Clinical Policy: Hospice Services

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Hospice is a coordinated, integrated program developed by an interdisciplinary team of professionals to provide end-of-life care primarily focused on relieving pain and symptoms specifically related to the terminal diagnosis of members/enrollees with a life expectancy of six months or less if their medical condition runs its expected course. This policy describes the medical necessity criteria for hospice services.

Policy
Initial Request
It is the policy of Louisiana Healthcare Connections that hospice is considered **medically necessary** when the *requirements in Criteria sections I, II, and III are met:*

I. The Required Documentation has been submitted, and
II. The member/enrollee meets one of the disease specific guidelines or decline in clinical status criteria:
  A. Cancer;
  B. ALS;
  C. Heart Disease;
  D. Pulmonary Disease;
  E. Dementia due to Alzheimer's Disease and Related Disorders;
  F. HIV;
  G. Liver Failure;
  H. Acute or Chronic Renal Failure;
  I. Stroke;
  ~~J.~~ Coma;
  K. Decline in Clinical Status;
III. The requested intensity of service is appropriate for one of the following:
  A. Routine Hospice Home Care;
  B. Continuous Hospice Home Care;
  C. Inpatient Respite Hospice Care;
  D. General Inpatient, Short Term (non-respite) Hospice Care;
IV. Not Medically Necessary Services;
V. Recertification of Hospice Services;

Note: Hospice room and board (long-term care/nursing home) coverage is based on the Benefit Plan Contract.

Criteria
I. Required Documentation

A. Documentation of hospice medical director certification of hospice appropriateness for the initial 90-day certification period, which includes all of the following:
   1. BHSF FORM HOSPICE-CTI (Certification of Terminal Illness)[13]
   2. The written certification must identify the terminal illness diagnosis that prompted the member/enrollee to seek hospice care, including a statement that the member/enrollee's life expectancy is six months or less if the terminal diagnosis runs its normal course;
   3. Details specific clinical findings supporting a life expectancy of six months or less;
   4. The documentation also includes a hospice election statement signed by the member/enrollee or the member/enrollee's healthcare proxy stating they understand the nature of hospice care.
   5. BHSF FORM HOSPICE-NOE (Notice of Election/Revocation/Discharge/Transfer)[13]
      a. An election statement for hospice care must be filed by the member/enrollee or by a person authorized by law to consent to medical treatment for the member/enrollee and must confirm understanding of the nature of hospice care.[13]

B. A plan of care that meets all of the following:
   1. Established at the time of initiating hospice services;
   2. Includes an assessment of the member/enrollee's needs and identifies services to meet these needs, including the management of discomfort and symptom relief;
   3. Includes detail of the scope and frequency of services needed to meet the needs of the member/enrollee and the family/caregiver;
   4. Updated if the member/enrollee's condition improves or deteriorates and when the level of care changes.
   5. Includes corroborating referral documentation, such as progress notes from the hospital, home health agency, or physician's office.[13]
   6. Includes physician orders for the plan of care.[13]
   7. Includes the original and current Minimum Data Set (MDS) form when the member/enrollee resides in a facility, along with: [13]
      a. Weight records;
      b. Laboratory results;
      c. Physician progress notes; and
      d. Nursing progress notes.

Note:

- The original and current MDS forms are not required for the initial request when the member/enrollee has resided in a long-term care facility for fewer than 30 days. The MDS forms must be provided with the subsequent request for continuation of hospice services.[13]

- The plan of care must be periodically reviewed by the attending physician or hospice medical director and the hospice interdisciplinary group when the member/enrollee's condition or level of care changes.
- The plan of care should be reviewed and updated by the hospice interdisciplinary group within the two weeks preceding the end of each certification period and before submission of a recertification request.

C. Documentation to support the member/enrollee's hospice appropriateness must include the following: [13]
   1. Paint a picture of the member/enrollee's condition;
   2. Illustrate why the member/enrollee is considered terminal and not chronic;
   3. Explain why the diagnosis has created a terminal prognosis; and
   4. Show how the body systems are in a terminal condition.

