

# Sharp HospiceCare Hospice Medicare Guidelines

Revised 2025



**SHARP**

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## Cancer

Please send the appropriate ICD-10 code.

1. Disease with metastases at presentation
- or
2. Poor functional status with expected progression of disease:
    - a. Despite treatment
    - b. Patient declines treatment

*Note: Certain metastatic cancers, such as breast and prostate with metastases to the bone only, may have a greater than 6-month prognosis.*

*Note: Certain cancers with poor prognoses (e.g., small-cell lung cancer, brain cancer and pancreatic cancer) may be eligible for hospice care without fulfilling the other criteria in this section.*

## COPD

ICD-10: J44.9

Items 1 and 2 should be present.

1. End-stage lung disease as supported by:
  - a. Disabling dyspnea at rest or with minimal exertion

- b. Bed-to-chair existence (due to poor activity tolerance)
  - c. Poor response to bronchodilators
  - d. Chronic fatigue and cough (due to poor pulmonary function)

2. Increasing emergency visits, hospitalizations, or home or office visits for pulmonary infections or respiratory distress

Additional supportive evidence:

- a. Room air oxygen saturation of 88% or less at rest, or  $pO_2 \leq 55$  mmHg on RA ABG
- or
- b.  $pCO_2 \geq 50$  mmHg on RA ABG
  - c. Cor pulmonale and right heart failure secondary to pulmonary disease
  - d. Progressive weight loss of  $\geq 10\%$  in the preceding 6 months
  - e. Resting tachycardia  $> 100$ /minute

# CVA

## ICD-10: I69.20 Unspecified

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40% (see Appendix B)
2. One of the following:
  - a. Weight loss > 10% in the last 6 months or > 7.5% in the past 3 months
  - b. Serum albumin < 2.5 g/dL
  - c. Current history of pulmonary aspiration not responsive to speech language pathology intervention
  - d. Sequential calorie counts documenting inadequate caloric or fluid intake
  - e. Dysphagia severe enough to prevent patient from continuing fluids or foods necessary to sustain life, and patient does not receive artificial nutrition and hydration
3. Additional supportive evidence — one of the following in the past 12 months:
  - a. Aspiration pneumonia
  - b. Pyelonephritis
  - c. Refractory decubitus ulcers, stage 3 or 4
  - d. Fever recurrent after antibiotics
4. Diagnostic imaging factors that support poor prognosis include:
  - a. Large volume hemorrhage or infarction
  - b. Ventricular extension of hemorrhage
  - c. Surface area hemorrhage equal to 30% of cerebrum
  - d. Midline shift > 1.5 cm
  - e. Obstructive hydrocephalus

# Dementia

ICD-10: G31.1

**F03.91 with behaviors**

**F03.90 without behaviors**

1. Patient demonstrates the following finding:
  - a. Functional Assessment Staging Tool (FAST) score:  
FAST usually no better than 7 (*see Appendix A*)
2. One of the following in the past 12 months:
  - a. Aspiration pneumonia
  - b. Pyelonephritis
  - c. Septicemia
  - d. Multiple decubitus ulcers, stage 3 or 4
  - e. Fever recurrent after antibiotics
  - f. 10% weight loss in the previous 6 months or a serum albumin < 2.5 g/dL

# Heart Disease

ICD-10: I50.9 Unspecified

**Items 1 and 2 should be present.**

1. NYHA Class IV = symptoms at rest
2. The patient must be on maximum medical therapy.  
This can be defined as no further reasonable medical therapy available, or the patient refuses further medical therapy. If a patient cannot tolerate further medical therapy, then they also qualify even if such therapy exists.

Additional supportive evidence:

- a. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias
- b. History of cardiac arrest or resuscitation
- c. History of unexplained syncope
- d. History of embolic CVA of cardiac origin

## Liver Failure

Please send the appropriate ICD-10 code.

Items 1 and 2 should be present.

