The Debility Dilemma: Guidance for Hospice Physicians
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For hospice claims reporting: Choose the diagnosis “most contributory” to the terminal illness as the principal diagnosis with all other prognosis-impacting secondary/comorbid conditions in the additional diagnoses fields.

Action Steps For New Admissions:
1. Do not use debility, adult failure to thrive, or other symptoms, signs and/or ill-defined conditions as the principal hospice diagnosis (ICD-9 codes 780-799).
2. Look for clues to identify the diagnosis most contributory to the patient’s terminal disease trajectory and limited prognosis. For example:
   a. Ask the referral source for the patient’s most recent problem list; for admissions from the hospital, ask for the most recent inpatient physician progress and consultation notes, laboratory and imaging results and if available, the hospital discharge summary;
   b. Review the Drug Profile (i.e., all prescription, over-the-counter, and complementary medications/treatments);
   c. Review the facility’s Medication Administration Record, if applicable; and,
   d. Ask the patient/representative about prior health issues, concerns, and challenges (including medical/surgical history, specialists consulted previously, etc.).
3. Where appropriate, use other conditions to support a 6-month prognosis. If contributory to the terminal prognosis, these conditions should be considered “related” (and covered under the hospice per diem payment).
4. For the principal hospice diagnosis, consider using the one a physician would list as the proximal cause of death on the death certificate.

Action Steps For Current Patients:
1. Review the current census to identify all patients with debility, adult failure to thrive, or other symptoms, signs and/or ill-defined conditions listed as the principal hospice diagnosis.
2. Review each identified clinical record to find clues to an alternate diagnosis. For example:
   a. Review the Plan of Care to determine which body systems, symptoms, and/or psychosocial/spiritual issues require palliative intervention(s);
   b. Review the Drug Profile; and,
   c. Try to identify the diagnosis most contributory to the patient’s terminal disease trajectory and limited prognosis.
3. As noted above, for the principal hospice diagnosis, consider using the one a physician would list as the proximal cause of death on the death certificate.
4. If the patient has no clear alternate diagnosis supported by clinical documentation, and if the plan of care has not changed over time to reflect end-of-life symptom management and progression along the disease trajectory, consider discharging the patient due to extended prognosis.
Determine:
- What diagnosis is most likely leading to the patient’s demise?
- What are the patient’s comorbid conditions? Are these related or unrelated the principal hospice diagnosis and terminal prognosis?
- What medications is the patient on? Are these related or unrelated to the principal hospice diagnosis and terminal prognosis?
- What is the nature of the patient’s decline?
- Do you believe it is more likely than not that the patient will have a terminal event in the next 6 months?
- Does the patient also suffer from debility?

Document:
- The principal hospice diagnosis; for changes in principal diagnosis for current patients, write a physician order and explain in the record the clinical reasoning behind the choice of the new diagnosis;
- All secondary and/or comorbid conditions contributing to the patient’s limited prognosis;
- Debility and adult failure to thrive as secondary conditions, if applicable [Note: the LCD guidelines for adult failure to thrive may be used to support clinical eligibility if it is listed as a secondary diagnosis];
- The structural, functional (KPS/PPS, ADL dependence, etc.), nutritional (BMI, MAC, albumin, etc.), and cognitive impairments (FAST for patients with Alzheimer’s disease or dementias secondary to other causes);
- All comorbidities that are unrelated to the terminal prognosis (do not include these in the physician’s narrative);
- The patient’s disease burden;
- The patient’s trajectory of decline (i.e., rapid, saw-toothed, or dwindling);
- The patient’s symptom burden; and,
- The patient’s/representative’s goals of care, including but not limited to advance directives.

Exceptions:
- There might be patients who are determined to be clinically eligible with a prognosis of 6 months or less, but for whom there is no well-defined principal diagnosis. This is the only case where an ill-defined diagnosis might be justifiable as principal hospice diagnosis (e.g., cachexia ICD-9 code 799.4), if determined to be the condition most contributory to the terminal prognosis. However, this exception is a last case scenario, when there is no other diagnosis that is more appropriate, and does not apply to debility and adult failure to thrive.