Note: A cover letter alone is not sufficient to support the request. Supporting information must be documented within the clinical record with appropriate dates and signatures.[13]

II. Disease Specific Guidelines

The presence of significant comorbidities should be considered when using these criteria to determine hospice appropriateness.

A. *Cancer* – meets all of the following:
   1. Palliative performance scale (PPS) (Appendix A) or Karnofsky performance status scale (KPS) (Appendix B) score < 70%;
   2. Dependence for at least two activities of daily living (ADLs) (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
   3. Disease status is one of the following:
      a. Metastatic cancer at presentation, and member/enrollee defers therapy;
      b. Progression to metastatic disease with decline despite therapy, or member/enrollee defers therapy;
      c. Brain, pancreatic, or small cell lung cancer;

B. *Amyotrophic Lateral Sclerosis (ALS)* – meets all of the following:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
   2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
   3. Disease status is one of the following:
      a. Signs or symptoms of impaired respiratory function, not electing tracheostomy or invasive ventilation, and forced vital capacity (FVC) < 30% (if results available);
      b. Rapid progression of ALS with critical nutritional impairment as demonstrated by all of the following:
         i. Absence of artificial feeding methods sufficient to sustain life, while permitting nutritional methods for relieving hunger
         ii. One of the following:
            a) Oral intake of nutrients and fluids insufficient to sustain life;
            b) Continuing weight loss;
            c) Dehydration or hypovolemia;

c. Rapid progression of ALS with other life-threatening complications (sepsis, recurrent aspiration pneumonia, pyelonephritis, recurrent fever after antibiotic therapy, stage 3 or 4 decubiti);
Note: Rapid progression of ALS may include ALS-related disability requiring extensive caregiver assistance with all ADLs, progression to a pureed diet, and speech that becomes barely intelligible or unintelligible.

C. *Heart Disease* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Meets one of the following:
   a. Member/enrollee is being optimally treated for heart disease or has had optimal medical treatment, including treatment with IV inotropes or has declined optimal medical treatment;
   b. Member/enrollee is not a candidate for a surgical procedure or declines a procedure;
4. Member/enrollee is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest.
   Note: Significant congestive heart failure may be documented by an ejection fraction of ≤ 20% but is not required if not already available.

D. *Pulmonary Disease* – has fixed obstructive disease OR restrictive disease and meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Severity, all:
   a. Disabling dyspnea at rest or with minimal exertion;
   b. Diminished functional capacity (e.g., bed-to-chair existence, fatigue, and cough);
   c. Forced expiratory volume in one second (FEV1) < 30% predicted, after bronchodilator (if able to obtain);
4. Progressiveness as evidenced by increasing visits to the ED or hospitalization for pulmonary infections and/or respiratory failure, or increasing physician home visits;
5. One of the following:
   a. Hypoxemia at rest on room air as evidenced by one of the following:
      i. Partial pressure of oxygen in arterial blood (PaO2) ≤ 55 mmHg;
      ii. Oxygen saturation (SpO2) or arterial oxygen saturation (SaO2) ≤ 88%;
   b. Partial pressure of carbon dioxide in arterial blood (PaCO2) ≥ 50 mmHg;

E. *Dementia due to Alzheimer's Disease and Related Disorders* – meets all of the following:
1. Increasing severity indicated by the Functional Assessment Staging Scale (FAST) (Appendix C) stage 7 or beyond;
2. Increasing medical complications indicated by one of the following in the past 12 months:
   a. Aspiration pneumonia;
   b. Pyelonephritis or other upper urinary tract infection;
   c. Septicemia;
   d. Multiple stage 3-4 decubiti;

e. Fever recurrent after a course of antibiotics;
f. Weight loss of at least 10% during the previous six months;
g. Albumin < 2.5 g/dl;

