Medical Necessity Guidelines: Hospice Services

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☐ No ☒**

Applies to:

COMMERCIAL Products

☒Tufts Health Plan Commercial products; Fax: 617.972.9409

☒Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products

☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☐Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☐Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

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.

CLINICAL COVERAGE CRITERIA

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.

Routine Hospice Care

Tufts Health Plan may provide coverage for hospice services in the Member's home or residence when all the following criteria are met:

- The PCP or attending practitioner determines such care is reasonable and medically necessary for a terminally ill member and certifies that life expectancy is 6 months or less.
- There is an initial hospice evaluation that includes an individualized assessment with member goals and multidisciplinary plan of care.
- The Member elects hospice care
- For home-based hospice services, there must be a caregiver in the Member's home who is willing and capable of assisting the Member
- The services are reasonable and necessary for the management and palliation of the terminal illness and related conditions
- The 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
- Services are provided by an appropriate, Medicare Certified Hospice Provider.

Ongoing Hospice Care
For ongoing routine hospice services beyond initial 90-day period to be covered the following requirements must be met:

- The Member continues to elect hospice care
- The Member continues to meet the criteria for hospice services
- The services continue to be reasonable and necessary for the management and palliation of the terminal illness and related conditions
- The established plan of care is periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program
- The care provided is consistent with the plan of care.
- Coverage for hospice services may be provided 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
Short-term inpatient care may be provided in a hospice inpatient unit, general inpatient hospital, or a nursing facility when all of the above criteria for Routine Hospice Care are met as well as the following criteria:

- For General Inpatient Care – if it conforms to the written plan of care and 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.

- For Respite Care – if it conforms to the written plan of care, may also be furnished to provide respite for the Member's family or other persons caring for the individual in their home up to 5 consecutive days.

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. Coverage of continuous home care may be provided 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.

LIMITATIONS

- Coverage 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.
- Respite care may be covered for no more than five consecutive days at a time.
- Coverage for respite care may not be provided for Members who are receiving hospice care in or 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.

CODES

The following CPT and revenue code(s) are associated with hospice services:

Table 1: CPT Codes

CPT Code	Description
S9126	Hospice care in the home, per diem (routine hospice care)
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour (continuous care)
S9123	Nursing care, in the home; by registered nurse, per hour (continuous care)
S9124	Nursing care, in the home; by licensed practical nurse, per hour (continuous care)
S9125	Respite care in the home, per diem

Table 2: Revenue Codes

Revenue Code	Description
0655	Inpatient respite care
0656	General inpatient care

REFERENCES

1. National Hospice and Palliative Care Organization, caringinfo.org. Accessed October 4, 2016.
2. United States Department of Health and Human Services, National Cancer Institute at the National Institutes of Health, cancer.gov/about-cancer/advanced-cancer/care-choices. Accessed October 3, 2016.
3. Centers for Medicare and Medicaid Services, Internet-Only Manuals, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf. Accessed September 30, 2016.
4. United States Department of Health and Human Services, National Cancer Institute at the National Institutes of Health, cancer.gov/about-cancer/advanced-cancer/care-choices#HC. Accessed March 24, 2020.
5. Centers for Medicare and Medicaid Services, Internet-Only Manuals, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf. Accessed March 24, 2020.

APPROVAL HISTORY

June 14, 2017: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), for effective date of October 1, 2017.

Subsequent endorsement date(s) and changes made:

- July 2017: Added RITogether Plan product to template.
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- March 27, 2020, reviewed. Effective March 30, 2020 per Clinical Decision Making and Execution Team Prior Authorization removed related in response to COVID 19 considerations
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- December 4, 2020: Fax number for Unify updated

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 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.

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.

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.