Clinical Policy: Hospice Services
Reference Number: WA.CP.MP.54
Last Review Date: 06/19

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

Description
Medical necessity criteria for hospice services. Palliative care is not Hospice. Pediatric Palliative Care, including curative medically necessary services, may be offered at the same time as hospice services to members age 20 and younger and is not addressed in this policy.

Policy/Criteria
Initial Request
It is the policy of Coordinated Care of Washington, Inc., that hospice is considered medically necessary when the requirements in Criteria sections I, and II are met. Medical necessity evaluation does not exclude an individual who has been previously treated with an investigational product so long as the individual is no longer being treated with that investigational product.

I. The Required Documentation has been submitted, and
II. The requested intensity of service is appropriate
   A. Routine Hospice Home Care, or
   B. Continuous Hospice Home Care, or
   C. Inpatient Respite Hospice Care, or
   D. General Inpatient, Short Term (non-respite) Hospice Care

III. Not Medically Necessary Services

Criteria
I. Required Documentation
   A. Documentation of hospice medical director certification of hospice appropriateness for the initial 90 day certification period.
      1. The written certification identifies 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, details specific clinical findings supporting a life expectancy of 6 months or less; and
      2. The documentation also includes a hospice election statement signed by the member or the member’s healthcare proxy stating they understand the nature of hospice care.

II. 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. The appropriate HCPCS or revenue (rev) code must be billed according to applicable contract provisions.
A. *Routine Hospice Home Care* (rev code 0651)
Routine hospice home care is medically necessary when < 8 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* (rev code 0652)
Continuous hospice home care is medically necessary to maintain the member at home, when the member requires ≥ 8 hours of nursing care in a 24 hour period (begins and ends at midnight). Up to 5 days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested.

C. *Inpatient Respite Hospice Care* (rev code 0655)
Respite hospice care is medically necessary to relieve family members or other primary caregivers of care duties for no more than 6 consecutive days in a 30 day period. Respite care is short term inpatient care, and not residential or custodial care. Up to 6 days of inpatient respite care may be approved per 30-day period.

D. *General Inpatient, Short Term (non-respite) Hospice Care* (rev 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's care team; and
2. The individual treatment plan is specifically directed at acute symptom management and/or pain control.
Up to 5 days of general inpatient, short term care may be approved with ongoing concurrent review for additional days requested.

III. *Not Medically Necessary Services*
Hospice services are considered NOT medically necessary under the following circumstances:

A. Members with any of the following as the primary diagnosis:
1. Debility or unspecified debility, or
2. Failure to thrive; or
B. The member is no longer considered terminally ill as evidenced by a review of the medical documentation; or
C. Services, supplies or procedures that are directed towards curing the terminal condition, with the exception of children under the age of 21, or
D. Member chooses to revoke the hospice election by submitting a signed, written statement with the effective date of the revocation; or
E. Member is discharged from hospice services; i.e. member is no longer considered terminally ill, member refuses services or is uncooperative, moves out of the area, or transfers to a non-covered hospice program. In the event a member is discharged from hospice, benefit coverage would be available as long as the member remained eligible for coverage of medical services.
Subsequent Requests
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. The appropriate codes must be billed according to applicable contract provisions.

It is the policy of Coordinated Care of Washington, Inc., that subsequent requests for hospice are medically necessary when meeting one of the following:

I. Request for continuation of routine home care for subsequent recertification period
Continuation of home care for subsequent recertification periods is medically necessary for additional 90 day periods following submission of a renewed hospice medical director certification of terminal illness.

II. Change to a higher intensity of service from routine hospice, one of the following:
   A. Continuous Hospice Home Care (rev code 0652)
      Continuous hospice home care is medically necessary to maintain the member at home, when the member requires ≥ 8 hours of nursing care in a 24 hour period (begins and ends at midnight). Up to 5 days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested.

   B. Inpatient Respite Hospice Care (rev code 0655)
      Respite hospice care is medically necessary to relieve family members or other primary caregivers of care duties for no more than 6 consecutive days per 30-day period. Respite care is short term inpatient care, and not residential or custodial care. Up to 6 days of inpatient respite care may be approved per 30-day period.

