

## Qualifying for Hospice

A patient must have a life expectancy of six months or less, diagnosed by a licensed physician. Your doctor is then required to present a medical justification for a patient to qualify for hospice benefits by writing a script. Once you and your doctor have chosen an hospice agency, the agency gathers information as to which insurance or Medicare/Medicaid is to pay for the services and submits this information for approval. Generally, you are admitted to the program the very same day. Unfortunately, because of the lack of hospice understanding, physicians refer patients for hospice at a very late stage in their course. The patients and families have little time to prepare for death and gain full benefits of hospice care.

### **Patient Eligibility for Medicare Benefits**

- Pt must be eligible for Medicare Part A (the hospitalization benefit)
- Pt must have a terminal illness, the prognosis being 6 months or less. This must be certified by patient's primary care physician and/or the medical director of the hospice.
- Patient or family (if the patient cannot do so) must give informed consent.
- Care must be provided by a Medicare-certified hospice.
- Hospice benefits can also be obtained through private and for-profit insurance policies.

### **Benefit Period**

- Currently the benefits run for two periods of 90 days followed by an unlimited number of 60 day periods. At the end of each period, the patient must have benefits renewed. To be "renewed," a patient must still have the terminal illness and must manifest a functional decline.

### **Guidelines**

A pattern of functional and physiologic decline is a good indicator that a person may be eligible for hospice. The following characteristics which should be present before the patient enters into a hospice program. Here are a few examples:

#### **General Guidelines**

- Expected life span of 6 months or less. The patient will not have hospice benefits revoked if he/she does not die within this time period but the patient must show persistent decline during this time. If the patient does decline, then hospice benefits can be renewed.
- Pt must have life limiting condition and the pt and/or the family must be aware of this
- Pt/decision maker must desire palliative approach rather than curative focus
- Progression of disease must be documented by: physical examination, labs or imaging. Multiple hospital or ER visits. A decline in their functional status. Have an impaired nutritional status.

#### **Disease-specific Guidelines (Non-Cancer Diseases)**

These are meant to provide a general prognosis.

### **Heart Disease**

- CHF symptoms at rest (NYHA class IV)
- Must be optimally treated with diuretics and after-load reduction
- The following help predict increased mortality: symptomatic supraventricular or ventricular arrhythmias, prior cardiac arrest, unexplained syncope, cardiogenic stroke, 51 and concomitant HIV disease.
- An ejection fraction of 20% or less is helpful, but not required for this category.

### **Pulmonary Disease**

- Dyspnea at rest, unresponsive to treatment
- Progressive disease that can be demonstrated with a declining FEV1 (> 40 ml/year) or by increased ER visits/hospitalizations (no specific number of visits, just looking for a trend)
- Cor pulmonale or right heart failure (not due to valvular cardiomyopathy or left heart failure)
- Resting tachycardia

### **Dementia**

- MMSE of 0/30 and basic ADL dependency alone are NOT SUFFICIENT; these patients, though profoundly demented, may live for some time.
- Presence of co-morbid conditions are associated with decreased survival: antibiotics
- If pt has g-tube, must demonstrate (and document) nutritional impairment. Weight loss of 10% or more over a 6 month period. Hypoalbuminemia.
- In the absence of G-tube (gastro feeding), decreased oral intake

### **Liver Disease**

- Clinical judgement in this category is essential—the following are guidelines
- Pt must not be a transplant candidate
- Pt should exhibit impaired synthetic function: Albumin < 2.5 g/L and PT < 5 sec over control
- Ascites despite maximum diuretics
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome
- Hepatic encephalopathy
- Recurrent variceal bleeding

### **Renal Disease**

- Creatinine clearance <10cc/min (<15 if diabetic) and serum creatinine >8 (>6 if diabetic)
- Signs or symptoms associated with uremia
- Oliguria
- Intractable fluid overload
- Not on dialysis