

PRIMER
for
HOSPICE &
PALLIATIVE CARE
MEDICINE

Clinical Palliative Care Issues
*including Pain & Non-Pain
Symptom Management*

**Medicare Clinical Guidelines
for Non-Cancer Hospice Referrals**
*with Suggested Criteria for Determining
Six-Month Prognosis*

Physician Billing Information



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References

- ¹AMDA White Paper on Hospice, 2005.
- ²Jerrard, J. Palliation Issues in LTC. *Caring for the Ages*, August 2004; Vol. 5, No. 8, p. 9-15.
- ³Storey P, Knight CF, Schonwetter RS. *Pocket Guide to Hospice/Palliative Medicine*, American Academy of Hospice and Palliative Medicine, 2003.
- ⁴Storey, Porter, MD, FACP, FAAHPM and Knight, Carol F. EdM. *Hospice/Palliative Care Training For Physicians, A Self-Study Program*, 2003.
- ⁵Palmetto GBA Medicare Part A Hospice Training Manual, 2004.
- ⁶Oxford Textbook of Palliative Medicine, Oxford University Press 1993;109.
- ⁷CMS Pub.100-2 & 100-4, Claims Filing & Coverage Guidelines section of MRG, Cahaba GBA, A CMS Contracted Intermediary, November 2003.

End-of-Life Care Resources

American Academy of Hospice and Palliative Medicine

4700 W. Lake Avenue
Glenview, IL 60025
847/375-4712
www.aahpm.org

American Medical Directors Association

10480 Little Patuxent Parkway, Suite 760
Columbia, MD 21044
410/740-9743
www.amda.com

Hospice Association of America

228 Seventh Street SE
Washington, DC 20003
202/546-4759
www.nahc.org/HAA/

Hospice Foundation of America

2001 S Street, NW, #300
Washington, DC 20009
202/638-5419
www.hospicefoundation.org

National Hospice and Palliative Care Organization

1700 Diagonal Road, Suite 300
Alexandria, VA 22314
703/837-1500
www.nhpco.org

PRIMER for HOSPICE & PALLIATIVE CARE MEDICINE

By

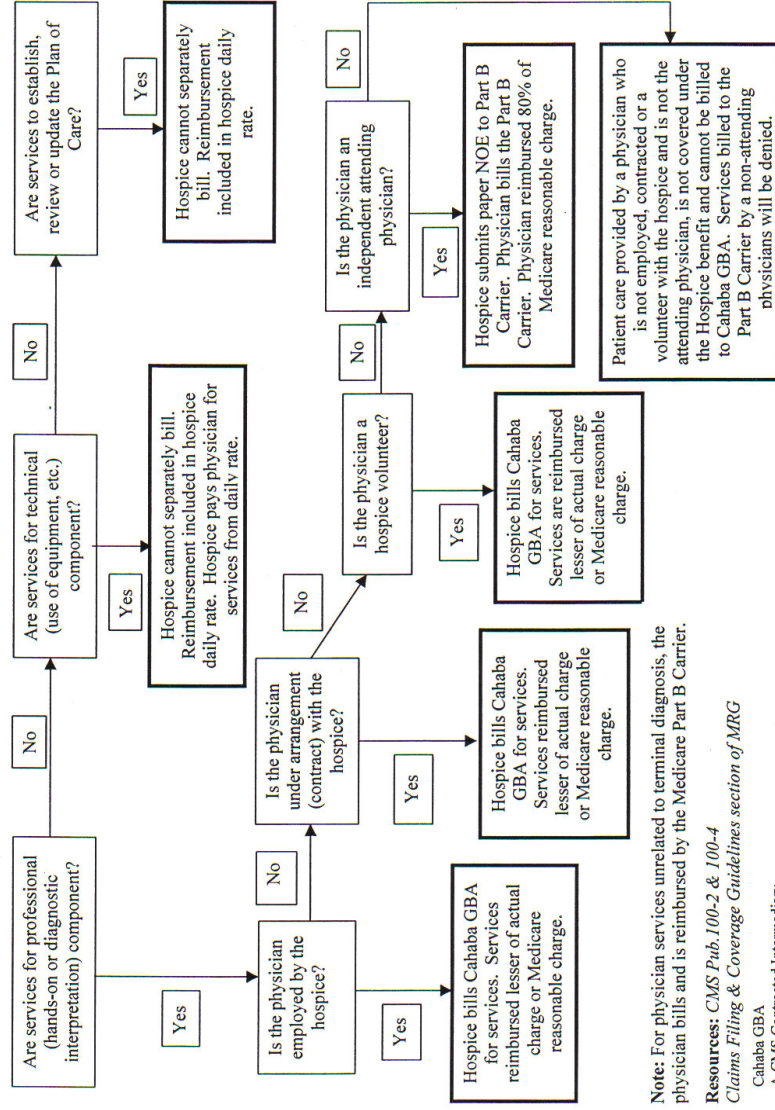
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Billing Hospice Physician Services (Related to Terminal Diagnosis)



Note: For physician services unrelated to terminal diagnosis, the physician bills and is reimbursed by the Medicare Part B Carrier.

