Hospice Services Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

The following payment policy applies to Tufts Health Plan contracting hospice providers who render hospice services and pre-hospice election professional services. For Senior Products, click here. For Tufts Health Public Plans, click here.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary hospice services for members who have been diagnosed as terminally ill, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Commercial Provider Services.

The following levels of care may be provided when clinical coverage criteria outlined in the Hospice Services Medical Necessity Guidelines are met:

- Routine hospice care provided in the member's home/residence
- Continuous home hospice care (provided in lieu of routine hospice care)
- Home respite care (provided in lieu of other home hospice services)
- Short-term inpatient care provided in a hospice inpatient unit, general inpatient hospital or skilled nursing facility

Note: The hospice provider is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

Initial Assessment/Evaluation

The initial pre-election hospice evaluation visit requires a provider order.

Post-Evaluation Care

Prior authorization is required for post-evaluation care and continuation of hospice services. Requests for continued hospice services are the responsibility of the hospice provider. If services are requested after hours, verification and authorization must be obtained on the next business day.

To request prior authorization for hospice care after the initial evaluation, the provider must fax a completed Universal Health Plan Home Assessment (UHHA) Form to the Precertification Operations

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

Department at 617.972.9409 **within two business days** of the initial evaluation and include a copy of the written interdisciplinary plan of care.

Subsequent/Ongoing Visits
For ongoing requests beyond the initial coverage period, the provider must fax the completed UHHA form at least **two business days** prior to the coverage period end date (or before the last visit, whichever is sooner) to prevent a gap in coverage. Documentation must include the most current clinical notes, interdisciplinary plan of care, and the level of hospice care being requested.

Note: UHHA forms that are not filled out completely (e.g., omission of defined medical goals and plan of care) will be rejected for lack of information. In rare circumstances, providers may be asked to provide the information in a shorter timeframe than those specified above. Tufts Health Plan reserves the right to deny provider requests when the provider fails to submit the required clinical information.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Refer to the Hospice Services Medical Necessity Guidelines for a list of codes that may be billed for hospice services.

- G0337 (pre-election hospice evaluation) should be submitted to Tufts Health Plan
- Claims submitted for services during hospice election must be submitted separately from claims submitted when the member is not on hospice

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

ADDITIONAL RESOURCES

- Home Health Care Payment Policy
- Skilled Nursing Facility Payment Policy

DOCUMENT HISTORY

- December 2020: Policy reviewed by committee; clarified authorization requirements, billing instructions, and compensation/reimbursement information; added reference to Hospice Services Medical Necessity Guidelines
- June 2018: Template updates
- March 2018: Template updates
- September 2017: Policy reviewed by committee; clarified authorization requirements for hospice services
- July 2017: Clarified levels of care effective for dates of service on or after October 1, 2017
- January 2017: Template updates
- September 2015: Template conversion, template updates
- June 2015: Policy reviewed, no content changes. Removed references to the CareLink Prior Authorization list, template updates
- April 2015: Template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the

provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.