F. *HIV* – meets all of the following:
1. CD4+ (T-cell) count < 25 or viral load > 100,000 copies/ml;
2. PPS (Appendix A) or KPS (Appendix B) score < 50%;
3. At least one of the following AIDS-related conditions:
a. Central nervous system or poorly responsive systemic lymphoma;
b. Wasting: loss of at least 10% lean body mass;
c. Mycobacterium avium complex (MAC) bacteremia;
d. Progressive multifocal leukoencephalopathy (PML);
e. Refractory visceral Kaposi's sarcoma (KS);
f. Renal failure in the absence of dialysis;
g. Cryptosporidium infection;
h. Refractory toxoplasmosis;

G. *Liver Disease* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Member/enrollee has end-stage liver disease;
4. Prothrombin time (PT) > five seconds over control or International Normalized Ratio (INR) > 1.5;
5. Albumin < 2.5 g/dl;
6. At least one of the following:
a. Recurrent bleeding esophageal varices despite therapy;
b. Refractory ascites;
c. Episode of spontaneous bacterial peritonitis;
d. Hepatorenal syndrome;
e. Hepatic encephalopathy;

H. *Acute or Chronic Renal Failure* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Member/enrollee is in renal failure, not receiving dialysis, and one of the following:
a. Serum Creatinine > 8 mg/dl (> 6 mg/dl for members/enrollees with diabetes);
b. Creatinine clearance < 15 ml/minute;
Note: Member/enrollee may still qualify for hospice if receiving dialysis for a condition not related to the terminal illness.

I. *Stroke* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) ≤ 40%;
2. Inadequate oral intake with one of the following:
a. Weight loss of > 10% body weight in the last six months, or > 7.5% in the last three months;
b. Serum albumin < 2.5 g/dl;
c. Recurrent pulmonary aspiration not responsive to speech-language pathology intervention;

d. Dysphagia and declining tube feeding and hydration;

J. *Coma* – member/enrollee is comatose with at least three of the following on day three of coma:
   1. Abnormal brain stem response;
   2. Absent verbal response;
   3. Absent withdrawal to painful stimuli;
   4. Creatinine > 1.5 mg/dl;

K. *Decline in Clinical Status* (the presence of significant comorbidities should be considered when using these criteria), all of the following:
   1. Irreversible decline, based on both baseline and follow-up determinations; and
   2. Clinical deterioration of one or more of the following:
      a. Progressive dependence for ADLs;
      b. PPS (Appendix A) or KPS (Appendix B) score < 70%;
      c. Increasing frequency of ER visits or hospitalizations;
      d. Worsening of one or more of the following:
         i. Clinical status - such as recurrent infections, inanition with progressive weight loss, dysphagia, or decreasing albumin or cholesterol;
         ii. Signs - such as hypotension, ascites, edema, pleural or pericardial disease, venous, arterial or lymphatic obstruction due to local progression or metastatic disease, weakness, or decreased consciousness;
         iii. Symptoms - such as dyspnea, intractable cough, nausea or vomiting that is poorly responsive to treatment, intractable diarrhea, or pain;
         iv. Laboratory results (when available)- arterial blood gases, tumor markers, electrolytes, calcium, creatinine, or liver function tests;
      e. Progressive or stage 3 to 4 decubiti despite medical therapy;
      f. Progressive decline in FAST for dementia not related to Alzheimer's disease (from 7A on the FAST).

III. Intensity Of Service (Level of Care)

The level of care and the dates of service requested must be specified. Only one level of care may be authorized for each day of hospice care provided to an eligible member/enrollee. *The appropriate HCPCS or revenue code must be billed according to applicable contract provisions*.

A. *Routine Hospice Home Care* (HCPCS T2042 or revenue code 0651)
Routine hospice home care is medically necessary when < eight hours of nursing care, which may be intermittent, is required in a 24-hour period. 90 days of routine hospice care may be approved.

B. *Continuous Hospice Home Care* (HCPCS T2043 or revenue code 0652)
Continuous hospice home care is medically necessary to maintain the member/enrollee at home when the member/enrollee requires ≥ eight hours of nursing care in a 24-hour period. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill member/enrollee at home.

C. *Inpatient Respite Hospice Care* (HCPCS T2044 or revenue code 0655)
Respite hospice care is medically necessary to relieve family members/enrollees or other primary caregivers of care duties for no more than five consecutive days per episode.