Resources: CMS Pub.100-2 & 100-4

Claims Filing & Coverage Guidelines section of MRG

Cahaba GBA

A CMS Contracted Intermediary

November 2003

Physician Billing For a Hospice Patient

According to the Health Care Financing Administration and American Medical Association’s CPT Information Services, “There are no specific CPT codes for evaluation and management services provided by a physician to a patient receiving hospice care in any location. When a Medicare beneficiary elects the hospice benefit, Medicare pays the hospice for all services related to the terminal illness through four set per diem rates. The exception to this is physician services.”

“Medicare hospice regulations, at 42 CFR 418.304(c), state that services of the patient’s attending physician, who is not employed by the hospice or providing services under arrangements with the hospice, are not considered hospice services. These services are billed directly to Medicare Part B according to procedures established in 42 CFR 405 subparts D and E. When provided by an attending physician, as described above, evaluation and management services provided to hospice patients would be billed in the following manner:

- If the evaluation and management services are provided to a hospice patient that is residing in a nursing facility, then the subsequent nursing facility care codes are billed (99301-99316 series).
- If the evaluation and management services are provided to a hospice patient in their private residence, the home service codes are billed (99341-99350 series). The physician must provide the evaluation and management services in the patient’s home in order for these codes to be billed.
- If the evaluation and management services are provided to a patient in a board and care type facility, including a hospice residential facility, then domiciliary/rest home codes are billed (99321-99333 series). Again, these services must be provided in the facility in order for the domiciliary/rest home codes to be billed.”

If another physician covers for the attending physician, the attending physician must bill Medicare Part B for the services using either the Q5 or Q6 modifier, in addition to the GV or GW modifier. Use the Q5 modifier for service furnished by a substitute physician under a reciprocal billing arrangement. Use the Q6 modifier for service furnished by a *locum tenens* (substitute) physician. The GV modifier indicates the service was related to the terminal illness, while the GW modifier indicates the service was not related to the terminal illness.

Table of Contents

Introduction to Hospice

Hospice Facts.....	1
Questions Frequently Asked by Physicians About Hospice.....	2
Hospice vs. Home Health Services for Terminally Ill.....	3

Clinical Palliative Care Issues

Palliative Pain Management	4
Non-Pain Symptom Management	5
End of Life Conversations.....	9
Ethics	10

Clinical Suggested Guidelines for Non-Cancer Hospice Referrals

Amyotrophic Lateral Sclerosis	12
Debility/Decline in Health Status.....	13
Dementia.....	14
Cardiac Disease	15
HIV Disease.....	16
Liver Disease.....	17
Pulmonary Disease	18
Renal Disease	19
Stroke and Coma	20

Appendices

Karnofsky Performance Status Scale	21
Functional Assessment Staging (FAST).....	22
Physician Billing For a Hospice Patient.....	23

Hospice Facts

- Hospice benefits include nursing, home health aide and counseling visits to address physical, personal, emotional and spiritual needs; medical equipment; medications related to the terminal illness; and bereavement support for the family for at least one year.
- Hospice provides four levels of care: routine home care, respite care, inpatient care and continuous care.
- Respite and inpatient levels of care can be provided at a hospital or in an approved nursing home.
- When the patient elects hospice, they waive all rights to Medicare payments for services *related to treatment of the terminal condition* by health care providers other than their hospice or their attending physician.
- Patients can continue to receive medical care from their attending physician for *all illnesses related and unrelated to the terminal diagnosis*. Attending physicians who are not employed by the hospice continue to bill Medicare for their services with the same ICD-9 and CPT codes they have previously used.
- Patients can be hospitalized and continue to receive medical care from health care providers other than the hospice and attending physician for *illnesses unrelated to the terminal diagnosis*.
- Patients can continue to receive Medicare room and board benefits in a nursing home for *conditions that are not related to the terminal diagnosis*.
- Patients can continue to receive home health benefits for *conditions that are not related to the terminal diagnosis*.
- By 2040, it is expected that one in two Americans will die in a nursing home. In 1986, the nursing home/facility was recognized as a surrogate home for America's elderly, and that hospice care was a patient's right in this new home setting. Now the nursing facility provides the daily care for the patient that used to be provided by the family (i.e., bathing, feeding, toileting, giving medicine, etc.) Hospice provides the same service as in any other home setting (i.e., specialized services of pain management, psychosocial and spiritual care, and bereavement care for at least a year).
- In a study conducted by the Center for Gerontology and Health Care Research, patients who receive hospice care are less likely to be hospitalized in their final days of life than those who don't. Also, many family members bemoaned the fact that hospice was brought in too late to be of much comfort to them or the patient.
- According to the Patient Self-Determination Act passed on November 5, 1990, Medicare hospice providers are prohibited from discriminating against a patient who does not have a Do Not Resuscitate (DNR) order.