1. The patient should have both a and b:
  - a. INR > 1.5 (not on anticoagulant medications)
  - b. Serum albumin < 2.5 g/dL
2. End-stage liver disease with at least one of the following features:
  - a. Refractory ascites (includes due to noncompliance)
  - b. History of spontaneous bacterial peritonitis
  - c. Hepatorenal syndrome
  - d. Refractory hepatic encephalopathy (includes due to noncompliance)
  - e. History of recurrent variceal bleeding despite intensive therapy

Additional supportive evidence:

- a. Progressive malnutrition
- b. Muscle wasting with reduced strength and endurance
- c. Continued active alcoholism
- d. Hepatocellular carcinoma
- e. HBsAg positive
- f. Hepatitis C refractory to therapy

## Renal Failure

ICD-10: N18.9 Unspecified

**Chronic Renal Failure: Items 1 and either 2 or 3 should be present.**

1. Any patient who is not seeking or has discontinued dialysis
2. Creatinine clearance < 10 cc/min (< 15 cc/min for patients with diabetes)
3. Serum creatinine > 8.0 mg/dL (> 6.0 mg/dL for patients with diabetes)

Additional supportive evidence:

- a. Uremia
- b. Oliguria (< 400 cc of urine per day)
- c. Intractable hyperkalemia (> 7.0)
- d. Uremic pericarditis
- e. Hepatorenal syndrome
- f. Intractable fluid overload

*Note: A patient can be admitted to hospice and stay on dialysis if the admitting diagnosis is something other than renal disease.*

## Supporting Criteria

If patients do not clearly qualify under a disease category listed in this handbook, these additional signs and symptoms are supportive evidence:

### 1. Clinical status

- a. Recurrent or intractable infections
- b. Wasting as documented by:
  - Unexpected weight loss
  - Decreasing serum albumin or cholesterol
- c. Dysphagia leading to recurrent aspiration and/or leading to inadequate oral intake

### 2. Symptoms

- a. Dyspnea or increasing respiratory rate
- b. Intractable cough
- c. Nausea and vomiting
- d. Intractable diarrhea
- e. Increasing pain

### 3. Signs

- a. Hypotension (off antihypertensive medications)
- b. Ascites
- c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
- d. Edema
- e. Pleural/pericardial effusion
- f. Weakness
- g. Change in level of consciousness

### 4. Labs

- a. Increasing pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>
- b. Increasing calcium, creatinine or liver function studies
- c. Increasing tumor marker
- d. Decreasing sodium or increasing potassium

### 5. Decline in KPS (Karnofsky Performance Status) or PPS (Palliative Performance Scale) to < 70%

### 6. Progressive decline in FAST (Functional Assessment Staging Tool) (see *Appendix A*)

*Continued*

7. Increased assistance with ADLs (ambulation, bathing, continence, dressing, feeding and transfer)
8. Progressive stage 3 or 4 pressure ulcers despite optimal care
9. Increasing visits of any type related to the hospice diagnosis

## Referral Process

- **Hospitals use CarePort**
- **Sharp Epic users:**
  - Select: Ambulatory Referral to Sharp Hospice [REF35]
  - Ref to Department: SHC HOSPICE
  - Referral Reason: Specialty Services Required
  - Referral Priority: Routine
  - Class: Internal Referral (for Sharp HealthCare only)
  - Dept Specialty: Hospice Services
- **Community non-Epic users**  
Referral form: [sharp.com/hospice](http://sharp.com/hospice)
  - Email: [HospiceIntake@sharp.com](mailto:HospiceIntake@sharp.com)
  - By phone: 619-667-1940
  - By fax: 619-740-8584 (with signed physician order)

For more information about our programs, visit [sharp.com/hospice](http://sharp.com/hospice).

# Appendix A:

## Functional Assessment Staging Tool (FAST)

Score	Description
1	No difficulty either subjectively or objectively
2	<ul style="list-style-type: none"><li>Complains of forgetting location of objects</li><li>Subjective work difficulties</li></ul>
3	<ul style="list-style-type: none"><li>Decreased job functioning evident to co-workers</li><li>Difficulty in traveling to new location</li><li>Decreased organization capacity</li></ul>
4	Decreased ability to perform complex tasks, such as: <ul style="list-style-type: none"><li>Planning dinner for guests</li><li>Handling personal finances (e.g., forgetting to pay bills)</li><li>Difficulty shopping, etc.</li></ul>
5	<ul style="list-style-type: none"><li>Requires assistance in choosing proper clothing to wear for the day, season or occasion</li><li>Repeatedly observed wearing the same clothing, unless supervised</li></ul>