Respite care is short-term inpatient care, and not residential or custodial care. Up to five days per episode of inpatient respite care may be approved.

D. *General Inpatient, Short Term (non-respite) Hospice Care* (HCPCS T2045 or revenue code 0656)
   1. General inpatient, short term care services are medically necessary when the intensity or scope of care needed during an acute crisis is not feasible in the home setting and requires frequent adjustment by the member/enrollee's care team;
   2. The individual treatment plan is specifically directed at acute symptom management and/or pain control and is not intended for curative treatment of the terminal illness.

Note: A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility. [13]

IV. Not Medically Necessary Services

Hospice services are considered **NOT medically necessary** under the following circumstances:

A. Members/enrollees with any of the following as the primary diagnosis:
   1. Debility or unspecified debility;
   2. Failure to thrive;
B. The member/enrollee is no longer considered terminally ill as evidenced by a review of the medical documentation;
C. Services, supplies or procedures that are directed towards curing the terminal condition, except for children covered under Medicaid or CHIP;
D. Member/enrollee chooses to revoke the hospice election by submitting a signed, written statement with the effective date of the revocation;
E. Member/enrollee is discharged from hospice services; e.g. member/enrollee is no longer considered terminally ill, member/enrollee refuses services or is uncooperative, moves out of the area, or transfers to a non-covered hospice program.

Note:

- In the event a member/enrollee is discharged from hospice, benefit coverage would be available as long as the member/enrollee remained eligible for coverage of medical services.
- A new certification period is required any time a member/enrollee is discharged from hospice and then re-elects hospice. There is no waiting period for the member/enrollee to re-elect hospice benefits. The member/enrollee forfeits hospice coverage for any remaining days in the current certification period.

V. Recertification of Hospice Services

Authorization is required for *each change* in the level of intensity of service. Only one level of care may be authorized for each day of hospice care provided to an eligible member/enrollee. *The appropriate HCPCS or revenue code must be billed according to applicable contract provisions*.

It is the policy of Louisiana Healthcare Connections that subsequent requests for hospice are **medically necessary** when meeting one of the following:

A. **Routine home care hospice is considered medically necessary when meeting one of the following:**
   1. Request for recertification within 180 days of beginning hospice services with submission of a renewed certification of terminal illness from the hospice medical director detailing the need for continued hospice services based on clinical findings supporting a life expectancy of six months or less if the terminal diagnosis runs its normal course;*
   2. Request for recertification beyond 180 days of hospice services, submission of all the following:*
      a. A renewed certification of terminal illness from the hospice medical director detailing the need for continued hospice services based on clinical findings supporting a life expectancy of six months or less if the terminal diagnosis runs its normal course;
      b. Documentation of a face-to-face encounter between the member/enrollee and a hospice physician or nurse practitioner completed prior to the end of each previous certification period;

Note:
Members/enrollees in the terminal stage of their illness who originally qualify for hospice but stabilize or improve while receiving hospice care yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.
The current hospice POC should be included when submitting a request for subsequent recertification periods.

B. Louisiana Medicaid Documentation Requirements for Subsequent Benefit Periods
   The following documentation must be submitted, as applicable, for subsequent benefit periods: [13]
   1. MDS forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the beneficiary resides in a nursing facility.
   2. An updated BHSF Form Hospice-CTI signed and dated by the hospice medical director or physician member of the interdisciplinary group (IDG). For the third and subsequent requested prior authorization periods, documentation of a face-to-face encounter performed and attested to by a hospice physician or nurse practitioner must also be submitted in accordance with Louisiana Medicaid timing and documentation requirements.
   3. An updated POC
   4. Updated physician's orders
   5. List of current medications (within last 60 days)
   6. Current laboratory/test results (within last 60 days if available)
   7. Description of hospice diagnosis
   8. Description of changes in diagnoses
   9. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain)

10. A social evaluation
11. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST)
12. The beneficiary's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the beneficiary's decline in detail. Compare last month's status to this month's status