Functional Assessment Staging (FAST)

Stage 7 or beyond indicates end stage dementia.

1. No difficulty either subjectively or objectively.
2. Complains of forgetting location of objects. Subjective work difficulties.
3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity.
4. Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty shopping, etc.
5. Requires assistance in choosing proper clothing to wear for the day, season or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised.
6.
 - A. Improperly putting on clothes without assistance or cueing (e.g., may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.
 - B. Unable to bathe properly (e.g., difficulty adjusting bath water temperature) occasionally or more frequently over the past weeks.
 - C. Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.
 - D. Urinary incontinence (occasionally or more frequently over the past weeks).
 - E. Fecal incontinence (occasionally or more frequently over the past weeks).
7.
 - A. Ability to speak is limited to approximately half a dozen intelligible different words or fewer in the course of an average day or in the course of an intensive interview.
 - B. Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview.
 - C. Ambulatory ability is lost (cannot walk without personal assist).
 - D. Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests/arms on the chair).
 - E. Loss of ability to smile.
 - F. Loss of ability to hold up head independently.

Karnofsky Performance Status Scale⁶

Rating of 50% or less with HIV Disease and 40% or less with Stroke/Coma is a predictor of poor survival.

Able to carry on normal activity and to work; no special care needed.	100	Normal; no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; diseases may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Questions Frequently Asked by Physicians About Hospice

How can you tell when a patient has six months or less to live in order to qualify for the Medicare hospice benefit?

The Centers for Medicare & Medicaid Services (CMS) have developed guidelines for establishing a six-month prognosis for several non-cancer terminal illnesses. Those guidelines, as contained in this booklet, are based on normal disease progression. If a patient's disease process does not run a "normal course," the benefits can be extended through recertification.¹

What are hospice benefit periods?

In the past, there were four benefit periods, (90, 60, 30 days, then a fourth period that was unlimited). Many patients had entered their 4th benefit period and were in fear of losing their hospice benefits if they were to remain on hospice until they died. Since the end of 1997, the benefit periods have been revised. Now the patient has 90, 90, then continuous 60 day benefit periods for physician recertification of terminality. For example, if a patient improves and is not felt to be terminal at the end of the 2nd benefit period, then the patient can come off of hospice care and be restarted when the patient's prognosis worsens again. For the initial 90-day benefit period, both the hospice medical director and the patient's attending physician must certify the patient. For all subsequent benefit periods, recertification is only required from the hospice medical director.¹

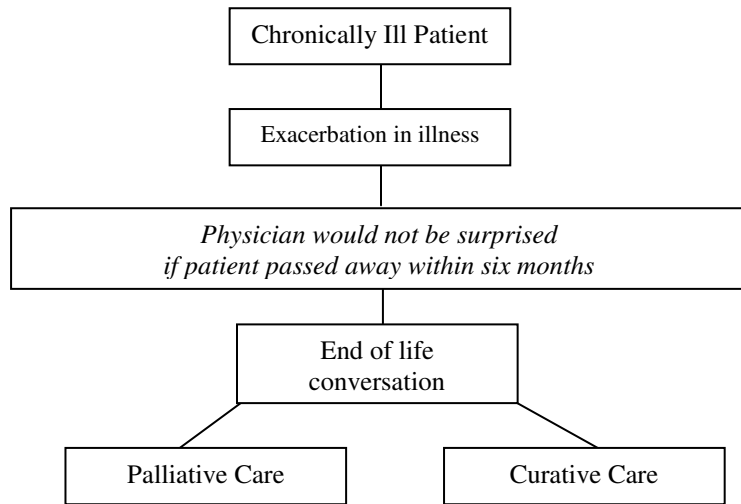
How is the attending physician reimbursed?

Attending physicians who are not employed by the hospice continue to bill Medicare for their services with the same ICD-9 and CPT codes they have previously used. If the physician is employed by the hospice caring for that patient, the hospice is billed for the level of service provided. If the physician is salaried by a different hospice and not by the hospice caring for the patient, Medicare is billed for the level of service provided. If an associate sees the patient, the attending physician of record must bill Medicare Part B for the services using either the Q5 or Q6 modifier, in addition to the GV or GW modifier. HCFA receives a record of the name of each attending physician for each hospice patient.¹ See pages 23 and 24 for more billing information.

Can a nurse practitioner serve as an attending physician?

Section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) amended the Social Security Act (Section 1861[dd][3][B]) and Section 1814(a)(7) to include nurse practitioners in the definition of an attending physician for hospice beneficiaries. Beginning December 8, 2003, Medicare pays for services, with the exception of certifying the terminal illness with a prognosis of 6 months or less, provided by nurse practitioners to Medicare beneficiaries who have selected a nurse practitioner as their attending physician. A physician will be required to certify the terminal illness and 6 month prognosis.

