline

• Diet change (specify type & date)
• Emergency Room visit(s) (specify number & date)
• Fall(s) (specify number & dates)
• Hospitalization(s) (specify number & dates)
• Infection(s) treated with antibiotics (specify date & type)
• Pressure ulcer(s) (specify stage(s) date)
• Relevant supporting diagnostic findings (specify source, location, type & date)
• Weight Maintenance (specify wt loss in number of pounds & time frame)

Affected Body Functions:

Mental

• Agitation
• Altered mental status
• Anxiety
• Changes in cognition, disorganized thoughts
• Delirium
• Depression
• Increased periods of sleep ___hrs/ 24hrs
• Loss of verbal communication, < 5 words
• Mood changes
• Seizures
**FUNCTIONAL ASSESSMENT**

**Sensory**
- Altered hearing
- Altered vision
- Numbness, tingling
- Pain
- Tightness in chest

**Voice & Speech**
- Voice difficult to understand – garbled/slurred
- Voice lacks strength

**Cardiovascular**
- BP irregularities
- Edema
- Palpitations
- Pattern of heart rate & rhythm

**Respiratory**
- Circumoral pallor or cyanosis
- Congestion
- Cough
- Dyspnea
- Fatigability
- HOB elevated to sleep/sleeping in recliner
- Oxygen dependency
- Pattern of respiratory rate & rhythm
- Use of accessory muscles

**Immunological**
- Anemia
- Bleeds, bruises easily
- Chills
- Fever
- Sweats
- Swollen glands
Digestive, Metabolic & Endocrine
- Abdominal tenderness or distention
- Ascites
- Bowel incontinence
- Cachexia
- Changes in diet or amount of food consumed
- Diarrhea
- Dysphagia, coughs while eating, increased salivation
- Esophageal bleeding
- Jaundice
- Loss of appetite
- Measurement of mid-arm circumference (MAC)
- Refusing or not responding to parenteral/supplemental feedings
- Results of 72 hour calorie count
- Specific weight loss past 6 months (BMI < 22 22kg/m2)

Genitourinary
- Oliguria < 40ml/day
- Urinary incontinence

Neuromuscular & Movement
- Decreased endurance
- Falls
- Gait disturbances
- Muscle wasting
- Muscle weakness
- Tremors-contractures

Skin
- Stage III or IV decubitus ulcer
- Urticaria
Building Blocks for Compassionate Care

- Do your best every day
- Respect each other
- Put patients and families first
- Do whatever it takes
- Timeliness
- Positive attitude
- Effective communication
- Respect
- Attentiveness

Compassion
How to Bill Services for Medicare Hospice Patients

1. PRIMARY ATTENDING PHYSICIAN
   The primary (attending) physician is chosen by the patient and listed as the hospice attending physician on the Medicare claim form. **BILLING FOR CARE RELATED TO THE TERMINAL DIAGNOSIS:** Only the hospice primary (attending) physician can bill Medicare Part B for care related to the terminal diagnosis. Use the applicable CPT® E/M code for the service, add the GV modifier, and submit with the ICD-9 code for the hospice diagnosis.

2. CONSULTING (SECONDARY) PHYSICIAN
   If you are not the physician designated as the hospice primary (attending) physician on the Medicare Election of Benefits, you are considered a consulting (secondary) physician for billing purposes. **BILLING FOR CARE RELATED TO THE TERMINAL DIAGNOSIS:** Any physician services for care related to the terminal diagnosis must be preauthorized by HPBC/HOBC. Authorization is obtained from the team caring for the patient.

   • A “Physician Consulting Agreement” must be signed before the care is provided. This allows HPBC/HOBC to bill Medicare for your services and meet regulatory requirements to reimburse physicians. Email contractadmin@spectrumhealthinc.com or call (561) 227-5188.

   • Only hospice can bill Medicare for physician services related to the terminal illness (except those provided by the hospice attending physician, as defined above). Bills submitted to Medicare B will be denied.
• The physician bills HPBC/HOBC using applicable CPT® E/M codes for both professional and technical components using a CMS 1500 form. Hospice bills Medicare Part A and reimburses the physician according to the terms of the “Physician Consulting Agreement.”

3. PHYSICIAN SERVICES NOT RELATED TO THE HOSPICE DIAGNOSIS
Any physician may provide care to a hospice patient for diagnoses that are NOT related to the terminal illness. Use the applicable CPT® E/M code for the service, add the GW modifier, and submit with the appropriate ICD-9 codes.

BILLING FOR OTHER SERVICES RELATED TO THE TERMINAL DIAGNOSIS: Only hospice can bill Medicare for ANY service related to the terminal diagnosis (except for hospice attending physician services, as described above).

Medications, diagnostic tests, and procedures must be pre-authorized by HPBC/HOBC. Authorization is obtained from the team supervisor caring for the patient. Payment will be based on the provider’s billing agreement with HPBC/HOBC.

CONTACT US:
• Call your Business Development Hospice Representative
• Call the Business Development Department @ (561) 227-5294
• Email us @ accountspayable@spectrumhealthinc.com

To submit a claim to HPBC/HOBC, please mail it to:
ATTN: Accounting Dept.
HPBC/HOBC Headquarters
5300 East Avenue
West Palm Beach, FL 33407
One team, one goal to continually embrace each patient and family through the journey no one wants to walk.