This information must be submitted for all subsequent benefit periods and must show a decline in the beneficiary's condition for the authorization to be approved. [13]

For prior authorization, the prognosis of terminal illness will be reviewed. A recipient must have a terminal prognosis in addition to a completed Hospice Certification of Terminal Illness form and proof of the face-to-face encounter. Authorization will be made on the basis that a recipient is terminally ill as defined in Federal Regulations. These regulations require certification of the prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence in the clinical record about the recipient's condition and not simply on the recipient's diagnosis. [13]

C. **Change to a higher intensity of service from routine hospice,** one of the following:

1. *Continuous Hospice Home Care* (HCPCS T2043 or revenue code 0652)
Continuous hospice home care is medically necessary to maintain the member/enrollee at home when the member/enrollee requires ≥ eight hours of nursing care in a 24-hour period. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill member/enrollee at home.
2. *Inpatient Respite Hospice Care* (HCPCS T2044 or revenue code 0655)
Respite hospice care is medically necessary to relieve family members/enrollees or other primary caregivers of care duties for no more than five consecutive days per episode. Respite care is short-term inpatient care, and not residential or custodial care. Up to five days per episode of inpatient respite care may be approved.
3. *General Inpatient, Short Term (non-respite) Hospice Care* (HCPCS T2045 or revenue code 0656), meets both:
    a. The intensity or scope of care needed during an acute crisis is not feasible in the home setting and requires frequent adjustment by the member's/enrollee's hospice care team;
    b. The treatment plan is specifically directed at acute symptom management and/or pain control.

Note: A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility. [13]

D. **Change to routine home care following higher intensity of service**

Continuation of routine home care following a higher level of care is medically necessary for the duration of the current 90-day certification period or 60-day recertification period.

Definitions

Levels of Care - four distinct levels of care are available

A. *Routine Hospice Home Care*
Routine hospice home care is care provided in the member/enrollee's home and is related to the terminal diagnosis and hospice plan of care written for the member/enrollee. Routine hospice home care may include up to 8 hours of skilled nursing care in a 24-hour period. This care may be provided in a private residence, hospice residential care facility, nursing facility, or an adult care home.

B. *Continuous Hospice Home Care*
Continuous hospice home care consists primarily of skilled nursing care at a member/enrollee's home during brief periods of crisis in order to achieve palliation or management of acute medical symptoms and only as necessary to maintain the member/enrollee at home. Continuous care must provide a minimum of eight hours of nursing care in a 24-hour period; the nursing care need not be continuous. Continuous care may be supplemented by home health aide or homemaker services, but at least 50% of the total care must be provided by a nurse, and the care required must be predominantly nursing, rather than personal care or assistance with activities of daily living. Continuous hospice home care is not intended to be respite care or an alternative to paid caregivers or placement in another setting. Continuous hospice home care may include any of the services outlined in the covered services definition below.

C. *Inpatient Respite Hospice Care*
Short-term inpatient respite hospice care is provided in an approved inpatient hospice facility, hospital or nursing home for no more than five consecutive days per episode. It is allowed to relieve family members/enrollees or other primary caregivers of the primary caregiving duties. A primary caregiver is an individual, designated by the member/enrollee, who is responsible for the 24-hour care and support of the member/enrollee in his or her home. A primary caregiver is not required to elect hospice if it has been determined by the hospice team that the member/enrollee is safe at home alone at the time of the election.

D. *General Inpatient, Short Term (non-respite) Hospice Care*
General inpatient care, under the hospice benefit, is short-term, non-respite hospice care and is appropriate when provided in an approved hospice facility, hospital or nursing home. It is specifically used for pain control and symptom relief which is related to the terminal diagnosis and cannot be managed in the home hospice setting. The goal is to stabilize the member/enrollee and return him/her to the home environment. General inpatient, short-term hospice care may include any of the services outlined in the covered services definition below.