Hospice vs Home Health Services for Terminal Condition



Referral to Hospice

In-home nursing visits for skilled and non-skilled care (patient does not need to be home bound)

Physical, occupational & speech therapies to promote comfort and preserve ability to perform ADLs

Home health aide services

Durable medical equipment

Social worker visits

Prescription and over-the-counter medications related to terminal illness provided and delivered

Counseling services for patient and family

Continuous care in-home for a medical crisis instead of hospitalization

Inpatient or nursing home care for family respite

Volunteers

Bereavement care for the family

Referral to Home Health

In-home nursing visits for skilled care (home bound patients only)

Physical, occupational & speech therapies to promote rehabilitation

Home health aide visits

Social worker visits

Stroke and Coma

Acute phase of hemorrhagic or ischemic stroke

1, 2 or 3 must be present

1. Coma or persistent vegetative state beyond 3 days
2. In post anoxic stroke, coma or severe obtundation accompanied by severe myoclonus beyond 3 days
3. Dysphagia which prevents sufficient intake of foods and fluids to sustain life and no artificial nutrition/hydration

Chronic phase of hemorrhagic or ischemic stroke

1, 2 or 3 must be present

1. Post stroke dementia (*all of the following*)
 - Stage seven or beyond according to the FAST scale
 - Unable to ambulate without assistance
 - Unable to dress without assistance
 - Unable to bathe without assistance
 - Urinary and fecal incontinence, intermittent or constant
 - Ability to speak six or fewer intelligible words
2. Poor functional status with Karnofsky score 40% or less
3. Poor nutritional status with >10% weight loss during the previous six months or serum albumin <2.5 gm/dl

Coma (any etiology): any 3 must be present, day three of coma

1. Abnormal brain stem response
2. Absent verbal response
3. Absent withdrawal response to pain
4. Serum creatinine > 1.5 mg/dl
5. Age over 70 years

ICD-9 Codes that Support Medical Necessity

432.9	Unspecified Intracranial Hemorrhage
434.91	Cerebral Artery Occlusion Unspecified with Cerebral Infarction
780.01	Coma

Renal Disease

1, 2 and 3 must be present

1. The patient is not seeking dialysis or renal transplant
2. Creatinine clearance <10 cc/min (<15 cc/min, diabetics)
3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics)

*Factors lending supporting evidence for **acute** renal failure*

- √ Mechanical ventilation
- √ Malignancy (other organ system)
- √ Intractable hyperkalemia (> 7.0)
- √ Uremic pericarditis
- √ Hepatorenal syndrome
- √ Intractable fluid overload
- √ Immunosuppression/AIDS
- √ Albumin <3.5 gm/dl
- √ Cachexia
- √ Platelet count <25,000
- √ Disseminated intravascular coagulation
- √ Gastrointestinal bleeding
- √ Chronic lung disease
- √ Advanced cardiac disease
- √ Advanced liver disease
- √ Sepsis

*Factors lending supporting evidence for **chronic** renal failure*

- √ Uremia
- √ Oliguria (<400 cc/day)
- √ Intractable hyperkalemia
- √ Uremic pericarditis
- √ Hepatorenal syndrome
- √ Intractable fluid overload

ICD-9 Codes that Support Medical Necessity

- 584.9 Acute Renal Failure Unspecified
585 Chronic Renal Failure

Clinical Palliative Care Issues²

Palliative Pain Management

End-of-life patients suffer several types of pain, including acute, chronic, non-malignant, and cancer pain. There is no decrease in sensitivity to pain with aging. Multiple studies show that a high percentage of nursing home residents suffer daily pain of some type, and under-treated pain can lead to physiological and psychological impairment, psychosocial deterioration, and physical deconditioning.

Monitoring and treating pain requires an interdisciplinary care team that includes the patient and their family, direct caregivers, nurses, therapists, the social worker, a nutritionist, consulting pharmacist, and the physician. A comprehensive approach to pain management must include:

- Educating staff, patient, and family;
- Screening, assessment, and reassessment;
- Communicating;
- Planning care;
- Managing and intervention; and
- Monitoring and continuous quality improvement.

Barriers to pain assessment may include psychological and physical comorbidities, spiritual or cultural beliefs, and language. Also, some elderly patients view pain as a sign of weakness, punishment for the past, or part of aging. As such, they may not communicate their pain issues to caregivers.

When evaluating your patient's pain, begin with a patient interview, intervention history, and physical exam. Include a functional assessment, and psychological evaluation, as well. For dementia patients, you can assess sleep disorders, functional independence and agitation. Assess their objective symptoms, including tachycardia, pallor, and affective responses such as grimaces.

Physicians should "start low, go slow" on treating pain in elderly patients, taking the least invasive routes and reassessing frequently. Use nonpharmacological treatments, including cognitive therapies, biofeedback, and behavior modification. Consider topical analgesics including counterirritants and capsaicin cream. As for pharmacological treatments, prescribe medications as scheduled rather than PRN (as-needed) dosing.