Score	Description
6	<ul style="list-style-type: none"><li>a) Improperly putting on clothes without assistance or cueing (e.g., shoes on wrong feet, day clothes over night clothes, difficulty buttoning)</li><li>b) Unable to bathe properly (e.g., difficulty adjusting bath water temperature)</li><li>c) Unable to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue)</li><li>d) Urinary incontinence — intermittent or constant</li><li>e) Fecal incontinence — intermittent or constant</li></ul>
7	<ul style="list-style-type: none"><li>a) Limited ability to speak 6 or more intelligible words in an average day or interview</li><li>b) Speech ability is limited to the use of a single intelligible word in a normal interaction — demonstrates repetitive actions</li><li>c) Ambulatory ability is lost (cannot walk without personal assistance)</li><li>d) Cannot sit up without assistance, or falls over if no lateral arm rests on chair</li><li>e) Loss of ability to smile</li><li>f) Loss of ability to hold up head independently</li></ul>

## Appendix B:

### Palliative Performance Scale (PPS) v2

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal Activity and Work, No Evidence of Disease	Full	Normal	Full
90%	Full	Normal Activity and Work, 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 to Do Normal Work, Significant Disease	Full	Normal or Reduced	Full
60%	Reduced	Unable to Do Hobby/Housework, 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 Most Activity, Extensive Disease	Mainly Assistance	Normal or Reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Normal or Reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Minimal to Sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Mouth Care Only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

## Instructions for Use of PPS (see also Definition of Terms for PPS)

1. PPS scores are determined by reading horizontally at each level to find a “best fit” for the patient, which is then assigned as the PPS % score.
2. Begin at the left column and read downward until the appropriate ambulation level is reached, then read across to the next column and downward again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, “leftward” columns (columns to the left of any specific column) are “stronger” determinants and generally take precedence over others.
  - **Example 1:** A patient who spends most of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances, but who is otherwise fully conscious with good intake, would be scored at PPS 50%.
  - **Example 2:** A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because they would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care, including lift/transfer. The patient may have normal intake and full conscious level.
- **Example 3:** However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care, such as feeding themselves, then the PPS would be higher at 40% or 50% because they are not “total care.”
3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two that seem better at a higher or lower level. One then needs to make a “best fit” decision. Choosing a “half-fit” value of PPS 45%, for example, is not correct. The combination of clinical judgment and “leftward precedence” is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient’s current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

## Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall “best fit” using all five columns.

### 1. Ambulation

The items “**mainly sit/lie**,” “**mainly in bed**” and “**totally bed bound**” are clearly similar. The subtle differences are related to items in the self-care column. For example, “totally bed bound” at PPS 30% is due to either profound weakness or paralysis such that the patient not only can’t get out of bed but is also unable to do any self-care. The difference between “sit/lie” and “bed” is proportionate to the amount of time the patient is able to sit up vs. need to lie down.

“**Reduced ambulation**” is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation, or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

### 2. Activity and Extent of Disease

“**Some**,” “**significant**” and “**extensive**” disease refer to physical and investigative evidence that shows degrees of progression. For example, in breast cancer, a local recurrence would imply “some” disease; one or two metastases in the lung or bone would imply “significant” disease; and multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be “extensive” disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, “some” may mean the shift from HIV to AIDS, and “significant” implies progression in physical decline, new or difficult symptoms, and laboratory findings with low counts. “Extensive” refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one’s work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3 course, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (e.g., trying to walk the halls).

### 3. Self-Care

“**Occasional assistance**” means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

“**Considerable assistance**” means that every day the patient regularly needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush their teeth or wash at least their hands and face. Food will often need to be cut into edible sizes, but the patient is then able to eat on their own.

“**Mainly assistance**” is a further extension of “considerable.” Using the above example, the patient now needs help getting up but also needs assistance washing their face or shaving, but “**total care**” means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to them.

### 4. Intake

Changes in intake are quite obvious, with “**normal intake**” referring to the person’s usual eating habits while healthy.

“**Reduced**” means any reduction from that and is highly variable according to the unique individual circumstances.

“**Minimal**” refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

### 5. Conscious Level

“**Full consciousness**” implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. “**Confusion**” is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. “**Drowsiness**” implies either fatigue, drug side effects, delirium or closeness to death, and is sometimes included in the term stupor. “**Coma**” in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24-hour period.

Palliative Performance Scale (PPS) v2 tool ©2001 Victoria Hospice Society.



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