E. *Service Intensity Add-On Rate (SIA)* (Revenue Code 0659)
A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse (RN) or a social worker, when provided during routine home care (0651) in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate. Claims for SIA services must be billed in units. Each unit is equal to 15 minutes. The maximum number of reimbursable units per day is 16 units. The seven-day maximum number of reimbursable units is 112 units. Documentation submitted should reflect the

arrival and departure time of the professional providing the services. Visits for the pronouncement of death only will not be reimbursed as an eligible visit. [13]

Certification Periods
Certification (benefit) periods include an initial 90-day benefit period, followed by a second, 90-day benefit period, followed by an unlimited number of 60-day benefit periods. Hospice care is continuous from one period to another, unless the member/enrollee revokes, or the hospice provider discharges or does not recertify.

Discontinuation of Hospice
If a member/enrollee revokes or is discharged from hospice care, the remaining days in the benefit period are lost. If/when the member/enrollee meets the hospice coverage requirements, they can re-elect the hospice benefit, and will begin with the next benefit period.

Covered Services
When the above coverage criteria are met, the following hospice care services may be covered as part of the hospice treatment plan:

A. Physician services;
B. Appropriate skilled nursing services;
C. Home health aide services;
D. Physical and/or occupational therapy;
E. Speech therapy services for dysphagia/feeding therapy;
F. Medical social services;
G. Counseling services (e.g., dietary, bereavement);
H. Short-term inpatient care;
I. Prescription drugs (all drugs and biologicals that are necessary for the palliation and management of the terminal illness and related conditions);
J. Consumable medical supplies (e.g., bandages, catheters) used by the hospice team.

Non-covered Services
The following services are considered not covered as part of the hospice treatment plan:

A. Services during an acute inpatient stay *for a diagnosis that is unrelated to the terminal illness* for which the member/enrollee is receiving hospice care;
B. Services for individuals no longer considered terminally ill;
C. Services, supplies or procedures, or medication that are directed towards curing the terminal condition, except for children enrolled in Medicaid or CHIP who are receiving concurrent care;
D. Services to primarily aid in the performance of activities of daily living;
E. Nutritional supplements, vitamins, minerals and non-prescription drugs;
F. Medical supplies unrelated to the palliative care to be provided;
G. Services for which any other benefits apply.

Provider Responsibilities
Responsibilities of the hospice provider include:

A. Verifying member/enrollee eligibility;

B. Obtaining authorization to provide hospice services before hospice care is initiated;
C. Notifying the health plan of any significant change in the member/enrollee's status or condition including revisions to treatment plans and goals;
D. Requesting each change in the level of hospice service including discharge from hospice.

Background

Most hospice services are provided at home by a licensed certified hospice provider under the direction of an attending physician, who may be the member/enrollee's primary care physician or the hospice medical director.[4] Hospice services are provided under a plan of care designed by the interdisciplinary team to meet the needs of members/enrollees who are terminally ill, as well as their families.

Hospice services include skilled nursing, homemaker and home health aide services, physician services, physical, occupational and speech therapy, medical social services, volunteer services, nutritional, spiritual, psychosocial/supportive and bereavement counseling related to the management of the terminal illness. Hospice includes drugs and biologics related to the management of the terminal illness, to relieve pain, provide hydration and to deliver enterals as a primary source of nutrition. Durable medical equipment and medical supplies are also included in hospice, when related to the management of a terminal illness.

Appendices

Appendix A: Palliative Performance Scale (PPS)[5]

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & 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 job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable to do hobby or housework Significant disease	Occasional assistance needed	Normal or reduced	Full confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full 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

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
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	Full or drowsy +/- confusion
0%	Death				

Appendix B: Karnofsky Performance Status Scale (KPS) Definitions Rating (%) Criteria[6]

Activity Level	Score	Detailed Activity Level
Able to carry on normal activity and to work; no special care needed.	100	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 personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease 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.