Pulmonary Disease

1 must be present with either #2 or #3

Physicians should avoid the following NSAIDs: indomethacin, meclufenamate, piroxicam, and tolmetin, as well as opioids: meperidine, propoxyphene, pentazocine, and nalbuphine. Also inappropriate for the elderly are trimethylbenzamide, flurazepam, amitriptyline, long-acting benzodiazepines, muscle relaxants, and anticholinergics.

If a patient experiences mild to moderate pain, consider a trial with acetaminophen as initial therapy. A combination of acetaminophen and tramadol provides greater pain relief than either by itself.

For moderate to severe pain, consider continuing with acetaminophen and adding an immediate-release opioid every four hours and adjust daily to desired effectiveness, 25% to 50% for mild or moderate pain, 50% to 100% for severe or uncontrolled pain. This can be adjusted without an upper dose limit for severe uncontrolled pain. Doses are product-specific, but typically given every 8, 12 or 24 hours. MS Contin (long-acting morphine in 15, 30, 60, 100 and 200 mg tablets) is generally effective as a 12 hour dose; however, OxyContin (long-acting oxycodone in 10, 20, 40, and 80 mg tablets) may be more effective if given q 8 hours. Patients should not crush or chew the tablets, and time-release granules can be flushed down feeding tubes. Continue with prn dose of immediate-release opioid PO or SL (in intensol form) for breakthrough pain, typically 10-20% of the 24-hour opioid dose, available q 1 hour. If patient requires a second dose in less than 2 hours, breakthrough dose should be doubled. When breakthrough doses are needed 3 or more times daily, extended-release dose should be increased.

To dose Duragesic patches, total the 24 hour oral morphine equivalent (in mg), divide in half, and apply closest patch size (in mcg) per hour. The onset of action is 12-24 hours. These patches should not be used in opiate-naive patients.

Common adverse effects of opioids may include constipation, dry mouth, nausea, vomiting, sedation and sweating. *Most side-effects will dissipate after a few days, with the exception of constipation.*

Non-Pain Symptom Management

Many of the common non-pain symptoms requiring aggressive palliation are outlined below. Caregivers should collect data on duration, time of onset, and quality of each symptom, as well as details on what aggravates and relieves the symptoms. It should also include the effect of previous treatments and the symptom's effects on function, mood, sleep, and relationships as well as a physical exam. Consider nonpharmacological interventions, which can work synergistically with medications. Also, be sure to repeat the full assessment process.

1. Severe chronic lung disease as shown 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 it 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. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but it is not necessary to obtain.)
2. Hypoxemia at rest on room air, as evidenced by $pO_2 < 55$ mmHg and oxygen saturation <88% on supplemental oxygen *or* hypercapnia, as evidenced by $pCO_2 > 50$ mmHg.
3. Cor pulmonale and right heart failure (RHF) secondary to pulmonary disease.

Factors which will add supporting documentation

- √ Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
- √ Resting tachycardia > 100/min.

ICD-9 Codes that Support Medical Necessity

There is no ICD-9-CM code for end stage pulmonary disease. Diagnoses for pulmonary disease which lead to end stage pulmonary disease will be accepted.

Liver Disease

1 and 2 must be present

1. The patient should show *both a and b*:
 - a. PT > 5 seconds over control *or* INR > 1.5
 - b. Serum albumin < 2.5 gm/dl
2. End stage liver disease is present and the patient shows *at least one* of the following:
 - a. Ascites
 - b. Spontaneous bacterial peritonitis
 - c. Hepatorenal syndrome: elevated BUN/CR, oliguria
 - d. Hepatic encephalopathy
 - e. Recurrent variceal bleeding

Factors which will add supporting documentation

- √ Progressive malnutrition
- √ Muscle wasting w/ reduced strength and endurance
- √ Continued active alcoholism (>80 gm ethanol/day)
- √ Hepatocellular carcinoma
- √ HBsAg (Hepatitis B) positivity
- √ 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 must be discharged from hospice.

ICD-9 Codes that Support Medical Necessity

155.0	Malignant Neoplasm of Liver Primary
571.2	Alcoholic Cirrhosis of Liver
571.40	Chronic Hepatitis Unspecified
571.41	Chronic Persistent Hepatitis
571.49	Other Chronic Hepatitis
571.5	Cirrhosis of Liver without Alcohol
571.6	Biliary Cirrhosis
572.2	Hepatic Coma
573.3	Hepatitis Unspecified

Agitation/anxiety: When assessing agitation and anxiety at end of life, keep an open mind and try to understand the cause. Agitation may have physical and psychological causes, such as urinary retention or delirium. These symptoms are often caused by pain in the cognitively impaired. Managing agitation and anxiety likely requires multifactorial interventions and may include environmental modifications, psychological support, and medications such as neuroleptics for delirium, antidepressants for depression, benzodiazepines for anxiety, and morphine for dyspnea or pain.

