Clinical Policy: Hospice Services

Reference Number: LA.CP.MP.54c
Last Review Date: 12/22

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 a multidisciplinary 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. This policy describes the medical necessity criteria for hospice services.

Policy

Initial Request

It is the policy of Louisiana Healthcare Connections that initial hospice benefit period (90 days) is considered **medically necessary** when *sections I and II are met:*

I. Terminal illness with a life expectancy of six months of less (refer to *Determining Terminal Illness Status* section of this guideline), and

II. All the following documentation must be submitted:

a. BHSF FORM HOSPICE-CTI (Certification of Terminal Illness)
   i. Written certification must identify the terminal illness diagnosis that prompted the member to seek hospice care, includes a statement that the member's life expectancy is six months or less if the terminal diagnosis runs its normal course
   ii. Details specific clinical findings supporting a life expectancy of 6 months or less

b. BHSF FORM HOSPICE-NOE (Notice of Election/Revocation/Discharge/Transfer)
   i. An election statement for hospice care must be filed by the member or by a person authorized by law to consent to medical treatment for the member and they understand the nature of hospice care.

c. Plan of Care (POC) include the following:
   i. Corroborating referral documentation (progress notes from hospital, home health, physician's office, etc.)
   ii. Physician orders for plan of care (POC); and
   iii. Include Minimum Data Set (MDS) form (original and current) if beneficiary is in a facility; weight chart; laboratory tests; physician and nursing progress notes. The MDS form (original and current) is not required if the beneficiary has been in a long-term care facility less than 30 days. The MDS form must be provided upon the subsequent request for continuation of hospice services.

d. Documentation to support beneficiary's hospice appropriateness include the following
   i. Paint picture of beneficiary's condition
   ii. Illustrate why beneficiary is considered terminal and not chronic

iii. Explain why his/her diagnosis has created a terminal prognosis; and
iv. Show how the body systems are in a terminal condition.
v. A cover letter attached to the required information will not suffice for supporting documentation. The supporting information must be documented within the clinical record with appropriate dates and signatures.

Second and Subsequent Period Request
It is the policy of Louisiana Healthcare Connections that the following information will be required for medical necessity review for the *second period, and each subsequent benefit period* request for hospice services are considered **medically necessary** when *sections I and II are met*:

I. Member's condition (terminal illness with a life expectancy of six months of less) continues to decline and
II. All the following documentation must be submitted:
a. MDS forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the beneficiary resides in a nursing facility
b. An updated Hospice CTI form (BHSF Form Hospice-CTI) and a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary group (IDG) for the third and subsequent requested PA periods
c. An updated POC
d. Updated physician's orders
e. List of current medications (within last 60 days)
f. Current laboratory/test results (within last 60 days if available)
g. Description of hospice diagnosis
h. Description of changes in diagnoses
i. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain)
j. A social evaluation
k. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST)
l. 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.

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.

Determining Terminal Illness Status
The following may be documented in the member's medical record as indication of decline in clinical status (not all inclusive):

- Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results
  - Clinical Status of Terminal Illness
    - Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
    - Decreasing serum albumin
    - Dysphagia leading to recurrent aspiration or inadequate oral intake documented by decreasing food consumption
    - Recurrent or intractable infections (e.g., pneumonia, sepsis, upper urinary tract)
    - Weight loss as evidenced by a decreasing BMI, not due to reversible causes such as depression or use of diuretics.
  - Symptoms of Terminal Illness
    - Anorexia
    - Cachexia
    - Cough (intractable)
    - Diarrhea (intractable)
    - Dyspnea
    - Nausea and vomiting, unresponsive to medical treatment
    - Pain requiring increasing doses of analgesics
    - Shortness of breath.
  - Signs of Terminal Illness
    - Ascites
    - Change in level of consciousness
    - Decline in systolic blood pressure below 90 or progressive hypotension
    - Edema
    - Pleural/pericardial effusion
    - Venous, arterial or lymphatic obstruction
- Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease
- Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis
- Progressive decline in Functional Assessment Staging (FAST) for dementia (from ≥7A on the FAST)
- Progression to dependence on assistance with additional activities of daily living
- Progressive stage 3-4 pressure ulcers in spite of optimal care
- The following are examples (not all inclusive) of medical conditions that may be considered for hospice care when ALL of the hospice care criteria are met:
  - Acquired immune deficiency syndrome (AIDS)
  - Alzheimer's disease
  - Amyotrophic lateral sclerosis
  - End-stage adult failure to thrive

- Metastatic or aggressive cancer, when curative therapy is not in the plan-of-care
- End-stage heart disease (e.g., congestive heart failure)
- End-stage liver disease (e.g., cirrhosis)
- Parkinson's disease
- End-stage pulmonary disease (e.g., chronic obstructive pulmonary disease (COPD))
- End-stage renal disease (e.g., acute or chronic renal failure) when dialysis is not in the plan of care
- End-stage stroke/cerebrovascular accident (CVA).

Levels of Care

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 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 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 8 hours of nursing care in a 24-hour period, which begins and ends at midnight; 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, or hospital for no more than 5 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 for the election of 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 inpatient hospice facility, or hospital. 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 659)
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 (HR651) 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.

Certification Periods
Hospice services are covered based on periods and requires prior authorization (PA). PA requests must be submitted within 10 calendar days of the hospice election date. A member may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; and
- Subsequent periods of 60 days each.

The periods of care are available in the order listed and may be used consecutively or at different times during the member's life span.

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 (e.g. dietary)
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., spiritual, bereavement)
H. Short-term inpatient care and Inpatient Respite 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[7] 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. Hospice services are provided under a plan of care designed by the multidisciplinary 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 enteral 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)

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 normal job/work Significant disease	Full	Normal or reduced	Full

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
60%	Reduced	Unable hobby/housework Significant disease	Occasional assistance needed	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	Full or drowsy +/- confusion
0%	Death				

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

Activity Level	Score	Detailed Activity Level
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; 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 5-6 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.

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
Policy created.	12/22	4/3/23

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20. LDH Hospice Provider Manual

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 Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.