Appendix C: Functional Assessment Staging Test (FAST) for Alzheimer's disease

Stage	Stage Name	Characteristic
1	Normal aging	No deficits
2	Possible mild cognitive impairment	Subjective functional deficit
3	Mild cognitive impairment	Objective functional deficit interferes with a person's most complex tasks
4	Mild dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling
5	Moderate dementia	Needs help selecting proper attire
6a	Moderately severe dementia	Needs help putting on clothes
6b	Moderately severe dementia	Needs help bathing
6c	Moderately severe dementia	Needs help toileting
6d	Moderately severe dementia	Urinary incontinence
6e	Moderately severe dementia	Fecal incontinence
7a	Severe dementia	Speaks 5 to 6 words during day
7b	Severe dementia	Speaks only 1 word clearly
7c	Severe dementia	Can no longer walk

7d	Severe dementia	Can no longer sit up
7e	Severe dementia	Can no longer smile
7f	Severe dementia	Can no longer hold up head

Coding Implications
The following codes are for informational purposes only. They are current at time of review of this policy. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

HCPCS Codes	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care, per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long-term care, room and board only; per diem
G0337	Hospice evaluation and counseling services, pre-election

Revenue Code	Description
0651	Hospice routine home care; per diem
0652	Hospice continuous home care, per 15 minutes
0655	Hospice inpatient respite care, per diem
0656	Hospice general inpatient, non-respite care, per diem
0658*	Hospice room and board, nursing facility
0657*	Hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657.
0659	Service Intensity Add-On (SIA)

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Policy created.	12/22	4/3/23	
Annual review. References reviewed and updated. Reviewed by internal specialist. HCPCS table added. Changed member to member/enrollee.	08/23	10/30/23	
Annual Review. Added to Description. Reformatted and adjusted numbering throughout. Updated sections under	08/24	10/23/24	11/22/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Initial requests. Added "The documentation also includes a hospice election statement signed by the member/enrollee or the member/enrollee's healthcare proxy stating they understand the nature of hospice care." Under I.A.(1). Removed determining terminal illness and added section II. Severity of Illness for guidance. Added section III. Intensity of level of care. Added IV. Not Medically Necessary Services. Added section I. and II. under subsequent requests. References reviewed and updated. Reviewed by external specialist.			
Annual review. Certification verbiage updated for clarification. References reviewed and updated.	08/25	11/17/25	12/18/25
Annual review. Description updated for clarity. Under the Policy Initial Request section, updated Criteria section II. to state the member/enrollee meets one of the disease specific guidelines or decline in clinical status criteria, Criteria section II.E. updated from "Dementia" to "Dementia due to Alzheimer's Disease and Related Disorders," Criteria section II.K. updated from "Non-Disease Specific Decline in Clinical Status" to "Decline in Clinical Status," and added Criteria section V. for Recertification of Hospice Services. Verbiage and formatting updated in Criteria I.A. for clarity. Added Criteria I.B. for plan of care (POC) requirements. Added Louisiana Medicaid requirements for the BHSF Form Hospice-CTI, including initial certification signature requirements, BHSF Form Hospice-NOE, corroborating referral documentation, physician orders, Minimum Data Set documentation, and documentation supporting hospice appropriateness. Updated title of Criteria II. from "Severity of Illness" to "Disease Specific Guidelines." Minor rewording and formatting to Criteria II.A.3.a. and II.A.3.b. for clarity. Expanded Criteria II.B.3.b. to include specific examples of critical nutritional impairment related to rapid progression of amyotrophic lateral sclerosis (ALS). Added clarifying language to Criteria II.B.3.c. and specified recurrent aspiration pneumonia and added recurrent fever after antibiotic therapy as examples of rapid progression of ALS with other life-threatening complications. Added note regarding rapid progression of ALS after Criteria II.B.3.c. Updated verbiage and formatting in Criteria II.C.3.a. and added criteria that member/enrollee is not a candidate for a surgical procedure or declines a procedure. Removed criteria for coronary artery disease under Criteria II.C.3. Updated Criteria II.D.3.a. to specify disabling dyspnea. Added	07/26	10/9/26	11/8/26