Bowel Obstruction: In subtotal obstruction, smooth muscle relaxation can be promoted with liquid morphine SL or B&O (Belladonna and Opium) suppositories. Liquid stool can be achieved with use of docusate sodium, 250-500mg/d. Edema can be decreased with steroids. Decadron 4mg TID may be initiated. Gut secretions can be reduced quickly with hyoscamine 0.125 mg/ml SL, 2.0 ml loading dose, then 1.0 ml q4h. If transdermal scopolamine patch is started at the same time, hyoscamine can often be DC'd after first 24 hours. Nausea can be treated topically with compazine 10mg/ml PLO gel on the wrists or a combination of any of the following topical agents in PLO gel: Ativan 0.5mg, Haldol 1.0mg, Benadryl 25mg, and Reglan 10mg (omit Reglan for complete obstruction) q4h. Persistent vomiting may be relieved by nasogastric suction prn for comfort.

For complete obstruction, feeding (including fluids, PO or IV) is never appropriate because it causes pain and suffering. If it becomes necessary to put the bowel to rest, morphine, haldol and decadron work well. At this point, the prognosis is days to weeks.^{3,4}

Constipation: Check the rectum for impaction, which can cause agitation, delirium, vomiting, pain, anorexia, urinary retention and new onset of incontinence. Oozing diarrhea may also be a sign of impaction.

To prevent constipation, institute scheduled toileting and have the patient sit up, if possible. Maintain scheduled evacuation for two days, and implement a system for documentation, assessment, and early intervention. Fiber may help, but results will be affected by dehydration and poor motility. Try increasing water intake or keep fluid in the gut with sorbitol. With constipation related to opioid use, a combination of senna and docusate may be effective. However, avoid stimulant laxatives such as senna or bisacodyl if constipation is associated with large bowel obstruction, as they may cause colic.

HIV Disease

1 and 2 must be present

Delirium and Terminal Restlessness: Benzodiazepines are no longer widely used to treat terminal delirium/restlessness, because of the high incidence of paradoxical effect. The antipsychotic, haloperidol, is the medication of choice to help calm the patient and improve mentation. Consider: haloperidol 2-4 mg PO hourly as needed to calm a crisis and determine therapeutic dose; then give that amount daily in two or three divided doses. May titrate down to desired effectiveness if overly sedated. If more sedation is needed, consider: chloral hydrate 500 mg hourly until calm to determine therapeutic dose; then give that combined amount at bedtime, BID or TID as needed. For non-swallowing patient, syrup (0.5 ml) may be extracted from 500 mg capsules and given SL.

Depression: The usual symptoms and signs of depression may be confused with or masked by symptoms and signs of delirium or masked by cognitive impairment. To manage depression, attend to what is distressing the patient, such as pain, other non-pain symptoms, or social issues. Social, emotional, and spiritual support as well as activities that involve others are beneficial. Consider a psychology referral and/or antidepressants.

Dyspnea: A common symptom at all stages of dying, dyspnea may limit your patient's activity and quality of life. It is strongly associated with anxiety, and each symptom may exacerbate the other. Dyspnea may be caused by pneumonia, bronchospasm, obstructive pulmonary disease, mucus plugs, severe anemia, tumor invasion, and several other factors.

Assess dyspnea as part of symptom history with a physical exam and workup based on the benefits and burdens, as well as patient's prognosis and preferences. Find out what works for the individual. It may be as simple as positioning, using a fan or opening a window, or trying relaxation techniques. You can suggest a trial of oxygen based on symptom relief, but avoid use of a face mask with most patients because it can be distressing.

Opioids remain the treatment of choice for dyspnea. Morphine sulfate is the most studied and versatile--known to block the sensation of air hunger.. Other medications to consider include benzodiazepines for anxiety; bronchodilators for wheezing; chlorpromazine; as well as steroids, diuretics and anticoagulants.

Fatigue: This may present prominently in cognitively intact patients. Fatigue can be associated with depression and should be assessed in relation to functional status and mood. Consider occupational therapy or physical therapy with the goal of improving quality of life versus function. You might also treat contributory factors such as anemia or electrolyte imbalance; however, you should warn the patient and family to anticipate increased fatigue as time passes.

1. CD4+ Count <25 cells/mc/L or persistent viral load >100,000 copies/ml, *plus one* of the following:
 - CNS lymphoma
 - Wasting (loss of 33% lean body mass)
 - Mycobacterium avium complex bacteremia
 - Progressive multifocal leukoencephalopathy
 - Systemic lymphoma
 - Visceral Kaposi's sarcoma
 - Renal failure in the absence of dialysis
 - Cryptosporidium infection
 - Toxoplasmosis
 - Advanced AIDS dementia complex
2. Decreased performance status, as measured by the Karnofsky Performance Status scale, of 50% or less. (*see page 21*)

Factors which will add supporting documentation

- √ Chronic persistent diarrhea for one year
- √ Persistent serum albumin <2.5 gm/dl
- √ Concomitant, active substance abuse
- √ Age > 50 years
- √ Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy
- √ Toxoplasmosis
- √ Congestive heart failure, symptomatic at rest

ICD-9 Codes that Support Medical Necessity

042 Human Immunodeficiency Virus (HIV) Disease

Heart Disease

1 and 2 must be present

1. Patient is already optimally treated with diuretics and vasodilators, or has a medical contraindication for those drugs, or has made a conscious decision not to take them.
2. Patient has significant symptoms of recurrent congestive heart failure at rest (i.e., inability to carry on any physical activity without discomfort; and if any physical activity is undertaken, discomfort is increased). Significant CHF may be documented by an ejection fraction of <20%, but is not required if not already available.