   C. General Inpatient, Short Term (non-respite) Hospice Care (rev code 0656), meets both:
      1. 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 care team; and
      2. The treatment plan is specifically directed at acute symptom management and/or pain control.
      Up to 5 days of general inpatient, short term care may be approved with ongoing concurrent review for additional days requested.

III. 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.

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’s home and is related to the terminal diagnosis and plan of care written for the member. 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. It can be provided only during a period of acute medical crisis or the sudden loss of a caregiver who was providing skilled nursing care, and only as necessary to maintain the client 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 placement in another setting and cannot be provided in a nursing facility, hospice care center or hospital. 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 6 consecutive days per 30-day period. It is allowed to relieve family members or other primary caregivers of the primary caregiving duties. A primary caregiver is an individual, designated by the member, who is responsible for the 24 hour care and support of the member 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 is safe at home alone at the time of the election. Inpatient Respite Hospice Care can be provided in an approved inpatient hospice facility, hospital or nursing home.

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 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. General Inpatient, Short Term, Hospice Care can be provided in an approved inpatient hospice facility, hospital or nursing home.

**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 revokes, or the hospice provider discharges or does not recertify.
Discontinuation of Hospice
If a member revokes or is discharged from hospice care, the remaining days in the benefit period are lost. If/when the member 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, enteral/parenteral supplies for a pre-existing diagnosis requiring enteral/parenteral support may be billed separately)
J. Consumable medical supplies (e.g., bandages, catheters) used by the hospice team.
K. Interpreter services

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 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
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
The hospice provider is responsible for:

A. Verifying member 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’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
Hospice is a coordinated, integrated program developed by a multidisciplinary team of professionals to provide end-of-life care, which is primarily focused on relieving pain and symptoms specifically related to the terminally ill diagnosis of members with a life expectancy
of six months or less. 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’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 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.

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.

<table>
<thead>
<tr>
<th>HCPCS Codes &amp; Modifiers</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0155</td>
<td>Services of Social Worker in hospice setting, each 15 minutes (service intensity add-on)</td>
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<tr>
<td>G0299</td>
<td>Direct skilled nursing services of an RN in a hospice setting, each 15 minutes (service intensity add-on)</td>
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<tr>
<td>Q5001</td>
<td>Hospice care provided in client’s home/residence</td>
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<tr>
<td>Q5002</td>
<td>Hospice care provided in assisted living facility</td>
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<tr>
<td>Q5003</td>
<td>Hospice care provided in non-skilled nursing facility</td>
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<tr>
<td>Q5010</td>
<td>Hospice home care provided in a hospice facility</td>
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<tr>
<td>-TG</td>
<td>Complex/high tech level of care (for RHC days 1-60)</td>
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<tr>
<td>-TF</td>
<td>Intermediate level of care (for RHC days 61+)</td>
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<tr>
<th>Revenue Code</th>
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<tr>
<td>0115</td>
<td>Hospice, room and board, private (nursing facility)</td>
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<tr>
<td>0125</td>
<td>Hospice, room and board, semi-private (nursing facility)</td>
</tr>
<tr>
<td>0135</td>
<td>Hospice, room and board, 3-4 beds (nursing facility)</td>
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<tr>
<td>0145</td>
<td>Hospice Care Center, room and board</td>
</tr>
<tr>
<td>0551</td>
<td>Skilled Nursing Visit (service intensity add-on)</td>
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<tr>
<td>0561</td>
<td>Medical Social Service Visit (service intensity add-on)</td>
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<tr>
<td>0651</td>
<td>Hospice routine home care; per diem</td>
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<tr>
<td>0652</td>
<td>Hospice continuous home care, per 15 minutes</td>
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<tr>
<td>0655</td>
<td>Hospice inpatient respite care, per diem</td>
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<tr>
<td>Revenue Code</td>
<td>Description</td>
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<tr>
<td>0656</td>
<td>Hospice general inpatient, non-respite care, per diem</td>
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### Reviews, Revisions, and Approvals

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<tr>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>Policy adopted. Previously WA.UM.21</td>
<td>06/19</td>
<td>06/19</td>
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<tr>
<td>Added Investigational Services clarification</td>
<td>07/19</td>
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### References


**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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.
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Note: For Medicaid members, 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.

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