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
additional examples of fatigue and cough to Criteria II.D.3.b. for diminished functional capacity for pulmonary disease. Updated verbiage and formatting in Criteria II.D.4. for clarity, removed specific number of emergency room visits and hospitalizations and their specific time frames, and removed criteria that member/enrollee states they do not want to be intubated. Reformatted and expanded Criteria II.D.5. to include hypoxemia at rest on room air and to include oxygen saturation measured by non-arterial methods. Updated title of Criteria II.E. from "Dementia" to "Dementia due to Alzheimer's Disease and Related Disorders." Updated Criteria II.E.2.f. from weight loss > 10% to weight loss of at least 10%. Removed "refractory" from Criteria II.F.3.g. regarding cryptosporidium infection. Excluded the corporate requirement that the member/enrollee is not seeking a renal transplant under Criteria II.H.3. because this requirement is not included in Louisiana Medicaid hospice requirements. Added clarifying language in Criteria II.H.3.a. Added Note at the end of Criteria II.H.3.b. stating that member/enrollee may still qualify for hospice if receiving dialysis for a condition not related to the terminal illness. Updated Karnofsky performance status (KPS) from < 40 to ≤ 40 under Criteria II.I.1. for stroke. Updated Criteria II.I.2.c. to specify recurrent pulmonary aspiration unresponsive to speech-language pathology intervention. Updated title of Criteria II.K. from "Non-Disease Specific Decline in Clinical Status" to "Decline in Clinical Status." Added decreasing cholesterol as an additional example of worsening clinical status in Criteria II.K.2.d.i. Added venous, arterial or lymphatic obstruction due to local progression or metastatic disease, and weakness as additional examples of worsening signs in Criteria II.K.2.d.ii. Added clarifying language to examples of worsening symptoms in Criteria II.K.2.d.iii. and expanded nausea example to include nausea or vomiting that is poorly responsive to treatment. Updated Criteria II.K.2.d.iv. to specify when laboratory results are available and added calcium laboratory result. Added Criteria II.K.2.f. for progressive decline in FAST for dementia not related to Alzheimer's disease. Under Criteria III.B. for continuous hospice home care, removed requirement that the 24-hour time period begins and ends at midnight, removed "up to five days of continuous home hospice care may be approved," and added "continuous home care is only furnished during brief periods of crisis." Under Criteria III.D.2. for general inpatient, short-term (non-respite) hospice care, specified that			

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
the treatment plan is not intended for curative treatment of the terminal illness. Reformatted Criteria IV.E. and added a Note at the end of the criteria to expand on hospice discharge guidelines and when a new certification period is required. Reformatted Criteria V. and updated title from "Subsequent Requests" to "Recertification of Hospice Services." Added Criteria V.A.1. regarding requests for recertification within 180 days of beginning hospice services and submission of a renewed certification of terminal illness. Added Criteria V.A.2. regarding requests for recertification beyond 180 days of hospice services, Criteria V.A.2.a. for submission of a renewed certification of terminal illness, and Criteria V.A.2.b. regarding documentation of a face-to-face encounter with the member/enrollee. Added a Note regarding members/enrollees who stabilize or improve and regarding submission of the current hospice POC when requesting recertification. Added Criteria V.B. for Louisiana Medicaid documentation requirements applicable to subsequent benefit periods, including updated BHSF Form Hospice-CTI, face-to-face encounter documentation, plan of care, physician orders, medication and laboratory information, clinical progress notes, updated clinical assessment scales, and documentation demonstrating continued terminal prognosis and decline. Removed requirement that the 24-hour time period begins and ends at midnight under Definition B. for continuous hospice home care. Retained the Louisiana Medicaid inpatient hospice cap as an administrative note. Updated Service Intensity Add-On language to clarify Revenue Code 0659 and routine home care Revenue Code 0651. Appendix A: Palliative Performance Scale (PPS) revised to update the PPS 10% level of consciousness from "drowsy or coma" to "full or drowsy +/- confusion." Coding and descriptions reviewed. References reviewed and updated. Reviewed by internal specialists. Reviewed by external specialist.			

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by the LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the LHCC has no control or right of control. Providers are not agents or employees of the Health Plan.

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