Factors which will add supporting documentation

3. ✓ Symptomatic arrhythmias
4. ✓ History of cardiac arrest or resuscitation
5. ✓ History of unexplained syncope
6. ✓ Brain embolism of cardiac origin
7. ✓ Concomitant HIV disease
8. ✓ Angina pectoris, at rest
9. ✓ History of previous myocardial infarction

ICD-9 Codes that Support Medical Necessity

- 411.1 Intermediate Coronary Syndrome
- 412 Old Myocardial Infarction
- 414.8 Other Specified Forms of Chronic Ischemic Heart Disease
- 428.0 Congestive Heart Failure Unspecified
- 428.1 Left Heart Failure
 - 428.9 Heart Failure Unspecified

Nausea: Opioids and other factors often cause nausea, which can be treated a number of ways. Prochlorperazine is an antidopaminergic, weak antihistamine, and anticholinergic agent. Haloperidol is a potent antidopaminergic agent. Promethazine can be useful for vertigo and gastroenteritis, but is not useful for opioid-related nausea. Scopolamine is a potent, purely anticholinergic agent.

Nonpharmacological interventions for nausea include applying a cool, damp cloth to the forehead, neck, and wrists; decreasing noxious stimuli including odors and noise; limiting fluids with foods; feeding only bland, cool, or room-temperature foods; practicing relaxation techniques; and utilizing acupuncture or acupressure.

Oral problems: Physicians should perform oral exams frequently to check for infections. Oral care should be administered at least daily for conscious patients, and at least three or four times a day for unconscious ones. This is a wonderful way to involve families in providing patient care.

For dry mouth, try any of the following: frequent sips of favorite liquids, popsicles, frozen fruit, tonic water, hard candies and artificial saliva. If the patient is unconscious, swab the mouth every one or two hours with water or spray with an atomizer. You can also apply Vaseline to the lips and front teeth.

Spiritual Pain: Clinicians can play a powerful role in eliciting and acknowledging their patients' spiritual concerns; however, you should not feel compelled to address those concerns yourself. Request interventions that include spiritual or religious counseling, diverse scriptures, and sacred objects and music.

Wounds: The underlying etiology of nonhealing chronic wounds is that they don't respond to treatment or the course of treatment is beyond the patient's endurance or stamina. If a wound won't close, communicate it to other staff and document the nonhealing nature of the wound.

Palliative care goals for chronic wounds should complement curative goals and focus on quality-of-life issues. Focus on cleansing the wound, reducing pain and bacterial burden, reducing exudates, and eliminating odor.

End-of-Life Conversations

In discussing end of life with patients and their families, it's important to know why communicating difficult news is important. Patients and families want to know what to expect during the dying process, and explaining what will happen strengthens the physician-patient/family relationship. It also fosters collaboration and permits planning and assessing coping behaviors in patients and families. You can follow a six-step protocol for delivering difficult news:

Step 1: Set up a meeting specifically to discuss a patient's end of life with the person and their family members. Plan what you'll say about their condition and their future. Create a conducive environment for the meeting. Choose a quiet place where you'll be undisturbed, and allot adequate time to answer questions.

Consider the number of people in the meeting and how informed they are going into the meeting. Determine the patient's decision-making capacity and who the patient would like to have present for the conversation. If the patient is cognitively impaired and has not chosen a durable power of health-care attorney, contact their next of kin or a known family member and invite them to meet with you.

Step 2: Establish what the patient and family already know, and assess their ability to comprehend new information. Postpone the conversation if they are emotionally unprepared to talk about end of life.

Step 3: Find out how much they want to know. If the family has indicated that they don't want the patient to be told their prognosis, explain the benefits of being informed and propose talking to the patient together.

Step 4: Promote dialogue by determining previous experiences. Avoid using medical jargon or euphemisms, and use periods of silence frequently. Check for the patient's and family's understanding--you can observe their facial expression for comprehension.

Step 5: Be prepared for outbursts of strong emotion or a broad range of reactions. This is a perfect opportunity to observe family dynamics, which may be useful in the future.

Step 6: Plan for next steps. Discuss potential sources of support; affirm your continued support; provide written information; and assess the patient before leaving.

