Medical Necessity Guidelines: Hospice Services

Effective: October 10, 2018


Applies to:
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409
☒ Tufts Health Public Plans products
☐ Tufts Health Direct – Health Connector; Fax: 888.415.9055
☐ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055
☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Hospice care involves a team-oriented approach to specialized medical, psychological, and spiritual care and support provided to individuals facing a life-limiting illness or injury and his or her loved ones. This specialized care focuses on caring, not curing, and on managing pain and other symptoms of illness so patients can remain as comfortable as possible near the end of life. In most cases, care is provided in the person’s home, but can also be provided in free-standing hospice centers, hospitals, nursing homes, and other long-term care facilities. The hospice team usually includes doctors, nurses, home health aides, social workers, clergy or other counselors, and trained volunteers. The team may also include speech, physical and occupational therapists, if needed. Hospice care is very individualized; the hospice team will work with the patient on his or her goals for end-of-life care, not a predetermined plan.

COVERAGE GUIDELINES
To be eligible for hospice services, a Member must be diagnosed as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that his or her life expectancy is 6 months or less if the illness runs its normal course.

A terminally ill member is covered without prior authorization for the initial hospice assessment/evaluation visit. Continued hospice care services do require prior authorization. To request prior authorization for ongoing visits, the Tufts Health Plan provider must:

- Complete an initial evaluation visit (provider order is required)
- Document the results of the initial evaluation including individualized member goals and the plan of care on a Universal Health Plan Home Assessment (UHHA) Form. All fields must be thoroughly completed.
- Include the level of hospice care being requested and the start of care date (i.e., the date of initial evaluation)
- Fax a legible UHHA form to the Tufts Health Plan Precertification Operations Department at the appropriate number listed above within 2 business days of the initial evaluation visit.
- Provide a copy of the written Interdisciplinary Plan of Care.

In order for hospice services to be covered, ALL of the following requirements must be met:

- The Member elects hospice care
- The services are reasonable and necessary for the management and palliation of the terminal illness and related conditions
- A plan of care must be established and periodically reviewed by the attending physician, the hospice medical director, and the interdisciplinary care team of the hospice program
- The plan of care must be established before hospice care is provided
- All services provided must be consistent with the plan of care
Subsequent Requests/Ongoing Hospice Care
For ongoing requests beyond the initial coverage period, documentation must be submitted on the UHHA with the following information:

- Documentation of the member’s current clinical status (to include the most current clinical notes), functional status, and the current Interdisciplinary Plan of Care
- The current level of hospice care being requested

Hospice services may be authorized for two 90-day periods and an unlimited number of 60-day periods if the above guidelines outlined above continue to be met.

Inpatient Care
In addition to basic hospice services, short-term inpatient care may be provided in a hospice inpatient unit, general inpatient hospital, or a nursing facility. Two levels of inpatient care are covered in the following limited circumstances and must conform to the written plan of care:

- General inpatient care – if it is documented that the physician and hospice interdisciplinary team believe the member needs pain control or symptom management that cannot feasibly be provided in other settings, and the member requires frequent skilled nursing care intervention on all three shifts directed toward pain control and symptom management
- Respite care – up to 5 consecutive days at a time may also be furnished to provide respite for the Member’s family or other persons caring for the individual in their home

Continuous Care
Continuous home hospice care consists primarily of nursing care on a continuous basis in the home. Home health aide (HHA) services may also be provided on a continuous basis at home. Continuous home care may be authorized on a limited basis when ALL of the following are met:

- The member is experiencing a period of crisis and the continuous care is necessary to maintain the Member at home. A member is considered to be in a period of crisis if he or she requires continuous care, which is predominantly nursing care, in order to manage acute medical symptoms or to achieve palliation.
- A minimum of 8 hours of nursing and HHA care is required in a 24-hour period, which begins and ends at midnight (care hours do not need to be continuous).
- More than 50% of the continuous hours must be nursing care provided by either an R.N. or L.P.N.

Note: When fewer than 8 hours of nursing and HHA care are required, the care is covered as routine hospice care in the home. Requests for changes in level of hospice care provided (e.g., for inpatient care or continuous care) must be submitted to the Tufts Health Plan Precertification Operations Department at the appropriate fax number listed above.

Refer to the Authorization Policy as well as the Authorizations chapter of the Commercial Provider Manual for specific authorization and notification requirements. Information on authorization and notification requirements is also available in the appropriate payment policies; these policies are available in the Provider Resource Center on the Tufts Health Plan web site

LIMITATIONS
- Respite care may be authorized for no more than five consecutive days at a time.
- Respite care may not be authorized for Members who reside in a facility.
- General inpatient care days are not covered in situations where the sole reason for the inpatient stay is that the Member’s caregiver support has broken down, without the guidelines for general inpatient care outlined above being met.
- Authorization for services and subsequent payment are based on the member's benefit plan document. Refer to the Electronic Services section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our website or by contacting Provider Services.
The following CPT and revenue code(s) require prior authorization:

### Table 1: CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>S9126</td>
<td>Hospice care in the home, per diem (routine hospice care)</td>
</tr>
<tr>
<td>S9122</td>
<td>Home health aide or certified nurse assistant, providing care in the home; per hour (continuous care)</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home; by registered nurse, per hour (continuous care)</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home; by licensed practical nurse, per hour (continuous care)</td>
</tr>
<tr>
<td>S9125</td>
<td>Respite care in the home, per diem</td>
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### Table 2: Revenue Codes

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0655</td>
<td>Inpatient respite care</td>
</tr>
<tr>
<td>0656</td>
<td>General inpatient care</td>
</tr>
</tbody>
</table>

### REFERENCES


### APPROVAL HISTORY


Subsequent endorsement date(s) and changes made:
- October 10, 2018: Reviewed by IMPAC, renewed without changes

### BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member’s benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink™ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.
Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.