Dementia

At least four of the following criteria must be present

1. Stage seven or beyond according to the Functional Assessment Staging Scale (*see page 22*)
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 meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Must have had one of the following

or some other documented significant condition in the past 12 months

- √ Aspiration pneumonia
- √ Pyelonephritis or other urinary tract infection
- √ 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

ICD-9 Codes that Support Medical Necessity

290.0	Senile Dementia Uncomplicated
290.40	Arteriosclerotic Dementia Uncomplicated
290.41	Arteriosclerotic Dementia with Delirium
290.42	Arteriosclerotic Dementia with Delusional Features
290.43	Arteriosclerotic Dementia with Depressive Features
294.1	Dementia in Conditions Classified Elsewhere
331.0	Alzheimer's Disease

Debility/Decline in Health Status

No specific number of criteria must be met.

They are listed in the order of their power to predict survival. poor

1. Progression of disease as documented by symptoms, signs, and test results.
2. Decline in Karnofsky Performance Status or Palliative Performance Score/Adapted Karnofsky. (*see page 21*)
3. Weight loss.
4. Dependence on assistance for *two or more* activities of daily living:
 - Feeding
 - Ambulation
 - Continence
 - Transfer
 - Bathing
 - Dressing
5. Dysphagia leading to inadequate nutritional intake.
6. Decline in systolic blood pressure or progressive postural hypotension.
7. Increasing need for skilled service.
8. Decline in Functional Assessment Staging (FAST) for dementia. (*see page 22*)
9. Progressive stage 3-4 pressure ulcers in spite of optimal care.

ICD-9 Codes that Support Medical Necessity

799.3 Debility Unspecified

When language is a barrier, use a skilled translator or telephone translation services. Avoid using a family member as the translator, which may confuse the translator, overwhelm their familiarity with medical terms, or cause them to modify the message to protect the patient.

Be conscious of intercultural dynamics. Common misunderstandings arise from a cultural resistance to discussing death, historical oppression leading to distrust; and cultural, social, economic, educational, and linguistic differences with health care providers. In providing palliative care to a patient near the end of their life, you may be tempted to soften difficult news. However, it deflects from other important issues such as final goodbyes, finishing projects, and reflecting on life. It's better to help the patient and family achieve realistic goals.

Also, patients and families are often waiting for providers' permission to let go. If a patient asks you, "How much time do I have?" avoid precise answers, but give a range of weeks or months. The needs of the patient and their family may vary, but some want time to plan. Others seek reassurance and don't want details.

Ethics

Every physician in end-of-life care faces fundamental ethical dilemmas. Basic principles of medical ethics include:

- No person's interests should be sacrificed as a means to an end.
- Everyone has a right to self-governance, self-direction, and freedom.
- Physicians and other caregivers should do nothing to, for, or concerning a patient against their will.
- You have an obligation to keep promises and contracts with patients, and to protect their privacy.
- One should not do harm, should intend to prevent harm, and should protect those we care for.
- One should act to do good and advocate for the good of the patient.
- One should determine a just or fair solution for patients, and consider what is fair in access to care and expectations of care.

Suggested Guidelines to Consider When Referring Non-Cancer Patients to Hospice

Medicare coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the terminal illness runs its normal course. Recognizing that determination of life expectancy during the course of terminal illness is difficult, the Centers for Medicare & Medicaid Services (CMS) has established medical criteria for determining prognosis for non-cancer diagnoses. These criteria form a reasonable approach to the determination of life expectancy based on available research.

Cancer patients who are determined to be hospice appropriate by their attending physician are not required to meet any other clinical guidelines. Not all hospice-appropriate non-cancer diagnoses are covered in this booklet. ICD-9 codes listed are not all-inclusive.

The Local Coverage Determinations (LCD's) included in this book are provided as general eligibility guidelines for patients with non-cancerous diagnoses. *The patient may not meet the criteria, yet still be appropriate for hospice care because of other co-morbidities or a rapid decline.*⁵

Amyotrophic Lateral Sclerosis

Any one of these clinical findings demonstrating a rapid progression of ALS must be present within 12 months preceding initial hospice certification.

1. Progression from independent ambulation to wheelchair, or to bed-bound status
2. Progression from normal to barely intelligible or unintelligible speech
3. Progression from normal to pureed diet
4. Progression from independence in most or all activities of daily living to needing major assistance by caretaker

In addition, any of the following constellation of clinical problems will signify terminal illness.

- A. Critically impaired breathing capacity
 - √ Vital capacity (VC) less than 30% of normal
 - √ Significant dyspnea at rest
 - √ Requiring supplemental oxygen at rest
 - √ Patient declines invasive artificial ventilation
- B. Critical nutritional impairment
 - √ Oral intake of nutrients and fluids insufficient to sustain life
 - √ Continuing weight loss
 - √ Dehydration or hypovolemia
 - √ Absence of artificial feeding methods
- C. Life-threatening complications
 - √ Recurrent aspiration pneumonia
 - √ Upper urinary tract infection, e.g., pyelonephritis
 - √ Sepsis
 - √ Fever recurrent after antibiotic therapy
- √ Decubitus ulcers, multiple, stage 3-4

ICD-9 Codes that Support Medical Necessity

335.20 Amyotrophic Lateral Sclerosis